



# Prescribing Guidelines for Pennsylvania



## Treatment of Pain in an Emergent Setting

**O**pioids, including heroin and fentanyl, contribute to thousands of overdose deaths in Pennsylvania and the nation. Emergency providers across Pennsylvania are facing one of the greatest public health crises of our time, as both prescription and illicit opioids have become a leading cause of death. Research has shown that opioid prescriptions for the treatment of acute pain can lead to long-term opioid use\*, therefore, providing

safeguards on acute prescribing from an emergent setting is of paramount importance.

One of the top reasons patients visit the emergency department is for pain management. In response to this epidemic, there has been a call for more judicious opioid prescribing by all healthcare providers. A recent study by Shah et al.<sup>7</sup> found that chronic opioid use increased with each additional day of medication prescribed. Since September 2016, prescriptions for



opioids have dropped 20 percent<sup>+</sup>. While progress is being made in curbing unnecessary prescriptions for pain management, there is more education and awareness needed.

The original guideline on Emergency Department pain treatment was published in 2014. This update reflects changes in best practices that have been developed since the publication of the original guidelines.

The purpose of this guideline is to present a balanced approach to analgesic therapy and to identify opioid alternatives for first line treatment; reserving opioid therapy for patients with severe acute pain. These guidelines are intended to identify and appropriately refer patients with opioid use disorder into evidence-based treatment with medication assisted therapy (buprenorphine-naloxone, methadone or injectable naltrexone) or referral for evaluation of detoxification and abstinence-based therapy. “Providers,” (for the purposes of this guideline) include physicians and other healthcare providers who care for patients in an acute or emergent setting including but not limited to emergency departments, fast-track emergency departments, and urgent care centers.

When considering therapy, providers should be aware of current and historical disparities in pain treatment for racial and ethnic minorities and female patients. Providers should also be aware of implicit biases that can lead to unintentional differences in how some patients are treated. To overcome these challenges, providers should use consistent and standardized approaches to treatment including Prescription Drug Monitoring Program (PDMP) queries and prescribing choices for all patients, regardless of gender, race or ethnic background.

The included guidelines address prescribing opioid pain medication once a patient is discharged from an emergent or acute setting. They are intended to help providers improve patient outcomes and to supplement, but not replace, the individual provider’s

clinical judgment. It is recommended that providers review other evidence-based guidelines and the Pennsylvania state guidelines on various medical subspecialties and patient populations, pharmacy guidelines, and dental guidelines, which may provide insight into treatment options for these populations.

## EXCLUSIONS

These guidelines exclude the management of opioids for cancer pain, the treatment of pain at the end-of-life, or for pain associated with sickle cell disease. Readers are referred to the NIH National Heart, Lung, and Blood Institute’s Evidence Based Management of Sickle Cell Disease Expert Panel Report.

## PRACTICE RECOMMENDATIONS

Providers should incorporate the following key practices into their care of patients presenting with pain in an emergency setting:

1. Non-opioid options should be considered as first line treatment in every patient presenting with pain and should be included in the analgesic regimen even when opioids are utilized to decrease overall dose and to rapidly transition off opioids when appropriate.
  - a. Non-opioid analgesic options include careful use of acetaminophen, oral and topical non-steroidal anti-inflammatory medications, anti-epileptic medications (such as gabapentin, pregabalin, oxcarbazepine, topiramate and others), tricyclic antidepressants, serotonin-norepinephrine reuptake inhibitors, and transdermal local anesthetics. Non-opioid analgesics confer sustained pain relief that may be as good or better than that associated with opioid administration.
  - b. Physical and other supportive pain treatment modalities, such as short-term rest, ice, elevation, reassurance, music, physical therapy, exercise,





chiropractic treatment, acupuncture, osteopathic manipulative therapy, cognitive-behavioral therapy, and mindful meditation may provide significant symptom control.

2. Opioid analgesics may be appropriate for acute illness or injury associated with moderate to severe pain that has been refractory to opioid alternatives. Opioids should be used in the lowest effective dose for the shortest duration possible, as both dose and duration of therapy are associated with increased risk of harm. Hydrocodone-acetaminophen offers the lowest potency of all commonly available formulations.
  - a. Discharge prescriptions for opioids should not exceed a 7-day supply.
  - b. Long-acting or controlled-release opioids (such as extended-release oxycodone, fentanyl patches, extended-release morphine, and methadone) should not be prescribed from the emergency department.
  - c. Patients should be advised of potential risks of any use of opioids. Expectations for duration and goals of therapy should be clearly set at the time of initial prescription including the increase in risks associated with subsequent opioid prescription refills\*.
3. Patients should be screened to identify increased risk of harm, including history of substance use disorder, especially opioid use disorder, concurrent use of benzodiazepines, and patients at increased risk for respiratory compromise (such as patients with significant pulmonary disease, or those with or at increased risk for sleep disordered breathing).
4. Pennsylvania law requires providers to obtain and review a report from the PDMP before prescribing any controlled substance. According to Pennsylvania law, Emergency Department providers must query the PDMP only prior to prescribing opioids at discharge. However, it is recommended that providers check the PDMP whenever an opioid is being provided to look for prior opioid prescriptions, concomitant benzodiazepine prescriptions or more than four opioid prescriptions from more than four providers.
5. Emergency providers should not replace lost or stolen prescriptions for controlled substances.
6. Emergency providers should not prescribe opioids for patients who report they have run out of pain medications. Opioid refills should be arranged with the primary or specialty prescribing provider.
7. Risk of harm associated with chronic opioid therapy increases significantly with increased prescribed daily dose. Daily doses of greater than 90 Morphine Milligram Equivalents per Day (MME/D) are associated with an increased risk of toxicity and accidental overdose deaths.
8. Chronic opioid therapy should be provided by a provider, who has the clinical expertise to provide appropriate monitoring. Consideration should be given for referral to a specialist as indicated by the patient's clinical needs, who may assist the prescribing physician in proper administration of opioids.
9. Patients at risk for opioid use disorder should be referred for evaluation and treatment. A provider may refer the patient to their insurance carrier or the Department of Drug and Alcohol Programs Get Help Line at 1-800-662-4357 (HELP) or [www.DDAP.PA.GOV](http://www.DDAP.PA.GOV). Emergency department nurses or social workers should provide current information to assist in this process including direct connection to local 'warm handoff' programs when appropriate.





- a. For patients with opioid use disorder and patients who use injection drugs, moderate to severe acute opioid withdrawal (as assessed by a standardized measurement instrument such as the COWS, in accordance with established institutional protocol) should be treated with buprenorphine-naloxone to stabilize symptoms and bridge to outpatient treatment. If the patient is pregnant, mono therapy with buprenorphine should be used instead of buprenorphine-naloxone. Please refer to the Commonwealth's guidelines on Obstetrics & Gynecology.
  - b. Providers do not require a DEA X-waiver to administer buprenorphine treatment to patients experiencing opioid withdrawal in the ED. However, prescribers must have a DEA X-waiver to prescribe these products for home use. If it is not possible to prescribe buprenorphine for outpatient use or if it is medically necessary, the ED provider may elect to have the patient return for a maximum of 72 hours for daily administration of buprenorphine until care can be transferred to an outpatient provider. Take home doses and prescriptions can only be supplied by providers who are specifically licensed.
  - c. Patients may require multiple doses of buprenorphine to obtain adequate symptom control during initial buprenorphine dose titration. While buprenorphine is often administered twice daily, the total daily dose can be safely administered once daily when patients are required to return to the ED to receive this medication.
10. Naloxone should be provided as a take home kit to patients who present to the ED following opioid overdose. Naloxone should also be prescribed to patients at increased risk for respiratory compromise with chronic opioid therapy. This includes patients receiving daily opioid doses above 50 mg / day MEDD, patients also taking benzodiazepines (which is contraindicated) or other centrally-acting sedating medications, patients at risk for or who have been diagnosed with sleep disordered breathing, and those patients with moderate or severe concurrent respiratory disease. In addition, consideration should be given to prescribing naloxone to patients with coexisting psychiatric conditions as well as those patients with a history of any substance use disorder, including tobacco use disorder. Family members of high risk patients should also be offered naloxone.
11. Opioids should be continued only if clinically-meaningful improvements are observed, and the patient is not experiencing unacceptable adverse effects. In most patients, opioids should not be abruptly discontinued, but rather should be slowly tapered. Tapering plans should be individualized and should minimize symptoms of withdrawal. Providers should refer to the CDC's Pocket Guide for Tapering Opioids for Chronic Pain. Rapid discontinuation of opioids should be reserved only for those patients engaged in addiction, diversion, or when continuation of opioids poses risk of harm. Patients may need to be referred to pain or addiction specialty care to facilitate discontinuation of opioid therapy.





## RESOURCES

NIH National Heart, Lung, and Blood Institute's Evidence Based Management of Sickle Cell Disease Expert Panel Report for management of sickle cell disease

+Pennsylvania Department of Health. Prescription Drug Monitoring Program Frequently Asked Questions (FAQs)

~Pennsylvania General Assembly. Safe Emergency Prescribing Act. Act of Nov. 2, 2016, P.L. 976, No. 122.

\*Shah, A., Hayes, C.J., and Martin, B.C. (2017). Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use – United States, 2006-2015.

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