



Pennsylvania Prescription Drug Monitoring Program (PDMP) System User and Stakeholder Training

Opioid Prescribing Guide

MODULE 4

GUIDE DOCUMENT

Pennsylvania Prescription Drug Monitoring Program (PDMP) System User and Stakeholder Training

Learning Objectives for Modules 1-7

Module 1: Why Using the PDMP is Important for Achieving Optimal Health for Pennsylvania Citizens

1. The status of substance use disorder in general, opioid use disorder, and overdoses nationally and in Pennsylvania;
2. Common misconceptions about substance use disorder and opioid use disorder treatment and recovery;
3. Costs associated with prescription drug and heroin-associated opioid use disorder and overdose; and
4. How pervasive prescriber and pharmacist PDMP use can reduce population opioid use disorder and overdose.

Module 2: What is a PDMP, How to Use the PDMP to Make Clinical Decisions, How to Integrate the PDMP into the Clinical Workflow, and How to Access Pennsylvania's PDMP

1. Detail Pennsylvania's requirements and regulations regarding PDMP use;
2. Explore options and actions Pennsylvania prescribers and pharmacists can take to integrate the PDMP into clinical workflows; and
3. Discuss how to use the PDMP system to make clinical decisions.

Module 3: Using the PDMP to Optimize Pain Management

1. Learn how to use the PDMP to address pain management for various patient populations and pain types;
2. Understand the basic nature of pain for different patient populations and how to manage their pain using the PDMP as a clinical tool; and
3. Discuss different ways of treating patient pain that do not involve the immediate use of opioids.

Module 4: Opioid Prescribing Guide

1. Provide guidelines to inform all healthcare providers when prescribing opioids in the acute phase of pain;
2. Instruct healthcare providers on how to prescribe opioids in the chronic phase of pain, which includes information on how to initiate or continue opioid therapy, select the correct dose, and/or discontinue opioids;
3. Instruct healthcare providers on how to assess risks and address harms associated with opioid use;
4. Instruct healthcare providers on the legal responsibilities related to prescribing opioids; and
5. Instruct healthcare providers on how they may direct patients to dispose of unused medications.

Module 5: Referral to Treatment for Substance Use Disorder Related to Opioid Use

1. Define “warm handoffs” and how they can best occur;
2. Provide a schema for how any healthcare provider can implement “warm handoffs” in any clinical setting;
3. Demonstrate how primary care practices can conduct “warm handoffs” by preparing, using validated screening tools, and using patient-centered communication with patients;
4. Demonstrate how healthcare providers can determine the best type of treatment for their patients;
5. Present information on patient confidentiality that providers should be aware of when working with patients with substance use disorders and performing “warm handoffs”; and
6. Present relevant Pennsylvania links for treatment and other resources.

Module 6: Approaches to Addressing Substance Use Disorder with Patients Identified by the PDMP

1. Learn how to integrate the PDMP with other screening tools to help identify those who may require substance use disorder treatment or increased monitoring;
2. Define Screening, Brief Intervention, and Referral to Treatment (SBIRT), its main goals, and its main components;
3. Learn how to screen a patient for a potential substance use disorder, conduct a brief intervention, and refer a patient to treatment;
4. Learn how to discuss a substance use disorder with a patient and handle patient resistance; and
5. Learn how to incorporate SBIRT into clinical practice.

Module 7: Effective Opioid Tapering Practices

1. Discuss how to use the PDMP to determine if a provider should consider tapering his/her patient;
2. Discuss several indicators that prescribers can look for when considering tapering opioids;
3. Inform prescribers on how to discuss tapering with patients using patient-centered techniques;
4. Present a general opioid tapering protocol and how to adapt this protocol to the needs of any patient; and
5. Present information on how to manage withdrawal and how to use tools to measure withdrawal symptoms in patients.

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Introduction

This summary document for prescribers and pharmacists/dispensers discusses opioid prescribing guidelines published by the Pennsylvania Department of Health for acute and chronic pain management in healthcare settings as well as information published by the Centers for Disease Control and Prevention for chronic and acute pain management in all medical practices.¹⁻⁴

It also discusses how the Prescription Drug Monitoring Program (PDMP) should be incorporated into patients' pain management and risk assessments when opioids are being used to manage pain. The PDMP should be used before and throughout therapy as a tool to help assess patient risk, monitor morphine milligram equivalent dose levels, screen for potentially harmful drug-drug interactions, and check for opioid misuse.⁴ It should be incorporated into the guidelines of all prescribers when prescribing opioids for acute and chronic pain in any healthcare setting.

In this module, prescribers will learn how to safely and accurately prescribe opioids throughout the different phases of pain for all patient populations. This module is meant to guide practitioners in healthcare settings and has the following objectives:

1. Provide guidelines to inform all healthcare providers when prescribing opioids in the acute phase of pain;
2. Instruct healthcare providers on how to prescribe opioids in the chronic phase of pain, which includes information on how to initiate or continue opioid therapy, select the correct dose, and/or discontinue opioids;
3. Instruct healthcare providers on how to assess risks and address harms associated with opioid use;
4. Instruct healthcare providers on the legal responsibilities related to prescribing opioids; and
5. Instruct healthcare providers on how they may direct patients to dispose of unused medications.

Prescribing Opioids in the Acute Phase of Pain

The acute phase of pain is considered to be the period of time that immediately follows the episode of pain until six weeks post-episode. The prescriber should reserve opioids for the treatment of acute pain that results from severe injuries or medical conditions, surgical procedures, or when non-opioid alternatives are ineffective at relieving the patient's pain. Prescribers who are concerned with perioperative settings are referred to the American Society of Anesthesiologists' guidelines for acute pain management in perioperative settings.⁵

Clinical Recommendations for Healthcare Providers

These recommendations for prescribing opioids for acute pain are based on the Centers for Disease Control and Prevention guidelines for prescribing opioids:⁴

1. The prescriber should optimize non-opioid pharmacological and nonpharmacological pain management methods before considering opioids (*see Module 3 for information on non-opioid pain management strategies*).
2. If opioids are going to be prescribed, query the PDMP and determine whether the patient is currently prescribed any medications, including opioids or benzodiazepines.
3. For initial prescriptions, prescribe immediate-release opioids instead of extended-release opioids at the lowest effective dose and only for the expected duration of the pain.
4. In most cases of acute pain not related to surgery or trauma, a supply less than or equal to three days is usually sufficient to effectively manage the patient's pain. However, a supply range less than or equal to a seven-day range may also be appropriate on a patient-by-patient basis. If opioids are considered for acute pain for longer than seven-days, a reassessment is suggested prior to another seven-day prescription.
5. Prescribers should re-evaluate a patient who is experiencing severe acute pain that is lasting longer than the expected duration before refilling an opioid prescription. For further recommendations and information related to acute and subacute pain management, prescribers are referred to the Washington Agency Medical Directors' Group Interagency Guidelines on Prescribing Opioids for Pain, Part II: Prescribing Opioids in the Acute and Subacute Phase.⁶



Clinical Recommendations for Dental Prescribers

Dental prescribers often provide acute pain treatment in cases of dental emergencies or as part of routine dental care. If properly trained, dental prescribers may also be involved in the treatment of chronic facial and neuromuscular pain that may require more potent opioids.³ The following are clinical recommendations for prescribing opioids for acute dental pain.^{3,7-9} These recommendations are based on the Pennsylvania guidelines.

1. Before beginning opioid treatment:
 - a. Conduct and document a medical and dental history that includes an update of all current medications, a PDMP query, and a physical examination;
 - b. Talk to all other prescribers, as appropriate, for the patient;
 - c. Conduct the appropriate diagnostic and imaging tests for the patient; and
 - d. Formulate at least a preliminary diagnosis for why the patient is having pain.

Continued ►

Prescribing Opioids in the Acute Phase of Pain *(continued)*

2. Clinicians should administer nonsteroidal anti-inflammatory drugs before administering opioids (unless there are absolute contraindications to nonsteroidal anti-inflammatory drugs), as most cases of dental pain include an inflammatory component. Nonsteroidal anti-inflammatory drugs have been demonstrated to be highly effective in the treatment of dental pain and are often more effective than opioids. Clinicians should consider beginning nonsteroidal anti-inflammatory drugs immediately before dental treatment and continue a scheduled dosage following the procedure.
 - a. Discuss and check the patient's medical history to determine if the patient is currently prescribed any anticoagulants, as nonsteroidal anti-inflammatory drugs can significantly increase the risk of bleeding when combined.
 - b. Use caution if the patient has a history of hepatic or renal impairment or has previously reported reactions to nonsteroidal anti-inflammatory drugs.
 - c. Use optimal dosages of non-opioid medications:
 - i. *Ibuprofen 400-800 mg, acetaminophen 1,000 mg, or a combination;*⁸
 - ii. *Acetaminophen has been shown to be synergistic with nonsteroidal anti-inflammatory drugs, and when combined, have the same efficacy as low-dose opioids.*
3. To avoid the use of opioids to treat acute pain following a procedure, clinicians should consider administering local anesthetics or regional nerve blocks to assist in pain management.
4. If an opioid is to be administered, the prescriber should ensure that the dose and duration of therapy only last for a short period of time.
 - a. Access the PDMP database before prescribing opioids and act in accordance with the current Pennsylvania state laws.
 - b. Document the patient's psychiatric status, substance use history, and assess opioid misuse risk and harm.
 - c. Choose the lowest potency opioid necessary to treat the patient's pain, as long-acting or extended-release opioids are not suggested for acute pain.
 - d. Check medical history and obtain a list of current medications, in order to determine any potential interactions with other prescriptions and assess the risks involved. Some of the risks include:
 - i. *Individuals taking benzodiazepines which interfere with the metabolism of some prescription opioids and increase the risk of adverse events or even death; and*
 - ii. *Individuals with obstructive sleep apnea are at an increased risk for adverse events from opioid-induced respiratory depression.*
5. Monitor the patient's total daily dose of acetaminophen in order to ensure that it does not exceed 3,000 mg/day across all current prescription medications.³
- f. Give specific opioid care instructions to the patient, including proper safekeeping and disposal.
5. Do not prescribe extended-release opioids unless the clinician has training and experience in treating chronic facial or neuromuscular pain.
6. Coordinate pain therapy with other clinicians before treatment if:
 - a. The patient is receiving chronic opioids as shown on his/her PDMP report;
 - b. The patient has a history of substance use disorder; or
 - c. The patient is at a high risk for aberrant drug-related behavior (*see Assessing Risks and Addressing Harms of Opioid Use on page 9*).
7. In general, it is not proper to prescribe opioids without a face-to-face encounter and evaluation with the patient.
 - a. If pain is more severe or lasts longer than expected, reassess the patient before prescribing additional opioids.
 - b. Patients who report unexpected or prolonged pain and do not show ongoing pathology should not be prescribed opioids. The prescriber should consider a specialist referral.
 - c. Proceed with caution if the patient requests opioids, especially if he/she is a new patient.
 - d. Prescribers should refer patients to substance use disorder treatment if there are reasons for concern.

Continued ►

Prescribing Opioids in the Acute Phase of Pain *(continued)*

Clinical Recommendations for Emergency Department Prescribers

Prescribers should obtain a medical history, physical examination, and order appropriate diagnostic testing, as necessary. The American College of Emergency Physicians recommends always checking the PDMP before prescribing or dispensing a controlled substance and stresses how useful the protocol is in the emergency department. The American College of Emergency Physicians also recommends that other guidelines for chronic and acute pain management be followed by physicians and other emergency department prescribers.¹⁰ The following are recommendations for prescribing opioids in the emergency department for healthcare providers.^{1,10-12}

These recommendations are based on the Pennsylvania guidelines.

1. Prescribers should consider non-opioid alternatives for pain management before prescribing opioids, such as nonsteroidal anti-inflammatory drugs, acetaminophen, and topical diclofenac, lidocaine, and capsaicin.
2. Prescribers should search the PDMP database before writing a prescription for opioids and benzodiazepines in accordance with Pennsylvania state laws.
3. Prescribers should only discharge patients with an appropriate amount of opioids, limited to how much is needed until their follow-up appointments, which are usually within seven days.
4. Prescribers should prescribe or dispense the lowest potency opioid necessary to relieve the patient's pain, such as codeine or tramadol.
5. Prescribers should only dispense enough medication for the patient's pain until he/she is able to access a pharmacy. Under Act 122, physicians in hospital emergency departments and urgent care facilities may not prescribe opioids in excess of a seven-day supply. **Exception:** If opioids will be prescribed in an excess of seven days to treat acute pain or pain associated with a cancer diagnosis or palliative care, the physician should document in the patient's medical records that a non-opioid alternative was not appropriate under the circumstances.
6. Prescribers should only prescribe short-acting or immediate-release opioids and avoid prescribing extended-release opioids unless discussed with the patient's outpatient prescriber.
7. Prescribers in the emergency department should not replace lost or stolen prescriptions for controlled substances.
8. Emergency department prescribers should not refill prescriptions for patients who run out of pain medications. Any refills should go through the patients' primary or specialty prescriber.
9. Prescribers should encourage the patient whose behavior raises addiction concerns to seek treatment. Emergency department staff should have referral information on hand to distribute to the patient. The law requires that physicians, nurse practitioners, physician assistants, and urgent care facilities refer individuals to treatment if they are believed to be at risk for a substance use disorder.
10. When a patient is assessed to likely require substance use disorder treatment for opioids, emergency department prescribers should initiate a "warm handoff" to substance use disorder providers, in order to increase the chance the patient will access substance use disorder treatment. For example, an emergency department prescriber could facilitate an introduction between the patient and a behavioral health specialist during discharge.



Prescribing Opioids in the Chronic Phase of Pain

The chronic phase of pain is defined as having pain on a daily basis for more than three months or pain on more days of the week than not for at least six months. These guidelines address adult (≥ 18 years old) pain management using prescription opioids in outpatient settings, or outside of active cancer treatment, palliative care, and end-of-life care.^{2,4,9,13-15} These recommendations are based on the Pennsylvania Medical Society and Centers for Disease Control and Prevention guidelines.

Initiation or Continuation of Opioid Therapy

1. Clinicians should only consider opioid therapy if the expected benefits outweigh the risks. Nonpharmacological and non-opioid therapies are preferred for chronic pain and should be combined with opioids whenever they are prescribed.
2. Before beginning opioid therapy, establish treatment goals with the patient regarding pain and function. Discuss how therapy will be discontinued if benefits do not outweigh risks and if the therapy is not related to a clinically meaningful improvement in pain or function.
 - a. Conduct a thorough medical history and physical examination and obtain a list of the patient's current medications.
 - b. Come to an agreement with the patient on what problem is being treated and the initial diagnosis for the pain complaint.
 - c. Identify the patient's treatment goals using specific and measurable descriptors, ideally in the patient's own words.
 - d. Present the opioids (or any other treatment for pain) as a trial. If opioids do not help achieve the specified goals, they will be discontinued so that other treatments can be implemented.
 - e. Review the risks associated with using opioids in pain management with the patient.
 - f. Acquire a signed patient agreement form (*Appendix I*) with informed consent and a plan of care that is written in a language that the patient can understand.
 - g. Review and potentially implement monitoring practices, such as urine drug tests, prescription refill policies, and the PDMP.
 - h. For the initial prescription, schedule a follow-up visit within two to four weeks to assess the effects of the pain medication.

3. Before and during therapy, clinicians should continue discussing the known risks of opioids and remain a responsible prescriber.

Opioid Selection, Dosage, Duration, Follow-up, and Discontinuation

1. When beginning therapy, prescribe immediate-release opioids instead of extended-release/long-acting opioids. The prescriber should also prescribe the lowest effective dose of the opioid.
 - a. The Centers for Disease Control and Prevention recommends that prescribers should reassess evidence of the benefits to the individual when increasing dosage to ≥ 50 morphine milligram equivalent/day (e.g., ≥ 50 mg hydrocodone; ≥ 33 mg oxycodone) and avoid increasing to ≥ 90 morphine milligram equivalent/day (≥ 90 mg hydrocodone; ≥ 60 mg oxycodone) when possible due to an increased risk of complications.
 - b. Refer to the PDMP to determine current morphine milligram equivalent levels in patients.
 - c. For current information on drug-drug interactions and other product-specific information, visit the [National Institutes of Health website](https://www.nid.nih.gov/).*
2. Evaluate benefits and harms of opioid therapy for chronic pain management within one to four weeks or before increasing the dosage.
 - a. Repeat the same evaluation every three months.
 - b. Optimize other therapies or consider tapering to lower dosages or discontinuing the opioids if benefits do not outweigh the harms.

* <https://dailymed.nlm.nih.gov/dailymed/>

Prescribing Opioids in the Chronic Phase of Pain *(continued)*

Assessing Risks and Addressing Harms of Opioid Use

1. Review the patient's medical history and query the PDMP when starting opioid treatment and throughout therapy whenever a new prescription for an opioid or benzodiazepine is prescribed to the patient.
2. Communicate with the patient's previous prescriber, if the patient is new.
3. Evaluate risk factors periodically and before beginning opioid therapy. Reassess the patient at return visits or as often as necessary.
 - a. Known risk factors for opioid misuse:¹⁶⁻¹⁹
 - i. Adults younger than 45 years old;
 - ii. Personal history of any substance use disorder: illicit or prescription drugs, alcohol, or nicotine;
 - iii. Family history of substance use disorders;
 - iv. Criminal or legal history;
 - v. Psychiatric disorders; and
 - vi. History of sexual abuse.
 - b. Incorporate strategies to mitigate risk for the patient. Consider offering naloxone, if the patient has a history of overdose, severe opioid use disorder, higher opioid dosages (≥ 90 morphine milligram equivalent/day), or concurrently uses benzodiazepines. For more information on prescribing naloxone, prescribers are referred to the Pennsylvania Department of Drug and Alcohol Programs and Pennsylvania Department of Health's [Provider Guide to Prescribing Naloxone to Patients Who Use Opioids](#).*
 - c. Use the three-item Pain, Enjoyment, and General Activity (*Appendix II*) validated scale to assess and reassess pain levels and/or by asking patients if they have had progress toward meaningful and functional goals. This scale is used to develop baseline levels of pain in order to measure a patient's response to a new regimen of medications or the addition of a nonpharmacological therapy. However, the prescriber cannot use the scale to compare two separate patients, as pain levels are subjective. A patient's Pain, Enjoyment, and General Activity score may decrease over time after therapy has begun. Keep in mind that if activity levels increase because of improved pain control, the overall rating of chronic pain by the patient may remain the same. The patient's score in each of the three categories should be averaged together. A 30% improvement from baseline is considered to be clinically meaningful, with the caveat noted above.
4. Administer a urine drug test before prescribing opioids and continue at least annually to assess potential drug misuse or diversion, as well as currently prescribed medication. Urine drug tests may need to be administered more often in cases of at-risk individuals or those who show signs of aberrant behavior.
5. If deemed necessary, consider pill counts to confirm adherence and minimize diversion of the prescription medication. As a suggestion, prescribe a 28-day supply (rather than 30-day), so that the patient has residual medication at appointments. Ask the patient to bring medications at each visit for identified risks or concerns. The prescriber can request random call-backs for immediate counts. Prescribers should also recommend that medications be kept in a locked container for medication safety.
6. Avoid concurrent benzodiazepine and opioid prescriptions, given the high risk of adverse drug-drug interactions, specifically respiratory depression and death. For current information on drug-drug interactions and other product-specific information, visit the [National Institutes of Health website](#).**
7. Offer or arrange evidence-based treatment for patients with moderate or severe opioid use disorders, such as buprenorphine or methadone in combination with behavioral therapies.

* <http://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Documents/SN%20-%20Naloxone%20for%20Opioid%20Safety%20-%20A%20Provider%27s%20Guide%20to%20Prescribing%20to%20Patients%20Who%20Use%20Opioids.pdf>

** <https://dailymed.nlm.nih.gov/dailymed/>

Legal Responsibilities Related to Prescribing Opioids in Other Situations

Prescribing Opioid Drug Products to Patients in an Emergency Department, Urgent Care Center, or Who Are in Observational Status in a Hospital

Effective January 1, 2017, opioid drug products can only be prescribed for up to seven days to a patient seeking treatment in an emergency department, urgent care facility, or who is in observation status in a hospital for up to seven days. If more opioid drugs are needed to treat a patient's acute condition, cancer diagnosis, or palliative care, he/she can be prescribed; however, the condition triggering the extension and an indication that a non-opioid treatment is not appropriate must be documented in the patient's medical record.

Prescribers in these facilities cannot refill a patient's opioid prescription regardless of the amount prescribed.

If a patient appears to be at risk for a substance use disorder, the practitioner must refer the patient to treatment.

Checking the PDMP is not required for any medication provided to a patient in the course of treatment while undergoing care in an emergency department. This exception does not apply to patients undergoing care in urgent care centers or when in observation status in a healthcare facility. If a medication prescription is issued during discharge, then the PDMP system must be queried. As part of good clinical practice, the Department of Health recommends that healthcare professionals check the system every time before a controlled substance(s) is prescribed or dispensed in any clinical setting (*refer to the Pennsylvania Guidelines on Emergency Department Pain Treatment for additional information*).

(Nov. 2, 2016, P.L. 976, Act 122)

Prescribing Opioid Drug Products to Minors

A minor can only be prescribed a controlled substance containing an opioid with the written consent of his/her parent or guardian for up to seven days. If consent is given by a minor's authorized adult (i.e., an adult who has a valid healthcare proxy to consent to the minor's

medical treatment), the prescription is limited to a single 72-hour supply. "Minor" does not include an individual under 18 years of age who is emancipated:

- By marriage;
- By entering the United States armed forces;
- By being employed and self-sustaining; or
- Is otherwise independent from the care of a parent, guardian, or custodian.

The seven-day limitation does not apply to prescriptions associated with a medical emergency or if the limitation would be detrimental to the minor's health. These exceptions must be noted in the minor's medical health record. Additional exceptions can be made when the prescription is for the management of pain associated with cancer, other chronic pain, or used in palliative or hospice care.

Before prescribing to a minor, the prescriber must:

1. Assess whether the minor has taken or is taking prescription medication for a substance use disorder by checking the PDMP system.
2. Discuss the following topics with the minor and his/her parent, guardian, or authorized adult:
 - a. The risks of addiction and overdose;
 - b. The increase risk of addiction for individuals suffering from a mental disorder; and
 - c. The dangers of taking a controlled substance containing an opioid with benzodiazepines, alcohol, or central nervous system depressants.
3. Obtain written consent from the minor's parent, guardian, or authorized adult before a controlled substance containing an opioid is prescribed. A consent form example is available at on the [Pennsylvania Bulletin website](#).*

The procedures do not apply if the minor's treatment is associated with a medical emergency or compliance with the procedures would be detrimental to the minor's health or safety. Exceptions must be documented in the minor's health record.

(Nov. 2, 2016, P.L. 983, Act 125)

* <http://www.pabulletin.com/secure/data/vol47/47-5/191.html>

Legal Responsibilities Related to Prescribing Opioids in Other Situations *(continued)*

A Patient's Voluntary Non-Opioid Directive Form

Practitioners and their patients can execute a voluntary non-opioid directive form developed by the Pennsylvania Department of Health. Before signing, a practitioner can assess the patient's personal and family history of alcohol or drug misuse and evaluate the risks for medication misuse. The practitioner must access the PDMP to see if there is an unusual or suspect pattern for prescribing opioids. The form can be revoked at any time, either in writing or orally.

Sharing data relative to the voluntary non-opioid directive form must comply with all federal and state confidentiality laws.

(Nov. 2, 2016, P.L. 987, Act 126)



David's Law (Good Samaritan Law): Opioid Overdose Reversal Act

Act 139 expands access to naloxone by allowing naloxone dispensing to individuals without a prescription. It also allows first responders, family members, and friends to administer naloxone to individuals experiencing an overdose, and it provides immunity to individuals who prescribe, dispense, and administer naloxone. Additionally, individuals who report drug overdoses and do possess drug paraphernalia and small amounts of drugs are protected under the law.

(Sep. 20, 2014, P.L. 2487, Act 139)

Disposal Guidelines for Opioids and Other Medications

Prescribers should instruct their patients on how to properly dispose of unused medications (*see below*). Some medications are more harmful than others and rarely include specific disposal instructions on their labeling, including flushing down the sink or toilet. While most medications are not recommended to be disposed of by flushing, a regularly updated list of medicines recommended for disposal by flushing is available from the [Food and Drug Administration](#).*



The following are guidelines for proper drug disposal.²⁰

1. Instruct patients to be aware of community prescription drug take-back programs that offer a central location for people to dispose of their unused medications. The Department of Drug and Alcohol Programs has a list of drug take-back boxes at: [Drug Take-Back Box Locator](#)**
2. Follow any specific disposal instructions presented on the label or in the patient materials that accompany the medication. Do not flush medications down the sink or drain unless instructed.
3. Dispose of drugs in the trash by removing the medication from the original container and placing it in a sealed bag with undesirable substances to make it less appealing to others, if there are no instructions or community take-back programs available. For example, place the medications in a sealed plastic bag filled with coffee grounds and then dispose in a waste canister.
4. Scratch off all identifying information from the prescription label before disposing of a bottle or taking it to a drug take-back program in order to keep medical history and identity private.

* <https://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm576167.htm>

** <https://apps.ddap.pa.gov/gethelpnow/PillDrop.aspx>

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Appendix I: Sample Opioid Medication Patient Agreement

Source: University of Denver – Anschutz Medical Campus.

<http://www.ucdenver.edu/Search/Results.aspx?k=sample%20patient%20agreement&s=All%20Sites>

This is an agreement between (the patient) and (the doctor) concerning the use of opioid analgesics (narcotic pain-killers) for the treatment of a chronic pain problem. The medication will probably not completely eliminate my pain, but is expected to reduce it enough that I may become more functional and improve my quality of life.

1. I understand that opioid analgesics are strong medications for pain relief and have been informed of the risks and side effects involved with taking them.
 2. In particular, I understand that opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like syndrome such as nausea, vomiting, diarrhea, aches, sweats, chills) that may occur within 24-48 hours of the last dose. I understand that opioid withdrawal is quite uncomfortable, but not a life-threatening condition.
 3. I understand that if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the opioids and withdrawal can be life-threatening for a baby.
 4. Overdose on this medication may cause death by stopping my breathing; this can be reversed by emergency medical personnel if they know I have taken narcotic pain-killers. It is suggested that I wear a medical alert bracelet or necklace that contains this information.
 5. If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else’s life in jeopardy.
 6. I understand it is my responsibility to inform the doctor of any and all side effects I have from this medication.
 7. I agree to take this medication as prescribed and not to change the amount or frequency of the medication without discussing it with the prescribing doctor. Running out early, needing early refills, escalating doses without permission, and losing prescriptions may be signs of misuse of the medication and may be reasons for the doctor to discontinue prescribing to me.
 8. I agree that the opioids will be prescribed by only one doctor and I agree to fill my prescriptions at only one pharmacy. I agree not to take any pain medication or physician without first discussing it with the above-named doctor. I give permission for the doctor to verify that I am not seeing other doctors for opioid medication or going to other pharmacies.
 9. I agree to keep my medication in a safe and secure place. Lost, stolen, or damaged medication will not be replaced.
 10. I agree not to sell, lend, or in any way give my medication to any other person.
 11. I agree not to drink alcohol or take other mood-altering drugs while I am taking opioid analgesic medication. I agree to submit a urine specimen at any time that my doctor requests and give my permission for it to be tested for alcohol and drugs.
 12. I agree that I will attend all required follow-up visits with the doctor to monitor this medication and I understand that failure to do so will result in discontinuation of this treatment. I also agree to participate in other chronic pain treatment modalities recommended by my doctor.
 13. I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.
- I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know that the doctor may discontinue this form of treatment.

Patient signature:

Doctor signature:

Date:

Appendix I: Sample Opioid Medication Patient Agreement

(continued)

Addendum:

[Sample statement that could be in this agreement or included in chart at each visit]

I understand that the medication is prescribed as follows:

Type of medication: _____

Number of pills and frequency: _____

Total number of pills: _____

Next Refill Due: _____

Patient signature:

Doctor signature:

Date:

This could avoid confusion if you are out of the office, if the patient is calling in for early refill, or if the patient says that you told them something different.

Appendix II: Pain, Enjoyment, and General Activity Scale

1. What number best describes your pain on average in the past week?

1	2	3	4	5	6	7	8	9	10
No Pain									Pain as Bad as You Can Imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

1	2	3	4	5	6	7	8	9	10
Does Not Interfere									Completely Interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

1	2	3	4	5	6	7	8	9	10
Does Not Interfere									Completely Interferes