PARTNERSHIP HEALTHPLAN RECOMMENDATIONS For Safe Use of Opioid Medications

Primary Care & Specialist Prescribing Guidelines

Introduction

Partnership HealthPlan is a County Organized Health System covering Medical and Mental Health Benefits for Medi-Cal beneficiaries in 24 counties in Northern California. Our mission is to help our members, and the communities we serve, be healthy. In this spirit, we have community-wide guidelines to promote safer use of opioid medications.

Based on their skill level, the primary care provider (PCP) should prescribe appropriate analgesics when indicated for the initial management of pain. In starting analgesics for new onset acute pain, the possibility the acute process will evolve into a chronic pain syndrome should be kept in mind. Chronic pain is defined as pain lasting longer than normally expected for the healing of an acute injury or tissue inflammation, usually in the range of 3-6 months. In this guideline, we are not addressing chronic pain associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease, conditions in which treatment goals and needs are different.

Use of opioid pain medications for pain not associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease related should be weighed carefully by any prescriber. Chronic use of opioids is associated with an increased risk of addiction, physiologic dependence, and tolerance. When combined with alcohol use or with other sedating medications such as benzodiazepines and muscle relaxants, opioid use is associated with an increased risk of accidental overdose and motor vehicle accidents. In addition, chronic use of opioids in high doses can cause opioid-induced hyperalgesia, which ultimately generates increased pain and debility. Unlike acute pain or pain related to metastatic cancer or end-of-life care, the goal of opioid therapy in chronic non-cancer, non-terminal pain is *improved functioning*, not necessarily *elimination of pain*.

The following standards for opioid use in patients' pain not associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease are suggested as a starting point from which each community in our Partnership regions can develop their own standards, for the good of our members and the community. These guidelines are not a replacement for clinical judgment or individualized, person-centered care.

Effective Jan. 1, 2027, Partnership will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Therefore, federal guidelines are cited throughout this policy attachment.

Recommendations

For all opioid prescriptions, write as intended to be taken (i.e., 1 tablet q 6 hrs prn (this is a max of 4 per day); or 1-2 q 4-6 hrs but no more than 4 per day (also a max of 4 per day)

A. Acute pain. The main goal is to treat pain without creating opioid physiologic dependency, tolerance, or hyperalgesia.
   1. Preferentially use non-narcotics as first line therapy, especially acetaminophen or NSAIDS. Remember to be cautious with NSAIDs in seniors and persons with hypertension and azotemia.
   2. Restrict use of narcotic pain medications to situations with more severe pain, e.g., traumatic injuries, and if prescribed, limit their use to short periods.
   3. Discuss the risk of opioid dependence, tolerance, and hyperalgesia with patients being initiated on opioid treatment.
   4. According to the Centers for Disease Control (CDC), the lowest effective dose of fast-acting opioid prescriptions should be prescribed for 3 days or less; more than 7 days will rarely be needed. Per these recommendations, prescriptions for acute treatment of pain should not go beyond a few days without reevaluation.
   5. Before initiating opioid therapy for acute pain, assess for risk of substance use disorder/diversion using a standardized tool (e.g., DIRE, see Appendix A). If patient is at high risk, consider a baseline urine toxicology screen and focus on the use of non-opioid modalities to treat pain. Patients between 18 and 25 years of age are at increased risk of misusing prescription drugs, so patients in this age range should be screened carefully.
   6. Advise patients that short-term opioid use can lead to unintended long-term opioid use and the importance of working toward planned discontinuation of opioid use as soon as feasible, including a plan to appropriately taper opioids as pain resolves if opioids have been used around the clock for more than a few days. Review communication mechanisms and protocols patients can use to inform clinicians of severe or uncontrolled pain and to arrange for timely reassessment and management. Advise patients about serious adverse effects of opioids, including potentially fatal respiratory depression and development of a potentially serious lifelong opioid use disorder that can cause distress and inability to fulfill major role obligations at work, school, or home. Advise patients about common effects of opioids, such as constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids. To prevent constipation associated with opioid use, advise patients to increase hydration and fiber intake and to maintain or increase physical activity as they are able. A cathartic (e.g., senna) with or without a stool softener or a laxative might be needed if opioids are used for more than a few days. Prescribing medicines to treat opioid-induced constipation is also an option. To minimize withdrawal symptoms, clinicians should provide and discuss an opioid tapering plan when opioids will be used around the clock for more than a few days (see Recommendation 7). Limiting opioid use to the minimum needed to manage pain (e.g., taking the opioid only when needed if needed less frequently than every 4 hours and the prescription is written for every 4 hours as needed for pain) can help limit development of tolerance and therefore of withdrawal once opioids are discontinued.
   7. If formulations are prescribed that combine opioids with acetaminophen, advise patients of the risks of taking additional over-the-counter products containing acetaminophen. Acetaminophen can be hepatotoxic at dosages of >3–4 grams/day and at lower dosages in patients with chronic alcohol use or liver disease (American Geriatrics Society Panel on the Pharmacological Management of Persistent Pain in Older Persons, 2009). To help patients assess when a dose of opioids is needed, explain that the goal is to reduce pain to make it manageable rather than to eliminate pain. Discuss effects that opioids might have on ability to safely operate a vehicle or other machinery, particularly when opioids are initiated or when other central nervous system depressants, such as benzodiazepines or alcohol, are used concurrently. Discuss increased risks for opioid use disorder, respiratory depression, and death at higher dosages, along with the importance of taking only the amount of opioids prescribed, i.e., not taking more opioids or taking them more often. Review increased risks for respiratory depression when opioids are taken with benzodiazepines, other sedatives, alcohol, non-prescribed or illicit drugs such as heroin, or other opioids. Discuss risks to

household members and other individuals if opioids are intentionally or unintentionally shared with others for whom they are not prescribed, including the possibility that others might experience overdose at the same or at lower dosage than prescribed for the patient, and that young children and pets are susceptible to unintentional ingestion. Discuss storage of opioids in a secure, preferably locked location and options for safe disposal of unused opioids (U.S. Food and Drug Administration, 2020a).

8. Discuss planned use of precautions to reduce risks, including naloxone for overdose reversal and clinician use of prescription drug monitoring program information.

B. Chronic pain in patients with a remote history of malignancy, but currently in remission, should be treated the same as those with chronic non-cancer pain. (See next section.)

C. Chronic pain not associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease.

1. Chronic pain not associated with the cancer or related to its treatment, end-of-life care palliative care, or sickle cell disease and not responding to non-opioid treatment modalities may benefit from chronic use of low dose opioid medications. This should be weighed against the risk of misuse and diversion. Use of a standardized Opioid Risk Tool should be considered.
2. According to the CDC 2022 Guidelines, additional dosage increases beyond 50 MME/day are progressively more likely to yield diminishing returns in benefits relative to risks to patients as dosage increases further. Clinicians should carefully evaluate a decision to further increase dosage based on individualized assessment of benefits and risks and weighing factors such as diagnosis, incremental benefits for pain and function relative to risks with previous dosage increases, other treatments and effectiveness, and patient values and preferences.
3. These guidelines are not a replacement for clinical judgment or individualized, person-centered care.
4. Other treatment modalities should be considered (if not previously utilized), including acupuncture, physical therapy, massage, exercise, counseling, chiropractic, activity modification, podiatric (for appropriate diagnoses), etc.
5. In neuropathic chronic pain, consideration should be given to the use of agents such as tricyclic antidepressants (e.g., amitriptyline or nortriptyline) and anticonvulsants (e.g., gabapentin, pregabalin or carbamazepine).
6. Emphasis should be placed on functional status as opposed to complete elimination of pain.
7. For patient safety, intramuscular and intravenous opioids should not be administered for pain not associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease.
8. In order to reduce the incidence and severity of neonatal abstinence syndrome (NAS) in pregnant individuals with chronic pain, consider consultation with obstetric specialists as well as targeting the lowest effective opioid dose and the use of appropriate non-opioid analgesics. Buprenorphine or similar classes of opioids may be helpful in addressing chronic pain in the setting of opioid dependence, and may carry less risk of severe NAS. For members of reproductive age on chronic opioids, consider discussing the pregnancy-specific risks of opioids, as well as contraception options.
9. The co-prescription of opioids, benzodiazepines, other sedative-hypnotic medications and muscle relaxants should be avoided.

D. Chronic pain not associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease already on opioid doses greater than 90 mg MED/day.

1. According to the CDC Guidelines, for patients already receiving higher opioid dosages, clinicians should carefully weigh benefits and risks and exercise care when reducing or continuing opioid dosage. If risks outweigh benefits of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper to lower dosages or, if warranted based on the individual clinical circumstances of the patient, to appropriately taper and discontinue opioids. Unless there are indications of a life-threatening issue, such as warning signs of impending

overdose, e.g., confusion, sedation, or slurred speech, opioid therapy should not be discontinued abruptly, and clinicians should not abruptly or rapidly reduce opioid dosages from higher dosages.

a. Substitution with buprenorphine or buprenorphine-naloxone products by a prescriber educated in the use of this medication. (Note: no longer does a prescriber require a DEA "X-Waiver" in order to prescribe buprenorphine products for the treatment of opioid use disorder.)
b. Combination of the above with involvement of a multidisciplinary team, including behavioral health and physical therapy, and non-opioid medication options. The goal is to optimize functional status as opposed to complete alleviation of pain as the latter is often not possible.
c. Reducing the opioid dose to a safer range can be time-consuming, and it requires both a discussion with the patient about the reasons why this reduction is needed and a clear, well-communicated plan for how this will happen. It is not advisable to allow the patient to decide whether to remain on an unsafe opioid doses.
d. In larger practices or in communities, consider establishing a "chronic pain review committee" to review cases where greater than 90 mg MED/day are requested, if other exceptions to the institutional policy are considered, and to review clinical management of difficult cases. This helps support clinicians with responding to challenging patient circumstances and gives good support for peer review, if a patient has an adverse outcome.
e. Prescribe naloxone to patients at risk of overdose. California law permits prescribing naloxone to patients taking opioids (legal or illegal) for use in an emergency to prevent accidental death. California law permits pharmacists to furnish naloxone without a physician's prescription and be reimbursed under AB 1114. If naloxone is furnished by a pharmacist outside of AB 1114 to a Medi-Cal patient, a presecription is required for the pharmacy to be reimbursed. (Note: naloxone is also now available over-the-counter without need of a prescription, but a prescription is required for Medi-Cal or Medicare reimbursement.)

E. Routine monitoring of patients on chronic opioid therapy.
1. The benefits and harms for patients on chronic opioid therapy should be assessed at least every three months for patients on stable doses of opioids. UpToDate suggests patients should be seen more frequently after dosing changes, particularly if initiating or increasing extended-release long-acting (ER/LA) opioids. The risks for overdose increase in the first week after a dosing change.
2. Patients who are transitioned to or have dosing increases of methadone should be seen within three days, or within one week for other ER/LA opioids.

F. The following monitoring standards for patients on opioid therapy should be used by all clinicians in Partnership's regions.
1. Request a random toxicology screen performed at least once a year to detect prescribed and non-prescribed opioids and other controlled or illicit drugs.
2. Consider utilizing a signed medication use agreement with the prescriber or prescribing office, renewed yearly.
3. Partnership recommends clinicians use best clinical judgment and seek consultation (when appropriate) when considering the risks of prescribing opioids to individuals who are using illicit substances, alcohol, marijuana(or derivatives thereof), and/or prescription medications.

G. For patients reporting current methadone maintenance for opioid use disorder, immediately contact their Narcotic Treatment Program (NTP) to verify dosing and standing with their program. Do not adjust or discontinue methadone dosing without consultation with the patient's NTP. Methadone maintenance dosing (e.g. daily) will not adequately provide analgesia for acute pain and these patients will often require additional analgesia (sometimes additional opioid medications) to obtain adequate analgesia.

H. Treating opioid use disorder with buprenorphine/buprenorphine-naloxone, or naltrexone extended release injection is within the scope of primary care practice. For facts about buprenorphine and important points to review with the patient, see the SAMSHA Buprenorphine Quick Start Guide. Further education and mentoring are also available through the Provider Clinical Support System (PCSS) and the UCSF warmline.

I. For patients presenting with acute pain who are on buprenorphine or naltrexone treatment for opioid use disorder, achieving analgesia may present unique challenges. Consider consulting available resources for analgesia strategies and protocols for these individuals (e.g., CA Bridge Program. .

J. For all patients with identified **opioid use disorder**, offer initiation of medications for addiction treatment (MAT; e.g., buprenorphine-naloxone, methadone, naltrexone). Example protocols and strategies can be found through the CA Bridge website.

1. Linkages to community MAT providers can be facilitated through consulting the Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment locator (https://www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator), or for patients who reside in Humboldt, Mendocino, Shasta, Siskiyou, Solano, Lassen, Modoc, contact Carelon Behavioral Health for treatment options: (855) 765-9703. A DEA X-waiver is no longer required for the prescribing of FDA-approved buprenorphine products for the treatment of opioid use disorder, and there are no longer any patient limits associated with this treatment.
2. Patients with OUD commonly use other substances. MAT for OUD should not be withheld solely because the patient is using other substances (i.e., cannabis). Of course, reasonable care should be taken when prescribing buprenorphine, for example, and the patient is also misusing alcohol or sedative-hypnotics, but the co-occurring use of these substances should not preclude the prescribing of buprenorphine for OUD treatment. The FDA has listed these as relative contraindications, not absolute contraindications. (FDA Drug Safety Communication: FDA urges caution about withholding opioid addiction medications from patients taking benzodiazepines or CNS depressants: careful medication management can reduce risks | FDA)

K. When opioids are prescribed for the treatment of pain, consider the following:

1. When prescribing opioids, review the patient's controlled-substance history. Review Controlled Substance Utilization Review and Evaluation System (CURES) no earlier than 24 hours, or the previous business day, before prescribing a Schedule II, Schedule III or Schedule IV controlled substance to the patient for the first time and at least once every 4 months thereafter if the substance remains part of the treatment of the patient. If a finding on the CURES report is not consistent with the patient's history, Partnership recommends contacting the relevant pharmacies to confirm the accuracy of the CURES report, as reporting errors do occur. While not mandatory, consider checking CURES even when prescribing Schedule V medications.
3. Schedule at least three office visits yearly for chronic pain patients using opioids.
4. Limit each opioid prescription to 28 days (exactly four weeks), writing this on the prescription (e.g., "must last 28 days".) Writing for a 28-day quantity and making sure this is scheduled for a Tuesday, Wednesday, or Thursday every 4 weeks, reduces the problems of refills being sought on weekends or holidays, and requests for early refills because the patient will be running out on a weekend day (which will happen frequently if prescriptions are written for a 30-day supply.)
5. Develop an office policy on breaches in the medication use agreement. Consider a tiered approach, depending on the breach. Examples of different tiers include: warning, modification of prescription frequency, reduced dosage of medication, cessation of medication.
6. Develop an office policy for offering medications for addiction treatment (MAT), and referral for substance use disorder treatment, if appropriate.
7. Monitor for sedation that would make driving motor vehicles unsafe, particularly if opioids are combined with other sedating medications, alcohol, or other substances. If the patient is potentially unsafe to drive a motor vehicle, recommend to the patient they not drive if impaired and consider reporting the patient to the Department of Motor Vehicles (DMV) for evaluation. Note that a stable dose of opioid alone has not been shown to decrease reaction time, but if a patient is involved in a motor vehicle accident while taking an opioid, the use of the opioid may be used by law enforcement or attorneys to attribute blame. At times prescribers have come under fire in situations like this.
8. Offer to prescribe naloxone to patients at risk of overdose, or to family members or friends (with consent of the patient) of those who may be at risk of overdose. California law permits prescribing naloxone to patients taking opioids (legal or illegal) for use in an emergency to prevent accidental

death. Although, California law permits pharmacists to furnish naloxone without a physician's prescription, a prescription or standing order is required for dispensing to Medi-Cal patients in order for the pharmacy to be reimbursed by Medi-Cal. See http://prescribetoprevent.org/ for details. Intranasal naloxone is available at a pharmacy without a physician's prescription, although Medi-Cal and Medicare payment require a prescription.

9. The co-prescription of opioids, benzodiazepines, other sedative-hypnotic medications and muscle relaxants should be avoided.
10. Medication lock boxes are available through Partnership's Medical Equipment Distribution Services (PMEDS) program.

Examples of a 90 Morphine Dose Equivalent (MED)
(Before use of any comparative dose data for patient use, please refer to listed reference below for dosing calculator)

Drug (Generic Name)	Mg	Low Cost Generic Available?	Brand Name Examples
Morphine (PO) Chronic	90	Yes	MS Contin, Avinza (Long Acting)
Codeine (PO)	600	Yes	
Fentanyl (Transdermal)	37.5mcg/hr	Yes	Duragesic (continuous release patch)
Hydrocodone (PO)	90	Yes	Vicodin, Norco (short acting only)
Hydromorphone (PO)	22.5	Yes	Dilaudid (short acting)
Levorphanol (PO) Chronic	7.5*	Yes	LevoDromoran
Methadone	20	Yes	
Oxycodone (PO)	60	Short Acting: Yes Long Acting: No	OxyContin (long acting)
Oxymorphone (PO)	30	No	Opana, Numorphan (short acting generic available but not low cost)
Tapentadol (PO)	225*	No	Nucynta

http://www.globalrph.com/narcotic.cgi

*https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Opioid-Morphine-EQ-Conversion-Factors-March-2015.pdf

Other Guidelines for Safe Opioid Prescribing

Dental Guidelines
Emergency Room Guidelines
Community Pharmacy Guidelines

Key Points from Other Guidelines

1. Emergency Departments should
   a. Check a CURES report on every patient who will receive an opioid prescription.
   b. Maximize the use of non-opioid analgesics, and limit the use of opioids in the treatment of acute pain. Exercise reasonable caution in the use of opioids in those individuals with evidence of substance misuse and in adults under the age of 25. Balance this caution, however, against the need to adequately treat pain.
   c. Limit opiate prescriptions to 4 days duration.
   d. Notify the PCP when an opioid is prescribed.
2. Dental Guidelines
   a. Preferentially use NSAIDs instead of opioids for dental pain (opioids are no better than placebo).
3. Community Pharmacies should
   a. Check a CURES report for all new opioid prescriptions.
   b. Notify the PCP if there is a prescription pattern suggesting misuse.
   c. Check the photo ID of any patient picking up an opioid prescription.
   d. Counsel patients on the risk of tolerance, addiction, opiate-induced hyperalgesia, and drug overdose.

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Appendix A

D.I.R.E. Score: Patient Selection for Chronic Opioid Analgesia

For each factor, rate the patient's score from 1-3 based on the explanations in the right hand column.

Score	Factor	Explanation
___	Diagnosis	1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, nonspecific back pain. 2 = Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain. 3 = Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis.
___	Intractability	1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process. 2 = Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness). 3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response.
	Risk	(R = Total of P + C + R + S below)
	Psychological:	1 = Serious personality dysfunction or mental illness interfering with care. Example: personality disorder, severe affective disorder, significant personality issues. 2 = Personality or mental health interferes moderately. Example: depression or anxiety disorder. 3 = Good communication with clinic. No significant personality dysfunction or mental illness.
	Chemical Health:	1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse. 2 = Chemical coper (uses medications to cope with stress) or history of CD in remission. 3 = No CD history. Not drug-focused or chemically reliant.
	Reliability:	1 = History of numerous problems: medication misuse, missed appointments, rarely follows through. 2 = Occasional difficulties with compliance, but generally reliable. 3 = Highly reliable patient with meds, appointments & treatment.
	Social Support:	1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles. 2 = Reduction in some relationships and life roles. 3 = Supportive family/close relationships. Involved in work or school and no social isolation.
___	Efficacy score	1 = Poor function or minimal pain relief despite moderate to high doses. 2 = Moderate benefit with function improved in a number of ways (or insufficient info – hasn't tried opioid yet or very low doses or too short of a trial). 3 = Good improvement in pain and function and quality of life with stable doses over time.

____ Total score = D + I + R + E

Score 7-13: Not a suitable candidate for long-term opioid analgesia
Score 14-21: May be a candidate for long-term opioid analgesia

Source: Miles Belgrade, Fairview Pain & Palliative Care Center © 2005.

Functional Pain Scale

(developed by Kaiser Health Plan)