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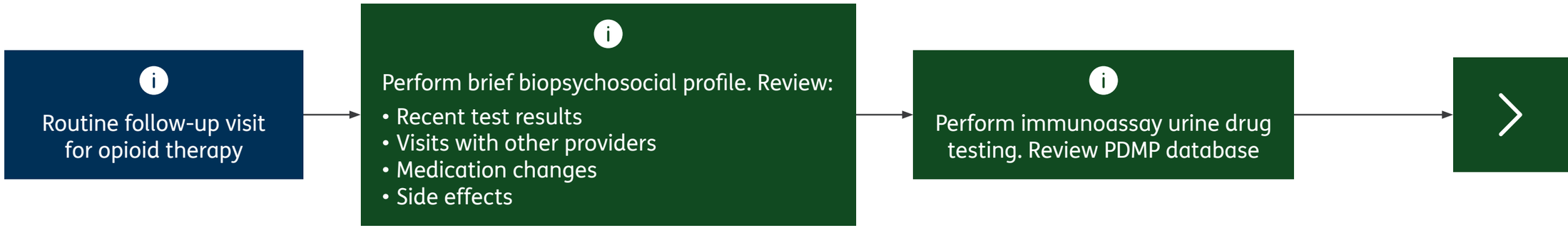

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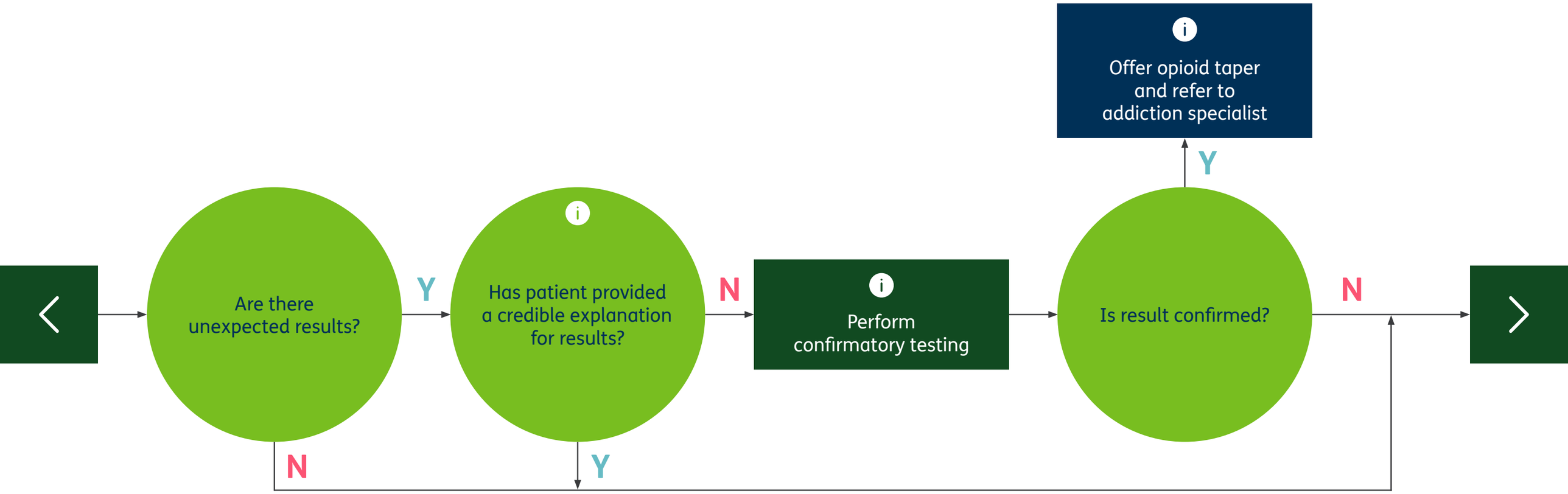
Clinical Practice Guidelines (CPG): PCP follow-up



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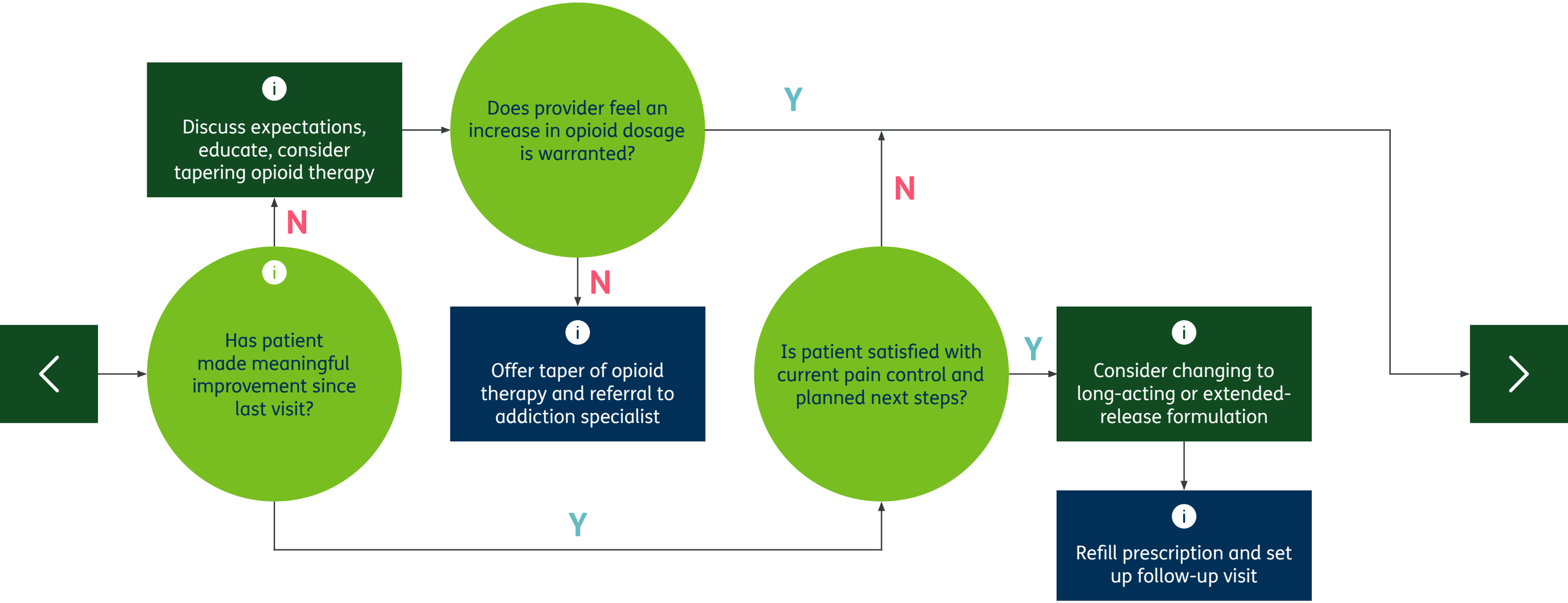

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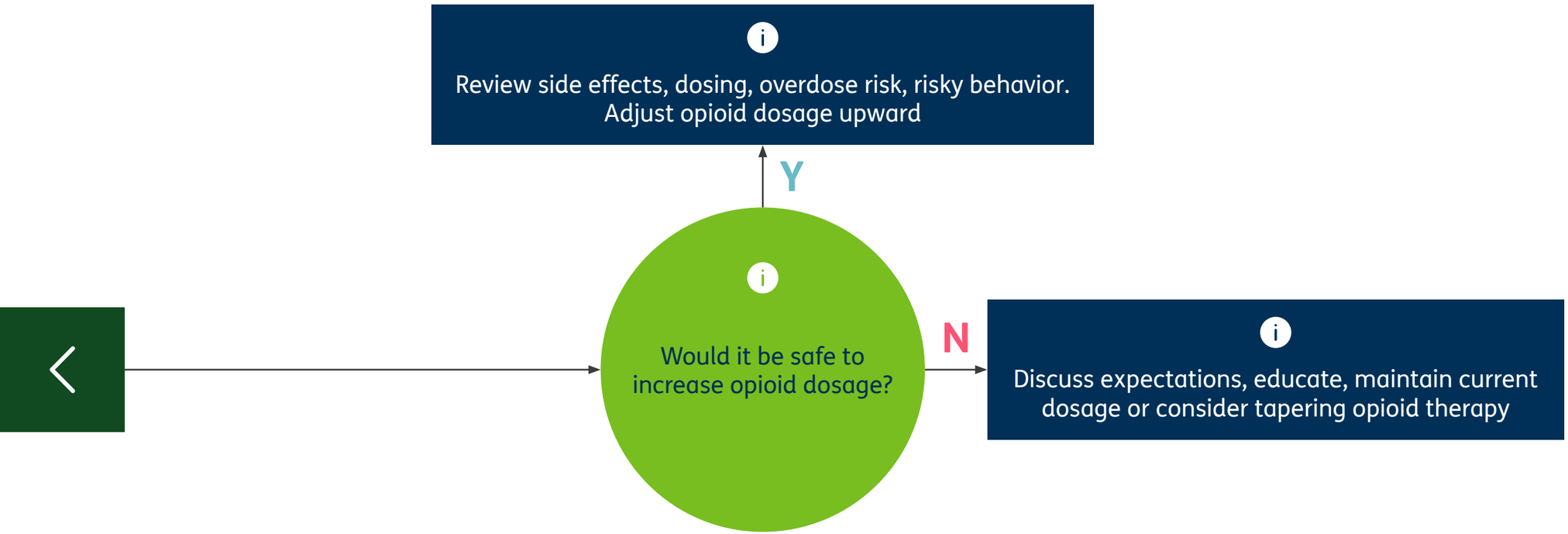

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Routine follow-up visit for opioid therapy.

The primary care manager (PCM) should assess the patient's progress within one month of initiating opioid therapy for chronic pain.

More frequent follow-up assessments are required for patients at higher risk for opioid misuse. [2]

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Perform brief biopsychosocial profile. Review recent test results, visits with other providers, medication changes and side effects.

The effects of pain involve biological, psychological, and social factors. PCMs should perform a brief biopsychosocial assessment during the follow-up visit. Information obtained from this assessment will help guide therapeutic decision making as well as identify patients susceptible to opioid-associated misuse, abuse, overdose, or other aberrant behaviors. [9]

This visit will also allow the PCM to gauge the following: meaningful pain and function improvements, side effects, and serious adverse events. [2]

The PCM should verify current medications, review recent laboratory studies, imagining, and diagnostic tests as well as review notes from visits with other providers.

Refer to the **Biopsychosocial Assessment of Pain** section for further details.

Perform immunoassay urine drug testing. Review PDMP database.

Urine drug testing may enhance compliance as well as deter and detect abuse. Consistent application of a predetermined urine drug testing policy may destigmatize the use of such testing.

Patients starting or maintaining opioid therapy should be informed that urine drug testing will routinely occur and will enhance patient safety. PCMs should educate patients on expected results from the screening. [11]

Urine drug testing should occur: [2]

- Before increasing opioid dosages
- At a minimum, annually for low risk patients, twice a year for moderate risk patients, and three to four times per year for high risk patients to monitor long-term use of opioid therapy
- Randomly if the practitioner suspects opioid diversion

The CDC guideline recommends reviewing the prescription drug monitoring program (PDMP): [2]

- Prior to initiating opioid therapy
- Intermittently during opioid therapy (i.e., every prescription refill or every three months)

Results from the PDMP database should be placed in the patient's medical record.

Each state has its own specific prescriber use mandates delineating database use frequency, prescribing restrictions, and which drugs prompt PDMP review. Since PDMP policies vary from state to state, it is recommended to review a specific state PDMP at **pdmpassist.org** or go directly to the specific state PDMP website. [25,26]

Refer to the **Opioid Therapy Risk Mitigation** section and **Appendix C: Urine Drug Testing** for further details.

Has patient provided a credible explanation for results?

Discuss the results with the patient and, if appropriate, allow for an explanation of unexpected results.

The PCM may consider initiating the conversation by asking:

> *"The results of your urine drug test were positive for [insert drug name]. Can you help me understand these results?"*

A lack of an unjustifiable explanation may warrant further confirmatory testing, using chromatography, mass spectrometry, liquid chromatography, or tandem mass spectrometry.

Be cognizant of the additional expenses associated with confirmatory testing. [2]

Refer to the **Opioid Therapy Risk Mitigation** section and **Appendix C: Urine Drug Testing** for further details.

Perform confirmatory testing.

A lack of an unjustifiable explanation may warrant further confirmatory testing, using chromatography, mass spectrometry, liquid chromatography, or tandem mass spectrometry.

Be cognizant of the additional expenses associated with confirmatory testing. [2,11]

While urine drug testing is effective in detecting the presence of a drug or its metabolite(s), urine drug testing is unable to provide definitive data regarding the dosage taken, when it was taken, or the ultimate drug source. [11]

Refer to the **Opioid Therapy Risk Mitigation** section and **Appendix C: Urine Drug Testing** for further details.

Offer opioid taper and refer to addiction specialist.

Reasons for discontinuation of opioid therapy may include: [2,11]

- Opioid use is not in compliance with best practices
- Development of aberrant behaviors, such as:
  - Diversion, illicit drug activities, or prescription forgery
  - Doctor and/or pharmacy shopping
  - Injecting oral or topical opioids
  - Aggressively insisting on receiving opioid prescriptions
  - Signs of intoxication or withdrawal

Weaning protocols should consider factors such as clinical setting and tapering schedule. Employing motivational interviewing skills may prove helpful in this conversation. [11]

Refer to the **Discontinuation of opioid therapy** section for further details.

Addiction specialty services:

- Patients deemed high risk for opioid misuse or opioid use disorder (OUD) may be candidates for referral to an addiction specialist
- Opioid treatment programs may occur in inpatient hospitals, residential addiction facilities, licensed intensive outpatient clinics, and outpatient care settings [28]
- **Quality treatment programs** have the following features:
  - State licensed or certified
  - Prescribes FDA approved medications to aid in recovery and prevent relapse
  - Offers evidence-based therapies such as motivational intervention, cognitive behavioral therapy, counseling and peer support
  - Allows family members to participate in the treatment process
  - Provides long-term treatments such as ongoing counseling, coaching and support, sober housing, employment supports
- Information on publicly funded Substance Use Disorder (SUD) treatment facilities may be found on SAMHSA's **Behavioral Health Treatment Services Locater** website.

Has patient made meaningful improvement since last visit?

The PCM can use a brief validated tool to assess function and pain. Evaluation of treatment efficacy should be defined, such as a 30% improvement in pain and function scores.

Continuation of opioid therapy is contingent upon achieving treatment goals with no evidence of adverse effects or aberrant behaviors.

Pain improvement without concurrent functional improvement does not represent Clinically Meaningful Improvement (CMI), excluding catastrophic injuries.

In the absence of sustained CMI in pain and function, a dosage reduction or discontinuation of opioid therapy may be warranted. [21]

A few tools to assess pain and/or functionality (Refer to **Biopsychosocial Assessment of Pain** section for full list):

- Numerical Rating Scale (**NRS**)
- Faces Pain Score (**FPS**)
- McGill Pain Questionnaire (**MPQ**)
- Oswestry Disability Index (**ODI**)
- Pain Average, Interference with Enjoyment of Life, and Interference with General Activity Assessment Scale (**PEG**)
- Two-Item Graded Chronic Pain Scale (**2-item scale**)

Discuss expectations, educate and consider tapering opioid therapy.

In the absence of sustained CMI in pain and function, a dosage reduction or discontinuation of opioid therapy may be warranted. [21]

The PCM and patient should reiterate expectations, realistic outcomes, and treatment goals. [2,9]

Weaning protocols should consider factors such as clinical setting and tapering schedule. Employing motivational interviewing skills may prove helpful in this conversation. [11]

Refer to the **Discontinuation of opioid therapy** section for further details.

Offer taper of opioid therapy and referral to addiction specialist.

Reasons for discontinuation of opioid therapy may include: [2,11]

- Opioid use is not in compliance with best practices
- Development of aberrant behaviors, such as:
  - Diversion, illicit drug activities, or prescription forgery
  - Doctor and/or pharmacy shopping
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  - Aggressively insisting on receiving opioid prescriptions
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Weaning protocols should consider factors such as clinical setting and tapering schedule. Employing motivational interviewing skills may prove helpful in this conversation. [11]

Refer to the **Discontinuation of Opioid Therapy** section for further details.

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Consider changing to long-acting or extended-release formulation.

Situations may present the necessity to switch from Immediate-Release/Short-Acting (IR/SA) to Extended-Release/Long-Acting (ER/LA) opioids for chronic pain.

Only patients who have received IR/SA opioids for at least one week should be considered for ER/LA opioid therapy.

It is preferable to select an ER/LA opioid with foreseeable pharmacokinetics to reduce the risk of overdose. Therefore, the use of methadone and transdermal fentanyl should be reserved for physicians familiar with their pharmacokinetics.

The use of ER/LA opioid therapy should not be used for intermittent use or in combination with IR/SA preparations.

Follow-up should occur within two weeks of conversion since the risk of nonfatal overdose is greater during this time period.

The practitioner should review the side-effect profile and adverse events with the patient and their representative. [2]

Refer to the **Follow-Up and Monitoring Ongoing Opioid Therapy** section and **Appendix D: Morphine Milligram Equivalent (MME) for Oral Opioids** for further details.

Refill prescription and set up follow-up visit.

Follow-up should occur within two weeks of conversion since the risk of nonfatal overdose is greater during this time period.

The practitioner should review the side-effect profile and adverse events with the patient and his/her representative. [2]

Only prescribe the quantity necessary for the duration between the initial visit and follow-up. Consider prescribing in multiples of a seven-day supply to avoid prescription ending on the weekend. [11]

Refer to the **Follow-Up and Monitoring Ongoing Opioid Therapy** section for further details.

Would it be safe to increase opioid dosage?

Patients whose pain improved but did not meet pain and function milestones may be a candidate for dosage escalation.

Key principals of opioid dosage escalation: [2]

- Slow dosage escalation in the smallest effective increment is recommended, with follow-up occurring one to four weeks after adjusting the dosage
- Caution should be exercised when escalating dosages of opioids combined with nonopioid agents (i.e., acetaminophen, aspirin, or other nonsteroidal anti-inflammatory drugs [NSAIDs]) to avoid toxic levels of nonopioid agents
- Continue to assess for CMI in function and pain; if no CMI is occurring with an escalated dosages, then consider tapering dosage to the previous dosage and discuss possible discontinuation with the patient
- Calculate the daily dosage of opioids using the morphine milligram equivalent per day (MME/day) metric to gauge potential risk of overdose and to help identify the need for dosage reduction or taper
- Be aware that the first three to seven days of an increase in opioid dosage presents the greatest risk for overdose

Research has not shown a demonstrable association between high-dose opioids and improvement in pain relief or functionality; however, high doses of opioids are also accompanied with greater incidences of overdose and death. Therefore, increasing opioid dosages to 50 MME or greater per day warrants caution and re-evaluating the necessity of high-dose opioids to accomplish the goals set forth in the treatment plan. Evidence strongly discourages prescribing doses greater than 90 MME/day due to the subsequent increases in fatal and nonfatal overdoses. [2]

Refer to the **Follow-Up and Monitoring Ongoing Opioid Therapy** section and **Appendix D: Morphine Milligram Equivalent (MME) for Oral Opioids** for further details.

Discuss expectations, educate, maintain current dosage or consider tapering opioid therapy.

The PCM and patient should reiterate expectations, realistic outcomes and treatment goals. [2,9]

If the practitioner determines that opioid therapy is providing a net benefit and to maintain therapy, routine follow-up visits should occur every three months to assure the goals of therapy continue to be met.

If harms outweigh benefits of continued opioid therapy, alternative therapies should be optimized and a weaning protocol initiated.

Lastly, evidence has shown that ineffective opioid therapy at one month is unlikely to be effective at six months. [2]

Refer to the **Follow-Up and Monitoring Ongoing Opioid Therapy** and **Discontinuation of Opioid Therapy** sections for further details.

Review side effects, dosing, overdose risk and risky behavior. Adjust opioid dosage upward.

The PCM should review common adverse effects associated with opioid therapy, including: [2,21]

- Side effects such as constipation, dry mouth, nausea, vomiting, drowsiness and confusion
- Potential for overdose and fatal respiratory depression
- Risks of developing physical dependence, withdrawal symptoms and OUD

Key principles for opioid dosage escalation: [2]

- Slow dosage escalation in the smallest effective increment is recommended, with follow-up occurring one to four weeks after adjusting the dosage
- Caution should be exercised when escalating dosages of opioids combined with nonopioid agents (i.e., acetaminophen, aspirin, or other NSAIDs) to avoid toxic levels of nonopioid agents
- Continue to assess for CMI in function and pain; if no CMI is occurring with an escalated dosage, then consider tapering dosage to the previous dosage and discuss possible discontinuation with the patient
- Calculate the daily dosage of opioids using the MME/day metric to gauge potential risk of overdose and to help identify the need for dosage reduction or taper
- Be aware that the first three to seven days of an increase in opioid dosage present the greatest risk for overdose

Refer to the **Follow-Up and Monitoring Ongoing Opioid Therapy** section and **Appendix D: Morphine Milligram Equivalent (MME) for Oral Opioids** for further details.

Biopsychosocial assessment

A comprehensive approach to pain is essential since the effects of pain involve biological, psychological, and social factors. Healthcare professionals, therefore, should perform a comprehensive assessment on patients presenting with pain. Information obtained from this assessment will help guide therapeutic decision making as well as identify patients potentially susceptible to opioid-associated adverse events, misuse, abuse, or overdose. [9]

Medical history

The medical history is an important component of the comprehensive assessment. The Primary Care Manager (PCM) should elicit detailed information about the history of the pain, including: [9]

Etiology	Intensity
Location	Duration
Pattern	Aggravating and alleviating factors
Pathophysiology (e.g., nociceptive pain, visceral pain, or neuropathic pain)	

The PCM should also review details about: [9]

Prior evaluation(s)	Opioid therapy
Prior treatment(s) (including outcome response)	Surgery or other invasive procedures
Current treatment regimen	Consultations
Nonpharmacologic options	Prior diagnostic test(s)
Nonopioid pharmacotherapy options	

The gold standard for measuring pain intensity to enable monitoring of treatment response is through the use of self-reporting. The unidimensional and multidimensional scales below are reliable and valid pain assessment tools that assist with accurately measuring pain. [10]

Unidimensional pain intensity scales

The below assessment tools are commonly used scales for evaluating pain intensity. Preferred scale use is patient-specific, with no specific scale being superior for detection of Clinically Meaningful Improvement (CMI) in function or minimum clinically important difference in outcome. [10,11]

Numerical Rating Scale (NRS)

- The **NRS** assesses pain intensity using an 11-point numerical scale of zero to 10, where zero equals no pain and 10 is the worst pain imaginable. This simple-to-use scale is the most commonly used instrument in healthcare. It can be administered both verbally and in written format.

Visual Analog Scale (VAS)

- The **VAS** is a continuous scale containing either a horizontal or vertical line from zero to 10. The line is anchored by the verbal descriptors “no pain” and “worst pain.” Patients are asked to place a mark on the line indicating their level of pain intensity. This scale can only be administered in written format.

Faces Pain Score (FPS)

- The **FPS** incorporates both numbers and facial expressions to determine a pain rating. This scale may be used for children, individuals with limited verbal abilities, and individuals whose native language is not English.

Multidimensional pain quality scale

A multidimensional pain quality scale captures sensory and affective attributes of pain. Below is a reliable and valid scale that provides pain characteristic information. [10]

McGill Pain Questionnaire (MPQ)

- The **MPQ** is a patient-reported assessment of sensory, affective, and evaluative aspects of pain. The questionnaire contains words of various descriptive qualities from which patients select to categorize their pain. The questionnaire also consists of a body illustration allowing patients to identify the location of their pain. A shorter version of the MPQ, known as the Short Form-McGill Pain Questionnaire (**SF-MPQ**), is also available. The instructions for the SF-MPQ are similar to the MPQ; however, the short form consists of fewer pain descriptor words.

Functional assessment scales

Assessing functionality is equally as important as assessing pain. The practitioner may initiate this conversation by asking the patient how the addition of an opioid would improve functionality and quality of life.

Determining the level at which pain interferes with a patient's daily activities through the use of questionnaires is a way to quantifiably assess functionality. The results obtained by this assessment allow the practitioner to correlate this information with reported pain intensity as changes occur over time. [11]

Oswestry Disability Index (ODI)

- The **ODI** is a validated, self-administered questionnaire assessing 10 activities of daily living. Each section consists of 6 statements correlating to scores of zero through five, with five representing the greatest disability. To calculate the index, the healthcare provider sums the statement scores, then divides the total statement score by the total possible score, and finally multiplies by 100 to obtain a percentage. The score categories are minimal disability (0% to 20%), moderate disability (21% to 40%), severe disability (41% to 60%), crippled (61% to 80%), and bed-bound or exaggerating symptoms (81% to 100%). To help reduce the potential for mathematical error12, a free **ODI calculator** is available online. Lastly, the ODI is considered the gold standard for assessing low back pain. [13]

Roland-Morris Disability Questionnaire (RMDQ)

- The **RMDQ** is an alternative screening tool developed to assess low back pain. This 24-item questionnaire has been validated for use in multiple languages. The tool may be administered as a self-report instrument or in interview format. The RMDQ is designed to identify only the reported functional areas adversely affected by pain. The healthcare provider adds the number of functional areas identified by the patient, which can range from zero to 24. The numerical result is not assigned a category descriptor (i.e., low, moderate, severe). Interpretation of clinical improvement results from analyzing questionnaire scores over time, with lower numerical scores representing improved functionality. [14]

Functional and pain assessment scales

The brief validated tools below are used to assess function and pain simultaneously.

Two-item graded chronic pain scale

- This **two-item scale** is a shorter version of the graded chronic pain scale, and is designed for use in the primary care setting to assess pain and functionality within the past month. This scale may be administered as a self-report instrument or in interview format. [11]

Pain, Enjoyment, General Activity (PEG) assessment scale

- The **PEG** assessment scale is a three-item scale assessing both pain intensity and functionality. The scale is available for self-administration or interview-administration. [15,16]

The PCM should also verify current and past medications (including prior opioid use to determine opioid tolerance), confirm allergies, obtain a family history, and review medical conditions including disabilities. [9] Acquiring the details of the patient's history provides an opportunity for the PCM to establish rapport with the patient, thus enhancing the provider-patient relationship.

Psychosocial history

Pain assessments should include a psychosocial history. The healthcare provider should interview the patient about alcohol, drug, and tobacco use, as well as the presence or history of mental health and psychiatric comorbidities. The healthcare provider should also inquire if the pain interferes with fulfilling work, school, or home obligations. [9]

Numerous instruments assessing psychosocial history are discussed in the Clinical Practice Guideline for Opioid Use Disorder in the Primary Care Setting. Refer to this guideline for detailed information describing these instruments.

Physical examination

A physical examination should be conducted prior to initiating pain therapy to determine baseline function and pain. The physical examination should include direct examination of the painful site, a neurological examination, and examination of the musculoskeletal area in question. [9] Information obtained from the history and physical examination should guide the PCM in the need for ordering additional laboratory studies, imaging, and diagnostic tests.

Treatment plan

The PCM should discuss clinical findings and diagnosis with the patient. The treatment plan should include the patient's preferences, and should be developed around improving pain and function as well as enhancing coping skills. The PCM and patient should discuss treatment options, side effects, expectations, realistic outcomes, establish treatment goals, re-evaluation frequency, and discontinuation of ineffective therapies if risks outweigh benefits. [2,9]

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Opioids are a class of drugs characterized as having analgesic and euphoric effects. The use of opioids for the treatment of pain may be associated with a number of side effects. Drowsiness, respiratory depression, nausea, vomiting, constipation, and pruritus commonly occur with opiate medications, and these agents are associated with risks of misuse, abuse, overdose, and diversion. Due to these negative effects, opioids are not recommended as first-line therapy for pain. Opioids may be considered for treatment of pain in patients who have failed to respond adequately to conventional therapies and where the benefits of using opioid therapy outweigh the risks. Concomitant therapy with nonpharmacologic and nonopioid treatments should be used when appropriate. [2,19]

Risk mitigation

Healthcare practitioners should adopt strategies to mitigate the risks associated with opioid therapy as opioid dependence occurs in 3% to 26% of patients seen in the primary care setting. Integration of various risk mitigation strategies into a treatment plan will help minimize the harms commonly associated with prescription opioid use. The Centers for Disease Control and Prevention (CDC) recommend evaluating for risk factors prior to initiating and during opioid therapy. [2]

Risk factors

Research has identified individual risk factors associated with opioid misuse or OUD. These risk factors include:

- A personal history of Substance Use Disorder (SUD), mental illness, and/or overdose [20]
- Younger age, psychotropic medication use, long-term or high-dose opioid use, and a family history of substance abuse [20]
- Comorbid medical conditions known to possibly increase the risk of opioid-related toxicities (i.e., chronic obstructive pulmonary disease, congestive heart failure, sleep apnea, severe asthma, kidney or liver dysfunction, older age) [11,21]
- Concurrent use of benzodiazepines or other sedative hypnotics [21]
- Known history of intestinal peristalsis issues [21]
- Additional aberrant behaviors that should prompt screening include calls after office hours, frequent early refill requests, doctor and/or pharmacy shopping, insistence that nonopioid medications are ineffective, and the need for only opioid therapy [22]

Patients identified with any risk factors and/or aberrant behaviors should be further assessed with a validated screening tool, and the PCM should check their state's Prescription Drug Monitoring Program (PDMP).

Screening tools

Numerous screening tools have been designed to help identify patients on prescription opioids who may be at high risk of developing opioid misuse or OUD. Some screening tools concentrate on prescreening patients prior to starting long-term opioid therapy, whereas others focus on monitoring aberrant behaviors while currently on long-term opioid therapy. Screening tools are imperfect and may not be accurate predictors of aberrant behaviors. If screening indicates the presence of potential opioid misuse or abuse, further assessment is indicated prior to giving an opioid prescription or continuing opioid therapy.23 Validated screening tools are described below with additional details and instruments in **Appendix B: Risk assessment instruments for opioid therapy**. Please be aware that the accuracy of these tools has been reported as inconsistent. [2]

- Current Opioid Misuse Measure (COMM)
  - The COMM is a validated 17-item questionnaire used for identifying aberrant behaviors in patients on long-term opioid therapy. This is a patient self-reported tool that takes less than 10 minutes to complete. An affirmative score of 9 or higher is suggestive of opioid misuse
- Diagnosis, Intractability, Risk, Efficacy (DIRE)
  - The DIRE tool is a 7-item instrument administered by the PCM to assess the likelihood of patient compliance and risk of opioid misuse or abuse prior to starting long-term opioid therapy. A score of 13 or less suggests that long-term opioid therapy may not be a suitable treatment for the patient
- Opioid Risk Tool (ORT)
  - The ORT consists of 5 yes/no questions to assess risk for opioid misuse or abuse. This scale has been validated for use in adult patients prescribed opioid analgesics for chronic pain management. The tool can be administered in interview format or as a self-report instrument, and takes less than a minute to complete. A risk score of 8 or more is indicative of high risk for exhibiting future aberrant behaviors
- Screener and Opioid Assessment for Patients with Pain (SOAPP)
  - The SOAPP version 1.0 is a 14-item questionnaire identifying risk factors for opioid misuse or abuse in patients being considered for long-term opioid therapy. The tool is a self-reported instrument and takes less than 8 minutes to complete. An affirmative score is 7 or higher. The SOAPP tool is also available in 5- and 24-item versions

Avoid concomitant opioid and benzodiazepine prescribing

Concomitant use of an opioid and a benzodiazepine increases the risk of adverse events and overdose since both drugs potentiate the effects of respiratory depression. Prescription opioids combined with benzodiazepines were detected in 51.6% of overdose deaths. The avoidance of concomitant use of opioids and benzodiazepine therapies is recommended. [24]

Prescription Drug Monitoring Program (PDMP)

Prescribing and dispensing providers (or their delegates, such as nurses or medical assistants) can register with their state PDMP in order to review information about patient-specific use of controlled substance prescriptions. These electronic databases aid in reducing misuse, abuse, and overdose by tracking prescription and dispensary behaviors. [25,26]

To date, PDMPs are available in 49 states, the District of Columbia, and Guam. Each state has its own specific prescriber-use mandates delineating database-use frequency, prescribing restrictions, and which drugs prompt PDMP review. Since PDMP policies vary from state to state, it is recommended to review a specific state's PDMP at **pdmpassist.org** or go directly to the specific state's PDMP website. [25,26]

The CDC guideline recommends reviewing the PDMP: [2]

- Prior to initiating opioid therapy
- Intermittently during opioid therapy (i.e., every prescription refill or every three months)

The PDMP may be integrated with other screening tools to assist with identifying patients at risk for overdose, opioid misuse, OUD, or diversion. Results from the PDMP database should be placed in the patient's medical record.

Urine drug testing

The use of urine drug testing may overcome the limited validity associated with self-reporting drug use and provide empirical data to supplement behavior monitoring. Urine drug testing may enhance compliance as well as deter and detect abuse. Consistent application of a predetermined urine drug testing policy may destigmatize the use of such testing. Patients starting or maintaining opioid therapy should be informed that urine drug testing will routinely occur and will enhance patient safety. Providers should educate patients on expected results from the screening. [11]

When determining which tests to perform, providers should target only substances that directly affect patient management. Inexpensive immunoassay screening is available for most situations when screening for commonly prescribed opioids. Standard urine drug testing is sensitive for detecting metabolites of certain opioids. Specialized testing is necessary for the prescribed opioids not detected by immunoassay screening. Providers should be knowledgeable with the metabolites associated with other drugs and their respective tests (see **Appendix C: Urine drug testing**). [2]

Urine drug testing should occur: [2,11]

- Prior to initiating opioid therapy
- Before increasing opioid dosages
- At a minimum, annually for low-risk patients, twice a year for moderate-risk patients, and three to four times per year for high-risk patients to monitor long-term use of opioid therapy
- Randomly if the practitioner suspects opioid diversion

Discuss the urine drug testing results with the patient and, if appropriate, allow for an explanation of unexpected results. A lack of an unjustifiable explanation may warrant further confirmatory testing, using chromatography, mass spectrometry, liquid chromatography, or tandem mass spectrometry. Be cognizant of the additional expenses associated with confirmatory testing. [2,11]

While urine drug testing is effective in detecting the presence of a drug or its metabolite(s), urine drug testing is unable to provide definitive data regarding the dosage taken, when it was taken, or the ultimate drug source. [11]

Naloxone

Naloxone is a Food and Drug Administration (FDA)-approved medication for reversal of opioid-induced overdose. Many state laws have become more accommodative regarding the prescribing of naloxone for overdose.25 Providers should consider prescribing naloxone for home use to individuals who are at high risk of opioid overdose (i.e., opioid prescription exceeding 50 morphine milligram equivalents per day (MME/day), concurrent benzodiazepine use, prior incidence of overdose, history of SUD). [2] Providers should refer to their specific state's policies and regulations. The Prescription Drug Abuse Policy System's Naloxone Overdose Prevention Laws database may provide additional information on this topic. [25] Family members and housemates should be trained on the use of Naloxone.

Treatment agreement

Treatment agreements may provide a sense of collaboration when a course of action is mutually agreed upon by the provider and patient. The provisions for such agreements could address multiple responsibilities, such as treatment goals, compliance monitoring, use of a single prescriber and pharmacy, approach to refills, use of other controlled substances (both prescribed and illicit), and noncompliance resolutions. Both the provider and patient should sign the treatment agreement prior to initiating long-term opioid therapy. [23]

Opioids are a class of drugs characterized as having analgesic and euphoric effects. The use of opioids for the treatment of pain may be associated with a number of side effects. Drowsiness, respiratory depression, nausea, vomiting, constipation, and pruritus commonly occur with opiate medications, and these agents are associated with risks of misuse, abuse, overdose, and diversion. Due to these negative effects, opioids are not recommended as first-line therapy for pain. Opioids may be considered for treatment of pain in patients who have failed to respond adequately to conventional therapies and where the benefits of using opioid therapy outweigh the risks. Concomitant therapy with nonpharmacologic and nonopioid treatments should be used when appropriate. [2,19]

Risk mitigation

Healthcare practitioners should adopt strategies to mitigate the risks associated with opioid therapy as opioid dependence occurs in 3% to 26% of patients seen in the primary care setting. Integration of various risk mitigation strategies into a treatment plan will help minimize the harms commonly associated with prescription opioid use. The Centers for Disease Control and Prevention (CDC) recommend evaluating for risk factors prior to initiating and during opioid therapy. [2]

Risk factors

Research has identified individual risk factors associated with opioid misuse or OUD. These risk factors include:

- A personal history of Substance Use Disorder (SUD), mental illness, and/or overdose [20]
- Younger age, psychotropic medication use, long-term or high-dose opioid use, and a family history of substance abuse [20]
- Comorbid medical conditions known to possibly increase the risk of opioid-related toxicities (i.e., chronic obstructive pulmonary disease, congestive heart failure, sleep apnea, severe asthma, kidney or liver dysfunction, older age) [11,21]
- Concurrent use of benzodiazepines or other sedative hypnotics [21]
- Known history of intestinal peristalsis issues [21]
- Additional aberrant behaviors that should prompt screening include calls after office hours, frequent early refill requests, doctor and/or pharmacy shopping, insistence that nonopioid medications are ineffective, and the need for only opioid therapy [22]

Patients identified with any risk factors and/or aberrant behaviors should be further assessed with a validated screening tool, and the PCM should check their state's Prescription Drug Monitoring Program (PDMP).

Screening tools

Numerous screening tools have been designed to help identify patients on prescription opioids who may be at high risk of developing opioid misuse or OUD. Some screening tools concentrate on prescreening patients prior to starting long-term opioid therapy, whereas others focus on monitoring aberrant behaviors while currently on long-term opioid therapy. Screening tools are imperfect and may not be accurate predictors of aberrant behaviors. If screening indicates the presence of potential opioid misuse or abuse, further assessment is indicated prior to giving an opioid prescription or continuing opioid therapy.23 Validated screening tools are described below with additional details and instruments in **Appendix B: Risk assessment instruments for opioid therapy**. Please be aware that the accuracy of these tools has been reported as inconsistent. [2]

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Appendix B: Risk assessment instruments for opioid therapy

Screening tool	Administration	Description	Scoring	Sensitivity and specificity
Current Opioid Misuse Measure (COMM)	Patient self-report	17-item questionnaire used for identifying aberrant behaviors in patients on long-term opiod therapy.	A score ≥9 is indicative of a positive test.	Sensitivity: 77% Specificity: 66%
Diagnosis, Intractability, Risk, Efficacy (DIRE)	Clinician	Seven-item instrument to help identify chronic pain patients who may be at risk for opioid misuse or abuse prior to initiating long-term opioid therapy.	A score of ≤13 suggests that long-term opioid therapy may not be a suitable treatment for the patient.	Predicting compliance: Sensitivity: 77% Specificity: 66%
Opioid Risk Tool (ORT)	Clinician or patient self-report	Five yes/no questions to assess risk for opioid misuse or abuse in adult patients prescribed opioid analgesics for chronic pain management.	Stratifies patients into three risk groups: low (0-3), moderate (4-7) and high (≥8). A risk score of ≥8 is indicative of high risk for future aberrant behaviors.	c-statistic for males: c=0.82 c-statistic for females: c=0.85 *study involved a small sample size
Pain Assessment and Documentation Tool (PADT)	Clinician	41-item instrument assessing outcomes in patients with chronic pain receiving opioid therapy.	The PADT has cutoff scores.	Not applicable
Pain Medication Questionnaire (PMQ)	Patient self-report	26-item questionnaire used to assess opioid misuse in patients with chronic pain prescribed opioids.	Higher scores (>30) are suggestive of opioid misuse or abuse.	Sensitivity: 34% Specificity: 77%
Prescription drug use questionnaire	Patient self-report	31-item instrument that helps identify opioid misuse or OUD	Ascore of 10 or higher is considered positive.	Sensitivity: 66.7% Specificity: 59.7%

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Appendix C: Urine drug testing

Drug	Detection timeline	Test to order	Positive test	Comments
Buprenorphine (semi-synthetic)	Three to four days	GC/MS or LC/MS/MS	Buprenorphine	Will screen negative on opiate immunoassay; Causes of false positives: Tramadol
Codeine (natural)	One to three days	Opiate immunoassay + GC/MS or LC/MS/MS opiates	Morphine, codeine, high-dose hydrocodone	Will screen positive on opiate immunoassay; Cannot differentiate various natural opiates; Causes of false positives: poppy plant/seed, quinine, quinolone antibiotics and rifampin
Fentanyl (sythetic)	One to two days	GC/MS or LC/MS/MS fentanyl	Fentanyl, norfentanyl	Will screen negative on opiate immunoassay; May not detect all fentanyl-like substances
Heroin (semi-synthetic)	One to two days	Opiate immunoassay	Morphine, codeine	Will screen positive on opiate immunoassay, as heroin is metabolized to morphine
Hydrocodone (semi-synthetic)	Two days	Opiate immunoassay GC/MS or LC/MS/MS opiates	Hydrocodone, hydromorphone	May screen negative on opiate immunoassay; Opiate assay may only detect high-dose of hydrocodone
Methadone (synthetic)	Two to 11 days	Methadone immunoassay GC/MS or LC/MS/MS methadone	Methadone	Will screen negative on opiate immunoassay; Causes of flase positives: Verapamil, quetiapine, diphenhydramine and doxylamine

Key: Gas Chromatography (GC); Mass Spectrometry (MS); Liquid Chromatography (LC)

References: Substance Abuse and Mental Health Services Administration. Part 2: addressing opioid use disorder in general medical settings; (2018). Agency Medical Directors' Group. Interagency guideline on prescribing opioids for pain. 2015; HHS Publication No. (SMA) 18-5063PT2. Keary et al. Toxicologic testing for opiates: understanding false-positive and false-negative test results. *Prim Care Companion CNS Disord*. 2012; 14(4):PCC.12f01371.

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Fentanyl (sythetic)	One to two days	GC/MS or LC/MS/MS fentanyl	Fentanyl, norfentanyl	Will screen negative on opiate immunoassay; May not detect all fentanyl-like substances
Heroin (semi-synthetic)	One to two days	Opiate immunoassay	Morphine, codeine	Will screen positive on opiate immunoassay, as heroin is metabolized to morphine
Hydrocodone (semi-synthetic)	Two days	Opiate immunoassay GC/MS or LC/MS/MS opiates	Hydrocodone, hydromorphone	May screen negative on opiate immunoassay; Opiate assay may only detect high-dose of hydrocodone
Methadone (synthetic)	Two to 11 days	Methadone immunoassay GC/MS or LC/MS/MS methadone	Methadone	Will screen negative on opiate immunoassay; Causes of flase positives: Verapamil, quetiapine, diphenhydramine and doxylamine

Key: Gas Chromatography (GC); Mass Spectrometry (MS); Liquid Chromatography (LC)

References: Substance Abuse and Mental Health Services Administration. Part 2: addressing opioid use disorder in general medical settings; (2018). Agency Medical Directors' Group. Interagency guideline on prescribing opioids for pain. 2015; HHS Publication No. (SMA) 18-5063PT2. Keary et al. Toxicologic testing for opiates: understanding false-positive and false-negative test results. *Prim Care Companion CNS Disord*. 2012; 14(4):PCC.12f01371.

Appendix C: Urine drug testing

Drug	Detection timeline	Test to order	Positive test	Comments
Buprenorphine (semi-synthetic)	Three to four days	GC/MS or LC/MS/MS	Buprenorphine	Will screen negative on opiate immunoassay; Causes of false positives: Tramadol
Codeine (natural)	One to three days	Opiate immunoassay + GC/MS or LC/MS/MS opiates	Morphine, codeine, high-dose hydrocodone	Will screen positive on opiate immunoassay; Cannot differentiate various natural opiates; Causes of false positives: poppy plant/seed, quinine, quinolone antibiotics and rifampin
Fentanyl (sythetic)	One to two days	GC/MS or LC/MS/MS fentanyl	Fentanyl, norfentanyl	Will screen negative on opiate immunoassay; May not detect all fentanyl-like substances
Heroin (semi-synthetic)	One to two days	Opiate immunoassay	Morphine, codeine	Will screen positive on opiate immunoassay, as heroin is metabolized to morphine
Hydrocodone (semi-synthetic)	Two days	Opiate immunoassay GC/MS or LC/MS/MS opiates	Hydrocodone, hydromorphone	May screen negative on opiate immunoassay; Opiate assay may only detect high-dose of hydrocodone
Methadone (synthetic)	Two to 11 days	Methadone immunoassay GC/MS or LC/MS/MS methadone	Methadone	Will screen negative on opiate immunoassay; Causes of flase positives: Verapamil, quetiapine, diphenhydramine and doxylamine

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Discontinuation of opioid therapy

Discontinuation of opioid therapy may occur for various reasons. Opioid-therapy termination should not signify the end of treatment. Alternative treatment options should be evaluated. The rationale for discontinuing opioid therapy should be documented in the patient's medical record. [2]

Reasons for discontinuation of opioid therapy may include: [2,11]

- Failure to attain treatment goals
- Emergence of intolerable side effects
- No documented evidence of sustained CMI while on opioid therapy for at least three months
- Risks of continued opioid therapy outweigh the benefits (i.e., decreased function, concomitant opioid-benzodiazepine use; increased risk for opioid-related toxicity or comorbid medical conditions)
- Serious adverse event or overdose
- Known history of SUD (excluding tobacco use)
- Development of aberrant behaviors, such as:
  - Diversion, illicit drug activities or prescription forgery
  - Doctor and/or pharmacy shopping
  - Injecting oral or topical opioids
  - Aggressively insisting on receiving opioid prescriptions
  - Signs of intoxication or withdrawal
- Opioid use is not in compliance with best practices

Individualized weaning protocols

Weaning protocols should consider factors such as clinical setting and tapering schedule. Additionally, the patient's readiness for opioid therapy discontinuation may influence the plan. Employing motivational interviewing skills may prove helpful in this conversation.

Clinical setting

Low-risk patients are classified as those not receiving high-dose opioids and/or not exhibiting comorbid SUDs or mental health disorders. This group of patients may be safely weaned in an outpatient setting. [11]

High-risk patients are classified as those receiving high-dose opioids, on concurrent opioid-benzodiazepine therapy, failing taper in an outpatient setting, and/or exhibiting comorbid SUDs or mental health disorders. This group of patients should receive referral to a specialist to allow for close monitoring during the weaning process. [11]

Tapering schedule

Weaning protocols should be individualized to the patient and consist of a tapering schedule based on safety considerations. [2,11]

Slow tapering schedules

Slow tapering schedules should occur gradually to minimize opioid withdrawal signs and symptoms in patients with no safety concerns, with an opioid dose reduction of 10% per week or month depending on the duration of opioid therapy. [2,11]

Rapid tapering schedules

Rapid tapers, however, may be necessary in certain situations (e.g., overdose cases or evidence of SUD). A rapid taper may occur over two to three weeks. [2,11]

Immediate discontinuation

Immediate discontinuation should be considered when the patient displays evidence of diversion or aberrant drug-related behaviors. [11]

Withdrawal symptoms or aberrant drug-related behaviors may result from a taper performed too rapidly. Having a treatment plan outlining the expectations, treatment options, and exit strategies when initiating opioid therapy may avert behavioral issues during the taper portion of opioid therapy. The practitioner should watch for emergence of undiagnosed mental health disorders, particularly those patients receiving prolonged or high-dose opioids. Lastly, abstention from using opioids may decrease the patient's tolerance to these drugs; therefore, the practitioner should warn the patient that there is an increased risk of overdose and death if the patient resumes previous opioid dosages. [11]

Assessment of opioid withdrawal

Withdrawal encompasses the physical manifestations that may occur during an opioid taper. Onset of acute withdrawal symptoms from short-acting opioids typically begin within hours of the last dose, while long-acting opioids usually start after several days of the last dose. [27]

Opioid withdrawal signs [11,27]

- Signs of early opioid withdrawal
  - Restlessness, yawning, diaphoresis, lacrimation, rhinorrhea, piloerection (goose flesh), mydriasis (pupil dilation)
- Signs of late opioid withdrawal
  - Anxiousness, fever, tachycardia, hypertension, and the appearance of being in pain

Signs and symptoms of opioid withdrawal may be assessed with one of the following validated tools: [11]

- Clinical Opioid Withdrawal Scale (COWS)
  - The COWS consists of 11 items that identifies signs and symptoms of opioid withdrawal
- Objective Opioid Withdrawal Scale (OOWS)
  - The OOWS is a 13-item list in which the practitioner observes for objective signs and symptoms of opioid withdrawal
- Subjective Opioid Withdrawal Scale (SOWS)
  - The SOWS is a self-reported, 16-item questionnaire identifying subjective symptoms of opioid withdrawal

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- Serious adverse event or overdose
- Known history of SUD (excluding tobacco use)
- Development of aberrant behaviors, such as:
  - Diversion, illicit drug activities or prescription forgery
  - Doctor and/or pharmacy shopping
  - Injecting oral or topical opioids
  - Aggressively insisting on receiving opioid prescriptions
  - Signs of intoxication or withdrawal
- Opioid use is not in compliance with best practices

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Continuing current opioid dosage

The practitioner should assess the patient's progress within one month of initiating opioid therapy for chronic pain. More frequent follow-up assessments are required for patients at higher risk for opioid misuse. This visit will allow the practitioner to gauge the following: meaningful pain and function improvements, side effects, serious adverse events, and presence of aberrant behaviors. If the practitioner determines that opioid therapy is providing a net benefit and to maintain therapy, routine follow-up visits should occur every three months to assure the goals of therapy continue to be met. If harms outweigh benefits of continued opioid therapy, alternative therapies should be optimized and a weaning protocol initiated. Lastly, evidence has shown that ineffective opioid therapy at one month is unlikely to be effective at six months. [2]

Opioid dosage escalation or conversion

Patients whose pain improved but did not meet pain and function milestones may be candidates for dosage escalation.

Key principles for opioid dosage escalation or conversion

Opioid dosage escalation:

- Slow dosage escalation in the smallest effective increment is recommended, with follow-up occurring one to four weeks after adjusting the dose
- Caution should be exercised when escalating dosages of opioids combined with nonopioid agents (i.e., acetaminophen, aspirin, or other NSAIDs) to avoid toxic levels of nonopioid agents
- Continue to assess for CMI in function and pain; if no CMI is occurring with an escalated dosage, then consider tapering dosage to the previous dose and discuss possible discontinuation with the patient
- Calculate the daily dosage of opioids using the MME/day metric to gauge potential risk of overdose and to help identify the need for dosage reduction or taper
- Be aware that the first three to seven days of an increase in opioid dosage present the greatest risk for overdose

Converting opioid therapy:

- When changing one opioid to another, the new opioid dosage should be lower than the calculated MME of the current opioid regimen to avoid unintentional overdose caused by incomplete cross-tolerance and differences in opioid pharmacokinetics
- Follow-up should occur within two weeks of conversion since the risk of nonfatal overdose is greater during this time period
- Calculate the daily dosage of opioids using the MME/day metric to gauge potential risk of overdose and to help identify the need for dosage reduction or taper

High dosage opioid therapy

Research has not shown a demonstrable association between high-dose opioids and improvement in pain relief or functionality; however, high doses of opioids are also accompanied with greater incidences of overdose and death. Therefore, increasing opioid dosages to 50 MME or greater per day warrants caution and re-evaluating the necessity of high-dose opioids to accomplish the goals set forth in the treatment plan. Evidence strongly discourages prescribing doses greater than 90 MME/day due to the subsequent increases in fatal and nonfatal overdoses. [2]

Key principles for high dosage opioid therapy [2]

High doses of opioids:

- Opioid dosages between 20 MME/day and 50 MME/day significantly increase the risk of adverse events, including unintentional overdose
- High dosages of opioids (50 MME) are associated with greater incidences of overdose and death
- When prescribing dosages greater than 50 MME/day, practitioners should monitor pain and function more frequently, perform more frequent urine drug testing, and consider prescribing naloxone for home use
- The practitioner should also discuss safety concerns regarding high dosage opioids and possible overdose as well as discuss reducing or tapering and discontinuing therapy if opioid-related risks materialize
- Calculate the daily dosage of opioids using the MME/day metric to gauge potential risk of overdose and to help identify the need for dosage reduction or taper

Extended-Release/Long-Acting opioid therapy

Situations may present the necessity to switch from IR/SA to ER/LA opioids for chronic pain. Only patients who have received IR/SA opioids for at least one week should be considered for ER/LA opioid therapy. It is preferable to select an ER/LA opioid with foreseeable pharmacokinetics to reduce the risk of overdose. Therefore, the use of methadone and transdermal fentanyl should be reserved for physicians familiar with their pharmacokinetics. The use of ER/LA opioid therapy should not be used for intermittent use or in combination with IR/SA preparations. Follow-up should occur within two weeks of conversion since the risk of nonfatal overdose is greater during this time period. The practitioner should review the side-effect profile and adverse events with the patient and his/her representative. [2]

See **Appendix E** for a list of clinical reminders for managing acute and chronic pain. Additional information about recommended starting doses and thresholds for selected opioids may be found in the **Interagency Guideline on Prescribing Opioids for Pain** starting on page 55.

Continuing current opioid dosage

The practitioner should assess the patient's progress within one month of initiating opioid therapy for chronic pain. More frequent follow-up assessments are required for patients at higher risk for opioid misuse. This visit will allow the practitioner to gauge the following: meaningful pain and function improvements, side effects, serious adverse events, and presence of aberrant behaviors. If the practitioner determines that opioid therapy is providing a net benefit and to maintain therapy, routine follow-up visits should occur every three months to assure the goals of therapy continue to be met. If harms outweigh benefits of continued opioid therapy, alternative therapies should be optimized and a weaning protocol initiated. Lastly, evidence has shown that ineffective opioid therapy at one month is unlikely to be effective at six months. [2]

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- Caution should be exercised when escalating dosages of opioids combined with nonopioid agents (i.e., acetaminophen, aspirin, or other NSAIDs) to avoid toxic levels of nonopioid agents
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- Calculate the daily dosage of opioids using the MME/day metric to gauge potential risk of overdose and to help identify the need for dosage reduction or taper

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Research has not shown a demonstrable association between high-dose opioids and improvement in pain relief or functionality; however, high doses of opioids are also accompanied with greater incidences of overdose and death. Therefore, increasing opioid dosages to 50 MME or greater per day warrants caution and re-evaluating the necessity of high-dose opioids to accomplish the goals set forth in the treatment plan. Evidence strongly discourages prescribing doses greater than 90 MME/day due to the subsequent increases in fatal and nonfatal overdoses. [2]

Key principles for high dosage opioid therapy [2]

High doses of opioids:

- Opioid dosages between 20 MME/day and 50 MME/day significantly increase the risk of adverse events, including unintentional overdose
- High dosages of opioids (50 MME) are associated with greater incidences of overdose and death
- When prescribing dosages greater than 50 MME/day, practitioners should monitor pain and function more frequently, perform more frequent urine drug testing, and consider prescribing naloxone for home use
- The practitioner should also discuss safety concerns regarding high dosage opioids and possible overdose as well as discuss reducing or tapering and discontinuing therapy if opioid-related risks materialize
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Situations may present the necessity to switch from IR/SA to ER/LA opioids for chronic pain. Only patients who have received IR/SA opioids for at least one week should be considered for ER/LA opioid therapy. It is preferable to select an ER/LA opioid with foreseeable pharmacokinetics to reduce the risk of overdose. Therefore, the use of methadone and transdermal fentanyl should be reserved for physicians familiar with their pharmacokinetics. The use of ER/LA opioid therapy should not be used for intermittent use or in combination with IR/SA preparations. Follow-up should occur within two weeks of conversion since the risk of nonfatal overdose is greater during this time period. The practitioner should review the side-effect profile and adverse events with the patient and his/her representative. [2]

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Continuing current opioid dosage

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Opioid dosage escalation or conversion

Patients whose pain improved but did not meet pain and function milestones may be candidates for dosage escalation.

Key principles for opioid dosage escalation or conversion

Opioid dosage escalation:

- Slow dosage escalation in the smallest effective increment is recommended, with follow-up occurring one to four weeks after adjusting the dose
- Caution should be exercised when escalating dosages of opioids combined with nonopioid agents (i.e., acetaminophen, aspirin, or other NSAIDs) to avoid toxic levels of nonopioid agents
- Continue to assess for CMI in function and pain; if no CMI is occurring with an escalated dosage, then consider tapering dosage to the previous dose and discuss possible discontinuation with the patient
- Calculate the daily dosage of opioids using the MME/day metric to gauge potential risk of overdose and to help identify the need for dosage reduction or taper
- Be aware that the first three to seven days of an increase in opioid dosage present the greatest risk for overdose

Converting opioid therapy:

- When changing one opioid to another, the new opioid dosage should be lower than the calculated MME of the current opioid regimen to avoid unintentional overdose caused by incomplete cross-tolerance and differences in opioid pharmacokinetics
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Appendix D: Morphine Milligram Equivalent (MME) for oral opioids

Opioid (doses in mg/day except where noted)	Conversion factor
Codeine	.15
Fentanyl transdermal (mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone: 1-20 21-40 41-60 ≥61-80	 4 8 10 12
Morphine (reference)	1
Oxycodone	1.5
Oxymorphone	3
Tramadol	10

Do not use to convert one opioid to another.

References: Centers for Disease Control and Prevention. Calculating total daily dose of opioids for safe dosage. Agency Medical Directors' Group. *Interagency guideline on prescribing opioids for pain*. 2015.

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Appendix E: Pain management clinical reminders

1. Preferred treatment for pain is nonpharmacologic therapy and non-opioid pharmacologic therapy. Opioids should not be considered first-line therapy for chronic pain.
2. Establish treatment goals prior to initiating opioid therapy.
3. Review potential risks and realistic benefits associated with opioid therapy as well as alternative pain treatment options.
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5. When initiating opioid therapy for chronic pain, the minimal effective opioid dose should be prescribed.
6. When initiating therapy for acute pain, it is recommended to begin with a low-dose, immediate release opioid. The quantity prescribed should be 3 days or less.
7. Assess the patient's progress within 1 to 4 weeks of initiating opioid therapy or dose escalation for chronic pain. If the practitioner determines that opioid therapy is providing a net benefit and to maintain therapy, routine follow-up visits should occur every 3 months to assure the goals of therapy continue to be met. If treatment goals are not being met, taper and discontinue opioid therapy. Alternative treatment options should be evaluated.
8. Before starting, and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms.
9. Review state prescription drug monitoring program prior to initiating opioid therapy and intermittently during opioid therapy (i.e., every prescription refill or every 3 months).
10. Urine drug testing should occur prior to initiating opioid therapy or before increasing opioid dosages. At a minimum, clinicians should perform drug urine testing annually to monitor long-term use of opioid therapy.
11. Evidence-based treatment interventions should be offered to individuals with opioid use disorder.

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CPG: FOLLOW-UP

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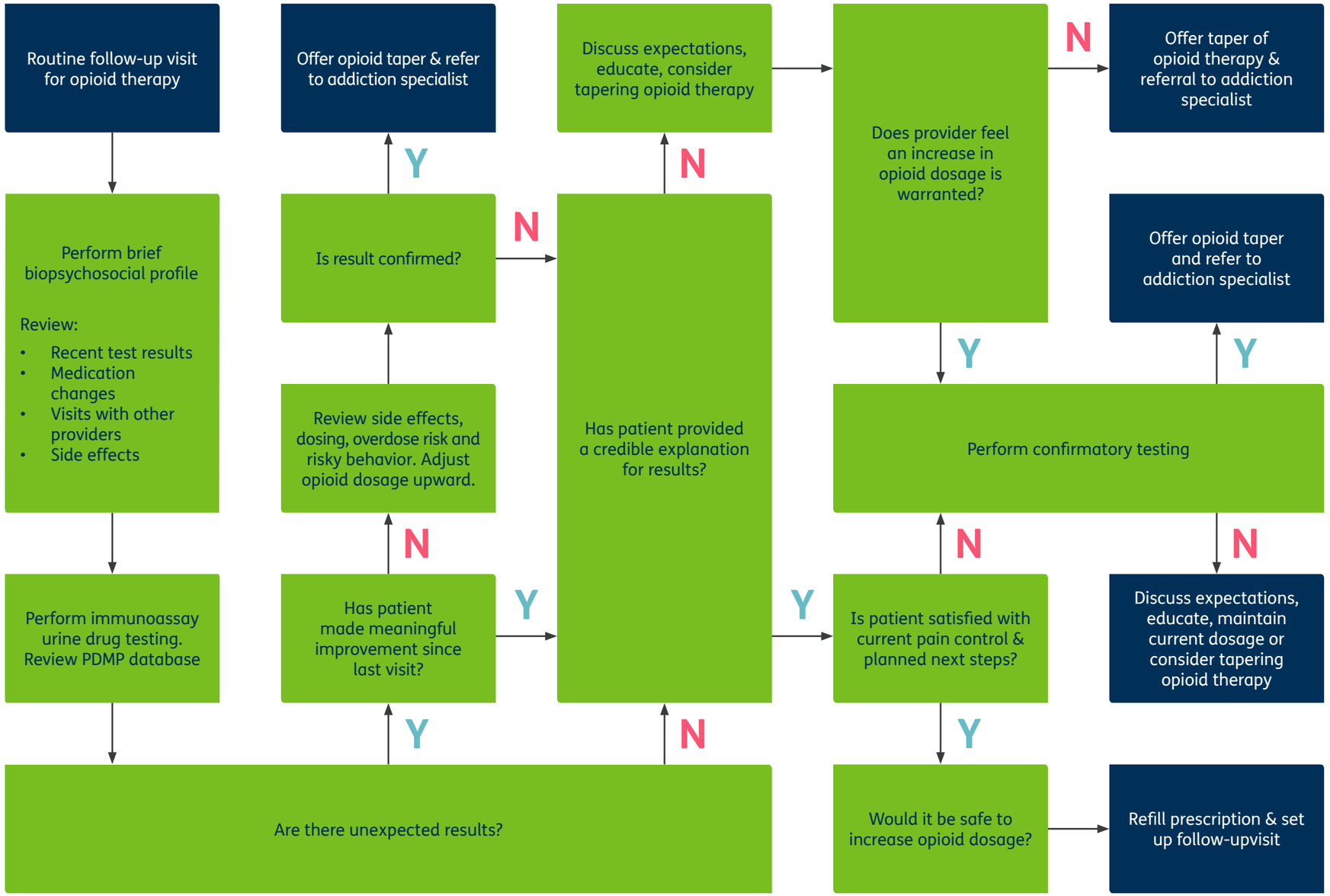

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