Strategies to Prevent, Treat, and Manage Opioid Use Disorder and Overdose

Presented by:

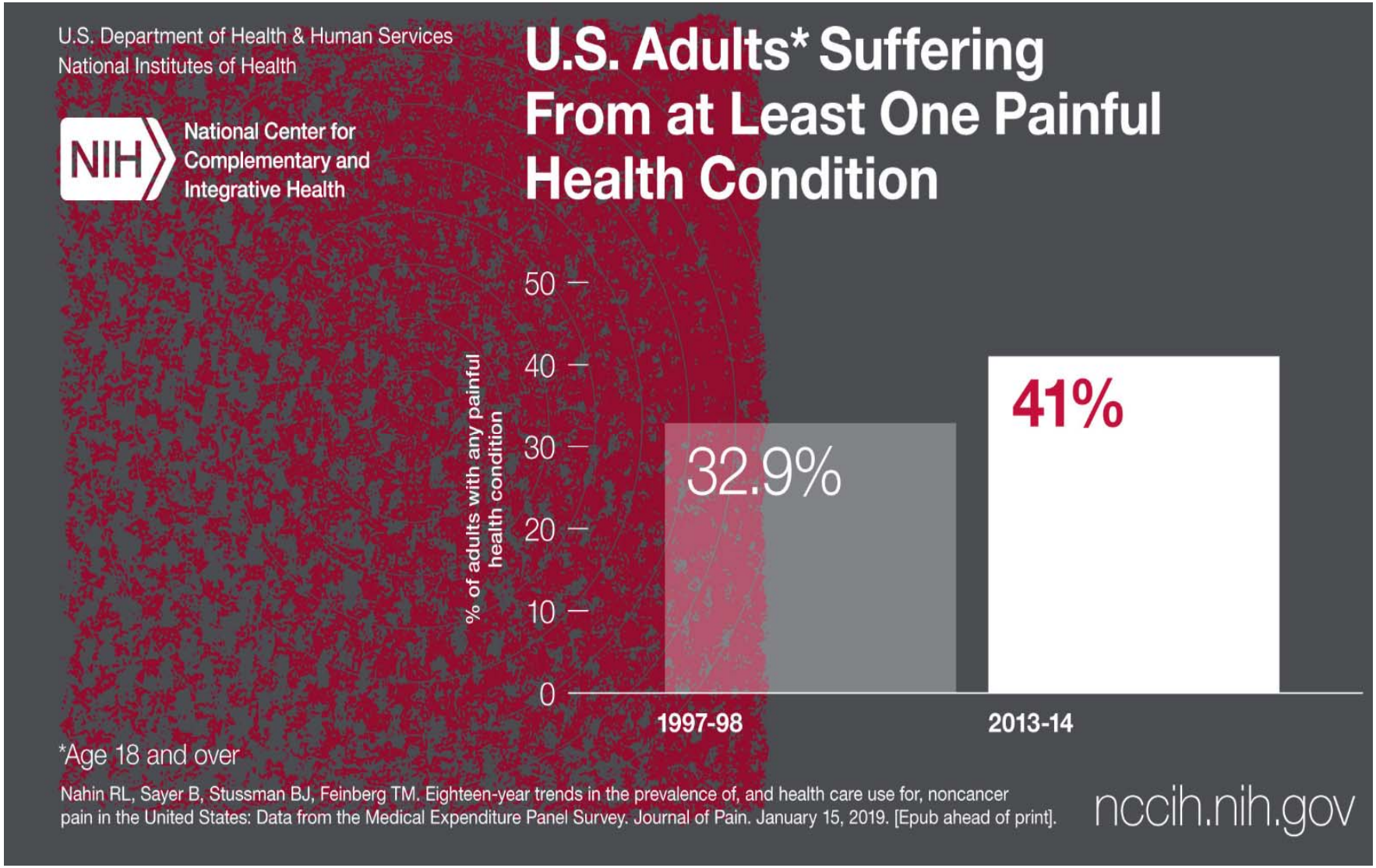
Mersedeh Hashemian, Pharm.D., APh
Health Net of California

10/21/2020

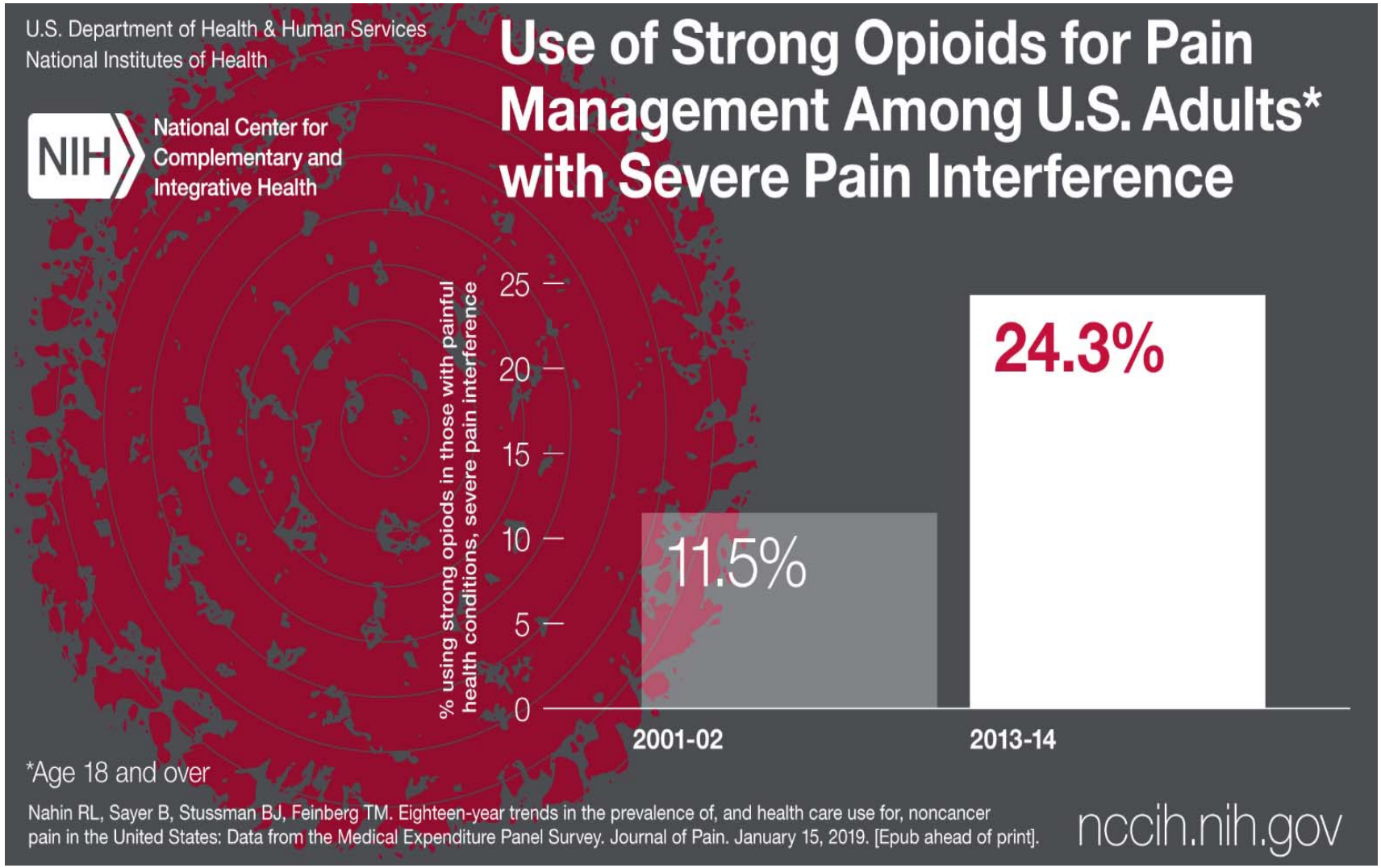
Health Net

Objectives

- Describe at least two different types of pain and treatment goals
- Explain at least three DSM-5 criteria to identify and treat opioid-dependent individuals
- List at least two ways to asses and monitor patients that are prescribed opioids



Nahin RL, Sayer B, Stussman BJ, Feinberg TM. Eighteen-year trends in the prevalence of, and health care use for, noncancer pain in the United States: Data from the Medical Expenditure Panel Survey. *Journal of Pain*. January 15, 2019.



Nahin RL, Sayer B, Stussman BJ, Feinberg TM. Eighteen-year trends in the prevalence of, and health care use for, noncancer pain in the United States: Data from the Medical Expenditure Panel Survey. *Journal of Pain*. January 15, 2019.

Definition of Pain

- An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.(IASP 1989)

- A complex experience embracing physical, mental, social, and behavioral processes, compromising the quality of life of many individuals. (SSI Commission for Evaluation of Pain)

https://www.ssa.gov/policy/docs/ssb/v50n1/v50n1p13.pdf

Health Net

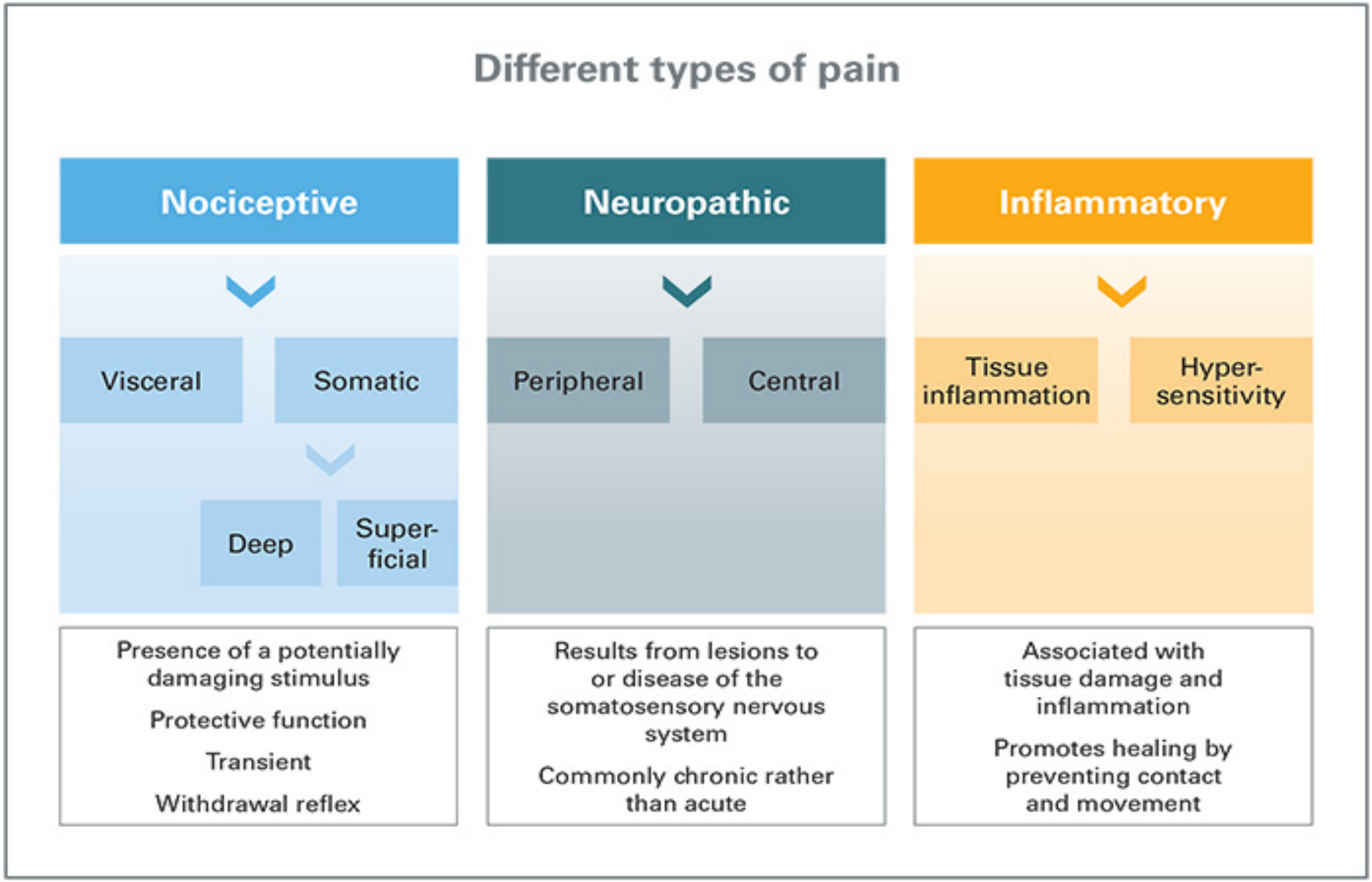
Classification Of Pain

Basis	Types of pain
Duration	❖ Acute ❖ Chronic
Cause	❖ Cancer ❖ Non-cancer
Mechanism	❖ Nociceptive ❖ Neuropathic ❖ Inflammatory

Health Net

Acute vs Chronic Pain

	Acute	Chronic
Onset/timing	Sudden, brief in duration, subsides when tissue heals	Insidious onset, pain persists despite tissue healing
Signal	Warning sign of actual or potential tissue damage	False alarm, not a warning signal of damage
Psychological effects (anxiety, stress, etc.)	Improve when pain resolves	Associated with anxiety, depression, and social withdrawal.



Cole BE; Pain Management: Classifying, Understanding, and Treating Pain; Hospital Physician: June 2002 (23-30).

Health Net

Treatment Goals

Acute Pain	Chronic Pain
• Recovery from the underlying injury, surgery, or disease • Minimize impact of pain on recovery activities • Reduction of pain to an acceptable level • Minimize medication side effects • Prevent to become chronic pain	• Restore function • Treat underlying cause • Minimize medication use • Prevention of secondary pain problems such as depression, poor coping, insomnia, etc.

Multimodal Analgesia

This term describes the use of multiple modalities that are used to provide pain relief with various parts of the pain pathway targeted and may include:

- Pharmacological
- Non-pharmacological & self-management techniques
- Interventional

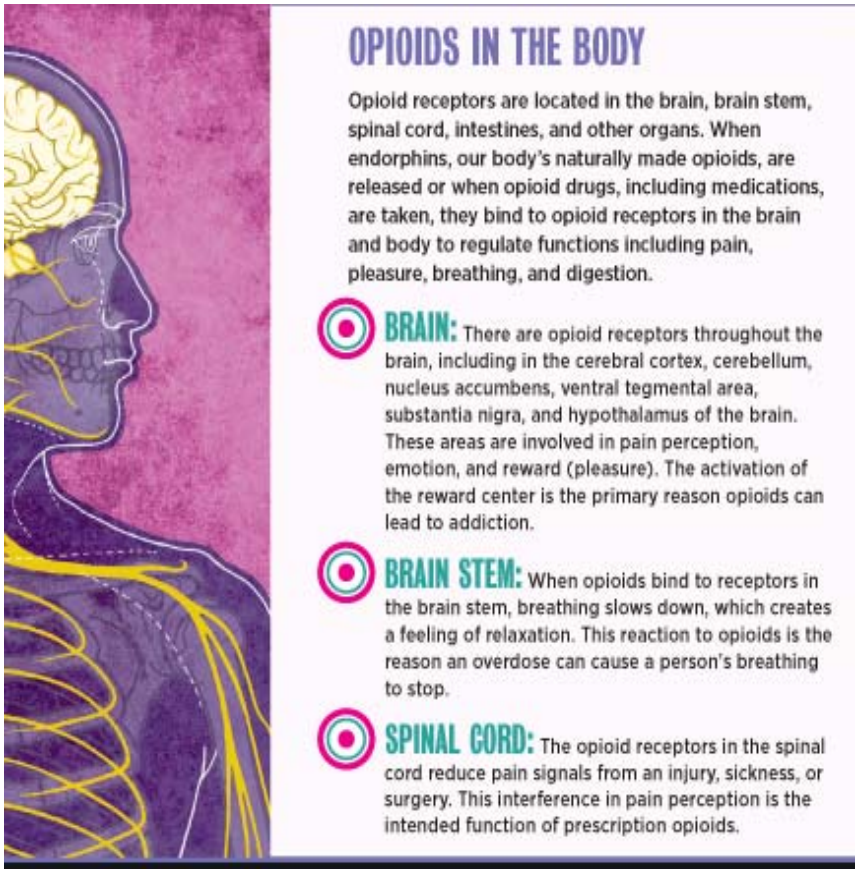
Health Net®

Non-pharmacologic Therapies

- Heat/cold
- Relaxation
- Distraction
- Acupressure/acupuncture
- Exercise therapy
- Cognitive therapy
- Massage therapy
- Mindfulness

Pharmacologic Therapies

Opioids



http://31j8fe2l56f122iue1wuvve1-wpengine.netdna-ssl.com/wp-content/uploads/2018/02/opioids-1.jpg

Non-opioids

- Over The Counter pain relief meds
- Select Anti-convulsants
- Select Antidepressants
- Corticosteroids
- Muscle relaxants
- Topical medications

Opioids

- Synthetic or partly-synthetic drugs that are manufactured to work in a similar way to opiates
- Examples: Methadone, Percocet, Percodan, OxyContin, Vicodin, hydrocodone, Fentanyl.
- When used as directed and for a short time, the patients are less likely to become addicted.
- After 8 days there is a 13.5% chance of becoming addicted. After 30 days there is a 29.9% chance of developing addiction.

Health Net

Opioid Side Effects

- Digestive system
- Cardiac
- Mood disturbances
- Lungs
- Opioid-induced hyperalgesia
- Increase in falls
- Endocrine problems
- Osteoporosis

Addiction and OUD

Addiction

Per American Society of Addiction Medicine: “a primary, chronic disease of brain reward, motivation, memory, and related circuitry”

Opioid Use Disorder (OUD)

Per DSM-5: “disorder characterized by loss of control of opioid use, risky opioid use, impaired social functioning, tolerance, and withdrawal"

US Department of Health and Human Services (HHS), Office of the Surgeon General. Facing Addiction in America: The Surgeon General’s Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016. addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf; Substance Abuse and Mental Health Services Administration (SAMHSA). Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series 63, Full Document. HHS Publication No. (SMA) 19- 5063FULLDOC. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018. store.samhsa.gov/system/files/sma18-5063fulldoc.pdf.

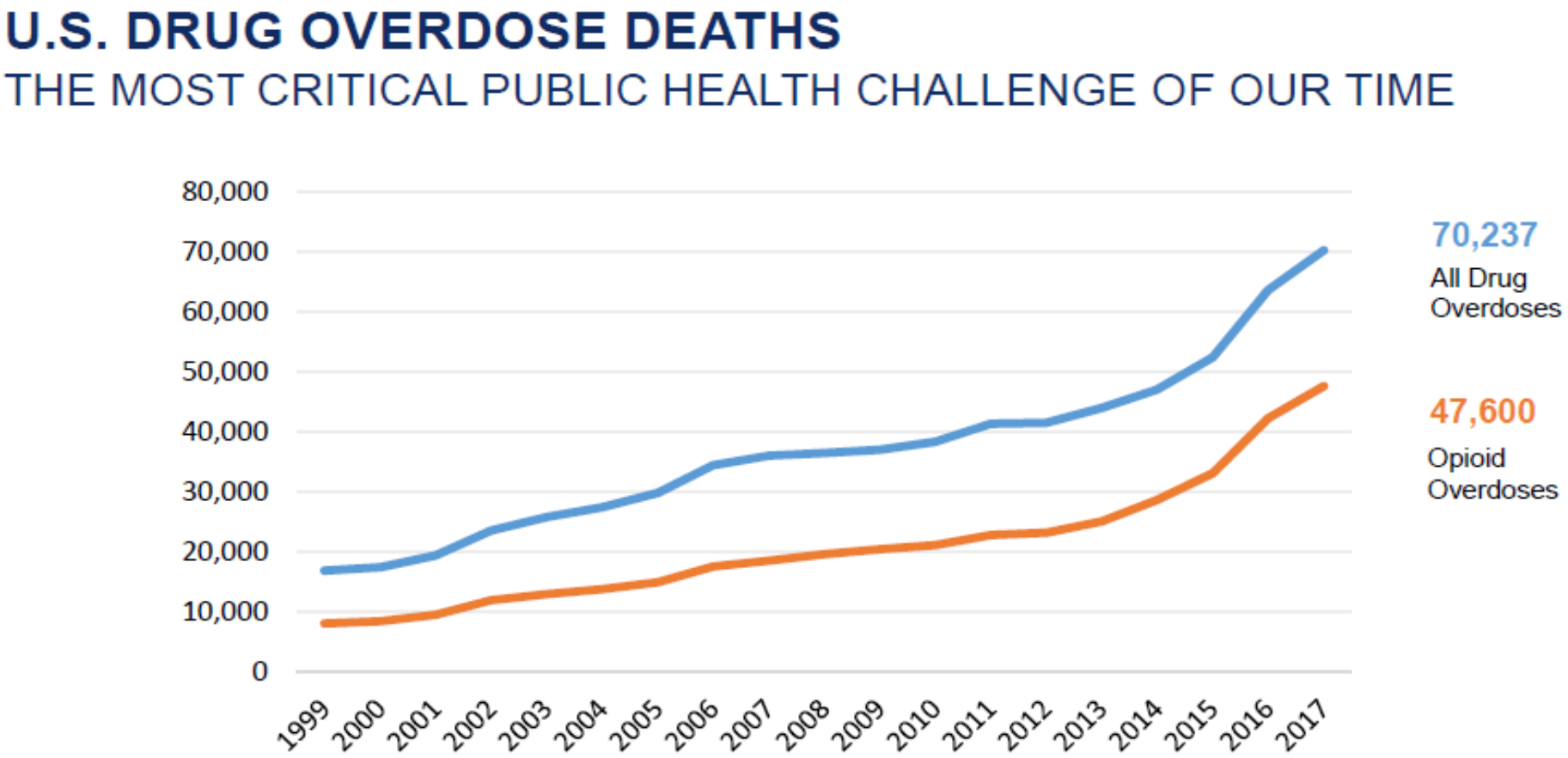
https://www.pharmacytimes.org, Transitioning Treatment Between Opioid Withdrawal and Induction of Maintenance Therapy in Patients With Opioid Use Disorder, Chris Herndon, PharmD, BCACP, FCCP

Prevalence of OUD

- An estimated **1.7M AMERICANS** have OUD related to opioid painkillers; **526K** have heroin- related OUD.
- Estimated cost of the **OPIOID EPIDEMIC** was **$504 BILLION** in 2015.
- Opioid overdose caused **46,800 DEATHS** nationwide in 2018— this exceeded the # caused by motor vehicle crashes.
- **OPIOID-RELATED** inpatient hospital stays **INCREASED 117%** nationally from 2005 to 2016.

https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006

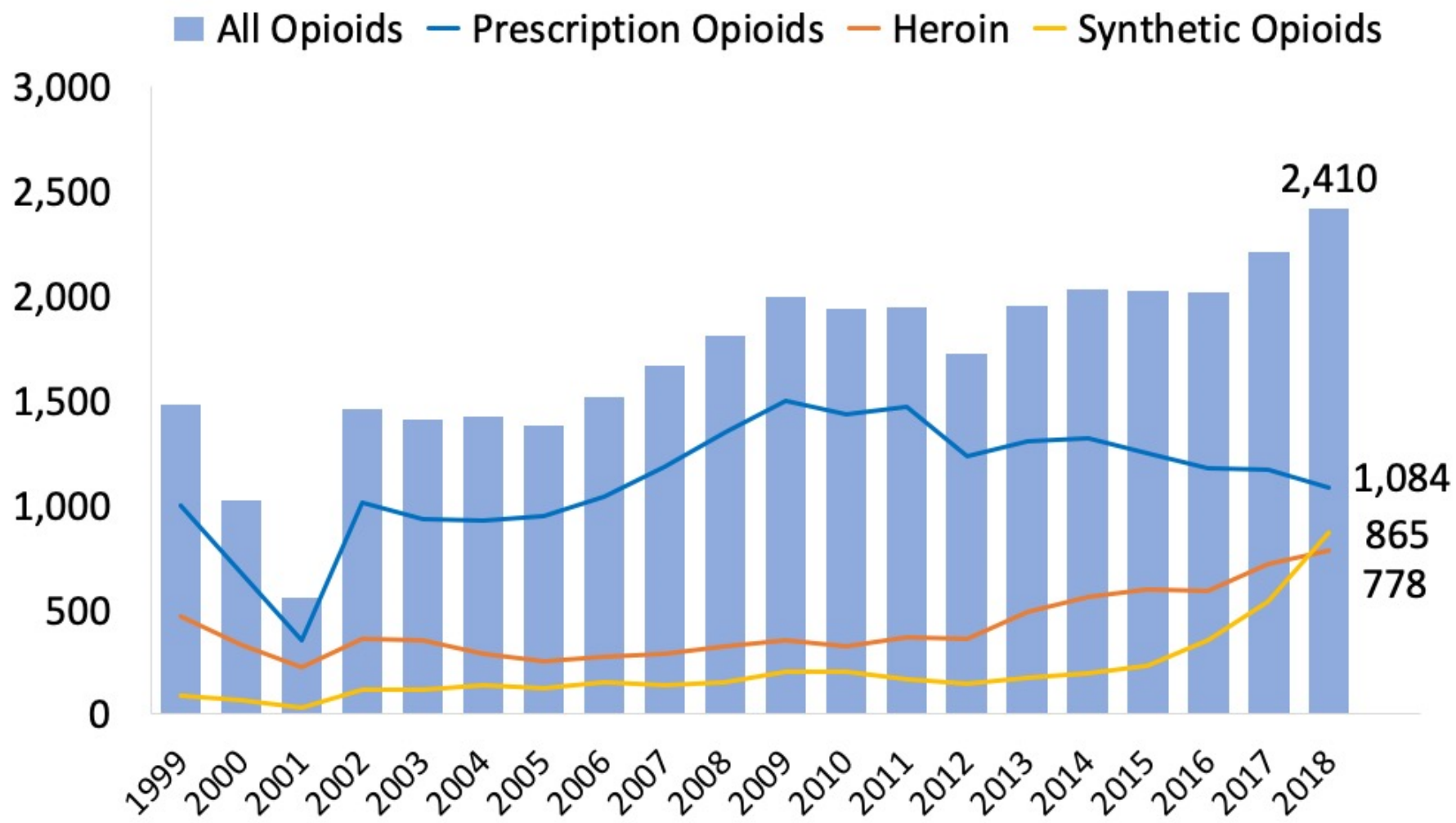
U.S. Drug Overdose Deaths



SOURCE: NCHS, National Vital Statics System, Mortality

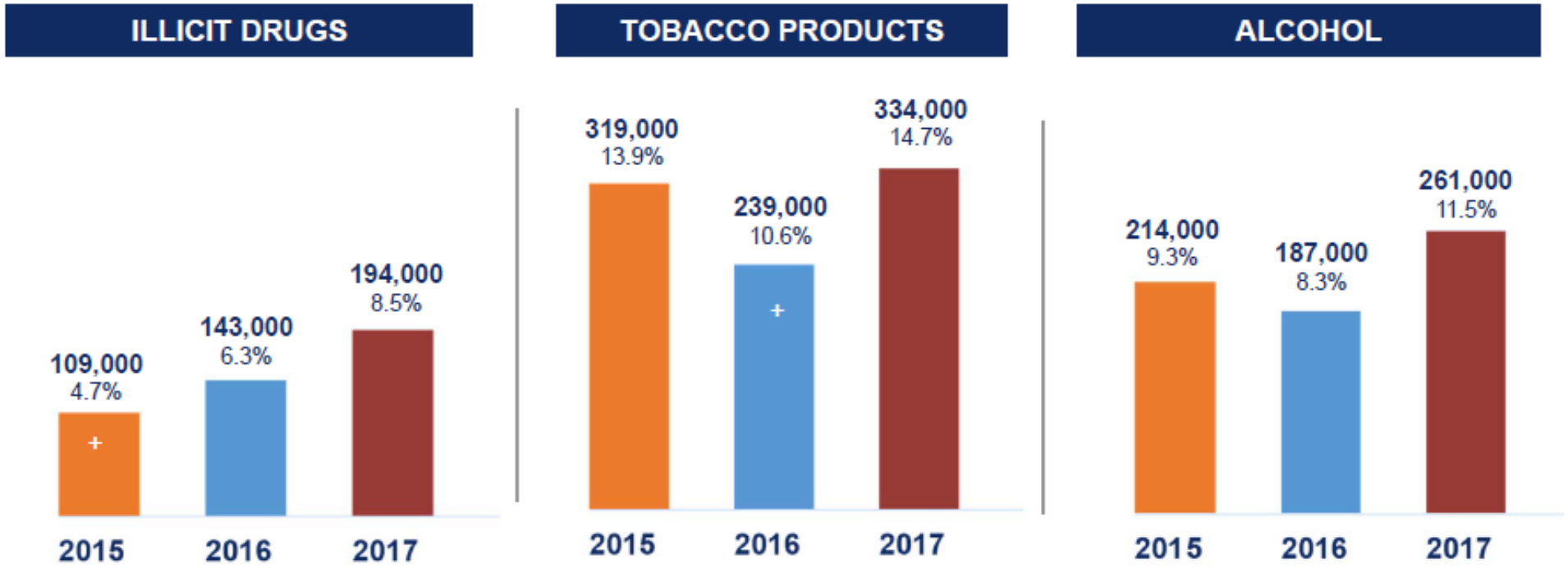
Health Net

Number of overdose deaths involving opioids in California, by opioid category



Source: CDC WONDER, 2020

Substance Use Among Pregnant Women



NSDUH, 2017 Data; published Sept. 2018

Infectious Disease and Opioid Epidemic

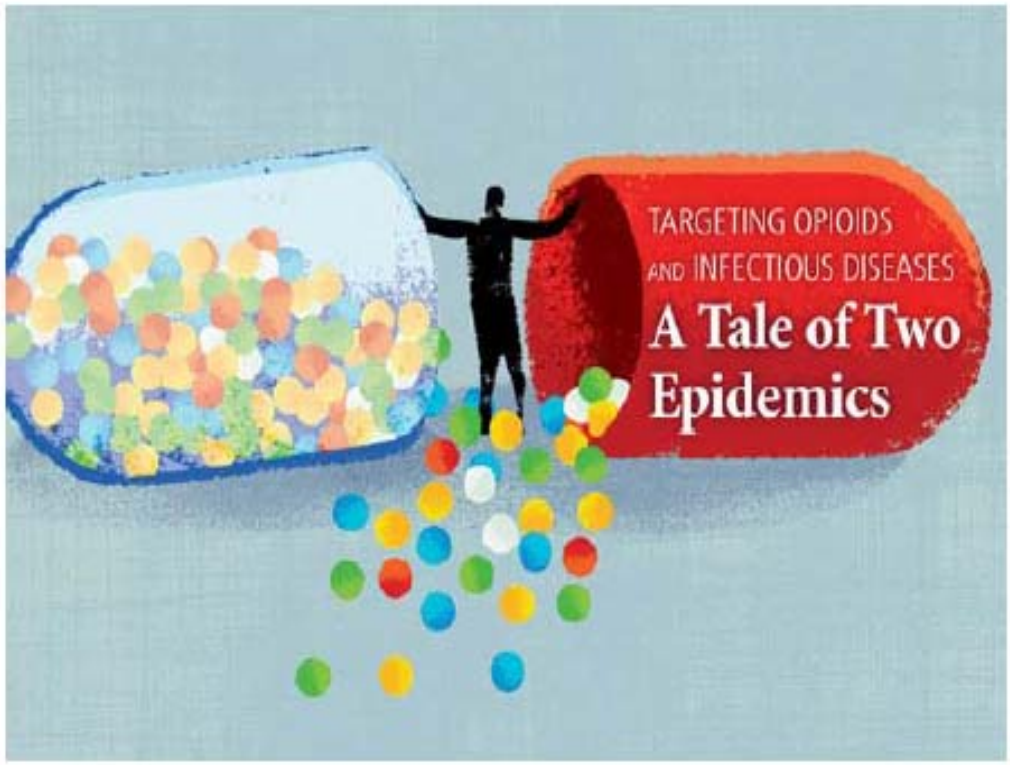
HIV

Hepatitis C

Hepatitis B

Endocarditis

Skin, bone, and joint infections



National Academies Workshop
Sponsored by OASH, Report July 2018

Goals to combat this epidemic

GOAL	EXAMPLES OF DATA SUPPORTING GOAL
Prevent. Decrease the number of new starts: fewer prescriptions, lower doses, shorter durations.	• Large health plan study showed 67% of members taking opioids for 90 days continued regular use two years later. • Risk of prolonged use of opioids increases by 1% per day over 3 days.
Manage. Identify patients on risky regimens (high-dose, or opioids and sedatives) and develop individualized treatment plans, avoiding mandatory tapers.	• Doses >100 morphine milligram equivalents (MME) per day increase the death rate almost nine fold compared to 1 to 20 mg daily. • Thirty percent of opioid overdose deaths include concurrent benzodiazepine use. • High dose opioid use fell more than 75% through Partnership Health Plan's multipronged initiative (treatment guidelines, formulary controls, prescriber education, and detailing).
Treat. Streamline access to evidence-based treatment for substance use.	• Buprenorphine and methadone decrease rates of death, HIV, and hepatitis, and increase retention in treatment compared to social model treatments. • Sixty-two percent of physicians whose patients have insurance coverage find it difficult to access MAT.
Stop Overdose deaths. Streamline access to naloxone for overdose reversal.	• Co-prescribing of naloxone with chronic opioid prescriptions lowered emergency department visits by 47%. • Communities with increased naloxone availability have lower death rates.

Source: Smart Care California 11/2017

When to initiate or continue opioids	Opioids selection, dosage, duration, follow up, and discontinuation	Assessing risk and addressing harms of opioid use
• **Opioids are not the first line.** • Establish treatment goals before starting opioid and a plan if therapy is discontinued. • Continue Opioids only there is clinically improvement in pain and function • Discuss risks and benefits	• Use Immediate-release opioids when starting. • Prescribe the lowest effective dose for short duration, provide no more than needed for the condition. • Follow up and review risks and benefits before and during therapy. • If benefits do not outweigh harms, consider tapering to lower doses and discontinue.	• **Offer risk mitigation strategies including naloxone for patients at risk for overdose.** • Review CURES before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every four months thereafter. • Perform UDT before and after therapy. • Avoid concurrent prescribing with benzos. • **Offer or arrange MAT for patients with OUD.**

U.S. Centers for Disease Control. Guideline for Prescribing Opioids for Chronic Pain – United States 2016.

Approaches to Better Pain Management

- Medication Reconciliation & Motivational Interviewing
- Start with a complete baseline assessment
- Be familiar with latest guidelines
- Start low and go slow when prescribing opioids
- Screen patients for mental health, drug abuse, and addiction problems
- Counsel patients and caregivers on safe use, including proper storage and disposal
- Emphasize using “one provider & one Pharmacy”
- Refer to specialists if needed

The Red Flags for Providers

Components of Addiction ***(The 3 "Cs")***	**Possible expression in patients on chronic opioids**
Loss of **C**ontrol	• Reports lost/stolen medication • Calls for early refills • Seeks opioids from other sources • Withdrawal symptoms noted at appointments
Craving, preoccupation with use	• Recurring requests for increases in opioids • Increasing pain despite lack of progression of disease • Dismissive of non-opioid treatments
Use despite negative **C**onsequences	• Over-sedation/somnolence • Decreases in activity, functioning and/or relationships

Credit/link: https://www.drugabuse.gov/sites/default/files/podat_1.pdf

The Red Flags for Pharmacists

- Forged prescriptions
- Prescription is from outside the immediate geographic area
- Altered prescriptions (e.g. multiple ink colors or handwriting styles)
- Cash payments
- Inconsistent or early fills
- Multiple prescribers

"The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription." (Title 21 Code of Federal Regulations Part 1306.04 (21 C.F.R. § 1306.04)

(https://www.pharmacytimes.com/contributor/jeffrey-fudin/2017/10/opioid-red-flags-for-consideration-)

Health Net®

Suspect opioid use disorder?

- Discuss your concern with your patient
- Provide an opportunity for your patient to disclose concerns
- Assess for opioid use disorder and arrange for treatment
- **Do not dismiss patients from care** use the opportunity to provide potentially life saving information and interventions

Risk Factors for OUD

- Personal and family history of substance abuse
- Age (16-45 at highest risk)
- Comorbid psychiatric illness: mood disorders, anxiety, PTSD, personality disorder, and suicide behavior/attempts
- More prevalent in uninsured, unemployed, and low income
- Significant history of legal problems or incarceration
- Recent completion of inpatient treatment

http://www.californiaopioidsafetynetwork.org.ca opioid dashboard, Edlund MJ, et al. Pain. 2007;129(3):355-362; Liebschutz JM, et al. J Pain. 2010;11(11):1047-1055; Webster LR. Anesth Analg. 2017;125(5):1741-1748.

Screening for OUD

- Always **SBIRT!**
  - **S**creening, **B**rief Intervention, **R**eferral to **T**reatment
- Screening
  - Drug Abuse Screening Test (DAST-10)
  - Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
  - Car, Relax, Alone, Forget, Friends, Trouble Screening Test (CRAFFT) – for ages 12 to 21 years
  - Screening to Brief Intervention (S2BI)
  - Others

SAMHSA. Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series 63, Full Document. HHS Publication No. (SMA) 19-5063Fulldoc. Rockville, MD; Substance Abuse and Mental Health Services Administration, 2018. store.samhsa.gov/system/files/sma18-5063fulldoc.pdf; National Institute on Drug Abuse (NIDA). www.drugabuse.gov. Accessed August 8, 2019.

WWW.pharmacytimes.org, Transitioning Treatment Between Opioid Withdrawal and Induction of Maintenance Therapy in Patients With Opioid Use Disorder, Chris Herndon, PharmD, BCACP, FCC

DSM-5: Opioid Use Disorder

- Taking larger amounts or taking over a longer period than intended.
- Persistent desire or unsuccessful efforts to cut down or control opioid use.
- Spending a great deal of time obtaining or using the opioid or recovering from its effects.
- Craving, or a strong desire or urge to use opioids
- Problems fulfilling obligations at work, school or home.
- Continued opioid use despite having recurring social or interpersonal problems.
- Giving up or reducing activities because of opioid use.
- Using opioids in physically hazardous situations.
- Continued opioid use despite ongoing physical or psychological problem likely to have been caused or worsened by opioids.
- Tolerance (i.e., need for increased amounts or diminished effect with continued use of the same amount)
- Experiencing withdrawal (opioid withdrawal syndrome) or taking opioids (or a closely related substance) to relieve or avoid withdrawal symptoms

DSM-5: Diagnostic and Statistical Manual of Mental Disorders- 5th edition https://www.psychiatry.org/patients-families/addiction/opioid-use-disorder/opioid-use-disorder

Health Net

Can Opioid Use Disorder be Treated? YES!

- There are medications for treatment of opioid dependency such as:
  - **Buprenorphine**
  - **Methadone**
  - **Naltrexone**
- MAT has proven to be very effective as part of an evidence-based treatment program that includes behavioral, cognitive and other recovery-oriented interventions, treatment agreements, UDT, and PDMP.

Treatment Guidelines/Protocols

- Treatment Improvement Protocol (TIP 63)

Tip 63 updated 2020

- ASAM National Practice Guidelines

ASAM National Practice Guidelines

https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006

Copyright permission pending: https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guidelinesupplement.pdf?sfvrsn=24

TIP 63 Main Points

- Addiction is a chronic, treatable condition.
- General principles of good care for chronic diseases can guide OUD treatment.
- Patient centered care empowers patients with
- information that helps them make better treatment
- decisions with the healthcare professionals involved in their care.
- Patients with OUD should have access to mental health services as needed, medical care, and addiction counseling, as well as recovery support services, to supplement treatment with medications.
- The words used to describe OUD and individuals with OUD are powerful.
- There is no “one size fits all” approach to OUD treatment.
- The science demonstrating the effectiveness for
- medication for OUD is strong.
- This doesn’t mean that remission and recovery only occur through medication.
- Medication for OUD should be successfully integrated with outpatient and residential treatment.
- Patients treated with medications for OUD can benefit from individual psychosocial supports.
- Expanding access to OUD medications is an important public health strategy.
- Improving access to treatment with OUD medications is crucial to closing the wide gap between treatment need and availability, given the strong evidence of effectiveness for such treatments.
- Data indicate that medications for OUD are cost effective and cost beneficial.

https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006

Health Net

ASAM National Practice Guidelines

- Identifies current practices and outstanding questions regarding the safe and effective use of medications for the treatment of opioid use disorder.
- Uses a methodology that integrates evidence-based practices and expert clinical judgment to develop recommendations on best practices in opioid use disorder treatment.
- Presents best practices in a cohesive document for clinicians' use to improve the effectiveness of opioid use disorder treatment.

Medication	MOA	Dosing frequency	Available through
Methadone	Full mu-Opioid receptor agonist	Maintenance doses usually 60-120 mg orally daily	OTPs, Take home doses available, not dispensed through pharmacy
Buprenorphine Buprenorphine/naloxone	Partial Opioid receptor agonist	8-16 mg/day up to 24 mg/day.	Waiver required. Oral administration @home
Buprenorphine ER Injections	Partial Opioid receptor agonist	100 mg SC monthly	Waiver required. Administer @ MDO
Buprenorphine implant	Partial Opioid receptor agonist	4 rods implanted in the upper arm (each rod ~80 mg buprenorphine	Waiver required. Must have been maintained on ≤8 mg/day buprenorphine.
Naltrexone	Mu-receptor antagonist	50 mg orally daily	Any prescriber. Use once have abstained from opioids 7-14 days. Administer @home.
Naltrexone ER	Mu-receptor antagonist	380 mg IM every 4 weeks	Any prescriber. Use once have abstained from opioids 7-14 days. Administer @MDO

https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder

HCP: Healthcare Practitioner, IM: intramuscular, MAT: Medication Assisted Treatment, SC: Subcutaneously

https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat

Medication	Possible ADRs	Regulations and Availability
Methadone	Constipation, hyperhidrosis, respiratory depression, sedation, QT prolongation, sexual dysfunction, severe hypotension including orthostatic hypotension and syncope, misuse potential, neonatal abstinence syndrome	Schedule II; only available at federally certifed OTPs and the acute inpatient hospital setting for OUD treatment
Buprenorphine	Constipation, nausea, precipitated opioid withdrawal, excessive sweating, insomnia, pain, peripheral edema, respiratory depression (particularly combined with benzodiazepines or other CNS depressants), misuse potential, neonatal abstinence syndrome **Implant:** Nerve damage during insertion/removal, accidental overdose or misuse if extruded, local migration or protrusion **Subcutaneous Injection:** Injection site itching or pain, death from intravenous injection	Prescribe outside OTPs **Implant:** Prescribers must be certifed in the Probuphine Risk Evaluation and Mitigation Strategy (REMS) Program. Providers who wish to insert/ remove implants are required to obtain special training and certifcation in the REMS Program **Subcutaneous Injection:** Healthcare settings and pharmacies must be certifed in the Sublocade REMS Program and only dispense the medication directly to a provider for administration
Naltrexone	Nausea, anxiety, insomnia, precipitated opioid withdrawal, hepatotoxicity, vulnerability to opioid overdose, depression, suicidality, muscle cramps, dizziness or syncope, somnolence or sedation, anorexia, decreased appetite or other appetite disorders **Intramuscular:** Pain, swelling, induration (including some cases requiring surgical intervention)	Not a scheduled medication; not included in OTP regulations; requires prescription; offce-based treatment or specialty substance use treatment programs, including OTPs

Withdrawal Symptoms and Onset

Grade	Stage	Onset SA Opioids	Onset LA Opioids	Signs/Symptoms
1	Early	8-24 hours	≤36 hours	Lacrimation, rhinorrhea, diaphoresis, yawning, restlessness, insomnia
2	Early	8-24 hours	≤36 hours	Dilated pupils, piloerection, muscle twitching, myalgia, arthralgia, abdominal pain
3	Fully developed	1-3 days	72-96 hours	Tachycardia, hypertension, tachypnea, fever, anorexia/nausea, extreme restlessness
4	Fully developed	1-3 days	72-96 hours	Diarrhea, vomiting, dehydration, hyperglycemia, hypotension

Total duration of withdrawal:
Short - acting (SA) opioids: 7-10 days
Long - acting (LA) opioids: 14+days

SAMHSA. *Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series 63,* Full Document. HHS Publication No. (SMA) 19-503FULLDOC. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018. store.samhsa.gov/system/files/sma18-5063fulldoc.pdf.

Management of Withdrawal Symptoms

- Opioid agonist therapy
  - Buprenorphine
  - Buprenorphine/naloxone
  - Methadone
- Alpha-2 adrenergic agonists
  - Clonidine
  - Lofexidine
  - Tizanidine
- Adjuvant, symptom-specific therapies
  - Gabapentin, loperamide, hydroxyzine, ondansetron, meloxicam

SAMHSA. *Medications for Opioid Use Disorder. Treatment Improvement Protocol (TIP Series 63, Full Document.* HHS Publication No. (SMA) 19-5063FULLDOC. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018. store.samhsa.gov/system/files/sma18-5063fulldoc.pdf; Doughty B, et al. *Ann Pharmacother.* 2019; 53 (7): 746-753; Charney DS, et al. *Arch Gen Psychaitry*. 1981; 38(11): 1273-1277; Rudolf G, et al. *Am J Drug Alcohol Abuse.* 2018; 44(3):302-309.

WWW.pharmacytimes.org, Transitioning Treatment Between Opioid Withdrawal and Induction of Maintenance Therapy in Patients With Opioid Use Disorder, Chris Herndon, PharmD, BCACP, FCCP

Health Net

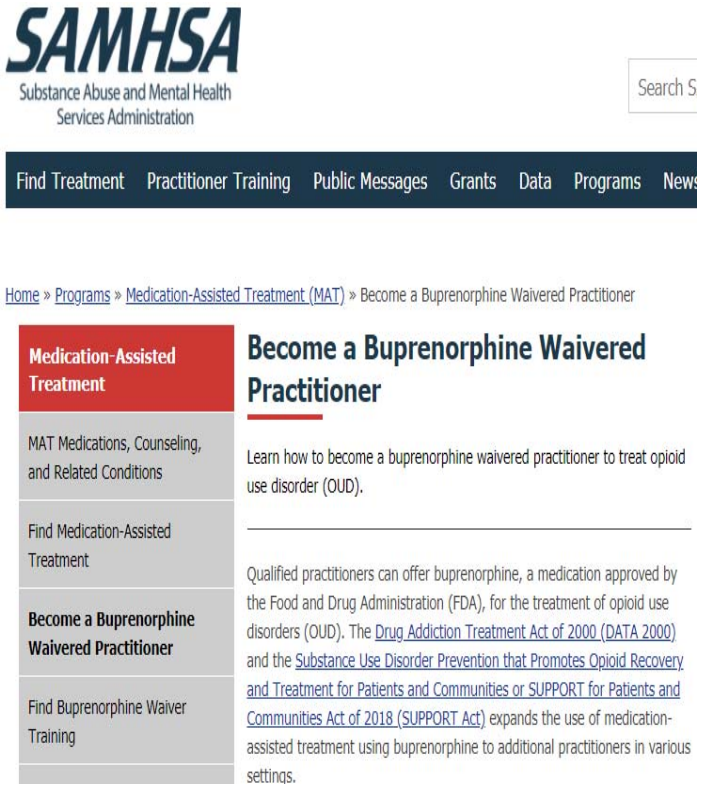
Overdose Prevention

- Overdose education and harm reduction
- Naloxone reverses opioid overdose
- For those at high risk of overdose and their friends or family
- Populations: needle exchange, exit from jail, in drug treatment, high risk prescribed opioids
- The FDA is working to fast-track approval of OTC naloxone.

- For the first year of waiver use, **all providers** can treat up to 30 patients at one time. However, providers who satisfy additional practice and reporting requirements, and physicians who are board certified in addiction psychiatry or addiction medicine, may request to treat up to 100 patients at a time in the first year of waiver use. Additionally, practitioners who provide MAT in "qualified practice settings," as defined in title 42, section 8.615 of the Code of Federal Regulations, may also request to treat up to 100 patients within the first year.

- After the first year of waiver use, **all providers** may request to increase their patient limit to 100.

- Physicians and other qualified providers who are board certified in addiction psychiatry or addiction medicine or who satisfy additional practice and reporting requirements may apply to increase their patient limit to 275 after a year at the 100-patient limit.



Waiver Resources

- **DEA X-Waiver** – Go to the Providers Clinical Support System website at: **pcssnow.org.** Attend free online webinars and get your certification.

- **Buprenorphine Waiver** – Get a waiver to prescribe or dispense buprenorphine. To learn more, visit https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner.

- **SAMHSA's shared decision-making tool** is helpful for educating patients and their families about OUD. The information this tool provides can help patients make informed decisions about their care (https://mat-decisions-in-recovery.samhsa.gov).

Recent News!

- The CDC released provisional data for drug overdose deaths in the United States from January 2019 to January 2020, which showed a 6.6 percent increase in overdose deaths nationally.

- In 2020, some states have seen more than double the number of opioid-related fatalities compared with a year ago.

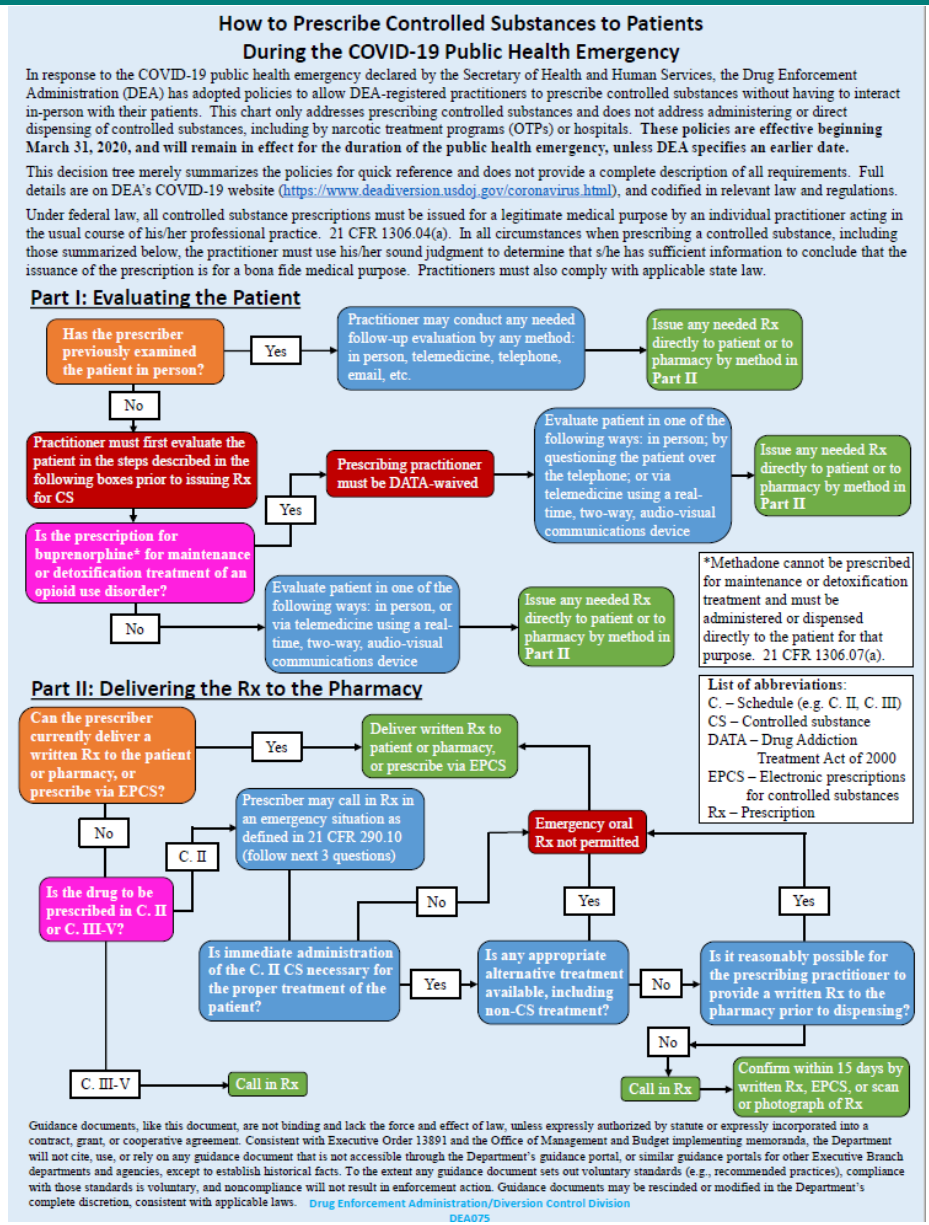
DHCSMATExpansion@dhcs.ca.gov.

https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

Changes to guidelines for the treatment of OUD during Covid-19

- The Substance Abuse and Mental Health Services Administration (SAMHSA) has released a set of FAQs about changes to the guidelines for provision of methadone and buprenorphine for OUD in light of the COVID-19 emergency. To view the FAQs, visit www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf.

- Department of Health Care Services (DHCS) has also released FAQs pertaining to medication-assisted treatment and telehealth. To view the FAQs, visit www.dhcs.ca.gov/provgovpart/Documents/COVID-19-FAQ-MAT-and-Telehealth_CSD.pdf.



How to Prescribe Controlled Substances to Patients During the COVID-19 Public Health Emergency

In response to the COVID-19 public health emergency declared by the Secretary of Health and Human Services, the Drug Enforcement Administration (DEA) has adopted policies to allow DEA-registered practitioners to prescribe controlled substances without having to interact in-person with their patients. This chart only addresses prescribing controlled substances and does not address administering or direct dispensing of controlled substances, including by narcotic treatment programs (OTPs) or hospitals. **These policies are effective beginning March 31, 2020, and will remain in effect for the duration of the public health emergency, unless DEA specifies an earlier date.**

This decision tree merely summarizes the policies for quick reference and does not provide a complete description of all requirements. Full details are on DEA's COVID-19 website (https://www.deadiversion.usdoj.gov/coronavirus.html), and codified in relevant law and regulations.

Under federal law, all controlled substance prescriptions must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his/her professional practice. 21 CFR 1306.04(a). In all circumstances when prescribing a controlled substance, including those summarized below, the practitioner must use his/her sound judgment to determine that s/he has sufficient information to conclude that the issuance of the prescription is for a bona fide medical purpose. Practitioners must also comply with applicable state law.

Part I: Evaluating the Patient

- Has the prescriber previously examined the patient in person?
  - Yes → Practitioner may conduct any needed follow-up evaluation by any method: in person, telemedicine, telephone, email, etc. → Issue any needed Rx directly to patient or to pharmacy by method in Part II
  - No → Practitioner must first evaluate the patient in the steps described in the following boxes prior to issuing Rx for CS
- Is the prescription for buprenorphine* for maintenance or detoxification treatment of an opioid use disorder?
  - Yes → Prescribing practitioner must be DATA-waived → Evaluate patient in one of the following ways: in person; by questioning the patient over the telephone; or via telemedicine using a real-time, two-way, audio-visual communications device → Issue any needed Rx directly to patient or to pharmacy by method in Part II
  - No → Evaluate patient in one of the following ways: in person, or via telemedicine using a real-time, two-way, audio-visual communications device → Issue any needed Rx directly to patient or to pharmacy by method in Part II

*Methadone cannot be prescribed for maintenance or detoxification treatment and must be administered or dispensed directly to the patient for that purpose. 21 CFR 1306.07(a).

Part II: Delivering the Rx to the Pharmacy

- Can the prescriber currently deliver a written Rx to the patient or pharmacy, or prescribe via EPCS?
  - Yes → Deliver written Rx to patient or pharmacy, or prescribe via EPCS
  - No → Is the drug to be prescribed in C. II or C. III-V?
    - C. II → Prescriber may call in Rx in an emergency situation as defined in 21 CFR 290.10 (follow next 3 questions)
      - Is immediate administration of the C. II CS necessary for the proper treatment of the patient?
        - Yes → Is any appropriate alternative treatment available, including non-CS treatment?
          - No → Is it reasonably possible for the prescribing practitioner to provide a written Rx to the pharmacy prior to dispensing?
            - No → Call in Rx → Confirm within 15 days by written Rx, EPCS, or scan or photograph of Rx
            - Yes → Emergency oral Rx not permitted
          - Yes → Emergency oral Rx not permitted
        - No → Emergency oral Rx not permitted
    - C. III-V → Call in Rx

List of abbreviations:
C. – Schedule (e.g. C. II, C. III)
CS – Controlled substance
DATA – Drug Addiction Treatment Act of 2000
EPCS – Electronic prescriptions for controlled substances
Rx – Prescription

Guidance documents, like this document, are not binding and lack the force and effect of law, unless expressly authorized by statute or expressly incorporated into a contract, grant, or cooperative agreement. Consistent with Executive Order 13891 and the Office of Management and Budget implementing memoranda, the Department will not cite, use, or rely on any guidance document that is not accessible through the Department's guidance portal, or similar guidance portals for other Executive Branch departments and agencies, except to establish historical facts. To the extent any guidance document sets out voluntary standards (e.g., recommended practices), compliance with those standards is voluntary, and noncompliance will not result in enforcement action. Guidance documents may be rescinded or modified in the Department's complete discretion, consistent with applicable laws. Drug Enforcement Administration/Diversion Control Division DEA075

DEAdecision tree oid prescribing an

https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-023)(DEA075)Decision_Tree_(Final)_33120_2007.pdf

How to Engage and Retain Patients

- Enhance motivation
- Avoid stigmatizing language/behavior
- Educate patients on the withdrawal process
- Use support system (friends, family)
- Maintain a drug free environment

Brewer C, Wong VS. (2004). Naltrexone: Report of lack of hepatotoxicity in acute viral hepatitis, with a review of the literature. Addiction Biology, 9(1):81-87.

Additional medical care for patients with opioid use disorder

Screening for infections such as HIV, hepatitis B, hepatitis C, sexually-transmitted infections and tuberculosis (at least annually for most patients)

Vaccinations such as hepatitis A, hepatitis B, tetanus-diphtheriapertussis, influenza and pneumococcus

Aggressive management of cardiac risk factors, particularly for people who also use stimulants or tobacco, including blood pressure and lipid control, as well as smoking cessation

Treatment of other comorbid substance use disorders, including tobacco and alcohol use disorders

Treatment of comorbid psychiatric disorders

Education about safer injection practices and provision of clean injection equipment

Source: Opioid Stewardship and Chronic Pain, CDPH, 2018

Health Net Opioid Management Programs

- Opioid utilization DUR programs
- Naloxone prescriber Intervention
- Implementation of a 7 day limit for Naïve patients.
- CMS Overutilization program
- Medicaid Opioid Edits
- Refer high dose opioid utilizers to care managers and SIU
- Distribute various provider and member educational flyers and hold series of webinars about pain management, prevention ,and opioid epidemic.
- Establish Health Net opioid work group
- Support and collaborate with Safe Med LA
- Remove prior authorization for Buprenorphine to increase access to MAT
- Prior authorization and quantity limit are in place for long acting /short acting opioids.
- Support Cal Hospital Opioid Care Honor Roll Program workgroup to implement safe opioid prescribing and MAT in the hospitals

Self Management Programs

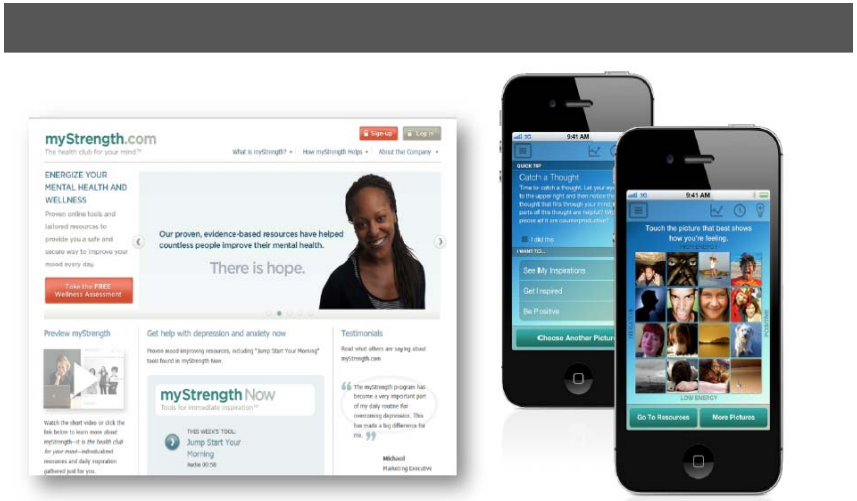
- Address physical , psychological, and social dimensions
- Teach patients coping strategies to reduce pain by changing their behavioral, cognitive, and emotional pain responses **("Rewiring" the Brain)**
- Self - management resources:
  - Health Net MyStrength program: MyStrength.com/HNWell to register
  - The American Chronic Pain Association has free support groups

http://www.apta.org/PTinMotion/2019/5/Feature/ChronicPain/

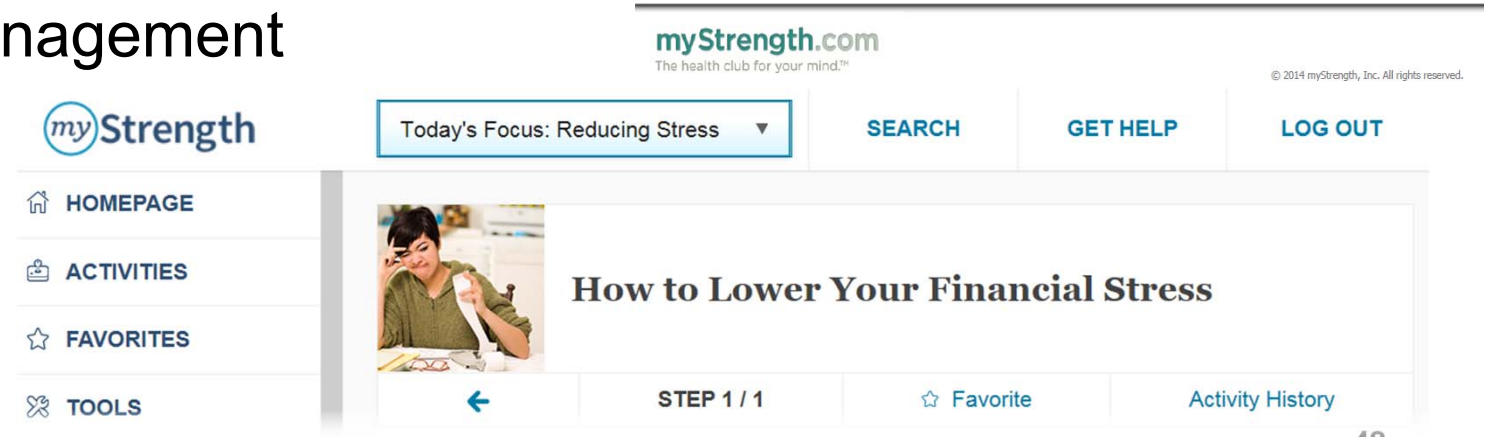
http://nationalpainreport.com/zap-your-brain-to-treat-chronic-pain-8831638.html

MyStrength – Web-Based and Mobile App

- MyStrength.com/HNWell to register
- Topics and resources for: anxiety, depression, alcohol, drug abuse, pain management and mindfulness
- Self-enroll and/or referral by case management



myStrength: Evidence-based, self-help resources offering healthcare payers/providers the ability meet consumer demand, extend access, improve outcomes and lower cost of care.



My Strength – Sign up

1. Go to www.myStrength.com/HNWell
2. Click “Sign-up.”
3. Complete the myStrength sign-up process with a brief Wellness Assessment and personal profile.
4. **Go Mobile!** The myStrength app for iOS and Android devices can be downloaded when you sign up for your account!

Health Net Resources

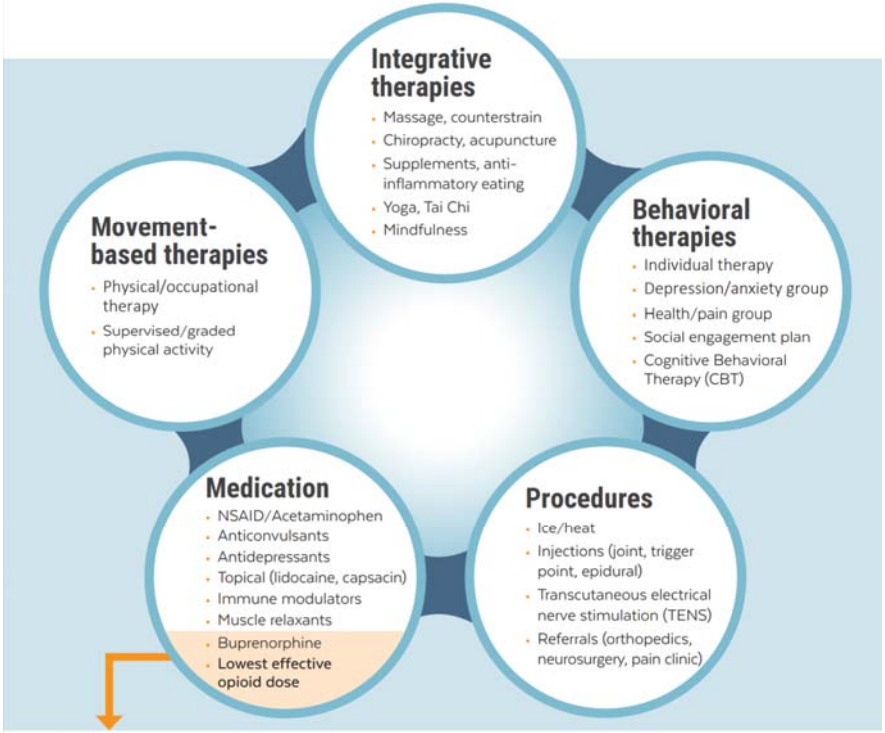
- Access the provider updates below in the Provider Library. After you log in at **provider.healthnet.com**, scroll to the bottom of the home page and select the Provider Library tile.

- Or, you can access the Provider Library directly at **providerlibrary.healthnetcalifornia.com.**

CA MAT Resources

- PCSS https://pcssnow.org/
- Project SHOUT & ED BRIDGE(CA BRIDGE) https://www.bridgetotreatment.org/

Managing Chronic Non-Cancer Pain



If opioid medication is part of the treatment plan, take the following steps:

- **ASSESSMENTS OF RISK, ADHERENCE, FUNCTION AND PAIN:** at least annually
- **INFORMED CONSENT OR CONTROLLED SUBSTANCE AGREEMENT:** at least annually
- **CONTROLLED SUBSTANCE MONITORING PROGRAM:** check CURES every 4 months
- **PRESCRIBE NALOXONE:** every two years

If managing opioid use disorder, options include:

- Prescribe buprenorphine
- Arrange for methadone maintenance or extended-release naltrexone
- Arrange for residential or outpatient treatment

Source: Opioid Stewardship and Chronic Pain, CDPH, 2018 PDF

Pain Resources

- The American Chronic Pain Association (The ACPA) at https://theacpa.org/
- American Pain Society at http://americanpainsociety.org/
- American Academy of Pain Medicine at http://www.painmed.org/
- American Academy of Integrative Pain Management http://www.aapainmanage.org/
- Guide to Pain Medication and Treatments https://theacpa.org/pain-management-tools/resourceguide-to-chronic-pain-treatments/resource-guide-to-chronic-pain-management/
- Understanding NSAIDS https://theacpa.org/pain-management-tools/videos/conditionstreatments/
- Using Opioids Safely https://theacpa.org/pain-management-tools/videos/conditionstreatments/
- Best Advice for People Taking Opioid Medication https://www.youtube.com/watch?v=7Na2m7lx-hU
- American Chronic Pain Association Videos https://theacpa.org/pain-managementtools/videos
- The Pain Toolkit http://www.paintoolkit.org/
- Questions to Ask Your Provider: Pain Management and Prescription Opioids
- Three Things You Need to Know About Prescription Opioids

https://www.theacpa.org/wp-content/uploads/2019/02/ACPA_Resource_Guide_2019.pdf
Allied Against Opioid Abuse