Long-term Opioid Use Practice Tips
MORE THAN 90 DAYS

When?
When is long-term opioid use appropriate?
- When alternatives have failed
- To maintain functional improvement
- When objective findings explain the pain

Type?
What type of opioid should you prescribe?
- Lowest effective dose/strength

Screens?
When should you screen for addiction or abuse?
- At the beginning of any long-term opioid therapy or upon physician request

Goals?
What are treatment goals?
- To stay at work
- To resume normal activities
  - Set expectations and document

Follow up?
What should you consider when following up with a patient on long-term therapy?
- Check Prescription Drug Monitoring Program (PDMP) at first visit
  - www.orpdmp.com
- Stay at lowest possible dosage/strength that maintains improved function
- Check PDMP at least every six months
- Encourage normal activity levels and document expectations

Agreement?
When should you make an opioid therapy agreement?
- At the start of long-term therapy

Consultation?
When should you consider a psychological or pain-management consultation?
- No objective findings explain continued pain
- Difficulty patient may have when tapering from long-term, high-dose opioids
- Patient is anxious or shows significant signs of depression
- Patient is on antidepressants or sedatives

Endorsed by the Oregon Medical Advisory Committee
Long-term opioid use
(3 months or longer)

When should you initiate long-term opioid therapy?
• When the medical diagnosis is supported by objective findings to explain the presence of the pain
• When the patient has measurable functional physical or medical limitations that are expected to improve with reduced pain
• When other therapies have failed to improve function
• When you have set patient expectations that opioid therapy will continue only as long as the therapy contributes to improved function

What are the treatment goals?
• Patient demonstrates improved function
• Patient stays at work or is able to return to work; resumes normal activities

Note: Set expectations with patient and document

What type of opioids should you prescribe?
• Lowest effective dose/strength

When should you screen for possible addiction or opioid abuse?
• When there is a history of prolonged disability
• When current or prior alcoholism or other substance abuse exists
• When the Prescription Drug Monitoring Program (PDMP) shows multiple, concurrent prescribers
  • www.orpdmp.com
• When the patient requests early refills, or reports lost or stolen medications
• When the patient shows an overwhelming focus on opioids at visits
• When psychological conditions including depression and personality disorders are present

When should you change opioid dosage?
• When the current dosage has led to functional improvement that you expect will continue with a small increase in dosage
  • Consider consultation with pain management expert before increasing dosage/strength
• If increased dosage doesn’t provide the expected functional improvement, then go back to lower dosage/strength
• When the patient has demonstrated increased function and decreased pain, consider decreasing the opioid dosage/strength to the lowest effective dose
• If decrease of dosage results in decreased function and increased pain, medication dose can be reinstated until patient has stabilized

When should you make an opioid therapy agreement?
• Whenever you start a patient on long-term opioid therapy

How should you follow up with a patient on long-term opioid therapy?
An office visit for patients on long-term opioid therapy should never be a routine visit
• Encourage return to normal activities and discuss the status of those activities
• Measure progress toward improved function while maintaining the lowest possible dosage/strength
• On a regular basis, discuss effective reduction or end of opioid therapy; document discussion
• Check the PDMP for evidence of multiple prescribers at first visit and at least every six months
  • www.orpdmp.com

When should you order a urine drug screen?
• At initial visit when beginning long-term opioid therapy
• If initial drug screen was not performed while on the short-term opioid therapy
• Random drug screens should be performed at least once a year, unless there is clinical justification for additional screenings

What should you do when there’s evidence of misuse or abuse?
• If confirmatory drug screen shows no opioids in system, immediately reconsider therapy
• If drug screen shows inconsistent, inappropriate opioid use, reconsider opioid therapy
• If drug screen shows overuse of opioids, remind patient of opioid agreement and discuss alternatives to continuation of opioid therapy, such as drug treatment programs
• If PDMP shows multiple prescribers, contact other prescribers; decide which provider will manage the opioid therapy
• Address findings with patient and document in chart notes

When should you consider a psychological or pain management consultation?
• When tapering from long-term, high-dose opioids expected to be difficult; when prior tapering attempts have failed
• After long duration opioid therapy – when there are no objective findings to explain the patient’s continued pain
• Patient is anxious, shows signs of depression, or patient is on antidepressants or sedatives
• May need to contact insurer regarding payment for consultation services
Workers’ Compensation Division
Short-term and Long-term Opioid Use Guidelines

References

7. Southern Oregon Opioid Prescribing Guidelines, A Provider and Community Resource
9. Washington State Department of Labor and Industries, Medical Treatment Guidelines, “Guideline for Prescribing Opioids to Treat Pain in Injured Workers”
   a. Opioid Dose Calculator
11. Work Loss Data Institute, “Just the facts on Opioid Management”

Provider Tools

<table>
<thead>
<tr>
<th>MEDs for Commonly Prescribed Opioids</th>
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<tbody>
<tr>
<td>10 mg of Morphine Corresponds to:</td>
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<tr>
<td>Opioid</td>
</tr>
<tr>
<td>Codeine</td>
</tr>
<tr>
<td>Fentanyl transdermal</td>
</tr>
<tr>
<td>Hydrocodone</td>
</tr>
<tr>
<td>Hydroxymorphone</td>
</tr>
<tr>
<td>Methadone chronic</td>
</tr>
<tr>
<td>Oxycodone</td>
</tr>
<tr>
<td>Oxymorphone</td>
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</table>

Methadone exhibits a nonlinear relationship due to its long half-life and accumulates with chronic dosing (MED may increase depending on the dose). Note: The Oregon Prescription Drug Monitoring Program (PDMP) uses a factor of 3.

<table>
<thead>
<tr>
<th>Methadone chronic</th>
<th>Factor</th>
<th>10 mg of Morphine Corresponds to:</th>
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<tbody>
<tr>
<td>Up to 20mg per day</td>
<td>4</td>
<td>2.50 mg</td>
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<tr>
<td>21 to 40mg per day</td>
<td>8</td>
<td>1.2 mg</td>
</tr>
<tr>
<td>41 to 60mg per day</td>
<td>10</td>
<td>1.00 mg</td>
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<tr>
<td>&gt; 60mg per day</td>
<td>12</td>
<td>0.83 mg</td>
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From the WA State L & I website, the following are useful tools for providers:

Access for all tools listed below: http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf

1. Guidance for Seeking Consultative Assistance
   FIND: Table 1. Page 4

2. Before you decide to prescribe opioids for chronic pain (1 page)
   FIND: Page 5

3. Using Urine Drug Testing (UDT) to Monitor Opioid Therapy for Chronic Non-cancer Pain
   FIND: Page 5

4. Graded Chronic Pain Scale (Figure 2)
   FIND: Page 7

5. Recommended Frequency of UDT (Table 2)
   FIND: Found on Page 8

6. Principles for safely prescribing chronic opioid therapy (1/2 page)
   FIND: Page 8

7. Tapering or Discontinuing Opioids (1/2 page)
   FIND: Page 10

8. Recognizing and managing behavioral issues during opioid tapering (1/2 page)
   FIND: Page 11

9. Reasons to discontinue opioids or refer for addiction management
   FIND: Page 13

10. Dosing Threshold for Selected Opioids (Table 4)
    FIND: Page 16

11. Opioid Risk Tool
    FIND: Page 19

12. Sample Doctor-Patient Agreements for Chronic Opioid Use
    FIND: Appendix G, Page 43

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The Importance of MED  Significant Increment in Risk p<0.05

*Source: Dunn et.al., Annual of Int. Med., 2010*

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<thead>
<tr>
<th>Relative Risk of Death</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<tr>
<td>Nonuser</td>
<td>0</td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>1-19 mg</td>
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<td>20-49 mg</td>
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<td></td>
<td></td>
<td>Nine-fold increase in risk relative to low-dose patients</td>
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<tr>
<td>100+ mg</td>
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### Relative Risk of Death

- **Nonuser**: 0
- **1-19 mg**: 1
- **20-49 mg**: 2
- **50-99 mg**: 3
- **100+ mg**: Nine-fold increase in risk relative to low-dose patients

### Source

*Source: Dunn et.al., Annual of Int. Med., 2010*