

# Opioid Prescribing Guidelines

## FOR PATIENTS IN THE EMERGENCY DEPARTMENT AND IMMEDIATE CARE CENTERS



These guidelines are meant to assist clinicians in treating patients with acute and chronic pain in the emergency department (ED) and immediate/urgent care settings. These guidelines are not intended for patients who are receiving treatment for cancer, palliative care or end-of-life care. The guidelines' purpose is to:

- ▶ **Provide safer, more effective care for patients with acute and chronic pain;**
- ▶ **Improve communication between clinicians and patients about the benefits and risks of using prescription opioids for chronic pain; and**
- ▶ **Help reduce opioid use disorder and overdose.**

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# ACUTE PAIN IN OPIOID-NAÏVE PATIENTS

## Recommendations

1

**Opioids are not first-line therapy for many patients with acute pain from minor injuries: Non-pharmacological therapy (e.g. heat, ice and physical therapy) and non-opioid analgesic therapy are preferred when clinically indicated.**

Non-pharmacologic therapy or drugs other than opioids (e.g. NSAIDs or acetaminophen) are considered appropriate first-line treatment for acute pain. Medical literature indicates that the combined use of both NSAIDs and acetaminophen is as effective in controlling acute pain as opioids alone.

2

**When starting opioid therapy for pain control, clinicians should evaluate patients for risk factors associated with opioid-related harm, including sleep apnea, being 65 or older, mental health conditions, alcohol and/or substance use disorder, and history of opioid overdose.**

The Centers for Disease Control and Prevention (CDC) has found that initiation of opioid therapy in patients with the above risk factors significantly increases the risk of opioid-related harm. Clinicians should discuss the potential for harm with these patients and suggest alternative, non-opioid treatment options.

3

**Clinicians should provide information on the risks and benefits of opioid use to patients prior to starting opioid therapy so that they understand the treatment goals and have appropriate expectations for pain relief.**

As with initiation of any new pharmacologic therapy, clinicians and patients should have a thorough discussion of the risks and benefits when beginning opioid therapy. Specific attention should be paid to the risk of addiction and potential side effects that impact a patient's ability to function (e.g. operate machinery or drive a vehicle). This discussion should include pain control goals and expectations for pain relief from both opioid and non-opioid treatments.



# ACUTE PAIN IN OPIOID-NAÏVE PATIENTS

## Recommendations

### 4

**When providing an opioid prescription for pain control, clinicians should consider prescribing:**

- a. Immediate-release products. Extended-Release/Long-Acting (ER/LA) opioid products should be avoided;**
- b. The lowest effective starting dose for a given medication when providing an initial prescription; and**
- c. The minimum amount needed to control the patient’s pain. A three-day course or less is often sufficient; more than seven days of medication is rarely necessary.**

Extended-release and long-acting opioid products—including methadone and transdermal fentanyl—are associated with an increased risk of overdose when initiating opioid treatment. They have not been shown to be more effective than immediate-release opioids. Higher opioid doses are also associated with an increased risk of overdose, developing opioid use disorder and motor vehicle injuries.

The recommendation to limit the duration of opioid therapy is based on the risk of developing physical dependence with long-term opioid use. The risk of long-term opioid use in opioid-naïve patients increases within the first several days of opioid use. For most cases of acute pain treated in an emergency department (ED) setting, a three-day course or less is typically sufficient. These recommendations are supported by the CDC and the American College of Emergency Physicians (ACEP).

### 5

**When starting opioid therapy, clinicians are strongly encouraged to use the Illinois Prescription Monitoring Program (ILPMP). ILPMP data can help determine if a patient is already receiving other prescriptions for opioids or sedating medications such as benzodiazepines.**

The ILPMP is a state-based database that consolidates information on controlled prescription drugs dispensed by pharmacies within the state every day. All prescribers of controlled substances can access the database free of charge. The database is available at <https://www.ilpmp.org>. According to the CDC, “most fatal overdoses were associated with patients receiving opioids from multiple prescribers and/or with patients receiving high total daily opioid dosages.” The database can help identify patients who receive opioids from multiple providers and assess the risk of overdose in patients already receiving high daily dosages of opioid medications.

# 6

## **Clinicians should avoid concurrent prescribing of opioid pain medication and benzodiazepines when possible, as the Centers for Disease Control and Prevention (CDC) has determined there is an association between unintentional overdose and the use of opioid pain medication and benzodiazepines together.**

As benzodiazepines and opioids are both depressants of the central nervous system, concurrent use can decrease the respiratory drive and increase the risk of a fatal overdose. In epidemiologic studies, concurrent benzodiazepine and opioid prescribing nearly quadrupled the risk of overdose compared with opioid prescribing alone. Although an opioid prescription may be appropriate for a patient already on chronic benzodiazepine therapy in certain situations, prescribers should avoid co-prescribing opioids and benzodiazepines whenever feasible.

# 7

## **Clinicians should provide patients who receive opioid prescriptions with information about the risks of developing opioid use disorder, the potential dangers to themselves and their family in misusing opioids, and appropriate storage and disposal of unused medications.**

According to the Substance Abuse and Mental Health Services Administration, there were 2.1 million new misusers of prescription opioids in the United States in 2016. Major risk factors for developing opioid use disorder include having a poorly controlled psychiatric disease and prior history of a substance use disorder.

According to the CDC, 60 percent of people who misuse prescription opioids received them from a friend or relative or stole the medication, often from a family medicine cabinet. All patients should be given information on properly disposing unused medications.

There are multiple ways to dispose of medication, including authorized drug disposal collection centers run by the Drug Enforcement Agency's Office of Diversion Control (800-822-9539), in local pharmacies or in household trash. If no collection site is available, the Food and Drug Administration recommends **disposing of medication** at home by:

- 1) Mixing medicine with unpalatable substances such as dirt or kitty litter;
- 2) Placing the mixture in a sealed plastic bag;
- 3) Throwing the bag in the trash; and
- 4) Scratching out all personal information on prescription pill bottles.



# CHRONIC PAIN IN PATIENTS RECEIVING LONG-TERM OPIOID THERAPY

## Recommendations

8

**Care coordination is important when treating patients receiving chronic opioid therapy. When possible, clinicians should:**

- a. Contact the provider who prescribes routine opioid therapy for the patient to discuss care options; and**
- b. Review medical records and case management plans for patients who frequently visit the ED or acute care facilities with pain-related complaints.**

ACEP's *Clinical Policy on Opioid Prescribing* highlights the importance of care coordination. Many patients receiving opioid therapy have a pain contract, and clinicians should consult with a patient's regular provider on how to manage their pain.

However, providers are often unavailable and cannot always be reached by the ED staff. To better coordinate care, in addition to using the ILPMP, hospital systems can develop care plans for patients who frequently visit the ED with exacerbation of chronic pain. Along with a review of previous visits recorded in electronic medical records, care plans can help clinicians decide how to best treat these patients.

9

**Clinicians should exercise extreme caution when asked to provide replacement prescriptions for opioids that were lost, destroyed or stolen.**

In an attempt to secure additional medication, patients who misuse or divert controlled substances may report their medications were lost or stolen. Pain specialists often stipulate in agreements with chronic pain patients that lost or stolen controlled substances will not be replaced.



# 10

## **Clinicians should exercise extreme caution before prescribing replacement doses of medications used in the treatment of opioid use disorder, including buprenorphine products and methadone.**

Methadone has a long half-life, and if patients who are part of a daily methadone treatment program miss a single dose, they should not go into opioid withdrawal for 48 hours. Patients should follow up the next day at their methadone clinic. However, clinicians in the ED can consider administering methadone to patients who are incarcerated or who cannot go to the clinic the next day if the dose can be verified by the methadone provider, electronic medical record (EMR) or another source.

Abuse and diversion of buprenorphine products is common. Therefore, extreme caution should be exercised before providing replacement prescriptions. Patients should be referred back to their medication-assisted treatment provider.

# 11

## **A review of CDC literature indicates that in patients receiving chronic opioid therapy, fatal overdoses occurred in those receiving average doses of $\geq 90$ morphine milligram equivalents (MME) per day. Patients taking more than 50 MME/day have double the risk of overdose of patients taking $\leq 20$ MME/day.**

### **Clinicians should carefully assess patients receiving more than 50 MME/day and use extreme caution when considering providing additional opioid therapy to patients with a dosage of $\geq 90$ MME/day. (See MME conversion table in Addendum.)**

A review of CDC clinical and contextual evidence found that opioid overdose risk increases in a dose-response manner. Dosages of 50 to  $\leq 100$  MME/day increase overdose risk by factors of 1.9 to 4.6 when compared to daily doses of 1 to  $\leq 20$  MME/day. Risk increases by factors of 2 to 8.9 when the dose is  $\geq 100$  MME/day.

While the review did not find a single dosage threshold value that eliminates overdose risk, it concluded that holding the daily dosage below 50 MME/day likely reduces risk for a large percentage of patients receiving opioid therapy.

# PATIENTS WITH OPIOID USE DISORDER AND ADDICTION

## Recommendations

12

**Hospitals and health systems should have a method for providing naloxone to patients deemed at risk of developing opioid use disorder or their family members (e.g. referral to a pharmacy that provides naloxone, provide a prescription for naloxone or other mechanism for patients to obtain the drug).**

The CDC and the American Medical Association recommend that clinicians consider offering naloxone to patients with factors that increase risk for opioid overdose, such as:

- ▶ History of overdose;
- ▶ History of substance use disorder;
- ▶ Opioid dosages of 50 or more MME per day;
- ▶ Concurrent benzodiazepine use;
- ▶ History of underlying mental health or other medical conditions that may make a patient more susceptible to overdose (e.g. sleep disorders, renal or hepatic insufficiency due to decreased ability to metabolize or excrete opioids, or being 65 or older).

13

**Hospitals and health systems should develop a method to refer patients with opioid use disorder to medication-assisted treatment and behavioral healthcare.**

The CDC and The Joint Commission recommend clinicians refer patients with opioid use disorder to substance use treatment. In various parts of Illinois, there may be a lack of available, affordable substance use treatment services. In these areas, hospitals and health systems should explore internal, community, regional and state resources to develop pathways for referral for patients with opioid use disorder who present to the ED.



## ADDENDUM

### Commonly Prescribed Opioids and Morphine Milligram Equivalent (MME) Conversion Calculator

Generic Name	Extended-Release/ Long-Acting Formulation Common Brand Names	Immediate- Release Formulation Common Brand Names	MME Conversion Factor
Morphine	Arymo ER Kadian Morphabond MS Contin Embeda <i>Generic available</i>	Roxanol <i>Generic available</i>	1
Codeine		Tylenol #3 or #4 <i>Generic available</i>	0.15
Hydrocodone	Hysingla ER Zohydro ER	Vicodin, Norc <i>Generic available</i>	1
Hydromorphone	Exalgo ER <i>Generic available</i>	Dilaudid, Dilaudid-5 Hydrostat IR <i>Generic available</i>	4
Oxycodone	OxyContin Targiniq ER Troxyca ER Xtampza ER <i>Generic available</i>	Roxicodone Percolone Percocet	1.5
Oxymorphone	Opana ER	Opana Numorphan	3
Methadone	Dolphine, Methadose <i>Generic available</i>		Dose Dependent Conversion: 1 - 20 mg/day: 4 21 - 40 mg/day: 8 41 - 60 mg/day: 12
Tapentadol	Nucynta ER Palexia		0.4

#### EXAMPLE CALCULATION

Percocet 5 mg tablets every 6 hours = 20 mg oxycodone per day.

20 mg oxycodone X 1.5 (conversion factor) = 30 MME per day

# WORKGROUP

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**Convened by the Illinois Health and Hospital Association (IHA)  
and the Illinois College of Emergency Physicians (ICEP) in  
April 2017, the workgroup includes the following physicians:**

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## IMPORTANT NOTICE – DISCLAIMER

This document brings together recommendations of other organizations, including the Centers for Disease Control and Prevention, The Joint Commission, the American Medical Association, the American College of Emergency Physicians, the American Academy of Emergency Medicine and the State of Illinois Opioid Action Plan. This document is for informational purposes only. It does not establish a standard of care. It does not constitute professional advice or opinion. Treatment decisions must be based upon professional judgment given a patient's medical history and condition, a provider's policies and procedures, and other relevant facts and circumstances.

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### ABOUT THE SPONSORS

#### IHA

With offices in Chicago, Naperville, Springfield and Washington D.C., IHA is dedicated to advocating for Illinois' more than 200 hospitals and nearly 50 health systems as they serve patients and communities throughout the state.

#### ICEP

Dedicated to the support of quality emergency medical care in Illinois, ICEP is the state medical specialty society representing more than 1,340 emergency physicians in Illinois.