Prescribing and Dispensing Profile

Washington

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NAMSDL
National Alliance for Model State Drug Laws

Schedule II Prescribing Limitations (not related to pain clinics)

Schedule II substances may only be dispensed on the written or electronic prescription of a practitioner

- May be dispensed on the faxed prescription of a practitioner in the following circumstances:
  - The prescription is for the patient of a long term care facility
  - The prescription if for a hospice patient
  - The prescription is for a substance to be compounded for direct administration to a patient
  - To a hospital for a patient being admitted to or discharged from the hospital
- May be dispensed on the oral prescription of a practitioner in an emergency
  - Must be promptly reduced to writing by the pharmacy
  - Emergency exists when the immediate administration of the drug is necessary for proper treatment and no alternative treatment is available and it is not possible for the physician to provide a written prescription prior to dispensing
  - Must provide a written prescription to the pharmacist within 72 hours

Schedule II prescriptions may not be filled more than six months after originally issued

Schedule II prescriptions must be maintained separately from other records

Schedule II prescriptions may not be refilled

Schedule III, IV and V Prescribing Limitations (not related to pain clinics)

Schedule III – V substances may only be dispensed on the written, oral, faxed, or electronic prescription of a practitioner

Schedule III – V prescriptions may not be filled or refilled more than six months after originally issued or refilled more than five times unless renewed by the practitioner

Schedule V substances may only be distributed or dispensed for a medical purpose

Schedule III – V prescriptions must be maintained separately from other records or in a form that is readily retrievable from other records

Miscellaneous Prescribing/Dispensing Requirements

A practitioner may dispense or deliver a controlled substance to or for an individual only for medical treatment in the ordinary course of that practitioner's profession

- Medical treatment includes dispensing or administering a narcotic drug for pain, including intractable pain

Prescribing/Dispensing Limitations for Dentists

Practice of dentistry includes the prescription of drugs for disease, pain, injury, deficiency, deformity, or physical condition

An accurate record of any medications prescribed or dispensed shall be clearly indicated on the patient history

Prescribing/Dispensing Limitations for Optometrists

Optometrists may prescribe or use diagnostic or therapeutic oral drugs so long as they are certified to do so

- See ADC 246-851-590 for a list of specific oral Schedule III – V controlled substances and legend drugs optometrists may prescribe
- See ADC 246-851-580 for a list of specific non-scheduled oral drugs and approved Schedule III – V drugs

No optometrist may use, prescribe, dispense, or administer an oral corticosteroid

An optometrist may not:

- Prescribe, dispense, or administer a controlled substance for more than seven days in treating a particular patient for a single trauma, episode, or condition or for pain associated with or related to the trauma, episode or condition
- Prescribe an oral drug within 90 days following ophthalmic surgery unless the optometrist consults with the treating ophthalmologist
- Use, prescribe, dispense, purchase, possess, or administer any Schedule I or II drug

Pain Clinic/Pain Management Regulations

Requires the commission to adopt new rules on chronic, non-cancer pain, that contain the following:

- Dosage criteria including:
  - A dosage amount that must not be exceeded unless a physician first consults with a practitioner specializing in pain management
  - Exigent or special circumstances under which the dosage amount may be exceeded without first consulting a pain management practitioner
- The rules regarding consultation with a pain management specialist must take into account:
  - Circumstances under which repeated consultations would not be necessary or appropriate for a patient undergoing a stable, ongoing course of treatment
  - Minimum training and experience sufficient to exempt a physician from the specialty consultation requirement
  - Methods for enhancing the availability of consultations
  - Allowing the efficient use of resources
  - Minimizing the burden on practitioners and patients
- Guidance on when to seek specialty consultation and ways in which electronic specialty consultations may be sought
- Guidance on tracking clinical progress by using assessment tools focusing on pain interference, physical function, and overall risk for poor outcome
- Guidance on tracking the use of opioids, particularly in the emergency department
- Rules don't apply to:
  - Provision of palliative, hospice, or other end-of-life care
  - Management of acute pain caused by an injury or surgical procedure

Pain Clinic/Pain Management Regulations, cont'd.

The commission recognizes that principles of quality medical practice dictate that the people of Washington have access to appropriate and effective pain relief

- Appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain
  - Inappropriate treatment of pain includes non-treatment, under-treatment, overtreatment, and the continued use of ineffective treatments
  - Inappropriate treatment of pain may result from a physician's lack of knowledge of pain management
  - Commission will consider the inappropriate treatment of pain a departure from standards of practice and will investigate such allegations, recognizing that some types of pain cannot be completely relieved, and taking into account whether the treatment is appropriate for the diagnosis
- Commission recognizes that controlled substances, including opioid analgesics, may be essential in the treatment of chronic pain, whether due to cancer or non-cancer origins
- Medical management of pain should include the use of pharmacologic and non-pharmacologic modalities according to the judgment of the physician
- Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration of the pain, and treatment outcomes
- Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not the same as addiction
- These rules do not apply to the provision of palliative, hospice, or other end-of-life care or to the management of acute pain caused by an injury or surgical procedure

Chronic, non-cancer pain means a state in which non-cancer pain persists beyond the usual course of an acute disease or healing of an injury, or that may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years

Physician shall obtain, evaluate, and document the patient's health history and physical examination in the health record prior to treating for chronic, non-cancer pain

- Patient's health history must include the following:
  - Current and past treatments for pain
  - Comorbidities
  - Any substance abuse
- Patient's health history should include the following:
  - Review of any available PMP or emergency department-based information exchange
  - Any relevant information from a pharmacist provided to a physician
- Initial patient evaluation shall include:
  - Physical examination
  - Nature and intensity of the pain
  - Effect of the pain on physical and psychological function
  - Medications

Pain Clinic/Pain Management Regulations, cont'd.

- Risk screening of the patient for potential comorbidities and risk factors using an appropriate screening tool
    - The screening should address the following:
        - History of addiction
        - Abuse or aberrant behavior regarding opioid use
        - Psychiatric conditions
        - Regular concomitant use of benzodiazepines, alcohol, or other central nervous system medications
        - Poorly controlled depression or anxiety
        - Evidence or risk of significant adverse events, including falls or fractures
        - Receipt of opioids from more than one prescribing practitioner or practitioner group
        - Repeated visits to emergency departments seeking opioids
        - History of sleep apnea or other respiratory risk factors
        - Possible or current pregnancy
        - History of allergies or intolerances
- Initial patient evaluation should include the following:
    - Any available diagnostic, therapeutic, and laboratory results
    - Any available consultations
- Health record shall be maintained in an accessible manner, readily available for review, and should include the following:
    - Diagnosis, treatment plan, and objectives
    - Documentation of the presence of one or more recognized indications for the use of pain medication
    - Documentation of any medication prescribed
    - Results of periodic reviews
    - Any written agreements for treatment between the patient and physician
    - Physician's instructions to the patient

A written treatment plan shall state the objectives that will be used to determine treatment success

- Treatment plans shall include, at a minimum, the following:
    - Any change in pain relief
    - Any change in physical and psychosocial function
    - Additional diagnostic evaluations or other planned treatments
- After treatment begins, the physician should adjust drug therapy to the individual needs of the patient
    - Physician shall advise the patient it is their responsibility to safeguard all medications and keep them in a secure location
- Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment

Physician shall obtain informed consent from the patient and shall discuss the risks and benefits of treatment options with the patient

Patients shall receive all pain management prescriptions from one prescriber and one pharmacy where possible

Pain Clinic/Pain Management Regulations, cont'd.

If the patient is at high risk for medication abuse, or has a history of substance abuse or psychiatric comorbidities, the prescribing physician shall use a written agreement for treatment with the patient outlining patient responsibilities which shall include:

- The patient's agreement to drug testing when requested
- The patient's agreement to take medications at the dose and frequency prescribed with a specific protocol for lost prescriptions and early refills
- Reasons for which drug therapy may be discontinued
- The requirement that all chronic pain management prescriptions are provided by a single prescriber or multi-disciplinary pain clinic and dispensed by a single pharmacy or pharmacy system
- The patient's agreement not to abuse alcohol or use other medically unauthorized substances
- A written authorization for:
  - The physician to release the agreement for treatment to local emergency departments, urgent care facilities, and pharmacies
  - Other practitioners to report violations of the agreement back to the physician
- Written authorization that the physician may notify the proper authorities if s/he has reason to believe the patient has engaged in illegal activity
- Acknowledgement that a violation of the agreement may result in a tapering or discontinuation of the prescription
- Acknowledgement that it is the patient's responsibility to safeguard all medications and keep them in a secure location
- Acknowledgement that if the patient violates the terms of the agreement, the violation and the physician's response to the violation will be documented, as well as the rationale for changes in the treatment plan

The physician shall periodically review the course of treatment, the patient's state of health, and any new information about the etiology of the pain

- Periodic reviews should take place every six months
  - For patients who are stable involving non-escalating daily doses of 40 mg of a MED or less, periodic reviews shall take place at least annually
- During the periodic review, the physician shall determine:
  - Patient's compliance with any medication treatment plan
  - If pain, function, or quality of life have improved or diminished using objective evidence
  - If continuation or modification of medications is necessary based on the physician's evaluation of progress toward treatment objectives
- Physician shall assess the appropriateness of continued use of the current treatment plan if the patient's progress or compliance with current treatment plan is unsatisfactory
  - Physician shall consider tapering, changing, or discontinuing treatment when:
    - Function or pain doesn't improve after a trial period
    - There is evidence of significant adverse effects
    - Other treatment modalities are indicated
    - There is evidence of misuse, addiction, or diversion
- Physician should periodically review any information available from the PMP or emergency department-based information exchange
- Physician should periodically review any information from a pharmacist provided to the physician

Pain Clinic/Pain Management Regulations, cont'd.

Long acting opioids, including methadone, should only be prescribed by a physician who is familiar with their risks and use and who is prepared to conduct the necessary careful monitoring

- Physician should have a one-time completion of at least four hours of continuing education related to this topic

Episodic care practitioners (for the purpose of emergency or urgent care) should avoid providing opioids for a chronic pain patient

- If opioids are provided, the practitioner should limit the use of opioids for the patient to the minimum amount necessary to control the pain until the patient can receive care from a primary care practitioner
- If the patient has a written treatment agreement and has provided a written authorization to release the agreement to episodic care practitioners, then the practitioner should report known violations to the treatment practitioner

Physician shall consider, and document the consideration, referring the patient for additional evaluation and treatment as needed to achieve treatment objectives

- Mandatory consultation threshold for adults is 120 mg MED (oral)
    - In the event a physician prescribes a dosage that meets or exceeds the consultation threshold, a consultation with a pain management specialist is required
        - Not required to consult with a specialist when s/he has documented adherence to all standards of practice and when any one or more of the following apply:
            - The patient is following a tapering schedule
            - The patient requires treatment for acute pain which may or may not include hospitalization, requiring a temporary escalation in dosage, with expected return to or below their baseline dosage level
            - Physician documents reasonable attempts to obtain a consultation and the circumstances justifying prescribing above the threshold without first obtaining a consultation
            - The physician documents the patient's pain and function is stable and the patient is on a non-escalating dosage of opioids
        - Not required to consult with a specialist if one or more of the following qualifications is met:
            - Physician is a pain management specialist
            - Physician has successfully completed, within the last two years, a minimum of 12 CME hours on chronic pain management with at least two of those hours dedicated to long acting opioids
            - The physician is a pain management practitioner working in a multi-disciplinary chronic pain treatment center or a multi-disciplinary academic research facility
            - The physician has a minimum three years of clinical experience in a chronic pain management setting, and at least 30% of his or her current practice is the direct provision of pain management care
    - Mandatory consultation shall consist of at least one of the following:
        - An office visit with the patient and the pain management specialist
        - Telephone consultation between the pain management specialist and the physician
        - An electronic consultation between the pain management specialist and the physician
    - Physician shall document each mandatory consultation
        - Any written record of the consultation shall be maintained as a patient record by the specialist
        - If the specialist provides a written record of the consultation to the physician, the physician shall maintain it as part of the patient record

Pain Clinic/Pain Management Regulations, cont'd.

Pain management specialist shall meet one or more of the following qualifications:

- Board certified or board eligible by an American Board of Medical Specialties-approved board (ABMS) or by the American Osteopathic Association (AOA) in physical medicine and rehabilitation, rehabilitation medicine, neurology, rheumatology, or anesthesiology
- Has a subspecialty certificate in pain medicine by an ABMS-approved board
- Has a certification of added qualification in pain management by the AOA
- A minimum of three years of clinical experience in a chronic pain management care setting and
  - Credentialed in pain management by an entity approved by the Washington state medical quality assurance commission for physicians or the Washington state board of osteopathic medicine and surgery for osteopathic physicians
  - Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years for physicians or three years for osteopathic physicians
  - At least thirty percent of the physician's or osteopathic physician's current practice is the direct provision of pain management care or is in a multidisciplinary pain clinic

Training or Education Requirements or Recommendations for Practitioners who Prescribe or Dispense Controlled Substances

No specific statutes or regulations identified.

Medical Marijuana or Controlled Substances Therapeutic Research Program Provisions

This section deals only with the conditions that qualify a patient for the use of medical marijuana or a therapeutic research program and the attendant physician responsibilities. For complete information on state medical marijuana and therapeutic research programs, please visit the NAMSDL website at www.namsdl.org.

Medical evidence suggests that some patients with terminal or debilitating medical conditions may, under their health care professional's care, benefit from the medical use of cannabis

- Those conditions include nausea, vomiting, and cachexia associated with cancer, HIV-positive status, AIDS, hepatitis C, anorexia, and their treatments; severe muscle spasms associated with multiple sclerosis, epilepsy, and other seizure and spasticity disorders; acute or chronic glaucoma; Crohn's disease; some forms of intractable pain

Terminal or debilitating medical condition means:

- Cancer, HIV, multiple sclerosis, epilepsy or other seizure disorder, or spasticity disorders
- Intractable pain, limited to mean pain unrelieved by standard medical treatments and medications
- Glaucoma, either acute or chronic, limited to mean increased intraocular pressure unrelieved by standard treatments or medications
- Crohn's disease with debilitating symptoms unrelieved by standard treatments or medications
- Hepatitis C with debilitating nausea or intractable pain unrelieved by standard treatments or medications

Medical Marijuana or Controlled Substances Therapeutic Research Program Provisions, cont'd.

- Diseases, including anorexia, which result in nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms, or spasticity, when these symptoms are unrelieved by standard treatments or medications
- Any other medical condition approved by the commission in consultation with the board

Until July 1, 2016, valid documentation means a statement signed by the qualifying patient's health care professional written on tamper-resistant paper, which states that, in the health care professional's professional opinion, the patient may benefit from the medical use of marijuana

- Beginning July 1, 2016, valid documentation means a form developed by the department that is completed and signed by a qualifying patient's health care professional and printed on tamper-resistant paper

A health care professional may not be arrested, searched, prosecuted, disciplined, or subject to other criminal sanctions or civil consequences or liability under state law, or have real or personal property searched, seized, or forfeited pursuant to state law, notwithstanding any other provision of law, for the following:

- Advising a patient about the risks and benefits of medical use of cannabis or that the patient may benefit from the use of medical cannabis
- Providing a patient with valid documentation, based upon the health care professional's assessment of the patient's medical history and current medical condition, where such use is within a professional standard of care or in the individual health care professional's medical judgment

Health care professional may only provide a patient with valid documentation authorizing the medical use of cannabis or register the patient with the registry if he or she has a newly initiated or existing documented relationship with the patient, as a primary care provider or a specialist, relating to the diagnosis and ongoing treatment or monitoring of the patient's terminal or debilitating medical condition, and only after:

- Completing a physical exam of the patient as appropriate, based on the patient's condition and age
- Documenting the terminal or debilitating medical condition of the patient in the patient's medical record and that the patient may benefit from treatment of this condition or its symptoms with the medical use of cannabis
- Informing the patient of other options for treating the terminal or debilitating medical condition
- Documenting other measures attempted to treat the terminal or debilitating medical condition that do not involve the medical use of cannabis

A health care professional shall not:

- Accept, solicit, or offer any form of pecuniary remuneration from or to a licensed dispenser, licensed producer, or licensed processor of cannabis products
- Offer a discount or any other thing of value to a qualifying patient who is a customer of, or agrees to be a customer of, a particular licensed dispenser, licensed producer, or licensed processor of cannabis products
- Examine or offer to examine a patient for purposes of diagnosing a terminal or debilitating medical condition at a location where cannabis is produced, processed, or dispensed
- Have a business or practice which consists solely of authorizing the medical use of cannabis
- Include any statement or reference, visual or otherwise, on the medical use of cannabis in any advertisement for his or her business or practice
- Hold an economic interest in an enterprise that produces, processes, or dispenses cannabis if the health care professional authorizes the medical use of cannabis

Medical Marijuana or Controlled Substances Therapeutic Research Program Provisions, cont'd.

"Controlled Substances Therapeutic Research Act"

- Legislature finds that recent research has shown that the use of marijuana may alleviate nausea and ill effects of cancer chemotherapy and radiology, and may alleviate the ill effects of glaucoma
- Legislature further finds that there is a need for further research and experimentation regarding the use of marijuana under strictly controlled circumstances
- Program is limited to cancer chemotherapy and radiology patients and glaucoma patients who are certified to the patient qualification review committee as being involved in a life threatening or sense-threatening situation
    - No patient may be referred without full disclosure by the physician of the experimental nature of the program and the possible risks and side effects of the proposed treatment
- The commission shall obtain marijuana through whatever means it deems most appropriate and consistent with regulations promulgated by the US FDA, DEA, and NIDA
    - Commission may use marijuana which has been confiscated by local or state law enforcement agencies and has been determined to be free from contamination
    - Commission shall distribute the analyzed marijuana to approved practitioners and/or institutions

PMP Requirements for Mandatory Registration and Access

Checking the PMP is required before prescribing opioids to worker's compensation patients in the subacute phase and repeat during chronic opioid therapy at intervals according to the worker's risk category

Before the department or self-insurer authorizes payment for opioids beyond the acute phase, the provider must perform and document that s/he has accessed the state PMP to ensure the controlled substance history is consistent with the prescribing record and worker's report

An agency providing chemical dependency opiate substitution treatment must ensure that the program physician completes a PMP review on a patient:

- At admission
- Annually after the date of admission
- Subsequent to any incidents of concern

Patient Referral to Treatment

No specific statutes or regulations identified.

Board Guidelines

Medical Marijuana Authorization Guidelines, Medical Quality Assurance Commission (Nov. 2014)

A health care professional may provide valid documentation to authorize medical marijuana to a qualifying patient under the following conditions

- Patient examination
  - Health care professional should obtain, evaluate, and document the patient's health history and physical examination in the health record prior to treating for a terminal or debilitating condition
    - The patient's health history should include current and past treatments for the terminal or debilitating condition, comorbidities, and any substance abuse
    - The health care professional should complete an initial physical examination as appropriate based on the patient's condition and medical history and review the patient's medications
- Treatment plan
  - A health care professional should document a written treatment plan that includes:
    - Review of other measures attempted to treat the terminal or debilitating condition that do not involve the use of medical marijuana
    - Advice about other options for treating the terminal or debilitating medical condition
    - Determination that the patient may benefit from treatment of the terminal or debilitating medical condition with medical use of marijuana
    - Advice about the potential risks of the medical use of marijuana to include:
      - The variability of quality and concentration of marijuana
      - Adverse events, including falls or fractures
      - The use of marijuana during pregnancy or breastfeeding
      - The need to safeguard all marijuana or marijuana infused products from children and pets or domestic animals
    - Additional diagnostic evaluations or other planned treatments
    - A specific duration for the medical marijuana authorization for a period no longer than twelve months
    - A specific ongoing treatment plan as medically appropriate
- Ongoing treatment
  - Health care professional should conduct ongoing treatment as medically appropriate to review the course of the patient's treatment, to include:
    - Any change in medical condition
    - Any change in physical and psychosocial function
    - Any new information about the patient's terminal or debilitating medical condition
- Maintenance of health records
  - Health care professional should maintain the patient's health record in an accessible manner, readily available for review, and include:
    - The diagnosis, treatment plan, and therapeutic objectives
    - Documentation of the presence of one or more recognized terminal or debilitating conditions
    - Results of ongoing treatment
    - The health care professional's instructions to the patient
- Continuing education
  - Health care professional issuing authorizations or valid documentation for the medical use of marijuana should complete a minimum of three hours of CME related to medical marijuana
    - Program should explain the proper use of marijuana, including the pharmacology and effects of marijuana, methods of administration, and potential side effects and risks

Board Guidelines, cont'd.

Interagency Guideline for Opioid Dosing for Chronic Non-Cancer Pain: An Educational Aid to Improve Care and Safety with Opioid Therapy, Agency Medical Directors Group (2010)

Dosing threshold for pain consultation

- Recommended that a practitioner not prescribe more than an average MED of 120mg without either the patient demonstrating improvement in function and pain or first obtaining a consultation from a pain management expert
  - High dose opioid therapy can be ineffective and/or unsafe
    - Higher strength pain medicines may be associated with poorer functional outcomes than lower strength opioids
  - Providers must pay attention to the development of tolerance and adverse outcomes of chronic opioid use
  - Safety and effectiveness of opioid therapy should be routinely evaluated by the prescriber
    - Assessing the effectiveness of opioid therapy should include tracking and documenting both functional improvement and pain relief
  - If there is evidence of frequent adverse effects or lack of response to an opioid trial, a specialty consultation should be considered

Before prescribing opioids for chronic pain

- It is critical that the prescriber comprehensively assess the risks and benefits of treatment prior to deciding whether to prescribe opioids
- Consider opioid therapy when:
  - Other physical, behavioral, and non-opioid measures have failed (e.g., physical therapy, cognitive behavioral therapy, NSAIDs, antidepressants, antiepileptics)
  - The patient has demonstrated sustained improvement in function and pain levels in previous opioid trial
  - The patient has no relative contraindication to the use of opioids (e.g., current or past alcohol or other substance abuse, including nicotine)
- Chronic opioid therapy lasting more than 90 days should only be initiated on the basis of an explicit decision and agreement between the prescriber and patient
  - Patient should be informed of the risks and benefits of opioid therapy of indefinite duration
- Screening for potential comorbidities and risk factors is crucial so that anticipated risk can be monitored accordingly
  - Depression and anxiety disorders are frequently associated with the use of opioids
  - Current and past substance abuse disorders appear to increase the risks of chronic opioid therapy
  - If substantial risk is identified through screening, extreme caution should be used and a specialty consultation is strongly encouraged

Board Guidelines, cont'd.

After you decide with the patient to prescribe chronic opioid therapy

- When instituting chronic opioid therapy, both prescriber and patient should discuss and agree on all of the following:
  - Risks and benefits of opioid therapy supported by an opioid agreement
  - Treatment goals, which must include improvements in both function and pain while monitoring for and minimizing adverse effects
  - Expectation for routine drug testing
  - Follow-up plan with specific time intervals to monitor treatment
- Once the decision is made to institute chronic opioid therapy, the prescriber is responsible for routinely monitoring the safety and effectiveness of ongoing treatment

Principles for safely prescribing chronic opioid therapy

- Single prescriber and single pharmacy
- Patient and prescriber sign opioid agreement
- Lowest possible effective dose should be used
- Be cautious when using opioids with conditions that may potentiate opioid adverse effects
- Do not combine opioids with sedative-hypnotics, benzodiazepines, or barbiturates for chronic pain unless there is a specific medical and/or psychiatric indication for the combination and increased monitoring is initiated
- Routinely assess function and pain status
- Monitor for medication misuse
- Random drug testing

Screening and monitoring patient

- Screening tools are available to help assess risk for aberrant drug-related behavior, current or former substance abuse, and mental health disorders
- Additional monitoring may include increased frequency of reassessment of pain, function, and aberrant behaviors, decreased number of doses prescribed, and increased frequency of drug testing

Assessing function and pain

- An assessment of function and pain should consistently measure the same elements to adequately determine the degree of progress
- Prescriber should assess the risks and benefits of the patient's current opioid therapy, which assessment should include:
  - Function and pain status
  - Possible adverse effects of current opioid doses
  - Potential psychiatric disorders affecting treatment
  - Possible drug combinations or conditions that may potentiate opioid adverse effects
  - Any relative contraindication to the use of opioids
- If function and pain don't improve after a sufficient opioid trial, consider discontinuing opioids
- When there is evidence of significant adverse effects from opioid therapy, the provider should reduce the opioid dose and reassess the patient's status
- Ongoing therapy entails ongoing assessment

Board Guidelines, cont'd.

Specialty consultation

- Recommended for ongoing severe pain symptoms with no significant improvement in function despite treatment with opioids
- Consultation should address possible undiagnosed conditions, psychological conditions affecting treatment, and alternative treatments
- The type of consultation obtained should be determined by the patient's presenting signs and symptoms and history

Tapering or discontinuing opioids

- Weaning from opioids can be done safely by slowly tapering the opioid dose and taking into account the following issues:
  - A decrease by 10% of the original dose per week is usually well tolerated with minimal physiological adverse effects
    - Some patients can be tapered more rapidly without problems
  - If opioid abstinence syndrome is encountered, it is rarely medically serious although symptoms may be unpleasant
    - Symptoms of abstinence syndrome, such as nausea, diarrhea, muscle pain and myoclonus, can be managed with medications during the taper while monitoring often for significant hypotension and anticholinergic side effects
  - Symptoms of mild opioid withdrawal may persist for six months after opioids have been discontinued
  - Consider using adjuvant agents, such as antidepressants, to manage sleep, irritability, or antiepileptics for neuropathic pain
  - Do not treat withdrawal symptoms with opioids or benzodiazepines after discontinuing opioids
  - Referral for counseling or other support during this period is recommended if there are significant behavioral issues
  - Referral to a pain specialist or chemical dependency center should be made for complicated withdrawal symptoms