

# Opioid Abuse Toolkit

## Resources for New Jersey Prescribers 2017



**RUTGERS**

Ernest Mario School  
of Pharmacy

## OBJECTIVE

The purpose of this toolkit is to raise awareness of the opioid epidemic in New Jersey and provide resources to healthcare providers for the appropriate management of patients who require opioids or medication-assisted treatment for opioid abuse.

## OVERVIEW

Prescription opioids and heroin have become the main source of drug overdose deaths in the United States.<sup>1</sup> The Centers for Disease Control and Prevention (CDC) cites that opioids have been implicated in 33,091 deaths in 2015 and opioid overdoses have quadrupled since 1999.<sup>1</sup> In New Jersey specifically, from 2014-2015, there was a significant increase of 16.4% in drug overdose deaths.<sup>2</sup> In response to the opioid overdose death epidemic, New Jersey Governor Chris Christie signed Executive Order 219 on January 17, 2017 declaring a public health crisis in the State of New Jersey.<sup>3</sup> The Executive Order created the Governor’s Task Force on Drug Abuse Control to coordinate state efforts to combat the opioid crisis. The Governor has also signed into law a bill that mandates provision of addiction treatment by insurance companies and limits the day supply for acute opioid prescriptions<sup>4</sup>, the details of which can be found on page 19 of this document.

Prescribers and health care professionals have a unique position to make a large impact in not only treatment opioid addiction, but preventing it. In a recently published analysis by the CDC,

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opioid-naïve patients were more likely to continue filling opioids long-term when given an initial prescription of a higher day supply at 1 and 3 years. The analysis found that even with just a 10-day supply of opioids, 1 in 5 become long-term users<sup>12</sup>. The correlation between prescription opioids and heroin and the establishment of prescription opioids as “gateway drugs” for illicit drug use has been extensively explored in published literature.<sup>5-7</sup> In one study, heroin users were 3.9 times as likely to report nonmedical use of opioids in the previous year when compared to people who did not use heroin.<sup>5</sup> Individuals who report nonmedical use of prescription opioids may use heroin because they develop tolerance to opioids and heroin represents a more cost-affordable alternative.<sup>7</sup> Appropriate management of these individuals may reduce mortality and economic burden, while improving quality of life for those affected and their families.

In 2016, the **Surgeon General’s Report on Opioids** brought national attention to the country’s opioid epidemic. Along with presenting the staggering statistics related to morbidity, mortality, and economic burden, the report also created the #TurnTheTide Campaign, calling 2.3 million healthcare providers to action, visiting America’s hardest hit communities, and engaging stakeholders. More information regarding the Report as well as the #TurnTheTide Campaign can be found at [www.surgeongeneral.gov](http://www.surgeongeneral.gov) and [www.turnthetiderx.org](http://www.turnthetiderx.org).

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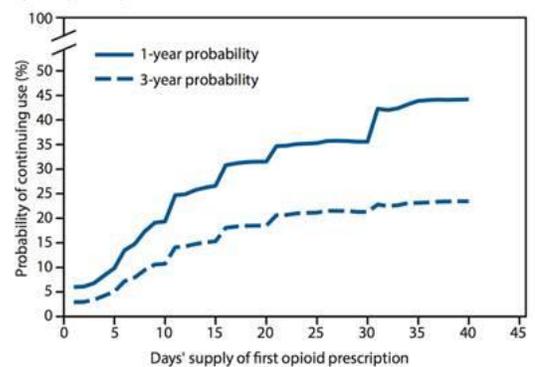
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# Section 1: Inpatient and Emergency Department Prescribing

## Overview

Rates of opioid addiction and overdose in the United States have significantly increased in recent years. Often, when those who become addicted to prescription opioid painkillers are seeking medication, emergency departments (ED) and hospital inpatient settings are a point of intervention that can potentially change the course of an addiction from further misuse and potential overdose, to a connection to treatment. Additionally, hospital inpatient settings and EDs are a major source of opioids that lead to initial addiction. A recent report from the Centers for Disease Control and Prevention (CDC) found that one and 3 year probabilities of continued opioid use among opioid-naïve patients were significantly higher depending on the day supply of the initial prescription<sup>16</sup> (Figure 1.). In 2014, New Jersey saw 214.5 opioid-related ED visits and 288.7 opioid-related inpatient stays per 100,000 people, higher than the national statistics of 177.7 ED visits and 224.6 hospitalizations for the same year.<sup>20</sup> Within this section of the toolkit, information for prescribers will be presented that can assist in reducing the extent of the opioid epidemic and potentially reduce opioid overdose deaths.

FIGURE 1. One- and 3-year probabilities of continued opioid use among opioid-naïve patients, by number of days' supply\* of the first opioid prescription — United States, 2006–2015



## Prescription Monitoring Program

### Background:<sup>21</sup>

The New Jersey Prescription Monitoring Program (NJMPMP), sometimes referred to as the Prescription Drug Monitoring Program (PDMP), is a statewide database that contains information on the outpatient dispensing of Controlled Dangerous Substances (CDS) and Human Growth Hormone (HGH). Through use of the NJMPMP, prior to writing or dispensing a prescription for a CDS medication, prescribers and pharmacists are able to identify whether a patient is going to multiple prescribers and pharmacies for the same medication, including prescriptions they fill for without insurance. In addition to recording data on prescriptions dispensed within the State of New Jersey, the NJMPMP includes information on CDS prescriptions dispensed in South Carolina, Minnesota, Rhode Island, Virginia, Connecticut, and Delaware.

### Access:

Access to the NJMPMP is provided to prescribers, delegates, and pharmacists who are licensed by the State of New Jersey and whose licenses are in good standing with their respective licensing boards.

Registered prescribers may delegate their authority to access the NJPMP to certain other healthcare professionals, including registered nurses, licensed practical nurses, dental hygienists, advanced practice nurses, and physician assistants.<sup>34</sup>

### **Requirements:**

For Prescribers:

Before issuing a prescription, a prescriber or his/her delegate, shall access prescription monitoring information for a new or current patient if:

1. The first time the prescriber has written a Schedule II CDS to a new or current patient for acute or chronic pain; and
2. On a quarterly basis (every 3 months) during the period of time a current patient continues to receive a prescription for a Schedule II CDS medication for acute or chronic pain.

Pharmacies are required to report information to the NJPMP on a daily basis and prescriptions must be reported to the database no more than one business day after the date the prescription was dispensed.

### **How to Register:**

In order to register for NJPMP database access Prescribers, their delegates, and Pharmacists must first register for PMP AWARe by completing the following steps:

1. Click on the following link: <https://newjersey.pmpaware.net/>
2. Click on "Create an Account" link to register. An e-mail address will be used as your login username (which cannot be shared).
3. Follow the instructions, including entering your license number, DEA number, NJ State CDS Number, and all other requested information.
4. Certified Medical Assistants (CMA) will be required to upload a notarized request for access form and a copy of their license.
5. Following the approval of your account, there is a brief and mandatory tutorial.

For more information, instructions for registering with the NJPMP can be found here:

<http://www.njconsumeraffairs.gov/pmp/Pages/register.aspx>

### **What to Assess When Using the NJPMP:**

When checking a patient's profile in the NJPMP, assessing a patient for patterns of abuse or misuse can be challenging. Some important terms to know are summarized below:

- Doctor shopping - the practice of multiple visits to different prescribers to obtain prescriptions for the same medication.
- Pill mill - describes a doctor, clinic, or pharmacy that is prescribing or dispensing narcotics inappropriately or for non-medical reasons.

When assessing whether your patient is diverting, abusing, or misusing CDS prescriptions check the following:

- History of multiple providers in different practices (different addresses or practice names)
- History of filling prescriptions at multiple pharmacies (keeping in mind pharmacy chains share the same prescription history for each patient)
- Filling medications without using insurance as a means of not hitting limits from the insurance company
- Many acute fills of opioid medications from emergency rooms, general practice providers, or dentists with a pattern of alternating pharmacies

## **Best Practices for Prescribing Opioids in the Emergency Department**

Based on CDC data on Ambulatory Healthcare, 70% of all emergency department (ED) visits are related to pain<sup>10</sup>. The use of prescription medication used to treat pain has also increased significantly in the US in the last 10 years. In the interests of effective triage, it is essential to differentiate the pain from acute or chronic pain. Some of the key challenges to providing proper care are balancing the delivery of prompt appropriate pain treatment and the prevention of addiction, diversion, and abuse. Emergency providers are well trained and equipped in the management of acute pain but chronic pain necessitates a multidisciplinary approach centered on a singular primary care provider. The table below has been adapted from the American Academy of Emergency Medicine (AAEM) and Oregon A.C.E.P. with the goal of capturing the current ED best practices on pain management.<sup>11, 40</sup>

Best Practices	Current Policy	Decision
Consult Prescription Monitoring Program before writing prescriptions for CDS		<input type="checkbox"/> Addressed in Current Policy <input type="checkbox"/> Integrate with changes <input type="checkbox"/> Integrate without changes
Patients who arrive with an opioid overdose should be offered follow up services such as counseling and detoxification programs		<input type="checkbox"/> Addressed in Current Policy <input type="checkbox"/> Integrate with changes <input type="checkbox"/> Integrate without changes
Administration of intravenous or intramuscular opioids in the ED for acute exacerbation of chronic pain is discouraged		<input type="checkbox"/> Addressed in Current Policy <input type="checkbox"/> Integrate with changes <input type="checkbox"/> Integrate without changes
Chronic pain should be managed by one primary care physician (PCP) and there should be an internal process to identify and provide notice to the PCP		<input type="checkbox"/> Addressed in Current Policy <input type="checkbox"/> Integrate with changes <input type="checkbox"/> Integrate without changes
Avoid initiating long acting opioids in ER  Prescribe no more than needed, starting with the lowest dose for no more than 3 days		<input type="checkbox"/> Addressed in Current Policy <input type="checkbox"/> Integrate with changes <input type="checkbox"/> Integrate without changes
ED health care practitioners should not refill prescriptions that have been lost, destroyed, or stolen		<input type="checkbox"/> Addressed in Current Policy <input type="checkbox"/> Integrate with changes <input type="checkbox"/> Integrate without changes

## Tapering Opioid Therapy<sup>13, 14</sup>

### Overview

High doses of opioid therapy for chronic pain have insufficient evidence to determine its effectiveness. As clinical trials are short in duration, often limited to 6-12 weeks of opioid use compared with placebo, and patients with high risk of abuse/overdose are excluded, obtaining a picture of the real world benefits and risks of long-term opioid therapy is difficult. Recent data analysis supports a dose-dependent risk for serious harms, such as overdose, mortality, fractures, and cardiovascular events.

In a large retrospective cohort study (n=9,940), recent opioid use associated with increased risk of any overdose events (adjusted hazard ratio [HR] 5.2; 95% CI = 2.1 - 12.5) and serious overdose events (adjusted HR 8.4; 95% CI = 2.5 - 28) versus non-use.<sup>41</sup> Similarly, a nested case-control study found a dose-dependent increase in overdose risk based on MME, which increased from an OR of 1.32 with an MME<20/day, to 2.04 for 50-99 MME/day, 2.04 for 100-199MME/day, and 2.88 for ≥200 MME/day.

An increased risk of myocardial infarction versus no-long term opioid therapy (adjusted incidence rate ratio [IRR] 2.66; 95% CI = 2.30 – 3.08) has been observed in a large retrospective cohort study.

If the detriment to the patient outweighs the benefits of opioid therapy, it's crucial to work with the patient to taper opioids for later discontinuation and trial of non-opioid options. CDC has advised caution with opioid doses over 50 morphine equivalents (MED) and has recommended against doses exceeding 90 MED.

### Identify Patients that Qualify for Tapering

Per CDC guidelines, tapering opioid use can be evaluated if any of the following are true:

- There is no sustained clinically meaningful improvement in pain or function
- Opioid doses ≥50 Morphine Equivalent Dose (MED)/day without evidence of benefit
  - o [MED Calculator](#)
- Concurrent benzodiazepines that cannot be tapered off
- If a patient requests dosage reduction or discontinuation
- Patient experiences an overdose or serious adverse events

Assess the patient for behavioral disorder that might complicate tapering. Depression is a risk factor for failing the taper and relapse.

- [Patient Health Questionnaire \(PHQ-9\) Screening Tool- SAMHSA.](#)

### Engage the Patient in a Collaborative Plan for Tapering

The CDC recommends a decrease of 10% of the original dose per week as a realistic starting point; however, tapering plans should involve the input of the patient. Clinicians should counsel the patient being tapered on the increased risk for overdose in the event of an abrupt return to a higher dose.

## Manage the Complications of Tapering

Monitor the patient for withdrawal symptoms during the taper and adjust the rate accordingly.

[The Clinical Opioid Withdrawal Scale \(COWS\)](#)<sup>17</sup> is an 11-item scale to measure the severity of common signs and symptoms of opiate withdrawal and monitor symptoms over time. The scale can be used both inpatient and outpatient. Below is a table that can be used to help guide clinicians to manage therapy for patients with opiate withdrawal:

Symptom	Therapy
Diarrhea	Loperamide
Nausea	Metoclopramide
Cramping	Dicyclomine
Insomnia	Trazadone
Pain or Fever	Ibuprofen

## Patient Engagement/Tapering Agreement<sup>14</sup>

It is critical to engage the patient into personally seeking greater control over their life. For maximum effect, it must be the patient taking a leading role in the tapering process rather than the physician issuing firm directive.

### Initial Discussion Questions

*The risks of high dose opioid therapy:*

- How has opioid medications affected your well-being?
- What do you believe are the risks associated with opioid therapy?
- How has opioids impacted your daily life and responsibilities?

*The benefits of a tapering regimen:*

- How would a gradual taper benefit your health?
- What do you believe to be a realistic tapering schedule?
- What do you want to set as a weekly goal for the tapering regimen?

*The management of withdrawal symptoms*

- After reviewing the possible symptoms, which one would bother you the most?
- How can we work together to manage your withdrawal symptoms?

### Dealing with Pushback

*Listen carefully to the points of concern*

- Patients are understandably worried about the process
- “I am hearing your frustrations with the tapering regimen”

*Establish rapport through summarizing*

- Demonstrate understanding of their predicament
- “I emphasize with your struggle with barriers of adequate family support”

*Encourage patients on their progress*

- Have them reflect on the end goal of being back in control
- “I truly appreciate your bravery in continuing with the tapering”

## Section 2: Overdose-Related Resources for Prescribers

### Overview

Nearly half of patients with non-fatal opioid overdoses received opiate doses >100 morphine milliequivalents (MME) in the preceding 60 days. In the 300 days following overdose, nearly all patients (91%) had received one or more new opioid prescriptions, with 17% having a subsequent overdose at 2 years.<sup>74</sup> The purpose of this section is to provide resources for prescribers in both the inpatient and outpatient setting to appropriately manage patients who are misusing opioids, especially those with a history of opioid overdoses, how to refer them to treatment, and reduce opioid overdose deaths.

### Poison Control Services<sup>18</sup>

The NJ Poison Information and Education System (NJPIES) is a great resource for health care providers to manage overdoses in an inpatient setting. Hospital practitioners should alert the NJ Poison Center when they have any patient who exhibits signs of a drug overdose or toxicity. Trained specialists can aid health care professionals in managing these patients by suggesting non-traditional supportive measures and management techniques. This public service is extremely valuable, especially for opioid overdose patients refractory to naloxone therapy or unresponsive patients. Additionally, NJ Poison Center specialists can help manage mixed drug overdoses and inform providers on and other systemic complications to monitor patients for.

*Dial 1-(800)-222-1222 to reach your local Poison Control Center.*

### Obtaining DEA-X Privileges

#### The Need for DEA-X Privileges

The Drug Addiction Treatment Act of 2000 (DATA), which amended the Controlled Substances Act, allows practitioners to dispense or prescribe Schedule III, IV or V controlled substances approved by the FDA for narcotic addiction treatment. Although prevention is key to reducing the opioid overdose epidemic, treatment options are necessary to treat those already addicted to opioids. There is a shortage of the number of prescribers who have DEA-X prescribing privileges, which unfortunately can lead to delays in starting addiction treatment and lead to subsequent relapses and overdoses. The purpose of this section is to inform prescribers on how to obtain DEA-X privileges and address the need for expansion of opioid dependence services.

#### Obtaining DEA-X Privileges

DEA-X privileges can be obtained through the federal Drug Enforcement Administration (DEA) to prescribe medication for the treatment of opioid dependence. Initially, a prescriber must successfully complete all of the state mandated requirements where the practitioner will conduct business and obtain a state license. If the practitioner fails to complete these requirements or has his/her license

revoked or rescinded, then the registration will be canceled. If an existing DEA registrant loses his/her state privileges, then the DEA will rescind or revoke the federal authority to prescribe such substances. Basic DEA privileges include the ability to administer a three day (72 hour) supply of narcotic treatment therapy for the purpose of relieving a patient's acute withdrawal symptoms while referring the patient to be placed in a maintenance/detoxification program. Prescribers have this privilege without having to formally register in a narcotic treatment program. Certain conditions apply to this privilege including not administering greater than a one day supply of the medication at one time or in a single day timeframe and no renewal or extension of this 72 hour period. Pursuant to the Narcotic Addict Treatment Act of 1974, any practitioner who wants to use Schedule II drugs for the purpose of maintenance and/or detoxification must submit a separate registration to the DEA as a narcotic treatment program. Under the provision, a practitioner is able to administer or dispense, but not prescribe scheduled narcotic drugs approved by the FDA for the maintenance and detoxification treatment of narcotic addiction which are methadone and levo-alpha-acetyl-methadol (LAAM).

The Drug Addiction Treatment Act of 2000 (DATA), which amended the Controlled Substances Act, allows practitioners to dispense or prescribe Schedule III, IV or V controlled substances approved by the FDA for narcotic addiction treatment. These practitioners must notify the Secretary of HHS in writing of their intent to engage in this activity and must certify that they are qualified through measures such as state licensure, certification, training or experience in the area of addiction treatment.

Once approval is granted, the practitioner will be authorized to dispense and/or prescribe under his/her DEA practitioner registration. The DEA will then assign a unique identification number to the practitioner's DEA registration beginning with the letter X denoting these unique privileges. Once they obtain their credentials, they are limited to treating only 30 patients at a time in the first year of certification, later expandable to 100 patients. Recently, the 100 patient limit regulation has been expanded to 275 patients for providers who have prescribed buprenorphine to at least 100 patients in a one year span.<sup>19</sup>

*More information on how to register/apply for a DEA-X registration can be obtained from the SAMHSA website, [here](#).*

### **Linking Patients to Opioid Dependence Treatment**

As prescription opioids are often gateway drugs to illicit drug abuse including heroin. This national epidemic stems from patients who do not have the medical need for opioid therapy receiving prescriptions for opioids in the emergency room for outpatient use. The most common opioid drugs that are misused include oxycodone, hydrocodone, and methadone<sup>21</sup>. Although specific laws and regulations have been passed to curb opioid drug abuse, such as the reclassification of hydrocodone as a Schedule II substance, there is much more need for involvement from health care professionals. Without reform, we may continue to see as many as 1 in 4 patients without chronic intractable pain who receive prescription opioids for long term use struggle with addiction<sup>21</sup>.

Connecting patients who are struggling with opioid addiction to appropriate care is a vital component of addressing the opioid addiction epidemic. In New Jersey, there are roughly 52-71 opioid prescriptions written per 100 people<sup>20</sup>. In January 2017, Governor Chris Christie signed an executive order to help curb the epidemic in New Jersey and limit the prescription of opioids for acute pain. Please refer to page 20 for further details on the manifestations of the opioid bill.

*To assist your patients to find a behavioral health treatment center through SAMHSA, [click here](#).*

## **Medication-Assisted Treatment (MAT)**

### **Overview**

There are a number of products available for the treatment of opioid dependence, each with their own specific advantages and disadvantages. It is important to select the right type of therapy for the right patient in order to assist in their addiction treatment. The purpose of this section is to provide an overview of treatment options for opioid dependence.

### **Screening Tools**

Prior to initiating medication-assisted treatment, it is critical that the prescriber asks the patient key questions to determine potential causes of the drug abuse and obtain the patient's medical background. Such questions may include the following, adapted from a SAMHSA toolkit.

- 1) Have you taken any medications within the past 6 months to enhance your mood, reduce anxiety, and make you feel better?
- 2) Have you ever used alcohol or drugs for similar purposes as listed in the previous question?
- 3) Have you ever taken a medication to help you with an alcohol or drug problem?
- 4) Have you previously sought help for drug addiction?
- 5) Have you been using any medications to help you sleep?

The patient history should be complete and include information about all other prescriptions, over the counter medications, such as cough and cold medications, alcohol use, and concomitant illicit drug use. Furthermore, to obtain more information about a patient's prescription opioid filling history, consult the NJPDMP.

There are numerous screening tools that may be used to assess if a patient is experiencing signs and symptoms of opioid dependence and the degree of withdrawal. Other screening tools help distinguish a patient's behavior as substance abuse or dependence and the likelihood that their overdose could lead to addiction. Most of the screening tools are created based on DSM-V criteria.<sup>22</sup>

[CRAFT 2.0 Self-Administered Questionnaire](#): Questionnaire for adolescent patients (under the age of 21) to determine their risk for drug and alcohol use disorders. Questions range from self-reflective, (e.g. if they ever have used prescription or illicit drugs for personal outcomes) to observatory questions (e.g. whether a family member or friend has ever noticed unusual behavior from the patient).

Scoring ranges from 0-6 and represents the probability that an adolescent has a diagnosis of substance abuse or dependence. Substance abuse and dependence are categorized according to DSM-IV criteria.<sup>23</sup>

Refer to Supplement 2 for further detail.

**Opioid Risk Tool:** The Opioid Risk Tool (ORT) is a self-reporting screening tool intended to be used by adult patients in a primary care setting to assess the risk of opioid dependence in patients prescribed opioids for chronic pain treatment. Criteria that patients are evaluated on include family and personal history, age, and concomitant psychological disorders. The scale is out of a total 27 points and takes approximately 1 minute to administer.

Point Range	Risk
≤3 points	Low risk for future opioid abuse
4-7 points	Moderate risk for future opioid abuse
≥8 points	High risk for future opioid abuse

Refer to Supplement 3 for further detail.

**Clinical Opiate Withdrawal Scale:** Measures patient symptoms and objective criteria, such as heart rate, pupil size, restlessness/irritability, and tremors. Various measures within each criterion are assigned a point value. The number of points signifies the degree of withdrawal.

Point Range	Severity of Withdrawal
5-12 points	Mild Withdrawal
13-24 points	Moderate Withdrawal
25-36 points	Moderately Severe Withdrawal
>36 points	Severe Withdrawal <sup>17</sup>

Refer to Supplement 4 for further detail.

### Treatment Options - Home Naloxone Therapy

Patients at high risk for overdosing on opioids at home can be prescribed naloxone via injection or intranasal spray to potentially save their lives in an overdose situation. Naloxone can be purchased without a prescription from all CVS/Pharmacy and Walgreens locations throughout New Jersey. For patients without insurance, the cheapest option is to purchase the naloxone nasal spray. There are a number of pharmacy coupons that can be used to lower the price, such as [GoodRx](#).

Naloxone hydrochloride is an opioid receptor antagonist, which blocks the uptake of opioid drugs at receptors in the brain. It's most notable effect is reversing respiratory depression associated with opioid overdose, which can be fatal. The two common dosage forms of naloxone that can be purchased from a community pharmacy include an intramuscular injection and intranasal atomizer. The Overdose Prevention Act signed in 2013 protects any party who dispenses or administers to an opioid overdose victim. This is an extremely significant fact to educate high school and college students; that if they

report overdoses, the law is non-punitive to them, regardless of whether they were with the individual while illegal or prescription drugs were on the premises.<sup>25</sup>

Purchasers can pay out of pocket for the medication and community pharmacists are available to train the purchasers on how to effectively administer the drug. The life-saving medication has no physical or psychological addicting properties and has no effect on patients who are not under the influence of opioids. With this large benefit to risk ratio, physicians should encourage people to purchase naloxone and keep it on hand for high risk individuals.<sup>26</sup>

Refer to Supplement 5 for a poster to provide to patients on how to administer naloxone

### **Medication-Assisted Treatment Options**

Medication-assisted treatment (MAT) is the use of medications along with behavioral therapy and counseling to treat patients with substance abuse disorders and addictions. MAT is primarily used for opioid addiction. One goal to keep in mind is to personalize MAT to each individual patient's need and in terms of what medication works best for them. The ultimate goal is full recovery and patients should be appropriately weaned off therapy when they tolerate it. Intermediate goals include increasing survival rates, helping patients maintain adequate social and economic status, and reducing the number of infants going through withdrawal at birth.<sup>27</sup> Refer to the [SAMHSA MAT Pocket Guide](#) for an overview of MAT and non-drug abuse resources for patients.

MAT is currently underutilized. The proportion of heroin admissions with treatment plans that included receiving medication-assisted opioid therapy fell from 35% in 2002 to 28% in 2010. Medication assisted therapy can help combat the psychological dependence, physical cravings, and withdrawal symptoms that these patients experience. In general, people may safely use MAT for months or several years, and plans to taper should only be done when the benefit surpasses the risk of relapse.<sup>27</sup>

Methadone, a medication that binds to CNS opioid receptors as well as a weak NMDA antagonist, is one option for MAT. It is available as a tablet, oral concentrate, and wafer, and is typically used daily by the patient. It is also the only MAT drug that is FDA approved for use in pregnant and breastfeeding women. Due to its safety profile, methadone has a wide scope of use. When a pregnant woman experiences withdrawal, the uterus contracts and may lead to a miscarriage or premature birth. Methadone use can prevent withdrawal symptoms by helping pregnant women manage their addiction and preserve the health of the mother and fetus. Although methadone maintenance treatment will not cause birth defects, some infants may experience withdrawal symptoms after birth. According to the National Institute on Drug Abuse, the length of methadone treatment should be a minimum of 12 months in all patients and be gradually decreased to prevent withdrawal.<sup>27,28</sup>

Naltrexone is an opioid antagonist that is available as a tablet (ReVia®) and an intramuscular injection (Vivitrol®). The tablet is usually taken daily by patients, while the intramuscular injection serves as convenient once monthly dosage form. Naltrexone helps prevent the euphoria and sedation associated with opioid use. Since it binds and blocks opioid receptors, it can help reduce opioid cravings in patients who use the medication. The safety profile of this medication is strong as it does not have diversion potential since it produces no opioid-like effects. However, it does have a precipitated withdrawal risk

and thus opioids should be stopped at least 7-10 days before starting naltrexone therapy. Additionally, there is an interaction with tranquilizers, alcohol, and sedatives. Therefore, in patients with concomitant addictions, it may not be the best option for MAT. Naltrexone has the potential to cause liver injury. Patients should seek evaluation if they experience symptoms or signs of liver disease. Injection site reactions are also possible from the injectable form (Vivitrol®).<sup>27,28</sup>

Buprenorphine is a partial *mu* receptor opioid agonist and a weak *kappa* receptor antagonist. It is the medication with the most extensive dosage forms available to patients, including sublingual tablet (Subutex®, Zubsolv®), sublingual film (Suboxone®), buccal film (Bunavail®), intramuscular/intravenous injection (Buprenex®), transdermal system (Butrans®), and subdermal implant (Probuphine®). With Probuphine® being the newest formulation of buprenorphine, there are few guidelines for which patient would most benefit from therapy. Probuphine® is the only 6-month buprenorphine treatment option for opioid dependence on the market, and is only indicated for patients who have undergone previous buprenorphine treatment and have maintained low-moderate daily levels of buprenorphine. The implant provides a low daily dose of buprenorphine daily for 6 months of therapy. If treatment requires to be continued past the 6 month mark, the implant should be removed and a new implant may be inserted under the skin of the other arm.<sup>27-29</sup>

Buprenorphine is the first medication that could be prescribed and dispensed in a physician's office, thus it is a convenient option for patients. Additionally, it has a low incentive for misuse as it is often co-formulated with naloxone. If patients attempt to crush tablets for rapid onset, the buprenorphine in the medication is partially blocked by the naloxone.<sup>27, 28</sup>

Lastly, LAAM (levo-alpha-acetyl-methadol) is a full opioid agonist and a Schedule II medication in the United States. Due to its potent effects, it serves as a 3 times/week dosage option who can receive the medication directly in a physician's office or clinic. As this medication is perhaps the most potent MAT option and therefore poses the highest risk for diversion, its use is usually reserved for patients who have failed traditional therapy options.<sup>27, 28</sup>

There are various resources available to educate patients on their MAT options and decide what may be the best medication for them. Patient education is helpful for both families and their families to provide a link of care and involve caregivers in the MAT process. The journey is a tough one, but with adequate information and realistic expectations provided at the beginning of treatment, patients are more likely to successfully complete MAT. Consider creating a patient education sheet to allow your patients to understand the treatment regimen and serve as a visual aid. Organize the educational sheet by the day of treatment to facilitate comprehension.

Refer to Supplement 7 for a sample buprenorphine patient education sheet.

A MAT checklist is provided in Supplement 8 to aid the MAT process.

## Recovery Resources

To suggest options for recovery treatment programs to patients based on their background, preference, and type of insurance coverage

### Opioid Treatment Programs (OTPs)

Opioid treatment programs provide a range of services to reduce, eliminate, or prevent the use of illicit drugs, potential criminal activity, and/or the spread of infectious disease. They also focus on improving the quality of life of those receiving treatment. Certified treatment programs must be accredited by a SAMHSA-approved accrediting body and certified by SAMHSA.<sup>27</sup>

There are several general service organizations, such as [TreatmentMatch](#) that are available to connect patients to care. TreatmentMatch, in particular, is a confidential service to match patients to buprenorphine providers in their area and for prescribers to connect with patients. These services help complete the link of care. Often, many patients have a hard time seeking help and discovering these resources and prescribers are able to connect with patients that require their services as well.<sup>31</sup>

In terms of recovery programs, there are numerous options available in New Jersey to patients. These programs range from workshops to Narcotics Anonymous meetings to programs that provide recovery housing. One established program in Morris and Warren counties is [CARESNJ](#). CARESNJ is a peer to peer, volunteer based recovery oriented sanctuary. It is not a 12 step program but includes many workshops and meetings. The facility has a Recovery Coach Academy in Warren County, NJ.<sup>32</sup>

As college students are among the highest at risk patient populations for prescription and narcotic drug abuse, many recovery resources and housing can be found on college campuses. Many colleges and Universities are opening dorms specifically for those in recovery. The [Rutgers Recovery House](#) is a great option for students who struggle with addiction. Certified professionals and counselors conduct group recovery meetings with student addicts and the facility has a 12 step program as well. This recovery house is not limited to opioid addiction but also treats students facing alcohol, marijuana, and other illicit drug addiction.<sup>33</sup> A large number of college students who abuse opioids do not abuse prescription narcotics or heroin alone. It is often paired with marijuana and alcohol use.

### Resources for Patients with Medicaid

There are many resources for patients with Medicaid in New Jersey who may not be able to afford the higher cost of many traditional recovery programs. These include reduced-cost programs and programs fully covered under Medicaid.

[Access to Recovery \(ATR\) vouchers](#) are an option for approximately 100,000 people per year. The ATR voucher program was announced in 2003 in former President Bush's State of the Union Address which allows individuals seeking drug and alcohol treatment recovery support to receive a voucher to pay for a range of appropriate services.

This criteria usually entails:

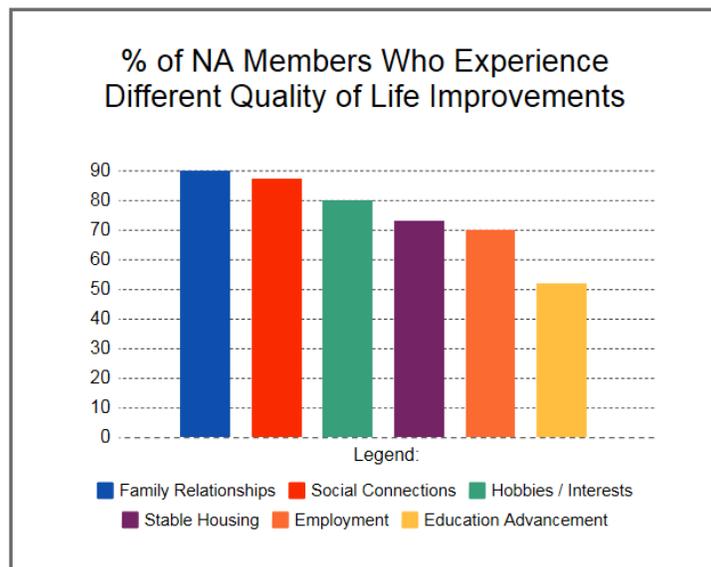
- Be at least 18 years of age
- Have a history of substance use or abuse
- Have an annual income that is below 200% of the federal poverty level
- Reside in the counties or jurisdictions that provide ATR to residents<sup>35</sup>

For patients that meet the above criteria, an ATR voucher can provide treatment services at no cost to the patient.<sup>27</sup>

While the cost of care in a state psychiatric hospital for one person per year cost around \$240,000, one year of community-based services only costs \$1,140. These community-based agencies service what health care professionals call “super users,” people who account for more than 50% of Medicaid costs. Not only do these programs often have more personalized care for their area's patients, but they are also overall much more affordable or free for patients compared to standard programs.<sup>27,35</sup>

### Assisting Patients without Insurance

Further expansion is needed in this area as a majority of current programs for this patient population are limited to charity based programs and services. Narcotics Anonymous is a 12 step program available to individuals battling drug addiction that is completely free of charge. Patients should be referred to Narcotics Anonymous if possible as there are strong support services for patients and their families at these workshops and meetings. Based on recent statistics, Narcotics



Anonymous participation does improve the quality of life of these patients and improves their relationships, which is one of the main goals for these patients.<sup>36</sup>

Secondly, online forums such as Addiction Survivors is a great resource for current addicts to seek advice from former addicts and the general community in terms of what programs worked for them and receive support. The link to access the forum and a patient brochure is as follows<sup>37</sup>:

- [Addiction Survivors Online Forum](#)
- [Addiction Survivors Brochure](#)

Community-based programs often provide food and shelter to patients in addition to recovery services and counseling. One program is [The Rescue Mission of Trenton](#) (Vince’s Place). This organization provides food and shelter in addition to recovery services for its patients. There are three units

depending on the level of care that the patient requires, long-term (180 days), a halfway house, and extended care. Volunteer work and charity funds are often how these programs are run.<sup>38</sup>

Finally, church based charities such as Catholic Charities Diocese of Metuchen - East Brunswick Family Service Center are great resources for those who may not be able to afford traditional treatment programs. The church also outsources to several family centers located in surrounding towns.<sup>39</sup> For church based charities, although the support network and counseling services are usually fantastic, those programs are unfortunately often limited to providing counseling services and “clean” housing. MAT is not routinely offered within most programs but the charities are able to help patients seek further help.

Furthermore, patients should take advantage of free testing services and health initiatives that are offered through support programs and town health centers. These services include discreet HIV testing, Hepatitis C resources, and referrals to mental health clinics.

## Section 3: Outpatient Resources for Prescribers

### Limiting the Number of Opioid Prescriptions

#### Overview

On May 16<sup>th</sup>, 2017 one of the strictest opioid laws in the country is set to go into effect in New Jersey. The law is consistent with the March 2016 “CDC Guidelines for Prescribing Opioids in Chronic Pain”, which advises prescribers to use the lowest effective dose with the shortest duration possible. The law exempts cancer patients, the terminally ill, and residents of long-term care facilities. In addition to the law’s stipulation that limits durations of treatment with opioids for acute pain, this law also increases access and insurance company coverage for treatment of individuals with substance use disorder.

#### Details of the Law

New Jersey Law S3/A3 stipulates the following:

- Initial opioid prescriptions for acute pain are limited to a 5-day supply or less
  - Excluding cancer, end-of-life care, and residents of long-term care facilities
- Prescribers must pass the following safeguards before prescribing an opioid prescription
  - Have a discussion with the patient/caregiver regarding the risks associated with opioids, including risks of addiction and overdose
  - Explain why the medication is necessary and what alternate treatments are available
  - Inquire about patients’ medical history and risk for abuse or addiction
  - Conduct a proper physical examination as necessary
  - Develop a patient-specific treatment plan focused on that individual’s pain
- On day 4 of the initial prescription, a prescriber may issue a second prescription after consultation with the patient, so long as:
  - The medication is still necessary and appropriate
  - The medication will not present an undue risk of abuse, addiction, or diversion
- If a third prescription is required, the patient and physician must enter into a pain management agreement (see supplement 10 for a template).
- Any healthcare professional authorized to prescribe opioids must undergo one CE credit per year related to the prescribing of opioids
- All prescription drugs used to treat substance use disorder are covered by insurance companies without prior authorization in New Jersey for certain members
  - This 180-day period applies to both inpatient and outpatient treatment, with the following stipulation:
    - An outpatient treatment day is only considered ½ an inpatient treatment day, therefore persons exclusively treated outpatient can have up to 360 days of treatment without insurance company interference
- If no facility with the capabilities of treating substance use disorder is immediately available in the patient’s network, the insurance company must provide one within 24 hours
- No inpatient utilization reviews (insurance company determination if inpatient stay is necessary) can occur within the first 28 days of inpatient stay.<sup>40</sup>

## Education and Interventions

### Overview

As medicine is advancing and embracing interprofessional teams, it is evident that the management of substance use should require interprofessional education and collaboration. This has already been exemplified by prescribers and pharmacists collaborating with regard to prescriber-patient pain management contracts.

### American Dental Association Guidance

Although many prescriptions are written by family physicians and general practitioners, America's dentists were responsible for 18 million immediate-release opioid prescriptions in 2009.<sup>42</sup> As such, in 2016, the American Dental Association (ADA) developed a position statement regarding use of opioids for dental pain.

The position statement dentists and dental students should conduct both a physical and dental history prior to prescribing opioids. Part of their discussion should include other analgesic options, including nonsteroidal anti-inflammatory agents as first-line. Secondly, dentists should utilize the NJPMP, and finally, dentists should attempt to coordinate care with other practitioners for patients who are being prescribed chronic pain medications.<sup>43</sup>

### Core Competencies for Health Care Professions

Dental schools, including all Massachusetts Schools of Dentistry, have adopted core competencies regarding opioid misuse that have been incorporated into school curriculum.<sup>44</sup> While only mandatory for the state's dental schools, these core competencies should be incorporated into other health sciences schools in every state, including medicine, pharmacy, and nursing. The benefits of this education fill a dearth in current medical curriculum, as evidenced by the fact that only 36% of primary care physicians report that medical school prepared them to identify opiate misusers. Furthermore, 67% of primary care physicians are concerned with their ability to correctly assess a patient's risk of opioid addiction.<sup>45</sup> These competencies were aimed at primary prevention (preventing abuse and misuse), identifying and safely and effectively treating patients at risk for these disorders, and managing individuals with substance use disorders. Even if a healthcare professional is not involved in didactic teaching, they can implement these core competencies when mentoring students, residents, and fellows.

Highlights of the MA dental schools' core competencies are outlined below:

- Preventing prescription drug misuse
  - Evaluate patient pain by utilizing demographics, history, physical exam, and imaging to develop appropriate differential diagnosis
  - Evaluate a patient's risk for substance use disorders using the above strategies, together with resources like psychiatric screenings and the PDMP
  - Identify all possible treatment options, opioid and non-opioid, pharmacologic and non-pharmacologic, and choose the most appropriate option together with the patient
- Treating patients at risk for substance use disorders
  - Refer patients to appropriate specialties
  - Use an evidence-based and patient-centered pain management strategy
  - Recognize the signs and symptoms of aberrant prescription use behaviors
- Managing substance use disorders as a chronic disease

- Recognize and utilize currently available screening instruments
- Eliminate the stigma associated with substance use disorders and regard it as a chronic disease that can be managed with effective and patient-specific treatment
- Develop interprofessional education and utilize interprofessional management strategies<sup>44</sup>

It may also be useful to provide students and residents with a quick-reference handout (see Supplement 9) that reviews the pathophysiology and treatment of chronic pain.

## Communicating with and Monitoring Patients on Opioids

### Overview

Communication between the prescriber and the patient is a key component of successful management of pain with opioids. Open communication and utilizing shared decision-making is a useful strategy with patients. It involves the prescriber discussing and creating a treatment plan with the patient including treatment goals, benefits and risks, plans for discontinuation and how to dispose of medication, among other components. Research indicates that patients who feel their provider is not legitimizing their pain or is dismissive of their pain may not be adherent and could potentially overdose.<sup>46</sup>

Because most patients will not remember everything that is said at an office visit, it is important to provide the patient with both verbal and written information. Written educational materials should be written at an 8<sup>th</sup> grade reading level, involving as little medical jargon as possible. Patients should be made aware that there any and all side effects should be reported and that there are ways to safely manage side effects.<sup>46</sup>

Monitoring of patients currently on opioids should consist of continuous use of the PDMP, urine drug screens, and reviewing patients' medical records for discrepancies. Patients on long-term opioids for chronic pain should regularly have follow-up visits to consider analgesia, daily activities, medication-related side effects, and aberrant or drug-seeking behaviors. Prior to and during treatment, it may be appropriate and useful to give some patients questionnaires (many of which are self-administered) that will help determine their risk for developing substance use disorder, including the [NIDA-Modified Assist tool](#).<sup>47</sup>

With respect to the importance of communication between prescriber and patient, a prescriber-patient agreement is a useful tool for encouraging and maintaining communication between both entities during chronic pain management. A sample prescriber-patient agreement is available in the supplementary material section at the end of this document. See Supplement 10 for a sample prescriber-patient agreement contract.

## Non-Pharmacologic Treatments for Substance Use Disorders & Wellness Centers

### Mental Health Support Services, Yoga, and Meditation

[The Veterans Affairs' 2015 Substance Use Disorder Guidelines](#) emphasize and encourage use of community support and mutual support groups.<sup>48</sup> [The APA 2006 Practice Guideline](#) on Substance Use Disorder also recommends involvement of community resources, especially if the patient is at a high risk for treatment failure or has a history of multiple treatment failures.<sup>49</sup>

Complementary and alternative medicine (CAM), which can include therapies like acupuncture, relaxation techniques, self-help groups, and yoga, have long been recognized as treatment modalities for many disease states, including those involving pain. Yoga, which derives from ancient Hindu culture, is actually much more than breathing techniques, postures, meditation, and strengthening exercises.<sup>50</sup> A survey of chronic pain users showed that 84% of patients have tried physical therapy and 52% have tried massages, however, alternative treatments like yoga and meditation may not be known to both patients and healthcare practitioners.<sup>45</sup>

Mindfulness-Based Relapse Prevention (MBRP) is an 8-week, group-based intervention that focuses on preventions strategies with meditation training.<sup>51,52</sup> The primary goal is to help patients tolerate cravings or difficult emotions, and it includes both components of meditation and yoga. The mechanism of action of meditation has been theorized to be related to its ability to decrease cortisol levels in the body secondary to reducing the body's physiologic stress response. This suggests that there may be potential to reduce stress-induced cravings and increase craving tolerance with meditation.<sup>53,54</sup> The mechanism by which yoga has a therapeutic effect is theorized to be related to an increase in GABA (gamma-aminobutyric acid), which may also help with concomitant psychiatric illnesses like depression and anxiety.<sup>53</sup> They have found that following yoga sessions in experienced practitioners, GABA levels are significantly increased as compared to an activity like reading.<sup>55</sup> Following MBRP therapy, patients have been found to have fewer drug-use days in subsequent follow-up periods as compared to cognitive-behavioral relapse prevention and "treatment as usual" approaches. MBRP has also been associated with significantly less drug craving than treatment as usual.<sup>57,58</sup> This suggests a lower relapse rate in patients enrolled in MBRP protocols.

While MBRP treatment originated at the University of Washington, there are many practitioners in New York, New Jersey, and Pennsylvania that are able to provide patients with the resources necessary to utilize this therapy. A comprehensive list of these individuals can be found at [www.mindfulrp.com](http://www.mindfulrp.com).<sup>52</sup>

A major barrier with physical interventions, like yoga and meditation, is that they are most effective when they are done on a regular basis. For patients with severe psychiatric illness, consistency may pose a problem and make these interventions less likely to be successful.<sup>53</sup> Therefore, as with most interventions for any disease state, compliance is a key predictor of success and this fact should be emphasized to patients upon initiation. It may be appropriate to reserve this treatment modality for reliable patients or patients likely to adhere.

### **Wellness Center Development**

A Wellness Center is a center devoted to the management of individuals who require social support upon reentering society after detox. Wellness Centers should be developed and utilized to create a haven for individuals with or affected by substance use disorder, including their families and friends. These facilities should be directed at promoting health and wellness in patients who are not undergoing withdrawal symptoms or currently going through detox, as they tend to require a higher level of care. Additionally, referral to Wellness Centers and the methods they employ, while potentially helpful for all patients, are likely to have better results with patients who are likely to be compliant with therapies and have good attendance at meetings.

Wellness Centers are typically housed in places of worship, such as Churches, temples, synagogues and mosques, or community and recreation centers. Below is a list of programs that could potentially be included as part of a Wellness Center:

- Peer-to-Peer Recovery Support for Client (recovering individual)

- Peer-to-Peer support for family/friends of Client
- Life Skills Mentoring
  - Bank Account/Doctor Appointments/Obtaining a Driver's License
  - Budgeting/Transportation Navigation/Insurance
- Job Skills Mentoring
  - Resume Writing/Interview Techniques
  - Job Coaching/Networking
- Legal Advice
  - Pro bono initial consultation
  - Referral to an Attorney
- Housing
  - Developing a list of sober living options/levels
- Hotline Setup for Additional Support
- Spiritual Support/Referral
- Relapse Prevention
- Develop Intake Procedures Including Documentation and Confidentiality
- Activities
  - Yoga/Meditation
  - Cooking Classes
  - Dance Classes
  - Music Therapy
  - Horticulture Therapy
  - Fitness Classes

## **The Ramifications of Opioid Over-prescribing**

Drug overdose is the leading cause of accidental death in the US, with over 52,000 deaths from drug overdose in 2015. Over 63% of these deaths were related to prescription pain relievers and heroin.<sup>59</sup>

In 2012, 259 million prescriptions were written for opioids, and from 2001 to 2009 the number of drug and alcohol substance use problems increased 70%, which could possibly be linked to the large number of opioid prescriptions. During this time there was a six-fold increase in office visits with involving a diagnosis of opioid painkiller abuse. Additionally, 59% of malpractice claims related to chronic pain management have involved inappropriate medication management by physicians.<sup>59-61</sup>

Safe prescribing is likely to lead to safe and efficacious pain management and over-prescribing is likely to lead to addiction. Over the past two decades, the CDC concludes that opioid prescriptions, opioid-related emergency department visits, opioid abuse treatment admissions, and opioid-related deaths have increased in parallel.<sup>63</sup>

Four of every five individuals who use heroin originally misused prescription painkillers, indicating that prescription opioids are often a "gateway" for other illegal and dangerous drugs.<sup>59</sup>

The mean annual healthcare costs for individuals who abuse opioids are nearly nine times greater than those who do not, indicating that there is a need to prevent substance misuse disorders to limit healthcare burden.<sup>61</sup>

## Approach for Younger Patients

There is a documented risk of drug diversion and addiction in pediatric patients, especially adolescents and children of high school age.<sup>64</sup> Therefore, when adolescent and other pediatric patients are prescribed opioids (and other controlled substances), the patient and parents/legal guardians should be educated on the following counseling points:

- The parents/legal guardians are responsible for managing the patient's medication administration while at home
  - The patient should be given no more tablets than specified on the instruction at any given time (i.e., given 2 tablets if the sig is "Take 2 tablets by mouth every 4 to 6 hours")
  - The patient should never be given the entire bottle of medication to self-manage their own pain
- Due to the new NJ law regarding a max duration of opioid therapy for acute pain of 5 days, you may request patients to do one of the following at the after 5 days duration
  - Return to your office at the conclusion of 5 days. At this time the patient's pain and necessity of treatment may be reassessed.
  - Request that the parents/legal guardians dispose of leftover medication at a police station's "Medication Drop Box". A comprehensive list of police stations offering this service can be found [here](#).

In patients aged 15 – 19, from 1994 to 2007, there was a significant increase in the number of controlled substance medications prescribed, and a significant increase in the number of patients prescribed multiple controlled medications. This effect was seen across emergency departments, doctor's offices, and hospitals. A controlled substance was prescribed at about one of every nine office visits for adolescents.<sup>64</sup>

Men are more likely to obtain opioids for free from friends and relatives and are also more likely to purchase them from a drug dealer, with young, white males being the group most associated with prescription drug abuse.<sup>61</sup> Details of a complete family history including family demographics may help in limiting substance use disorders for both patients and their family members. Important considerations when prescribing to minors include:

- Most adolescents who misuse prescription pain relievers are given them for free by a friend or relative<sup>59</sup>
  - These "distributors" are generally unaware of the dangers or nonmedical opioid use<sup>59</sup>
  - 50% of patients prescribed opioids for acute pain did not finish their pain medication, generally in an attempt to save their medication for later use<sup>45</sup>
  - No group of prescribers – even pain management specialists, oncologists, and surgeons – told their patients more than 50% of the time either:
    - Where to store their medication(s)
    - What to do with unused medication(s)
    - What to do with expired medication(s)<sup>45</sup>
- Only 35% of patients using opioids acutely report taking their medications exactly as prescribed<sup>45</sup>
- Use of prescription opioids in patients before the 12<sup>th</sup> grade is associated with a 33% increased risk for future opioid misuse among patients with little drug experience and who disapprove of illegal drug use<sup>65</sup>
- The American Academy of Pediatrics recommends use of IV opioids (continuous infusion or bolus) for infants with ongoing pain or postoperative pain following an acute procedure, but do

not recommend that prescriptions be sent home with patients for either infants or older children<sup>66</sup>

It is important to note, although this does not occur for all children, even when prescribed for only 7 days after a procedure or an acute injury, pediatric patients can develop dependence, and can exhibit withdrawal symptoms upon abrupt discontinuation after 5 days of opioid use. Children who are prescribed opioids for at least 14 days should be weaned off of these medications (by decreasing the dose by 10 – 20% every 24 – 48 hours.<sup>67</sup> While long-term use is more likely in hospitalized patients, it is important to note that with the new NJ law, prescriptions for use of opioids in treating acute pain cannot exceed a duration of 5 days.<sup>40</sup>

## Discussing Opioid and Marijuana Use with Youth and Adolescents

Successfully identifying signs and symptoms of opioid and marijuana use and appropriate intervention by a pediatrician may prove beneficial to reducing illicit substance use and decreasing the incidence of substance use disorder. During high school check-ups and pre-college physicals, pediatricians may be able to identify children and young adults who are manifesting signs and symptoms of misusing illicit and prescription drugs.

Marijuana is the most commonly used illicit drug in America, and is used more commonly in teens than adults.<sup>68</sup>

- Common signs and symptoms of acute marijuana use include<sup>69-72</sup>:
  - Red, bloodshot eyes
  - Dizziness and difficulty maintaining proper gait
  - Laughing for no reason
  - Poor short-term memory (e.g., forgetting what was just said to them)
  - When a large amount is smoked, nausea and vomiting
  - Loss of interest and motivation
  - Periodontal disease (with marijuana as a behavioral risk factor)
  - With long-term use, lung findings significant with obstructive lung disease (short-term use may actually be associated with bronchodilation)
  - Marijuana has a unique, pungent odor, which individuals may try to conceal with cologne or perfume
- Common “street names” for marijuana include<sup>70,73</sup>:
  - Blaze, Blunt, Bud, Bush, Dank, Doobie, Dope, Ganja, Grass, Herb, Joint, Kush, Mary Jane, Pot, Reefer, Roach, Weed
  - Alternative names may vary by geographic regions

For patients with substance use disorder who are misusing opioids, often times a complete history, as well as speaking with a family member, may aid in identifying candidates with this condition

- Common signs and symptoms of opioid use disorder include<sup>74-76</sup>:
  - Strong desire for opioids (e.g. drug-seeking behaviors, like spending large amounts of time to obtain opioids, asking prescriber for specific opioids)
  - Inability to control or reduce use
  - Continued use despite interference with daily functioning and social life
  - Use of larger amounts over time and development of tolerance
  - Multiple reports of lost or stolen prescriptions
  - Refusal to comply with random urine drug screens and pill counts
  - Use of multiple physicians and pharmacies

- Symptoms of acute opioid use as well as withdrawal symptoms are outlined elsewhere in this toolkit
- Common “street names” for opioids include<sup>75</sup>:
  - Heroin: Junk, H, Tar, Black Tar, China white, Dog Food, Skag, Brown Sugar
  - Oxycodone: Percs, Kickers, Blue, Oxy, Killers
  - Hydrocodone: Norco (like the brand name), Vikes, Hydro

When a healthcare professional believes they have identified a patient at risk for or with a substance use disorder, and the patient admits they have a substance use disorder, healthcare professionals should be very careful not to stigmatize the condition any further than it already is. The healthcare practitioner should be advised to look for signs of suicidal ideation as well as signs of domestic violence. However, these may be more common in other phases of disease, such as during withdrawal, or during MAT treatment. When it is inconclusive if the patient is misusing opioids, patient assessment tools like the Current Opioid Misuse Measure and Prescription Drug Use Questionnaire may prove useful.<sup>75, 76</sup>

When speaking to patients, especially young adults, whom you suspect are misusing opioids, without being judgmental or confrontational, ask the patient about their drug use in the past year, including tobacco, alcohol, illicit drugs, and prescription medications. It may be necessary to specify that the prescription drugs should be reported if they were obtained from another source or used in ways other than what was prescribed. Reiterate to the patient that you are asking about their illicit or illegal drug ONLY to better diagnose and treat them. If the patient refuses the screen, they should be educated on the risks and potential harms of drug use. In a similar manner as you did for drug use in the last year, ask the patient about drug use in their lifetime. If the patient has used any illegal or prescription drugs, consider beginning the [NIDA-Modified Assist tool](#), a questionnaire developed by the NIH to categorize patients based on risk for developing substance use disorder.

- Once patients are stratified based on risk, the following steps may be taken (if necessary):
  - Advise the patient about drug use and the potential harms and risks
    - Recommend tapering/quitting before problems develop
    - Educate patient on the treatment options available
    - Provide an objective recommendation based on the individual’s NIDA-Modified Assist risk category
  - Assess the patient’s readiness to quit by phrasing a question like, “Given our conversation, do you want to change your drug use?”
    - If the patient answers “No,” reinforce the potentials harms and risks
    - If the patient answers “Yes,” reinforce their current efforts and assist the patient in their attempt to change their drug use
  - Assist the patient by asking them to do some of the following
    - Having them jointly create a progress note with you
    - Having the patient complete a change “plan” before leaving the office
    - Providing reading level appropriate resources about quitting
    - Providing resources such as websites ([www.samhsa.gov](http://www.samhsa.gov), [www.drugabuse.gov](http://www.drugabuse.gov)) or hotlines (1-800-662-HELP)
    - Scheduling follow-up appointments
    - Prescribing medications for office-based treatment, if appropriate
    - Referring the patient to other healthcare practitioners, specialists, or detox, if appropriate

- Arrange for the patient to receive specialty care, medications, subsequent visits, as appropriate
- Generally, subsequent office visits should occur within 1-2 weeks

## Cannabis Hyperemesis Syndrome

### Background<sup>78, 79</sup>

Associated with the increasing use of marijuana, Cannabis Hyperemesis Syndrome (CHS) is a condition characterized by chronic use, cyclical nausea and vomiting, and the learned behavior of hot bathing. The exact mechanism is unknown, but high dose cannabidiol and cannabigerol are proposed to induce emesis at the 5-HT<sub>1A</sub> receptor, whereas low doses of cannabidiol create an anti-emetic effect.

### Diagnosis<sup>78, 79</sup>

There are 3 phases associated: prodromal, hyperemetic, and recovery. The prodromal phase may last from months to years, and common symptoms are nausea in the morning and abdominal pain. During the hyperemetic phase, nausea and vomiting is very severe, which can be debilitating. An idiosyncratic behavior during this phase is repeated hot showers, which may relieve symptoms. The recovery phase is a relative return to regular eating and normal frequency of showers, which can last from days to months.

CHS is often misdiagnosed as cyclic vomiting syndrome (CVS) due to very similar presentations. Key differences are psychological comorbidities, such as depression and anxiety, and a significant medical history of migraines among those with CVS.

Those presenting with CHS are misdiagnosed for a significant amount of time with frequent emergency room visits so early diagnosis is key. Several other conditions must be ruled out due to its general presentation so a comprehensive history and screening are paramount. The syndrome is often underreported, which contributes to the fact it's misdiagnosed.

### Treatment<sup>78, 79</sup>

Therapy is divided by the hyperemetic phase and prevention of relapse. Supportive care is the primary treatment during the hyperemetic phase, which includes intravenous fluids and anti-emetics (5-HT<sub>3</sub> antagonists, D<sub>2</sub> antagonists, H<sub>1</sub> antagonists, and neurokinin-1 antagonists). To relieve abdominal pain, caution should be employed when using opioids due to their potential to induce vomiting. Proton pump inhibitors are recommended due to the presence of esophagitis and gastritis in patients.

Hot showers are unusually effective in relieving abdominal pain, nausea, and vomiting. The mechanism of how it works remains unknown but the proposed mechanism is that it corrects the dysregulation of thermal temperature caused by marijuana.

The key in preventing relapse of CHS is abstinence from marijuana for extended periods. Risk of relapse is high if the patient uses cannabis again during the recovery phase. Patients may reuse marijuana believing it may relieve their nausea. An important counseling point is to inform patients of how chronic marijuana use may lead to CHS. Referrals to rehabilitation programs are also important to bolster long-term abstinence. Cognitive behavioral therapy is also beneficial.

## **Electronic Prescribing**

### **Overview**

Electronically prescribed prescriptions (E-prescriptions) increase patient safety by identifying patients who are receiving controlled substances from multiple prescribers, as well as decreasing fraud by ensuring the prescription has not been tampered with prior to being received by the pharmacy. Many states have implemented laws that mandate E-prescribing in most situations (with exceptions for emergencies or when the patient fills at a pharmacy out of state that does not accept electronic prescriptions). In New Jersey, E-prescribing is not mandatory but the majority of pharmacies accept controlled prescriptions through electronic means.

### **Where to Register**

Prescribers can register [here](#).

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### 3. [Opioid Risk Tool](#)

**Opioid Risk Tool**

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
<b>Family history of substance abuse</b>		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
<b>Personal history of substance abuse</b>		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16–45 years	1	1
History of preadolescent sexual abuse	3	0
<b>Psychological disease</b>		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.  
 Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk tool. Pain Med. 2005; 6 (6) : 432

### 4. [Clinical Opiate Withdrawal Scale \(COWS\)](#)

**Clinical Opiate Withdrawal Scale (COWS)**

Flow-sheet for measuring symptoms over a period of time during buprenorphine induction.

For each item, write in the number that best describes the patient's signs or symptoms. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

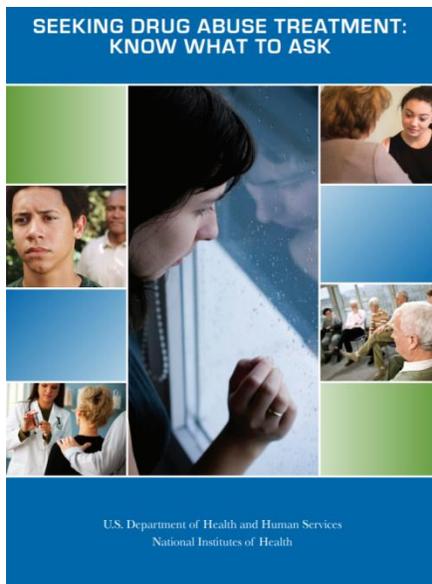
Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Buprenorphine induction: \_\_\_\_\_  
 Enter scores at time zero, 30min after first dose, 2 h after first dose, etc.  
 Times: \_\_\_\_\_

Resting Pulse Rate (record beats per minute) Measured after patient is sitting or lying for one minute 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120				
<b>Sweating:</b> <i>over parts of face not accounted for by room temperature or patient activity.</i> 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 <i>more pronounced</i> wet face				
<b>Restlessness:</b> <i>Observation during assessment</i> 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 4 <i>unable to sit still for more than a few seconds</i>				
<b>Pupils:</b> 0 pupils pin-point or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 4 <i>pupils so dilated that only the rim of the iris is visible</i>				
<b>Itch or Itch when Patient is Having Pain:</b> <i>Previously, only the additional component attributed to opiate withdrawal is scored</i> 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort				
<b>Rhinitis:</b> <i>Itch or tearing not accounted for by cold, conjunctivitis or allergic symptoms</i> 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks				

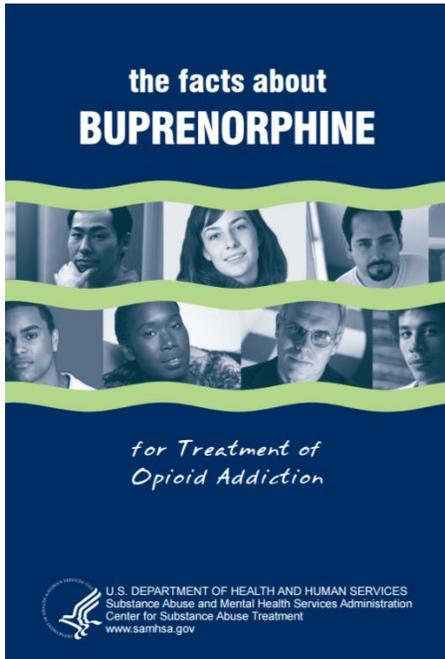
5. [Naloxone Administration Poster](#)



6. [National Institute on Drug Abuse - Seeking Drug Abuse Treatment: Know What to Ask \(Guide for Patients\)](#)



## 7. [The Facts About Buprenorphine for Patients](#)



## 8. [Medication-assisted Treatment \(MAT\) Implementation Checklist \(SAMHSA\)](#)

**Medication Assisted Treatment Implementation Checklist**

This checklist provides policymakers, state and local officials, and other community stakeholders key questions to consider before engaging in efforts to increase access to medication assisted treatment (MAT) for addiction in their communities.

**Assess Economic Environment**

- Are all the medications approved for addiction treatment (see list on the Medicaid formulary in your state)? If not, who specifically will provide the leadership to get these medications on the Medicaid formulary? Who specifically will talk with health plans and pharmacy benefit managers to get these medications on their formularies?
- Are these medications available through the 340B program administered through HRSA and the health centers in your state? This is particularly important for individuals without insurance.
- Are these medications used in the private sector in your state? Check with state psychiatric associations, state ASAM chapters, and associations of family practice and internal medicine.

**Assess The Treatment Environment**

- Which treatment programs in your state/area currently use medications in the treatment of addiction?
  - Are there structural problems?
  - Are there Medication cost concerns?
  - Are there implementation cost concerns?
  - Are there state regulations and policy barriers?
- Who will provide the leadership to address these barriers?
  - How do you plan to address which treatment programs are most likely to work with you (i.e., early adopters) to adopt medication assisted treatment?
- For treatment programs that use medications, how do you access physicians? Are they:
  - Full or part-time staff members?
  - Contracted?
  - Affiliated with a primary care clinic?
  - Affiliated with or embedded in a health center/PHC?
- Do health centers and other providers have an appropriately trained integrated care team available?
- Are any treatment programs co-located with health centers? If so, where are they specifically located? If there are none, what do you need to do to have medical care and behavioral health care provided on the same site?
- What can you do to support the development of networks of treatment providers that include both primary care providers and addiction treatment programs?
- Are there any comprehensive treatment programs in your state that include primary care within an addiction treatment program? Is the primary care program co-located and under different management or part of the addiction treatment program? How can these different organizational structures serve as models for other addiction treatment programs?
- How will you work with medical and non-medical clinicians to ensure that coexisting services accompany use of medications in addiction treatment?

SAMHSA-HRSA CENTER FOR INTEGRATED HEALTH SOLUTIONS

## 9. Treatment of Chronic Pain Handout for Prescribers

### The Pathophysiology and Treatment of Chronic Pain

Type of Pain	Nociceptive Pain	Neuropathic Pain	Sensory Hypersensitivity
Definition	Pain related to tissue damage due to trauma, inflammation, or other non-healing injury	Pain related to damage of the peripheral or central nervous system	Pain without identifiable nerve or tissue damage resulting from persistent neuron dysregulation
Conditions	Osteo- and rheumatoid arthritis, tendonitis, sickle-cell disease, inflammatory bowel disease	Post-herpetic neuralgia, diabetic peripheral neuropathy, multiple sclerosis pain	Fibromyalgia, irritable bowel disease, restless leg syndrome, tension-type headaches
Symptoms	Sore, throbbing, dull, tender, aching, cramping	Burning, pins-and-needles, tingling, prickling, numbness	Widespread pain, allodynia, poor sleep, hyperalgesia
First Line Treatment	Acetaminophen, NSAIDs, treat the underlying disorder	Anti-epileptic drugs, tricyclic antidepressants, serotonin-norepinephrine reuptake inhibitors	
Opioid Considerations	Only when other medications are inadequate and long-term treatment for severe pain is required (use IR opioids)		Opioids should be avoided in these patients

References:  
 1. Stanos S, Braszko M, Agraffo C, et al. Rethinking chronic pain in a primary care setting. *Postgrad Med* 2016;128(5):502-15  
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## 10. [Template] Patient-Prescriber Pain Management Agreement

### Patient-Prescriber Pain Management Agreement

Please read both sections before signing this agreement.

#### For the patient:

I acknowledge that I have uncontrolled pain, which limits my daily functioning. In an attempt to improve my daily functioning, I have tried other pharmacologic and/or non-pharmacologic treatments without success. While this medication's intent is to control my pain, I acknowledge the following with respect to the medication to be prescribed to me:

- This medication may not fully alleviate my pain
- My prescriber has reviewed the risks associated with taking this medication, including side effects and the risk of dependence and addiction
- My prescriber has reviewed the consequences of misuse, including but not limited to, overdose
- My doctor may choose to only give me written / electronic [circle one] prescriptions for this medication
- I understand that my prescriber may, at any time, revoke my ability to receive prescriptions for opioids based on evidence of treatment failure, misuse, and/or dependence and addiction

I also acknowledge the following responsibilities required of me, including, but not limited to:

- I will take this medication exactly as written by the below prescriber, and my prescriber may ask me to bring in my medication bottles to verify I am taking my medication as directed
- I will inform my prescriber of any and all medications I am taking, including new medications prescribed during the duration of treatment with this medication. I will stop taking all other pain medications, unless the prescriber below explicitly informs me otherwise
- I will not seek, accept, or knowingly administer medications for the management of pain other than those that are prescribed by my doctor. This includes using illicit drugs, receiving controlled substances from other prescribers, and obtaining controlled substances from other individuals
- I will not cancel my appointments with this prescriber without due notice
- At any time during the management of my chronic pain, my prescriber can request my completion of a urine drug screen
- I will obtain all of my medications, when possible, from a single pharmacy
- My prescriber may choose to contact other healthcare professionals participating in my care, friends, or family members if such action is deemed necessary by him/her

#### For the prescriber:

I acknowledge that this patient has tried other pharmacologic and/or non-pharmacologic options for his/her pain, and the next appropriate treatment option is the below medication. As the prescriber for the below medication, I further acknowledge that I will:

- Regularly and thoroughly ensure that the below patient does not experience any untoward side effects, misuse, or dependence and/or addiction from this medication. If this patient does, I will adjust or stop therapy with this medication according to my best judgment
- Keep track of my patients controlled substance use and administer urine drug screens as clinically indicated
- Thoroughly outline a treatment plan, with goals of therapy and expected duration of opioid use
- Help this patient get appropriate treatment should they develop a substance use disorder

Patient name: \_\_\_\_\_ Patient signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Prescriber name: \_\_\_\_\_ Prescriber signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Medication name, strength: \_\_\_\_\_ Medication sig: \_\_\_\_\_

Pharmacy name: \_\_\_\_\_ Pharmacy phone number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

# 11. Protocol for Prescribing Opioids – Rutgers Health

RUTGERS HEALTH  
 PROTOCOL FOR PRESCRIBING OPIOIDS  
 Amendment to P.L.2017, c.28.

**\*\*\*First Prescription\*\*\***

*If patient has never received a prescription for an opioid or if it has been greater than 1 year since last use/administration, proceed to Section I. If it has been less than a year since the patient's last opioid prescription, proceed to Section II.*

**Section I.**

**Step 1.** Check off the following once documented in patient's chart:

- 1)  Verify that prescription is an initial prescription
  - As per patient
  - As per Prescription Monitoring Program (last opioid fill and abuse potential)
  - As per available medical records
- 2)  Medical History: including patient's experience using:
  - Non-opioid medication
  - Non-pharmacological pain management approaches
  - Substance abuse history
  - Nature, frequency, and severity of any pain
- 3)  Physical Exam, psychological evaluation, and evaluation of comorbidities
- 4)  Develop a treatment plan: particular attention on determining the cause of the patient's pain (specialist consultation, imaging studies, physical therapy, and/or other interventions), objectives by which treatment success is to be evaluated
- 5)  Check Prescription Monitoring Program (PMP)
- 6)  Limit day supply of opioids: no more than 5 days as determined by dosage/frequency
- 7)  Prescription information: complete name of controlled substance, dosage, strength, quantity, and instructions for use

**Step 2:** Prior to issuing initial prescription, you must discuss with the patient, patients parent or legal guardian if the patient is under 18 years of age and is not an emancipated minor, the risks of the medications being prescribed including but not limited to:

Task (Please check off once completed)	Yes
1.1 The risks of addiction and overdose associated with opioids including dangers of taking with alcohol, benzodiazepines and other CNS depressants	<input type="checkbox"/>
1.2 Reasons why prescription is necessary	<input type="checkbox"/>
1.3 Alternative treatments that may be available	<input type="checkbox"/>
1.4 Risks associated with use of developing a physical or psychological dependence	<input type="checkbox"/>

**\*\*A note must be included in the patient's medical record, acknowledging the information discussed\*\***