Opioid Abuse Toolkit

Resources for New Jersey Prescribers

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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 misuse.

OVERVIEW

Opioids, especially prescription or illicit synthetic opioids, have become a main driver of drug overdose deaths in the United States. The Centers for Disease Control and Prevention (CDC) cites that opioids have been implicated in ~70,000 deaths in 2020, an eight fold increase since 1999, and over 82% of those deaths involved synthetic opioids.[1,2] 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.[3] 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[4], the details of which can be found on page 34 of this document. Prescribers and health care professionals have a unique position to make a large impact in not only treatment of opioid addiction, but preventing it. In a recently published analysis by the CDC, 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.[5] 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.[6-9] 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.[6] 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.[8] Appropriate management of these individuals may reduce mortality and economic burden, while improving quality of life for those affected and their families. While overdose death totals remained steady between 2017 and 2018, recent estimates place the 2020 overdose death total in the United States at 93,331, with about 75% of that being adults. This is a 32% increase from 2019.[10] Research indicates that the start of the pandemic is associated with an increase in overdose deaths, nationally, regionally, and locally.[10] This can be attributed to the many consequences of the pandemic, such as social isolation, increased stress, and reduced access to resources.[10] The CDC states that efforts related to all opioids, particularly deaths involving synthetic opioids, should be strengthened to sustain and accelerate declines in opioid-involved deaths. Comprehensive surveillance and prevention measures are critical to reducing opioid-involved deaths.[11] By implementing the efforts mentioned in the toolkit, we can aim to optimize opioid therapies and aim to see a higher declines in opioid overdose and deaths.

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Section 1: Inpatient and Emergency Department Prescribing

Overview

The 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain emphasizes a patient-centered approach, promoting shared decision-making between clinicians and patients about pain management options. The guideline focuses on maximizing the use of nonpharmacologic and non-opioid therapies for pain whenever possible. If opioid therapy is deemed necessary, clinicians should prescribe immediate-release opioids at the lowest effective dosage for the shortest duration possible, especially for acute pain, with three days often being sufficient and seven rarely needed. These guidelines are intended to be flexible and adaptable to individual patient needs, recognizing the complexities of pain management and aiming to improve patient safety and reduce the risks associated with opioid use.

Importance

This clinical practice guideline is intended to improve communication between clinicians and patients about the benefits and risks of pain treatments, including opioid therapy; improve the effectiveness and safety of pain treatment; mitigate pain; improve function and quality of life for patients with pain; and reduce risks associated with opioid pain therapy, including opioid use disorder, overdose, and death. Ethically, it is crucial that opioids are prescribed when needed in cases of severe pain, while following guidelines to avoid inappropriate use.

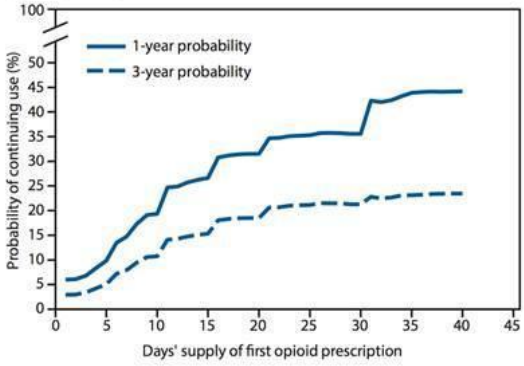
The guideline also highlights the importance of assessing risk factors for opioid-related harms, using state Prescription Drug Monitoring Programs (PDMPs) to review a patient's history, and considering urine drug testing. With the widespread availability of naloxone, there are interventions that can be made in advance to prevent deaths caused by overdose.

Role for Prescriber

The guideline encourages clinicians to avoid prescribing dosages exceeding 90 MME (morphine milligram equivalents) per day and to carefully weigh the benefits and risks when considering increasing dosages to or exceeding 50 MME/day. Regular evaluations of the benefits and harms of continued therapy are recommended, with optimization of other therapies and gradual tapering of opioids if benefits don't outweigh risks. It is important to practice in ways to mitigate risk to patients. Clinicians should consider offering naloxone, especially in cases of higher opioid dosages or concurrent use of benzodiazepines. It is also recommended for a provider to follow-up with the patient after an initial opioid prescription to ensure the continued pain management is appropriate. For patients diagnosed with Opioid Use Disorder (OUD), the guideline strongly recommends offering or arranging evidence-based treatment, primarily with medications for OUD (MOUD), in conjunction with behavioral therapies.[12]

Rates of opioid misuse and overdoses in the United States have significantly increased in recent years. In 2022, New Jersey saw a 32% annual increase in suspected opioid overdose emergency department (ED) visits, significantly surpassing the 1% annual increase seen across the US.[13] As a result, ED and hospital inpatient settings become a point of intervention that can change the course from further misuse and potential overdose, to a treatment connection. However, hospital inpatient settings and EDs are also a major source of opioids that may serve as the gateway to misuse. A report from the Centers for Disease Control and Prevention (CDC) found that the 1 and 3 year probabilities of continued opioid use among opioid-naïve patients were dependent on the days supply of the initial prescription they received (Figure 1).[14] Within this section of the toolkit, the information presented aims to reduce 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



**CDC developed these recommendations using the method developed by the GRADE working group (https://www.gradeworkinggroup.org).*

Summary of the CDC Guidelines[12]

CDC Recommendations for Determining Initiation of Opioids for Pain

Recommendation 1: Nonopioid therapies are at least as effective as opioids for many common types of acute pain. Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient. Before prescribing opioid therapy for acute pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy (recommendation category: B; evidence type: 3).

Recommendation 2: Nonopioid therapies are preferred for subacute and chronic pain. Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient. Before starting opioid therapy for subacute or chronic pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy, should work with patients to establish treatment goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks (recommendation category: A; evidence type: 2).

CDC Recommendations for Selecting Opioids and Determining Opioid Dosages

Recommendation 3: When starting opioid therapy for acute, subacute, or chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release and long-acting (ER/LA) opioids (recommendation category: A; evidence type: 4).

Recommendation 4: When opioids are initiated for opioid-naïve patients with acute, subacute, or chronic pain, clinicians should prescribe the lowest effective dosage. If opioids are continued for subacute or chronic pain, clinicians should use caution when prescribing opioids at any dosage, should carefully evaluate individual benefits and risks when considering increasing dosage, and should avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients (recommendation category: A; evidence type: 3).

Recommendation 5: For patients already receiving opioid therapy, clinicians should carefully weigh benefits and risks and exercise care when changing opioid dosage. If benefits outweigh risks of continued opioid therapy, clinicians should work closely with patients to optimize nonopioid therapies while continuing opioid therapy. If benefits do not outweigh risks of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper to lower dosages or, if warranted based on the individual circumstances of the patient, appropriately taper and discontinue opioids. Unless there are indications of a life-threatening issue such as warning signs of impending overdose (e.g., confusion, sedation, or slurred speech), opioid therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages from higher dosages (recommendation category: B; evidence type: 4).

CDC Recommendations for Deciding Duration of Initial Opioid Prescription and Conducting Follow-Up

Recommendation 6: When opioids are needed for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids (recommendation category: A; evidence type: 4).

Recommendation 7: Clinicians should evaluate benefits and risks with patients within 1–4 weeks of starting opioid therapy for subacute or chronic pain or of dosage escalation. Clinicians should regularly re-evaluate benefits and risks of continued opioid therapy with patients (recommendation category: A; evidence type: 4).

CDC Recommendations for Assessing Risk and Addressing Potential Harms of Opioid Use

Recommendation 8: Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss risk with patients. Clinicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone (recommendation category: A; evidence type: 4).

Recommendation 9: When prescribing initial opioid therapy for acute, subacute, or chronic pain, and periodically during opioid therapy for chronic pain, clinicians should review the patient's history of

controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose (recommendation category: B; evidence type: 4).

Recommendation 10: When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances (recommendation category: B; evidence type: 4).

Recommendation 11: Clinicians should use caution when prescribing opioid pain medication and benzodiazepines concurrently and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants (recommendation category: B; evidence type: 3).

Recommendation 12: Clinicians should offer or arrange treatment with evidence-based medications to treat patients with opioid use disorder. Detoxification on its own, without medications for opioid use disorder, is not recommended for opioid use disorder because of increased risks for resuming drug use, overdose, and overdose death (recommendation category: A; evidence type: 1).

Prescription Monitoring Program

Background

The New Jersey Prescription Monitoring Program (NJPMP), sometimes referred to as the Prescription Drug Monitoring Program (PDMP), is a statewide database containing information on outpatient dispensing of Controlled Dangerous Substances (CDS), Human Growth Hormone (HGH), and gabapentin. Prior to writing or dispensing a prescription for a CDS medication, prescribers and pharmacists can check the NJPMP and identify whether a patient is going to multiple prescribers and pharmacies for the same medication (including prescriptions they fill without insurance). The NJPMP includes data on CDS prescriptions dispensed in most other states, enhancing its effectiveness in tracking potential misuse or diversion across state lines. [15]

Access

Access to the NJPMP 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.[15]Authorized users must certify before each search that they are seeking data for patient healthcare and sharing NJPMP access credentials is prohibited. Unauthorized access or disclosure can lead to civil penalties up to $10,000 per offense and disciplinary action by licensing boards. A delegate's noncompliance may also result in disciplinary action against the practitioner. For further details, please refer to the New Jersey Division of Consumer Affairs website.[15]
https://www.njconsumeraffairs.gov/pmp

Requirements[15]

For Prescribers:

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

1. It is the first time the practitioner has written a Schedule II CDS or any opioid to a new or current patient for acute or chronic pain AND
2. It is the first time the practitioner has written for a benzodiazepine drug that is a Schedule III or IV CDS AND
3. If the practitioner has reasonable belief that a patient may be seeking a CDS for any purpose other than the treatment of an existing medical condition, such as for purposes of misuse, abuse, or diversion, the first time a non-opioid drug other than a benzodiazepine drug that is a Schedule III or IV CDS is prescribed AND
4. Any time the prescriber writes for a Schedule II CDS for acute or chronic pain to a patient receiving care or treatment in the Emergency Department of a general hospital AND
5. On a quarterly basis (every 3 months) during the period a current patient continues to receive a prescription for a Schedule II CDS, an opioid drug for acute or chronic pain, or for a benzodiazepine drug that is Schedule III or IV CDS.

For Pharmacists:

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

How to Register[16]

To register for NJPMP database access prescribers, their delegates, and pharmacists must first register for PMP AWARxE by completing the following steps:

1. Click on this link: https://newjersey.pmpaware.net/
2. Click on "Create an Account" to register.
    a. 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.
    a. Pharmacists will be required to enter their pharmacy's DEA number
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.

More information 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 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 same/similar medications.
- **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 for the following:

- History of multiple providers in different practices (different addresses or practice names)
- History of filling prescriptions at multiple pharmacies
- Keep in mind pharmacy chains share the same prescription history for each patient
- Filling medications without using insurance
    - Often done to avoid 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
- Frequent early refill attempts
- Filling in pharmacies in different states and/or locations far away from the home address

For more information on the Prescription Monitoring Program, please visit the New Jersey Prescription Monitoring Program Data Submission Guide for Dispensers. This visual guide goes over topics such as reporting requirements for dispensers in the state of New Jersey, data file submission guidelines and methods, creating a PMP clearinghouse account, creating a data file, uploading or reporting data, and understanding and correcting errors.[17]

Best Practices for Prescribing Opioids in the Emergency Department

Based on 2014 CDC data, 70% of all emergency department (ED) visits in the US and Canada were related to painful conditions.[18] In 2010, 49.1% of adults aged 18 to 44 years old who went to the ED for pain were given or prescribed an opioid. However, due to increased awareness and more conservative prescribing habits, opioid prescriptions at discharge for aged 18 to 44 years decreased to 21.3% in 2020. In the interests of effective triage, it is essential to differentiate acute pain from chronic pain.[19] A key challenge to providing proper care is balancing the delivery of prompt, appropriate pain management and the prevention of addiction, diversion, abuse, and misuse. 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 list below was adapted from the American Academy

of Emergency Medicine (AAEM) and Oregon A.C.E.P. with the goal of capturing the best current ED practices on pain management.[19,20]

- Consult Prescription Monitoring Program before writing prescriptions for CDS
- Patients who arrive with an opioid overdose should be offered follow up services such as counseling and detoxification programs
- Administration of intravenous or intramuscular opioids in the ED for acute exacerbation of chronic pain is discouraged
- 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
- Avoid initiating long-acting opioids in ER
- Prescribe no more than needed, starting with the lowest dose for no more than 3 days
- ED health care practitioners should not refill prescriptions that have been lost, destroyed, or stolen

Tapering Opioid Therapy

Overview

For patients already receiving opioid therapy, clinicians should carefully weigh benefits and risks and exercise care when changing opioid dosage. If benefits outweigh the risks of continued opioid therapy, clinicians should work closely with patients to optimize nonopioid therapies while continuing opioid therapy. If benefits do not outweigh risks of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper to lower dosages or, if warranted based on the individual circumstances of the patient, appropriately taper and discontinue opioids. Unless there are indications of a life-threatening issue such as warning signs of impending overdose (e.g., confusion, sedation, or slurred speech), opioid therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages from higher dosages.[12]

Many patients do not experience benefit in pain relief or function from increasing opioid dosages to ≥50 morphine milligram equivalent (MME)/day but are exposed to progressive increases in risk as dosage increases. Therefore, before increasing total opioid dosage to ≥50 MME/day, clinicians should pause and carefully reassess evidence of individual benefits and risks. If a decision is made to increase dosage, clinicians should use caution and increase dosage by the smallest practical amount. The recommendations related to opioid dosages are not intended to be used as an inflexible, rigid standard of care; rather, they are intended to be guideposts to help inform clinician-patient decision-making. [12]

If the risks outweigh the benefits of opioid therapy, it is crucial to work with the patient and begin opioid tapering. With the goal of eventual discontinuation, create a plan to reduce opioid use and encourage non-opioid modalities for therapy management.[12]

Identify Patients that Qualify for Tapering[12]

Clinicians should consider tapering to a reduced opioid dosage or tapering and discontinuing opioid therapy and discuss these approaches with patients before initiating changes if:

- The patient requests dosage reduction or discontinuation
- Pain improves and might indicate resolution of an underlying cause
- Opioid therapy has not meaningfully reduced pain or improved function
- The patient has been treated with opioids for a prolonged period (e.g., years) and the benefit-risk balance is unclear (e.g., decreased positive effects because of tolerance and symptoms such as reduced focus or memory that might be due to opioids)
- The patient is receiving higher opioid dosages without evidence of benefit from the higher dosage
- The patient experiences side effects that diminish quality of life or impair function
- Evidence of opioid misuse exists
- The patient experiences an overdose or other serious event (e.g., an event leading to hospitalization or injury) or has warning signs for an impending event (e.g., confusion, sedation, or slurred speech)
- The patient is receiving medications (e.g., benzodiazepines) or has medical conditions (e.g., sleep apnea, liver disease, kidney disease, or fall risk) that increase risk for adverse outcomes.

Coordinate with other health care providers to coordinate treatment plans, especially for high-risk patients such as pregnant or opioid use disorder patients. Make sure patients are treated as a whole and receive appropriate psychosocial support and treatment. These extra points of care can be very beneficial for successfully completing a taper and preventing future relapse.

Engage the Patient in a Collaborative Plan for Tapering

The CDC recommends a decrease of 10% of the original dose per week or slower (until approximately 30% of the original dose is reached, followed by a weekly decrease of approximately 10% of the remaining dose) for patients who have taken opioids for shorter durations (weeks to months), as this is less likely to trigger withdrawal. A decrease of 10% of the long-term dose per month would be for patients who have been chronically on opioids for more than a year.[12] However, tapering plans should involve the input of the patient and be customized to what works best with them. Clinicians should counsel the patient on the risks of tapering and provide different solutions and resources to combat them.[12]

Manage the Complications of Tapering

Monitor the patient for withdrawal symptoms during the taper and adjust the rate accordingly. Below is a table with common symptoms of opioid withdrawal and medications that can help with symptomatic management of patients with opioid withdrawal: [12]

Symptom	Medication
Autonomic Symptoms (sweating, tachycardia)	Clonidine, Lofexidine
Diarrhea	Loperamide
Nausea	Ondansetron
Cramping	Dicyclomine
Insomnia	Trazodone
Pain or Fever	Ibuprofen

Patient Engagement/Tapering Agreement

It is critical to engage the patient in 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 have opioid medications affected your well-being?
- What do you believe are the risks associated with opioid therapy?
- How have opioids impacted your daily life and responsibilities?

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"

Opioid Taper Agreement (Key Points)

- Formal rationale for opioid taper
- Taper start and planned end dates
- Weekly/monthly reduction plan
- Outline risks, such as withdrawal symptoms, and management thereof
- Patient agrees to:
    - Keep all regularly scheduled appointments with the treatment staff
    - Comply with other consultations as requested by the physician
    - Contact the treatment physician immediately to discuss continuation or changes in the plan if an issue occurs
    - Engage in relevant pain management strategies concurrent with the taper
    - Regular urine toxicology and prescription monitoring program checks
    - No changes to plan without conferring with the prescribing physician
    - No controlled substances from other physicians without pre-notification of prescribing physician
    - No new medication without agreement of prescribing physician
    - Notify the physician of any factors, such as development of increasing depression symptoms, that may be a barrier to success
    - Where appropriate, actively involve a significant other or family member for support
- Provisions for taper failure
- List state-specific locations where remaining opioids can be appropriately disposed of[22]

Section 2: Overdose-Related Resources for Prescribers

Overview

According to a 2016 cohort study, nearly half of patients with non-fatal opioid overdoses received opiate doses >100 MME in the preceding 60 days.[22] In the 300 days following overdose, nearly all patients (91%) had received one or more new opioid prescriptions, with 17% having a subsequent overdose within 2 years.[23] The purpose of this section is to provide resources for prescribers so they can appropriately treat patients who are misusing or abusing opioids. These resources provide information

on managing patients with a history of overdose, in inpatient and outpatient settings, and how to refer them to long-term treatment.

Poison Control Services

The NJ Poison Information and Education System (NJPIES) is a great resource to guide health care providers in the management of 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 providers in the treatment of these patients by suggesting non-traditional supportive measures and management techniques. This public service is extremely valuable, especially for opioid overdose patients that are refractory to naloxone or who are completely unresponsive. Additionally, NJ Poison Center specialists can help manage mixed drug overdoses and inform providers about any other systemic complications to monitor patients for.

*Dial **1-(800)-222-1222** to reach your local Poison Control Center.*[24]

Bridging Treatment: Linking Patients to Opioid Use Disorder Treatment

The Elimination of the DEA-X Waivers

As of January 12, 2023, the federal requirement for practitioners to submit a waiver to prescribe medications, like buprenorphine, for the treatment of opioid use disorder (OUD) has been removed by Section 1262 of the Consolidated Appropriations Act, 2023 (Omnibus bill).[25] Originally, the Drug Addiction Treatment Act of 2000 (DATA 2000) mandated prescribers to apply for a special waiver prior to prescribing schedule III, IV, or V narcotics approved for the treatment of OUD. The waiver also included discipline restrictions, patient limits, and certification related to provision of counseling.[26] Now, all practitioners who have a current DEA registration the includes Schedule III authority, may prescribe buprenorphine for OUD in their practice if permitted by applicable state law.[25] Although prevention is key to combating the opioid epidemic, treatment options are necessary to help those addicted to opioids. The removal of the waiver increases access to treatment for OUD, especially in areas where there was a shortage of prescribers who had DEA X-waivers. All practitioners who have a current DEA registration that includes Schedule III authority, may now prescribe buprenorphine for OUD in their practice if permitted by applicable state law.

Section 1263 of the 'Consolidated Appropriations Act of 2023' requires new or renewing Drug Enforcement Administration (DEA) registrants, starting June 27, 2023, upon submission of their application, to have at least one of the following[25]:

- A total of eight hours of training from certain organizations on opioid or other substance use disorders for practitioners renewing or newly applying for a registration from the DEA to prescribe any Schedule II-V controlled medications;
- Board certification in addiction medicine or addiction psychiatry from the American Board of Medical Specialties, American Board of Addiction Medicine, or the American Osteopathic Association; or
- Graduation within five years and status in good standing from medical, advanced practice nursing, or physician assistant school in the United States that included successful completion of an opioid or other substance use disorder curriculum of at least eight hours.

Importance of Linking Patients to Opioid Use Disorder Treatment

Prescription opioid use, even when used as prescribed by a doctor can lead to a substance use disorder, which takes the form of addiction in severe cases. Recently, most opioid overdose deaths involve synthetic opioids, which is largely illicitly made fentanyl.[27] 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 a need for health care professionals to become more involved.

Connecting patients who are struggling with OUD to appropriate care is a vital component of addressing the opioid epidemic. 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.[26] Please refer to page 34 for further details on the manifestations of the opioid bill.

> *To assist your patients to find a behavioral health treatment center through* Substance Abuse and Mental Health Services Administration (*SAMHSA), go to findtreatment.samhsa.gov/*.

Medication-Assisted Treatment (MAT)

Overview

There are multiple products available for the treatment of opioid dependence, each with their own advantages and disadvantages. It is important to individualize therapy for each patient to adequately manage treatment. The purpose of this section is to provide an overview of treatment options for opioid dependence. It is important to emphasize that if the patient can tolerate these medications, they can be treated for as long as possible. Just like the current hypertension and diabetes treatments available, OUD should be managed as a chronic condition.

Screening Tools

Prior to initiating MAT, it is critical that a prescriber asks the patient key questions to identify potential causative and enabling factors for substance abuse, as well as obtain the patient's medical background. Such questions may include the following (adapted from SAMHSA):

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 with substance abuse?
4. Have you previously sought help for substance abuse?
5. Have you been using any medications to help you sleep?

The patient history should be complete and include information about use of all other prescriptions, over the counter medications (e.g. cough and cold medications), alcohol, and illicit drugs. In addition, NJPDMP should be consulted to determine the patient's history of filling opioids.

Although, according to the FDA, concomitant use of buprenorphine or methadone with benzodiazepines or other CNS depressants increases the risk of serious adverse reactions like overdose and death creating barriers to MAT can pose an even greater risk of morbidity and mortality due to OUD.[28]

There are numerous screening tools that may be used to assess if a patient is experiencing signs and symptoms of opioid dependence and/or withdrawal. Additional screening tools help distinguish a patient's behavior as substance misuse and assesses the likelihood that an overdose could lead to addiction. Most of the screening tools are created based on DSM-V criteria.[29]

Opioid Risk Tool (ORT): The ORT is a self-report instrument given to adult patients, who are prescribed opioids for chronic pain, in a primary care setting to assess the risk of opioid dependence. Criteria used for evaluation include family and personal histories of substance use, age, and comorbid psychological disorders. The scale is out of a total 27 points and takes approximately 1 minute to complete.[30]

Point Range	Risk[33]
≤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 (COWS): The COWS allows practitioners to rate patient-reported symptoms and objective signs (i.e. heart rate and pupil size) of opioid withdrawal. Various measures within each criterion are assigned a point value. The number of points signifies the degree of withdrawal.[32]

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

Refer to Supplement 4 for further detail.

Medication-Assisted Treatment Options

Medication-assisted treatment (MAT) is the use of medications, along with behavioral therapy and counseling, to provide a "whole patient" approach to the treatment of substance use disorders.[31] MAT is primarily used for opioid addiction. To be optimal, treatment must be individualized so each patient receives the best agent that suits their needs. Research shows that a combination of medication and therapy can successfully treat substance use disorders, and for some medications can help sustain recovery. Medications are also used to prevent or reduce opioid overdose.[31] The goal of MAT is full recovery, including the ability to live a self-directed life. Some intermediate goals include increasing survival rates, helping patients maintain adequate socioeconomic status and improve birth outcomes among pregnant women who have substance use disorders[31] Refer to the SAMHSA MAT for OUD resource for an overview of MAT and non-drug abuse resources for patients.[32]

MAT is currently underutilized. It is important to increase utilization since MAT helps combat the psychological dependence, physical cravings, and withdrawal symptoms patient's experience. In general, people may safely use MAT for months, years, or even a lifetime and plans to taper should only be done when the benefit surpasses the risk of relapse.[31] The provider should give guidance to patients who want to taper off their current MAT therapy. Providers should instruct patients of the risks of relapse associated with tapering off MAT.

	Methadone[31,33]	Buprenorphine[31,34,35]	Naltrexone[31,36]
Brand Names	Dolophine®, Methadose®, Methadone HCl Intensol®, Diskets Dispersible®	Belbuca®, Buprenex®, Butrans®, Sublocade®, Brixadi®, and Subutex Co-formulated with Naloxone Brands: Bunavail®, Suboxone®, and Zubsolv®	ReVia®, Vivitrol®
Mechanism	Opioid agonist at mu opioid receptors Weak NMDA antagonist	Partial opioid agonist at mu opioid receptors	Opioid antagonist at the mu opioid receptors

		Weak antagonist at opioid kappa receptors Naloxone is an opioid antagonist	Weak antagonist of kappa and delta opioid receptors
Dosage forms[a]	Oral tablet Soluble tablet Oral concentrate Oral solution Injectable solution Intravenous solution	Sublingual film or tablet *(+/- naloxone)* Buccal film *with Naloxone* Transdermal Patch Intradermal Implant Long-acting injection Subcutaneous Solution	Oral tablet Long-acting injection
Dosing frequency	Daily	Daily *(tablet or film)* Monthly *(injection)* Every 6 months *(implant)*	Daily *(tablet)* Monthly *(injection)*
When to start[b]	Any time	Patient with mild to moderate withdrawal	After 7-10 days of abstinence from opioids
Who can provide treatment?[c]	Certified opioid treatment program (OTP)	Any prescriber with current DEA registration that includes Schedule III authority if permitted by applicable state law *DEA X waiver is no longer required. Please refer to page 12 for more details*	Any prescriber
Treatment delivery	Generally requires frequent clinic visits (telehealth options now available)	No frequent clinic visits required (may be take-home prescription or physician-administered injection/implant)	Take-home prescription or physician-administered injection
Patient characteristics	Helpful for patients with history of failed treatment and/or need daily support	Preferred as first-line for most patients	Mild opioid use disorder or unable to tolerate treatment with agonists
Contraindications	Hypersensitivity to methadone Respiratory depression and/ or acute bronchial asthma Paralytic ileus	Hypersensitivity to buprenorphine or naloxone	Hypersensitivity to naltrexone Patients engaged in current opioid use or are currently undergoing withdrawal
Precautions	Generally safe to use but requires supervised treatment due to risk of drug diversion	Administer with caution to patients with poly-substance abuse and those with compromised respiratory function or severe hepatic disease	Administer with caution to patients with active liver disease or moderate to severe renal disease

	Administer with caution to patients at risk for prolonged QTc or serious arrhythmia	Significant respiratory dysfunction has been seen with intravenous administration of buprenorphine and/or concomitant CNS depressants Injection site reactions may occur	Discontinue in the event of signs of acute hepatitis Patients may become sensitive to lower opioid doses and this may result in life-threatening overdoses Injection site reactions may occur
Use in pregnancy[d]	Recommended	Recommended to use formulations <u>without</u> naloxone	Not recommended
Drug Diversion potential	Yes	Yes *(risk is minimized with naloxone co-formulations)*	No

[a]Sublocade® is a monthly, physician-administered, subcutaneous depot only indicated for patients who have received at least 7 days of transmucosal buprenorphine. It has a REMS program that requires pharmacies and healthcare settings to be certified and comply with the REMS requirements in order to dispense the product.[35] **<u>Use caution when determining candidates for long-acting buprenorphine injections or implants, as follow-up may not be as frequent as with the daily-dosed products.</u>**

[b]It is important to determine whether a patient is currently using opioids, undergoing withdrawal, or is abstinent. Due to their mechanisms of action, buprenorphine and naltrexone pose a risk of precipitating withdrawal in patients with full opioid agonists in their systems. Naltrexone should only be initiated once a patient has been fully detoxed (i.e. 7-10 days without any opioid use). Caution should be taken if he/she has recently used any long-acting opioids (such as methadone, Oxycontin®, or sustained-release morphine). Further, patients should be educated on the risk of overdose with methadone, concomitant opioids, and other CNS depressants (i.e. alcohol or benzodiazepines).[37,38]

[c]Office-based outpatient treatment (OBOT) can be provided in both primary care and specialty substance use disorder settings. This would involve regular appointments with a provider and provision of take-home prescriptions for the patient (or physician-administered injection/implant). Opioid treatment programs (OTP) are federally-regulated facilities providing more frequent, often daily, supervised care and support. During the COVID-19 emergency era, flexibilities enabled physicians to prescribe medications for OUD via telehealth. In 2024, the Biden Administration continued these policies permanently, due to a final rule published by the SAMHSA. When deciding the most appropriate treatment setting, consider the following patient characteristics:[37,39]

Criteria	OBOT	OTP
Can an office-based setting proved needed resources for the patient?	Yes	No
Patient's psychosocial supports	Good	Poor
Previous failed treatment attempts with opioid maintenance	None/few	Many
Difficulty accessing OTP (geographic distance, DoD mobility requirements, etc.)	Yes	No
Pain conditions that requires ongoing or recurrent treatment with short-acting opioids	No	Yes

[d]During pregnancy, untreated opioid addiction has been associated with a lack of prenatal care, increased risk of fetal growth restriction/death, maternal morbidity, and loss of child custody. Traditionally, methadone was recommended as the only treatment for OUD during pregnancy, but more recent data shows buprenorphine (without naloxone) is also safe and effective. Naloxone and naltrexone have insufficient data to show safety and should be avoided. It is important to also identify other areas of concern during pregnancy and treating the patient as a whole with specialized multidisciplinary care. Pregnant women with OUD often suffer from co-occurring mental health conditions, particularly depression, history of trauma, posttraumatic stress disorder (PTSD), and anxiety.[40]

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

Opioid Overdose Treatment - Naloxone

Naloxone hydrochloride is an opioid receptor antagonist, which blocks the uptake of opioid drugs at neuroreceptors. Its most notable effect is the reversal of respiratory depression associated with opioid overdose that can be fatal. The three FDA-approved dosage forms of naloxone that can be purchased from a community pharmacy include an intramuscular injection, autoinjector, and nasal spray. Patients who are at high risk for an opioid overdose that should be prescribed naloxone include:[41]

- Patients who misuse prescription opioids or illicit synthetic opioids
- Patients with an opioid use disorder, especially those completing opioid detoxification or being discharged from treatment that does not include ongoing use of MAT
- Patients recently discharged from emergency medical care following an overdose
- Patients being released from incarceration who have a history of opioid misuse or opioid use disorder
- Patients taking opioids for long-term management of chronic pain, especially with higher doses or use of concomitant alcohol or CNS depressants
- Patient prescribed 90 MME or higher
- Patient on concurrent benzodiazepine and opioid therapies

Naloxone can also be obtained without a prescription from almost all pharmacies throughout New Jersey and as of March 2023, the FDA has approved Narcan (naloxone hydrochloride) 4 mg nasal spray

for OTC. In fact, it is recommended that family, friends, healthcare providers, and community members who interact with at-risk patients should obtain this overdose-reversing drug. Naloxone has no physical or psychological addictive properties nor does it affect patients not under the influence of opioids. Further, the Overdose Prevention Act, signed in 2013, protects any party who dispenses or administers naloxone to an opioid overdose victim. As such, providers should enforce the importance of carrying naloxone and calling 911 when there is a suspected overdose, especially in cases where there may be hesitance (i.e. high school or college parties).[42]

Purchasers can pay out-of-pocket for the medication and community pharmacists are available to train them on how to effectively administer it. There are also many pharmacy coupons and programs that can be used to help cover the cost of the medication.[41-43]

Refer to Supplement 5 for a Naloxone Administration poster.

Withdrawal Management with Alpha-2 Adrenergic Agonists[37,38]

Two main strategies have evolved for treating opioid withdrawal. The first is the tapering method of opioid agonists, typically buprenorphine or methadone. The other strategy involves the use of alpha-2 adrenergic agonists such as lofexidine and clonidine. Lofexidine was FDA-approved in 2018 as the first non-opioid treatment for the management of opioid withdrawal symptoms. Clonidine is not FDA-approved for opioid withdrawal syndrome in the US but is used off-label in the clinical setting for over 25 years. Both strategies have their advantages and disadvantages, however, both were shown to be superior to placebo in reducing withdrawal severity. Recent studies have shown that the use of alpha-2 agonists had similar results as a methadone taper for the management of withdrawal symptoms. The benefit of using alpha-2 agonists over opioid agonists is that with proper planning of naltrexone, rapid initiation of alpha-2 agonists may be used for withdrawal treatment instead of a taper. This may also help prevent misuse of opioid agonists when being used for withdrawal treatment.

Lofexidine is administered orally for three 0.18 mg tablets four times daily. This can be continued for up to 14 days depending on the symptoms. It should be discontinued through tapering over 2 to 4days. Clonidine is administered at doses of 0.1-0.3 mg every 6-8 hours, with a maximum dose of 1.2 mg. Clonidine may be used in combination with other opioid withdrawal agents such as benzodiazepines for anxiety, loperamide for diarrhea, acetaminophen for pain, and ondansetron for nausea. Alpha-2 adrenergic agonists may also be used with medications to treat opioid use disorder to supplement treatment. Lofexidine is generally the preferred alpha-2 adrenergic agonist as it has the better safety and efficacy profile compared to clonidine.

Recovery Resources

The purpose of this section is to help find the most optimal treatment programs for your patients based on their preferences, background, and type of insurance coverage.

Opioid Treatment Programs (OTPs) and Other Treatment Options in New Jersey

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

There are several general service organizations, such as TreatmentMatch, available to connect patients to care. Treatment Match is a confidential service connecting patients to buprenorphine providers in their area and alerts providers when new patients register for the match. This service, and others like it, creates a network of patients and providers who can reach out to one another and allows more patients to become linked to care.[44]

In terms of recovery programs, there are numerous options available in New Jersey. These include educational workshops, Narcotics Anonymous meetings, and recovery programs that provide housing. One established program is The Center for Addiction Recovery Education & Success (CARES) located in Rockaway NJ. CARES is a peer-to-peer, volunteer-based, recovery-oriented sanctuary. Patients are able to attend a variety of workshops and meetings in order to facilitate recovery.[45]

As college students are the one of the highest-risk populations for prescription and narcotic drug misuse, numerous recovery resources can be found on college campuses. Many colleges and universities are opening dormitories specifically to house those in recovery. The Rutgers Recovery House is a great option for students recovering from alcohol and/or drug dependence at Rutgers University in New Brunswick. Certified professionals and counselors conduct group recovery meetings, academic support, and career guidance with students and the facility has a 12 step program as well. There are no signs outside of the recovery house and sober activities, such as hiking, intramural sports, and campus events are offered year-round.[46]

Other Resources:

- NJ 2-1-1: helps people find solutions to personal needs by informing them of resources in their community.

- My Resource Pal: a tool that allows you to find food, housing, transportation services and more in and around South Jersey

Resources for Patients with Medicaid

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

Access to Recovery (ATR) vouchers are an option for approximately 100,000 people per year. The ATR voucher program, established in 2003, allows individuals to receive a voucher to pay for a range of for drug and alcohol addiction treatment services.

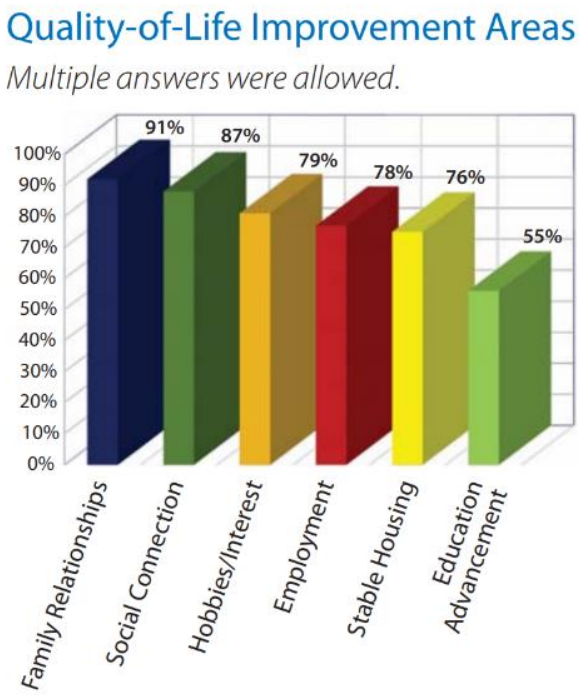
The criteria usually entails that an applicant[47]:

- 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

For patients who meet the above criteria, an ATR voucher can provide treatment services for as little as no cost to the patient.

Assisting Patients without Insurance

Further expansion targeted toward uninsured patients is needed as a majority of current programs are limited to charity-based programs and services. Narcotics Anonymous is a 12-step program available to individuals battling drug addiction and is completely free of charge. Patients should be referred to Narcotics Anonymous when possible as there are strong support services for patients and their families at these workshops and meetings. Based on the 2018 Narcotics Anonymous Membership Survey, participation in the program improves the quality of life and personal relationships for patients, which is a major goal of treatment.[48]



Online forums, such as Faces and Voices of Recovery, is great resource for current addicts to seek advice from recovered individuals and other patients engaged in or seeking treatment. The link to access the forum is listed below:[49]

- Faces and Voice of Recovery

Some community-based programs may also provide food and shelter to patients in addition to recovery services and counseling. One program is The Rescue Mission of Trenton. It offers a state licensed addictions treatment facility, providing long-term, halfway house, and ambulatory services. They also have a nine-week experience available called The New Direction Program that provides individuals in recovery with the opportunity to learn, be challenged, reflect, and create an inspiring plan for the future. Volunteer work and charity funds are often how these programs are run.[50]

Finally, church-based charities, such as Catholic Charities Diocese of Metuchen, 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.[51] Although the support network and counseling services of church-based charities are usually beneficial, those programs are 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 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

The Ramifications of Opioid Over-prescribing[52-55]

In 2024, the CDC reports an estimated 80,400 drug overdose deaths in the US, a 27% decline from the estimated 110,000 in 2023. Opioid involved fatalities have dropped from 83,140 in 2023 to 54,743 in 2024.

Four of every five individuals who use heroin started from originally misusing prescription painkillers, indicating prescription opioids are often a "gateway" for other illegal and dangerous drugs.

The mean annual healthcare costs for individuals who abuse opioids are nearly nine times greater than those who do not; indicating there is a need to prevent substance use disorders to limit healthcare burden.

Over-prescribing opioids is likely to lead to addiction. Over the past two decades, the CDC concluded that opioid prescriptions, opioid-related emergency department visits, opioid abuse treatment admissions, and opioid-related deaths have
increased in parallel.

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 for effective management. The prescriber should discuss and create a treatment plan with the patient including treatment goals, benefits and risks, plans for discontinuation, and how to dispose of medication safely. Research indicates that patients who feel their providers are not legitimizing their pain or are dismissive of their pain may not be adherent and could potentially overdose. [56,57,58]

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 8th grade reading level, involving as little medical terminology as possible. Patients should be made aware of potential adverse effects when using opioids and be instructed on how to safely manage these adverse effects. Electronic follow-up via a patient portal is becoming the new best practice. [56,57,58,59,60]

Monitoring of patients currently on opioids should consist of continuous use of the PDMP, urine drug screenings, and reviewing patients' medical records for discrepancies. Patients on long-term opioids for chronic pain should regularly have follow-up visits to consider efficacy and appropriateness of pain management. 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.[57]

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 8 for a sample prescriber-patient agreement contract.

Education and Interventions

Overview

As medicine is advancing and embracing interprofessional healthcare teams, it is evident, the management of substance use should require interprofessional education and collaboration. This has already been exemplified by prescribers and pharmacists collaborating to help manage a patient's pain.

American Dental Association Guidance

In 2016, the American Dental Association (ADA) developed a position statement regarding use of opioids for dental pain. Since then, prescription rates for opioids written by dentists have decreased. In 2019, US dentists provided 10.9 million opioid prescriptions, representing 7.6% of the opioid prescriptions dispensed that year, compared to 18 million that was dispensed by dentists in 2009.

The position statement recommends dentists and dental students 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. Dentists should utilize the NJPMP to identify patients who are at risk of opioid abuse. Lastly, dentists should attempt to coordinate care with the patient's other prescribers who are also prescribing chronic pain medications.[58]

Core Competencies for Health Care Professions

Dental schools, including all Massachusetts Schools of Dentistry, have incorporated core competencies regarding opioid abuse and misuse into school curriculum.[59] While only mandatory for the state's dental schools, these core competencies should be incorporated into other healthcare-related schools in every state, including medicine, pharmacy, and nursing. The benefits of this education fill a missing component in current medical curriculum, as evidenced by the fact only 36% of primary care physicians report medical school has prepared them to identify opiate abusers. Furthermore, 67% of primary care physicians are concerned with their ability to correctly assess a patient's risk of opioid addiction.[60]These competencies were aimed at primary prevention (preventing abuse and misuse): safely and effectively identifying, treating, and managing patients 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 abuse
    - Evaluate a patient's 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, including opioid, 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 substance abuse behaviors
- Managing substance use disorders as a chronic disease
    - Recognize and utilize screening instruments
    - Eliminate the stigma associated with substance use disorders and identify it as a manageable chronic disease with effective and patient-specific treatment
    - Utilize interprofessional management strategies.[59]

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 the use of community support and mutual support groups.[38] 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.[61]

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 pain management.[62] Yoga, which derives from ancient Hindu culture, consists of breathing techniques, postures, meditation, and strengthening exercises.[63] 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.[61]

Mindfulness-Based Relapse Prevention (MBRP) is an 8-week, group-based intervention that focuses on preventions strategies with meditation training.[63,64] The primary goal is to help patients tolerate cravings or difficult emotions through meditation and yoga. The mechanism of action of meditation has been theorized 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.[64-66] Yoga has been theorized to increase GABA (gamma-aminobutyric acid) levels, which may also help with concomitant psychiatric illnesses like depression and anxiety.[67] Studies have found that following yoga sessions in experienced practitioners, GABA levels are significantly increased as compared to other activities such as reading.[67]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 traditional approaches. MBRP has also been associated with

significantly less drug cravings than treatment as usual, suggesting a lower relapse rate in patients enrolled in MBRP protocols. [768,69]

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.[64]

A major barrier with these non-pharmacological interventions, like yoga and meditation, is they need to be done on a regular basis. For patients with severe psychiatric or debilitating illness, consistency may pose a problem and make these interventions less likely to be successful.[64]Therefore, compliance and adherence should be emphasized to patients during initiation. It may be appropriate to reserve this treatment modality for patients who are likely to adhere.

Wellness Center Development

A wellness center is a comprehensive program devoted to the management of individuals who require social support upon reentering society after rehabilitation. Wellness centers should be utilized to create a safe environment for individuals with or affected by substance use disorder, including not only patients, but also 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 detoxification, as they tend to require a higher level of care. Wellness centers have the best efficacy when patients are compliant with therapies and have good attendance at meetings.

Wellness centers are typically housed in places of worship, such as churches, temples, synagogues, 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

Getting Naloxone

Overview

In 2021, 70,421 people in the U.S. died as a result of drug overdoses involving opioids.[70] Naloxone has long been used by emergency medical services and first responders. New legislation has allowed for easier prescribing of naloxone and increased availability in pharmacies. While naloxone dispensing has increased over the years, additional efforts should be made to make naloxone more available for patients at risk of opioid overdose.

Naloxone

Naloxone is a pure opioid antagonist that competes for binding at the opioid receptor site. The route of administration for naloxone can be intravenous, intramuscular, subcutaneous, inhalation via nebulizer, and intranasal. After administering the naloxone, the onset of action is roughly 2-5 minutes, except for intranasal administration which can take 8-13 minutes. If the patient is still unresponsive after 2-3 minutes, administer a second dose and repeat giving a dose every 2-3 minutes if more are available and are needed[71]

Who Should Receive Naloxone

- Although there have not been any studies specifically examining the outcomes of prescribing naloxone with opioid medications in the primary care setting, naloxone distribution in communities has decreased the risk for opioid overdose death. In 2022, the CDC updated its Guidelines for Prescribing Opioids for Chronic Pain. The CDC now recommends proactive prescribing of Naloxone to all patients receiving opioids or at risk. The recommendations apply

to clinicians who are prescribing opioids for outpatients in the following settings[12]Aged >/= 18 years

- Acute (duration <1 month) or subacute (duration of 1-3 months) pain
- Chronic (duration of >/= 3 months) pain

The guidelines do not apply to patients who have sickle cell disease-related pain management, cancer pain treatment, palliative care, and end-of-life care.

How to get Naloxone

On June 9th, 2017, the Pharmacy Practice Act was signed into law which allowed pharmacists to dispense an opioid antidote without a prescription to a patient at risk of an opioid overdose or an individual who can administer to someone at risk pursuant to a standing order issued by the Department of Health. Pharmacists who are licensed and in good standing in New Jersey may request the standing order from the Department of Health. A pharmacist can also obtain a standing order from a healthcare practitioner to dispense an opioid antidote. Patients should be informed of these resources if there are concerns for the risk of opioid overdose.[72]

During the COVID-19 pandemic of 2020, concerns were raised that individuals with respiratory diseases may be more susceptible to opioid overdoses, that increased isolation and anxiety brought on by the COVID-19 crisis may increase rates of drug abuse, and that the pandemic may disrupt addiction treatment and support systems. On May 21, 2020, an administrative order was issued by the NJ Attorney General that requires prescribers to co-prescribe naloxone to any patient continuously receiving opioids for chronic pain management if the patient has one or more prescriptions totaling 90 MME or more per day, or is concurrently taking an opioid and a benzodiazepine. The Administrative Order also applies to prescribers licensed by the State Boards of Dentistry, Nursing and Optometrists. The Administrative Order on co-prescribing may be in effect for the duration of the public health emergency or the state of emergency declared by Governor Murphy, whichever is longer.[73]

As of March 29th 2023, the FDA has approved the first over the counter version of naloxone (Narcan). The approval for the second version came a little later on July 28th 2023, with brand name RiVive. The only difference between the two is that Narcan comes in 4mg, with RiVive comes in 3mg. Both are now available OTC, increasing access for patients and community members. Prescribers should counsel at-risk patients and their household contacts on locating and using OTC naloxone.[74,75]

Discussing Opioid and Comorbid Substance Use Disorders

Identifying Patients with Substance Use Disorder

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. A patient with opioid use disorder often times has a comorbid substance use disorder including alcohol, tobacco, marijuana, or other drug use. The healthcare practitioner should be advised to look for signs of mental illness as well as signs of dangers to self and others. 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.[76,77]It is also important to differentiate patients who are physically dependent and psychologically dependent on opioids to effectively take the appropriate next steps in treatment.

For patients with substance use disorder who are misusing or abusing 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: [76-77]
    - 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[77]
    - 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

Alcohol Use Disorder

Alcohol use disorder (AUD) is one of the most prevalent substance use disorders, less than tobacco and more than marijuana and opioid use disorder (OUD).[78]Opioid and alcohol use disorders are commonly comorbid conditions. A cohort study of 5,307 adult patents with opioid use disorder found that 23.4% had a diagnosis of alcohol use disorder.[79]A study from the National Institute on Drug Abuse Clinical Trials Network on 1,397 patients seeking opioid treatment had 38% of patients with a comorbid alcohol use disorder.[80]Whether or not one substance use disorder leads to the other has not been studied.

It is important to identify comorbid alcohol and opioid use disorder as there is increasing evidence that alcohol use is a contributing factor in opioid overdose deaths. Both alcohol and opioids are central nervous system depressants and when used together can cause respiratory depression leading to increased opioid risk. In studies from the Drug Abuse Warning Network (DAWN) from the SAMHSA, there was an 84% increase in drug-related emergency department (ED) visits from 2005 to 2011.[82]More serious outcomes during the ED visits occurred when alcohol was involved than when alcohol was not involved. A DAWN study using medical examiner data across 13 U.S. states in 2010 found that out of 3,883 opioid deaths, 22.1% involved alcohol and out of 1,512 benzodiazepine deaths, 21.4% involved alcohol.[82]

Further studies need to be conducted on the combination treatment for OUD and AUD. Extended-release naltrexone is one of the most promising medications as it has FDA indications to treat both OUD and AUD. Naltrexone decreases the pleasurable sensations associated with opioid use thus decreasing the motivation to seek opioids. Although the exact mechanism is unknown, it was found that naltrexone also decreases the same sensations for alcohol, leading to similar outcomes. A small pilot study found that extended-release naltrexone was safe and effective in treating OUD and AUD in patients from an HIV clinic setting, however the pilot study only included 8 patients.[83] There have been increasing efforts to increase treatment from a non-pharmacological standpoint. One such effort consists of using a collaborative practice between primary care and a clinical psychologist to treat AUD and/or OUD.[84]Other efforts include using techniques such as mindfulness-based interventions[85], cognitive behavioral treatment[86], and pain management[87].

Marijuana Use Disorder

There has been increasing public and professional interest in the possibility that increasing marijuana use may decrease opioid use disorders. Two ecological analyses showed states that permit medical marijuana have significantly lower annual death rates due to opioid overdoses. Opioid prescribing has also decreased following the passage of medical marijuana laws. However, these studies should not be used to draw conclusion about individual behaviors and the relationship between cannabis use and the risk of developing opioid use disorder, as this has not been thoroughly studied.[88]

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-HT1A receptor, whereas low doses of cannabidiol create an anti-emetic effect.[89]

A study published in the American Journal of Psychiatry found that using logistic regression models cannabis use was associated with an increased incident of nonmedical prescription opioid use and opioid use disorder (opioid use: adjusted odds ratio = 2.62, 95% CI = 1.86-3.69; opioid use disorder:

adjusted odds ratio = 2.18, 95% CI = 1.14-4.14).[88] The risk of developing marijuana use disorder from opioid use has not been studied.

Successfully identifying signs and symptoms of opioid and marijuana use and appropriate intervention by a physician may prove beneficial to reducing illicit substance use and decreasing the incidence of substance use disorder. Marijuana is the most commonly used illicit drug in America and is used more commonly in teens than adults.[90-94]

- Common signs and symptoms of acute marijuana use include: [90-94]
    - 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 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[,95]:
    - Blaze, Blunt, Bud, Bush, Dank, Doobie, Dope, Ganja, Grass, Herb, Joint, Kush, Mary Jane, Pot, Reefer, Roach, Weed
    - Alternative names may vary by geographic region

52.5 million people, or about 19% of Americans have used marijuana at least once in 2021. Studies have shown that 3 in 10 people who use cannabis have a cannabis use disorder. The risk of developing cannabis use disorder is even greater for people who begin to use it before age 18. [96]

New Jersey's Cannabis Regulatory, Enforcement Assistance, and Marketplace Modernization (CREAMM) Act allows for the legal sale and use of cannabis and cannabis products for residents 21 years and older. A medicinal card, or health condition is not required and anyone over the age of 21 can purchase at their own risk.[97]

Approach for Younger Patients

There is a documented risk of drug diversion and addiction in pediatric patients, especially teenagers and adolescents of high school age.[98]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 should be 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 directions 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
- In accordance with the new NJ law limiting the max duration for a new opioid prescription to a maximum of 5 days, you may request patients to do one of the following after this 5 day 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 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 at Project Medicine Drop.[99]

From 1994 to 2007, in patients aged 15 – 19, 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 trend 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.[100]

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.[100] Obtaining 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 get them for free from a friend or relative[98,99.101-103]
    - These "distributors" are generally unaware of the dangers of nonmedical opioid use
    - 50% of patients prescribed opioids for acute pain do not finish their pain medication, generally in an attempt to save their medication for later use
    - Many prescribers – including pain management specialists, oncologists, and surgeons – do not tell their patients:
        - Where to store their medication(s)
        - What to do with unused medication(s)
        - What to do with expired medication(s)
- Only 35% of patients using opioids acutely report taking their medications exactly as prescribed

- Use of prescription opioids in patients before the 12th 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
- 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

It is important to note that 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).[104]While long-term use is more likely in hospitalized patients, it is important to note with the new NJ law, prescriptions for use of opioids in treating acute pain cannot exceed a duration of 5 days.

During high school check-ups and pre-college physicals, nurses and pediatricians may be able to identify children and young adults who are manifesting signs and symptoms of misusing and abusing illicit and prescription drugs. When speaking to patients, especially young adults, whom you suspect are misusing or abusing opioids, without being judgmental or confrontational, ask the patient about their drug use in the past year and in their lifetime, 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 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. 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:
        - Have the patient jointly create a progress note with you

        - Have the patient complete a "plan" before leaving the office
        - Provide reading level appropriate resources about quitting
        - Provide resources such as websites (www.samhsa.gov, www.drugabuse.gov) or hotlines (1-800-662-HELP)
        - Schedule follow-up appointments for 1-2 weeks
        - Prescribe medications for office-based treatment, if appropriate
        - Refer the patient to other healthcare practitioners, specialists, or programs, if appropriate
    - Arrange for the patient to receive specialty care, medications, subsequent visits, as appropriate

Updates in Landscape of Opioid Abuse in the Community:

Currently, xylazine (also known as "tranq") is increasing in popularity amongst communities. With the addition of this drug intended for use in sedation and pain management in veterinary medicine, CNS depression is a growing concern.

- **Effects:** CNS depression—decreased breathing, heartrate, and blood pressure, soft tissue sores
- **Treatment**: naloxone does not reverse the effects of xylazine but should still be administered due to likely combination with opioids
- **Administration**: via injecting, snorting, swallowing or inhaling; often mixed with fentanyl (often times without users knowing)[104]
- **Prevalence: ove**rall trending upwards
    - 23% of fentanyl powder and 7% of fentanyl pills seized by the DEA In 2022 contained xylazine
    - -In Philadelphia, xylazine was found in 31% of overdoses that involved heroin and/or fentanyl[101]
        - Per CDC, xylazine-involved overdose deaths increased over 1000% from 2018-2021, and in 2023 the White House declared it an emerging drug threat.[105]

Prescribers should also be aware of emerging novel synthetic opioids such as nitazenes (e.g., metonitazene, isotonitazene), which are not reliably detected on standard urine drug screens and may be 10-100 times more potent than fentanyl. Suspect nitazene overdoses may require higher or repeated doses of naloxone. [106]

Section 4: Other Resources for Prescribers

New Jersey Opioid State Law

Overview

On May 16th, 2017 one of the strictest opioid laws in the country went into effect in New Jersey, stating that new opioid prescriptions must be limited to a five-day supply for patients who had not been on opioids for over a year prior. This law is more stringent than the 2022 CDC Guidelines for Prescribing Opioids in Chronic Pain, which advises prescribers to use the opioid guidelines with flexibility, and that pain management should be individualized to each patient. Since the New Jersey laws are stricter than the federal guidelines, it is important for clinicians to remember they must adhere to rules and regulations which are stricter when those that are federal and state are not in alignment. In addition to the day supply limitation, the New Jersey law increased access and insurance company coverage for treatment of individuals with substance use disorder.

Details of the Law

New Jersey Law S3/A3[33]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 8 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.[33]

Electronic Prescribing (E-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, electronic prescribing for Schedule II controlled substances is NOW MANDATORY as of May 1, 2023. Limited exemptions apply (e.g., technological failure, patient hardship, pharmacy not equipped for electronic prescriptions). Prescribers should ensure their systems are compliant and document any use of an exemption.[107]

Where to Register

Prescribers can register at www.veradigm.com/eprescribe/.[108] Veradigm™ is the business unit of Allscripts Healthcare LLC.

Attention Deficient Hyperactivity Disorder (ADHD)

ADHD is one of the most common childhood mental disorders that can persist through adolescence into adulthood. Primary symptoms are a lack of attention, trouble focusing, and having spontaneous thoughts/behaviors. The primary treatment for these patients are stimulant medications, of which most are controlled substances such as prescription stimulants. Stimulant therapy is an evidence-based treatment for ADHD, but it can also be harmful if used without prescription or guidance from clinicians. Prescription stimulants are generally considered safe and effective when taken as prescribed; however, their psychoactive properties make them subject to misuse for cognitive and physical performance enhancement and recreational purposes. Prolonged stimulant misuse can lead to several detrimental

health effects including cardiovascular conditions, depressed mood, overdoses, psychosis, anxiety, seizures, and stimulant use disorder.[109, 110]

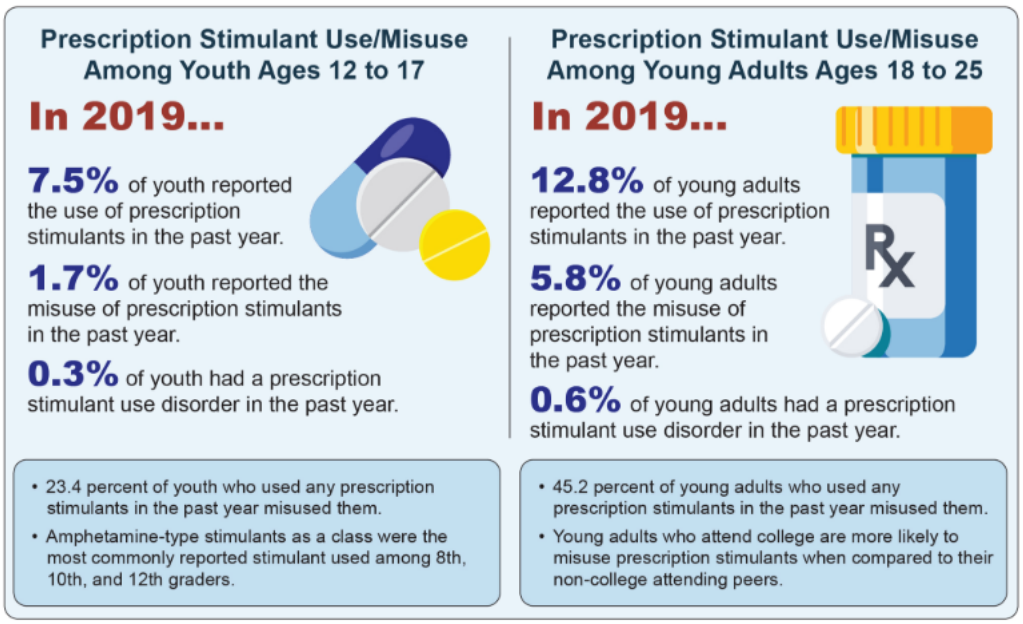
Abuse with stimulant medications has always been prevalent, but when telehealth options increased during COVID-19 pandemic, an increase in prescriptions was seen. With the amount of stress the pandemic placed on people, there was a greater risk for substance use in general, especially among those who experienced hardships. A statistic taken from June 2025 found that among 18- to 64-year-old US adults using prescription stimulants, 25.3% reported misuse, and 9.0% had PSUD" [109, 110]

More than 60% of youth and young adults reported they obtained prescription stimulants from a friend or relative. Youth and young adults with valid prescriptions for stimulants will sometimes sell, trade, or give away their medications to those who want to use them illegally. While ADHD diagnoses and prescribing of stimulants has increased significantly in the U.S. over the past 20 years, few studies have looked at the relationship between stimulant therapy and prescription stimulant misuse in schools. The most recent study published in JAMA highlights the need for assessments and education in schools and communities to prevent medication sharing among teens. The study found that, across 231,141 student participants surveyed at 3,284 secondary schools, the school-level prevalence of nonmedical use varied from 0% to over 25% of students. Schools with a greater number of students (12% or higher) reporting prescription stimulant therapy for ADHD tended to have the highest percentages of their student body reporting prescription stimulant misuse (8% of total student body). By comparison, schools with fewer students (0 to 6% of student body) reporting stimulant therapy for ADHD were associated with lower rates of prescription stimulant misuse (4 to 5% of student body). [109, 110]

Most prescription stimulants are taken orally and are available as tablets, capsules, or liquids. Misusing prescription stimulants can be done orally, as well as by snorting/inhaling, smoking, or injecting a powder from crushed tablets or opened capsules, with snorting/inhaling being the most common mode of nonoral use. Oral misuse of prescription stimulants can be a precursor to the non-oral misuse of prescription stimulants, which itself can be a precursor to the abuse of other substances. One study, based on data collected from youth in 10 U.S. cities, found that as many as 17% who used prescription stimulants, regardless of how they were obtained, misused them via a nonoral route in the past 30 days. Some studies have found that participants who reported the non-oral use of prescription stimulants were more likely to report adverse mental health outcomes and negative health outcomes in general when compared to participants who used prescription stimulants orally and for medical purposes. [109, 110]

Increases in prescription stimulant use may be attributable to increases in the prevalence of ADHD diagnoses in the United States. In recent years, between 11 and 13% of youth aged 12 to 17 and between 4 and 8% of young adults aged 18 to 25 have been diagnosed with ADHD. More than two-thirds of youth and young adults diagnosed with ADHD are prescribed medication. [109, 110]

Prevalence of Prescription Stimulant Misuse Among Youth and Young Adults



Drug Overdose Stats & Trends

- **Drug overdose deaths involving stimulants (cocaine, meth, prescription stimulants) rose 374% from 2015 to 2022.**
- Nearly 70% of stimulant-involved overdose deaths in 2022 also involved fentanyl.

Source: https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates#Fig6

Drug Overdose Deaths: Facts and Figures | National Institute on Drug Abuse. National Institute on Drug Abuse. Published August 21, 2024. https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates#Fig6

Other Substance Use [109, 110]

Over 97% of youth who misuse prescription stimulants by age 18 have also used at least one other substance in the past year. Two-thirds of high school seniors who reported the misuse of prescription stimulants in the past year did so simultaneously with other substances, usually alcohol or marijuana. Similarly, college students who misuse prescription stimulants are over six times more likely to report heavy drinking than those who do not. A survey of college students from a Midwestern university found that those who used prescription stimulants non-medically tended to report polydrug use.

Prescriber Considerations:

Prescribers and other providers who care for youth and young adults with ADHD should help prevent the misuse of prescription stimulants by doing the following:

- Before prescribing stimulant medications, confirm an ADHD diagnosis
- Carefully consider medication, dose, and formulation (e.g., prescribing longer-acting formulations with lower abuse potential)
- Provide detailed counseling and education (and their guardians, as applicable) who are prescribed prescription stimulants
- Closely monitor all patients who receive prescription stimulant medications and regularly check those patients' histories in the state's PDMP
- Screen all patients who have a diagnosis of ADHD and/or receive prescription stimulant medication for substance use disorders and other behavioral health conditions

Prescription Stimulant Misuse Prevention Programs:

Generation Rx

Expectancy Challenge

Prescription Stimulant Misuse Prevention Program at Miami University in Ohio

Prescription Stimulant Misuse Prevention Program at Syracuse University

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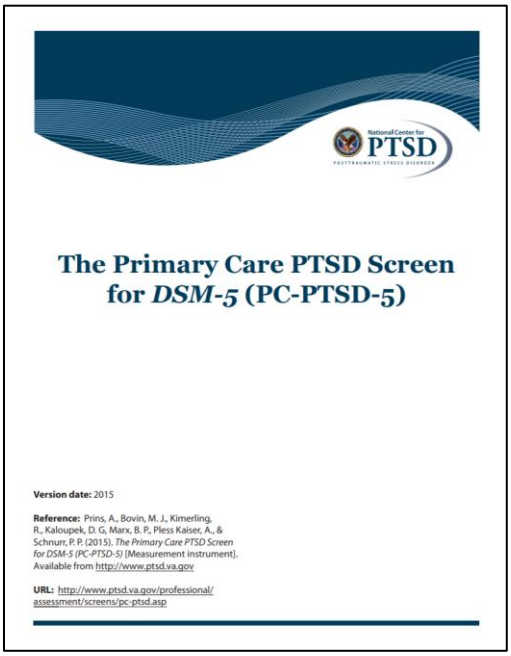
Supplements

1. Primary Care PTSD Screen (PC-PTSD)



National Center for PTSD
POSTTRAUMATIC STRESS DISORDER

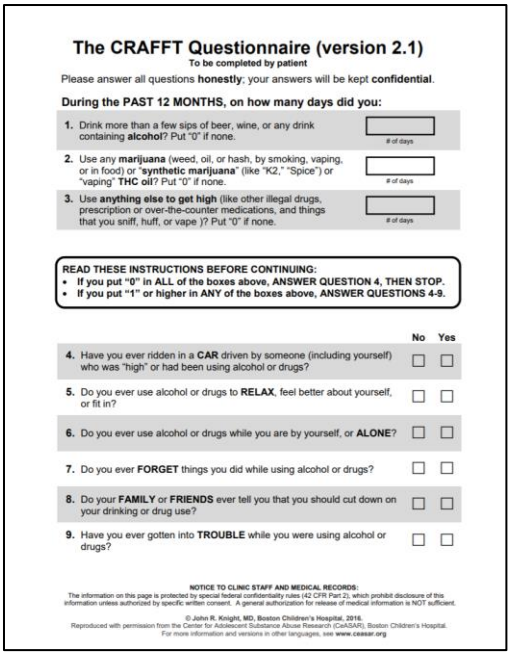
The Primary Care PTSD Screen for *DSM-5* (PC-PTSD-5)

Version date: 2015

Reference: Prins, A., Bovin, M. J., Kimerling, R., Kaloupek, D. G, Marx, B. P., Pless Kaiser, A., & Schnurr, P. P. (2015). *The Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)* [Measurement instrument]. Available from http://www.ptsd.va.gov

URL: http://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp

2. CRAFFT 2.1 Questionnaire [CRAFFT 2.1 Questionnaire]



The CRAFFT Questionnaire (version 2.1)

To be completed by patient

Please answer all questions **honestly**; your answers will be kept **confidential**.

During the PAST 12 MONTHS, on how many days did you:

1.	Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Put "0" if none.	# of days
2.	Use any **marijuana** (weed, oil, or hash, by smoking, vaping, or in food) or "**synthetic marijuana**" (like "K2," "Spice") or "vaping" **THC oil**? Put "0" if none.	# of days
3.	Use **anything else to get high** (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? Put "0" if none.	# of days

READ THESE INSTRUCTIONS BEFORE CONTINUING:

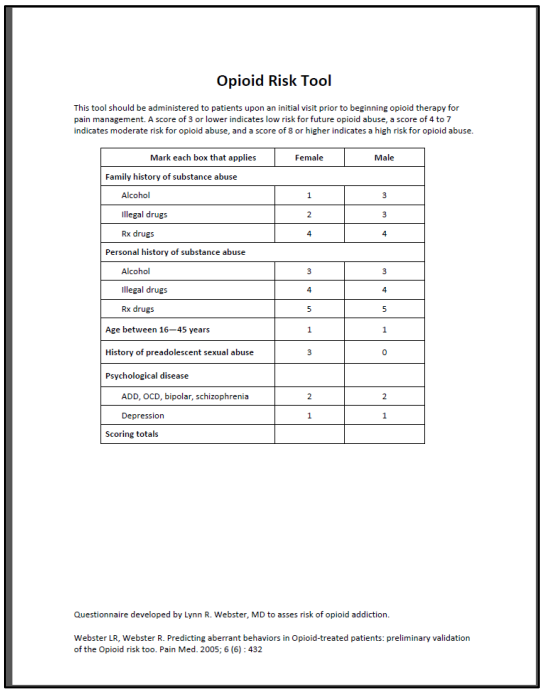
- **If you put "0" in ALL of the boxes above, ANSWER QUESTION 4, THEN STOP.**
- **If you put "1" or higher in ANY of the boxes above, ANSWER QUESTIONS 4-9.**

		No	Yes
4.	Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
5.	Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
6.	Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
7.	Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
8.	Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
9.	Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:

The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.

3. Opioid Risk Tool



Opioid Risk Tool

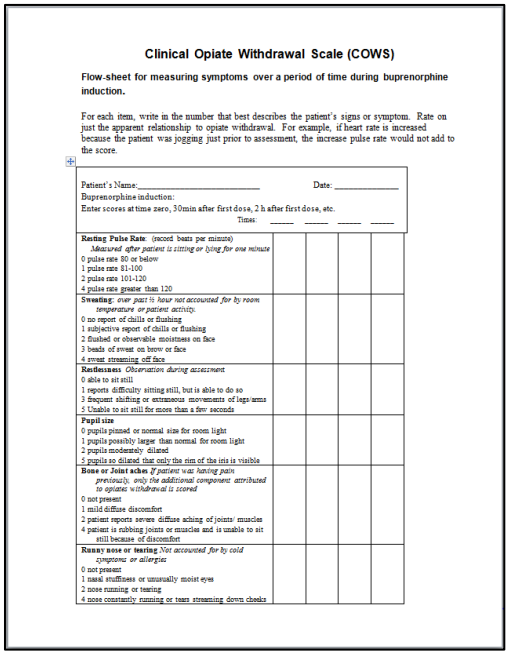
This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for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

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
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
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Questionnaire developed by Lynn R. Webster, MD to asses risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. 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.

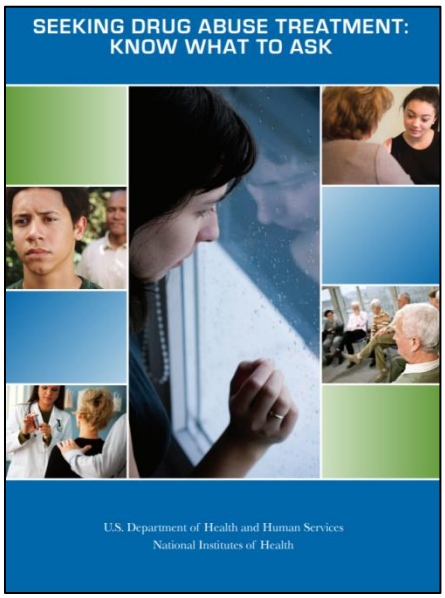
For each item, write in the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

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

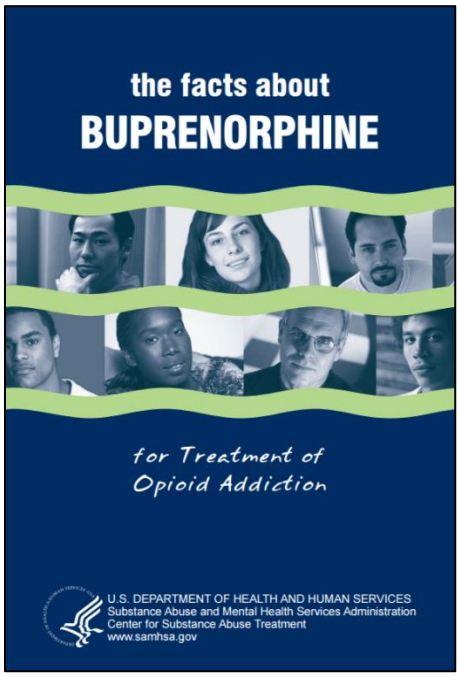
Resting Pulse Rate: (record beats per minute) *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120				
Sweating: *over past ½ hour not accounted for by room temperature or patient activity.* 0 no report 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 sweat streaming off face				
Restlessness *Observation during assessment* 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 5 Unable to sit still for more than a few seconds				
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible				
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 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				
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 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

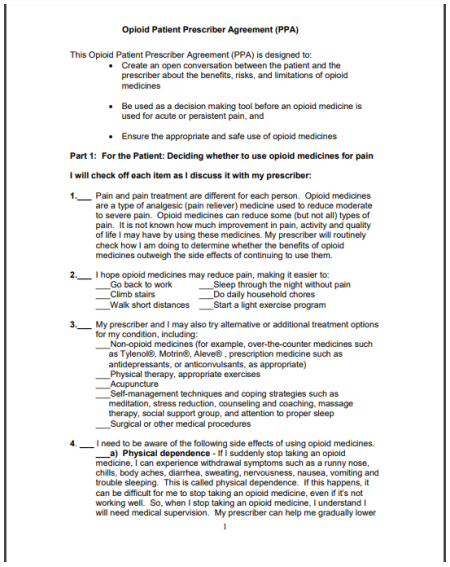
6. Seeking Drug Abuse Treatment: Know What to Ask (NIDA)



7. The Facts about Buprenorphine for Treatment of opioid Addiction



8. Opioid Patient Prescriber Agreement Sample



Opioid Patient Prescriber Agreement (PPA)

This Opioid Patient Prescriber Agreement (PPA) is designed to:

- Create an open conversation between the patient and the prescriber about the benefits, risks, and limitations of opioid medicines
- Be used as a decision making tool before an opioid medicine is used for acute or persistent pain, and
- Ensure the appropriate and safe use of opioid medicines

Part 1: For the Patient: Deciding whether to use opioid medicines for pain

I will check off each item as I discuss it with my prescriber:

1.___ Pain and pain treatment are different for each person. Opioid medicines are a type of analgesic (pain reliever) medicine used to reduce moderate to severe pain. Opioid medicines can reduce some (but not all) types of pain. It is not known how much improvement in pain, activity and quality of life I may have by using these medicines. My prescriber will routinely check how I am doing to determine whether the benefits of opioid medicines outweigh the side effects of continuing to use them.

2.___ I hope opioid medicines may reduce pain, making it easier to:
___Go back to work ___Sleep through the night without pain
___Climb stairs ___Do daily household chores
___Walk short distances ___Start a light exercise program

3.___ My prescriber and I may also try alternative or additional treatment options for my condition, including:
___Non-opioid medicines (for example, over-the-counter medicines such as Tylenol®, Motrin®, Aleve® , prescription medicine such as antidepressants, or anticonvulsants, as appropriate)
___Physical therapy, appropriate exercises
___Acupuncture
___Self-management techniques and coping strategies such as meditation, stress reduction, counseling and coaching, massage therapy, social support group, and attention to proper sleep
___Surgical or other medical procedures

4. ___ I need to be aware of the following side effects of using opioid medicines.
___a) Physical dependence - If I suddenly stop taking an opioid medicine, I can experience withdrawal symptoms such as a runny nose, chills, body aches, diarrhea, sweating, nervousness, nausea, vomiting and trouble sleeping. This is called physical dependence. If this happens, it can be difficult for me to stop taking an opioid medicine, even if it's not working well. So, when I stop taking an opioid medicine, I understand I will need medical supervision. My prescriber can help me gradually lower

1

9. CDC Clinical Practice Guideline for Prescribing Opioids for Pain

CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022

Deborah Dowell, MD[1]; Kathleen R. Ragan, MSPH[1]; Christopher M. Jones, PharmD, DrPH[2]; Grant T. Baldwin, PhD[1]; Roger Chou, MD[3]

[1]Division of Overdose Prevention, National Center for Injury Prevention and Control, CDC; [2]Office of the Director, National Center for Injury Prevention and Control, CDC; [3]Pacific Northwest Evidence-based Practice Center and Oregon Health & Science University, Portland, Oregon

Summary

This guideline provides recommendations for clinicians providing pain care, including those prescribing opioids, for outpatients aged ≥18 years. It updates the CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016 (MMWR Recomm Rep 2016;65[No. RR-1]:1–49) *and includes recommendations for managing acute (duration of <1 month), subacute (duration of 1–3 months), and chronic (duration of >3 months) pain. The recommendations do not apply to pain related to sickle cell disease or cancer or to patients receiving palliative or end-of-life care. The guideline addresses the following four areas: 1) determining whether or not to initiate opioids for pain, 2) selecting opioids and determining opioid dosages, 3) deciding duration of initial opioid prescription and conducting follow-up, and 4) assessing risk and addressing potential harms of opioid use. CDC developed the guideline using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework. Recommendations are based on systematic reviews of the scientific evidence and reflect considerations of benefits and harms, patient and clinician values and preferences, and resource allocation. CDC obtained input from the Board of Scientific Counselors of the National Center for Injury Prevention and Control (a federally chartered advisory committee), the public, and peer reviewers. CDC recommends that persons with pain receive appropriate pain treatment, with careful consideration of the benefits and risks of all treatment options in the context of the patient's circumstances. Recommendations should not be applied as inflexible standards of care across patient populations. This clinical practice guideline is intended to improve communication between clinicians and patients about the benefits and risks of pain treatments, including opioid therapy; improve the effectiveness and safety of pain treatment; mitigate pain; improve function and quality of life for patients with pain; and reduce risks associated with opioid pain therapy, including opioid use disorder, overdose, and death.*

Introduction

Background

Pain is one of the most common reasons adults seek medical care in the United States (*1*). Acute pain, a nearly universal experience, is a physiologic response to noxious stimuli that can become pathologic. Acute pain is usually sudden in onset and time limited (defined in this clinical practice guideline as having a duration of <1 month) and often is caused by injury, trauma, or medical treatments such as surgery (*2,3*). Unresolved acute pain or subacute pain (defined in this clinical practice guideline as pain that has been present for 1–3 months) can evolve into chronic pain (*4*). Chronic pain typically lasts >3 months (*4*) and can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or unknown cause (*2*). Approximately one in five U.S. adults had chronic pain in 2019 and approximately one in 14 adults experienced "high-impact" chronic pain, defined as having pain on most days or every day during the past 3 months that limited life or work activities (*5*). Pain, especially chronic pain, can affect almost every aspect of a person's life, leading to impaired physical functioning, poor mental health, and reduced quality of life, and contributes to substantial morbidity each year (*6*). In 2011, the economic costs of chronic pain were estimated to range from $560 to $635 billion in annual direct medical costs, lost productivity, and disability (*2*).

Pain is a complex phenomenon influenced by multiple factors, including biologic, psychological, and social factors (*7*). This complexity means substantial heterogeneity exists in the effectiveness of various pain treatments, depending on the type of underlying pain or condition being treated (*7–11*). Patients might experience persistent pain that is not well controlled (*6*). Chronic pain often co-occurs with behavioral health conditions, including mental and substance use disorders (*12,13*). Patients with chronic pain also are at increased risk for suicidal ideation and behaviors (*14,15*). Data from death investigations in 18 states during 2003–2014 indicate that approximately 9% of suicide decedents had

Corresponding author: Division of Overdose Prevention, National Center for Injury Prevention and Control, CDC. Email: cdcinfo@cdc.gov.

10. Commonly Used Long-Acting Opioids Chart (NIDA)

Commonly Used Long-Acting Opioids

Compound	Strengths	Typical Starting Dose and Dosing Interval	Name Branding
Morphine controlled-release tablet	15, 30, 60, 100, 200 mg	15–30 mg every 8–12 hours	MS Contin® Oramorph® SR
Morphine controlled-release capsule	20, 30, 50, 60, 100 mg	20 mg every 12 or 24 hours	Kadian®
Morphine extended-release capsule	30, 60, 90, 120 mg	30 mg every day	Avinza®
Oxycodone controlled-release	10, 20, 40, 80 mg	10 mg every 12 hours	OxyContin®
Oxymorphone extended-release	5, 10, 20, 30, 40 mg	5 mg every 12 hours	Opana® ER
Hydromorphone extended-release	8, 12, 16 mg	8 mg once daily	Exalgo® ER
Fentanyl transdermal	25, 50, 75, 100 mcg/hr patch	25 mcg applied every 3 days	Duragesic®
Buprenorphine transdermal	5, 10, 20 mcg/hr patch	5 mcg applied every 7 days	Butrans®

11. How to Change Routes of Administration of Opioids (NIDA)

Adapted from:
Virtual Mentor
Online Ethics Journal of the American Medical Association
January 2003, Volume 5, Issue 1

Clinical Pearls: How to Change Routes of Administration of Opioids
By Audiey C. Kao, MD, PhD

Pain management is a critical competency in medicine especially when palliation, and not treating the underlying disease, is the physician's focus. Oftentimes physicians need to change the route of administration of opioid analgesics. For example, a patient may be unable to take oral medications, and may require pain medication parenterally. When changing routes of administration an equianalgesic table is a useful guide for dose selection.

Equianalgesic Doses of Opioid Analgesics

Oral/Rectal Dose (mg)	Analgesic	Parenteral Dose (mg)
100	Codeine	60
--	Fentanyl	0.1
15	Hydrocodone	--
4	Hydromorphone	1.5
2	Levorphanol	1
150	Meperidine	50
15	Morphine	5
10	Oxycodone	--

- To switch between routes of opioid administration use the equianalgesic information on the horizontal axis. For example, 150 mg meperidine orally per day is equivalent to receiving 50 mg of meperidine intravenously.
- To switch between opioids, use the information on the vertical axis. For example, 10 mg of oxycodone orally is equivalent to 50 mg of meperidine intravenously.
- Long term opiate use can lead to tolerance which requires increasing the dose of medication to achieve pain control. When switching between opioids, *there is the possibility of cross tolerance, which is usually incomplete.* A patient may have some tolerance to a new opiate as a result of being on a previous opiate. Therefore, experts suggest that you **begin the new opiate between 50 and 75 percent of the equianalgesic dose.**

Curriculum resource author note: methadone doses have been removed from the table in the original publication

12. Buprenorphine dosing algorithm for ED