7. UTILIZING THE PDMP

- Patient history of controlled substance prescriptions
- Prescription Data Monitoring Program (PDMP)
- Currently available in 49 states
- Prior/ongoing opioid prescriptions
- Dangerous combinations increasing overdose risk
Welcome to the Wisconsin Enhanced Prescription Drug Monitoring Program

The ePDMP is a new tool to help combat the ongoing prescription drug abuse epidemic in Wisconsin. By providing valuable information about controlled substance prescriptions that are dispensed in the state, it aids healthcare professionals in their prescribing and dispensing decisions. The ePDMP also fosters the ability of pharmacies, healthcare professionals, law enforcement agencies, and public health officials to work together to reduce the misuse, abuse, and diversion of prescribed controlled substance medications.

www.pdmp.wi.gov
This is a SECURE SITE operated by the State of Wisconsin, Department of Safety and Professional Services
Patient Query

First Name: sherloc
Last Name: 
Date of Birth: MM/DD/YYYY
Zip Code: Optional

States to Query: Wisconsin is searched by default.

Cancel  Submit
WI ePDMP training materials, pdmp.wi.gov
Law Enforcement Alerts Types:

- 🚨 ALERT
  Stolen Rx prescription

- 🚨 ALERT
  Overdose event

- 🚨 ALERT
  Suspected Violation

- 🚨 ALERT
  Overdose death

WI ePDMP training materials, pdmp.wi.gov
According to the CDC, calculating the total daily dose of opioids helps identify patients who may benefit from measures to reduce risk of overdose. Concurrent use of benzodiazepines and opioids can place an individual at an increased risk for severe respiratory distress that can lead to overdose death. On the chart below, the line indicates the patient's cumulative daily dose of opioids and the red shading indicates when the patient had concurrent opioid and benzodiazepine prescriptions.
<table>
<thead>
<tr>
<th>Drug Info</th>
<th>Drug Amt</th>
<th>Rx Dates</th>
<th>Prescriber</th>
<th>Dispenser</th>
<th>Patient</th>
<th>Patient Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fentanyl Citrate 100MCG/2ML</td>
<td>Qty: 5</td>
<td>Prescribed: 12/20/2016</td>
<td></td>
<td></td>
<td>HOLMES, SHERLOCK</td>
<td>1400 E WASHINGTON AVE MADISON WI, 53703 Pay Type: Private Pay</td>
</tr>
<tr>
<td>Solution Rx# TEST5</td>
<td>Days: 45</td>
<td>Dispensed: 12/21/2016</td>
<td></td>
<td></td>
<td>DOB: 1/6/1954</td>
<td></td>
</tr>
<tr>
<td>Pseudoephedrine HCl 30MG/</td>
<td>Qty: 100</td>
<td>Prescribed: 12/20/2016</td>
<td></td>
<td></td>
<td>HOLMES, SHERLOCK</td>
<td>1400 E WASHINGTON AVE MADISON WI, 53703 Pay Type: Private Pay</td>
</tr>
<tr>
<td>Tablet Rx# TEST6</td>
<td>Days: 30</td>
<td>Dispensed: 12/20/2016</td>
<td></td>
<td></td>
<td>DOB: 1/6/1954</td>
<td></td>
</tr>
<tr>
<td>Clonazepam 1MG/Tablet</td>
<td>Qty: 45</td>
<td>Prescribed: 12/12/2016</td>
<td></td>
<td></td>
<td>HOLMES, SHERLOCK</td>
<td>1400 E WASHINGTON AVE MADISON WI, 53703 Pay Type: Private Pay</td>
</tr>
<tr>
<td>Rx# TEST4</td>
<td>Days: 30</td>
<td>Dispensed: 12/18/2016</td>
<td></td>
<td></td>
<td>DOB: 1/6/1954</td>
<td></td>
</tr>
<tr>
<td>Drug Name</td>
<td>Prescriptions</td>
<td>Quantity Dispensed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>---------------</td>
<td>-------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HYDROCODONE/ACETAMINOPHEN</td>
<td>389,632</td>
<td>22,269,636</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DEXTROAMPHETAMINE/AMPHETAMINE</td>
<td>208,954</td>
<td>10,100,647</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>TRAMADOL HCL</td>
<td>198,362</td>
<td>15,095,871</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OXYCODONE HCL</td>
<td>190,063</td>
<td>16,472,754</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALPRAZOLAM</td>
<td>173,583</td>
<td>10,199,304</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LORAZEPAM</td>
<td>172,093</td>
<td>8,348,298</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLONAZEPAM</td>
<td>141,305</td>
<td>8,434,444</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OXYCODONE HCL/ACETAMINOPHEN</td>
<td>140,847</td>
<td>9,457,861</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ZOLPIDEM TARTRATE</td>
<td>139,336</td>
<td>4,615,915</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>METHYLPHENIDATE HCL</td>
<td>94,914</td>
<td>4,862,880</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LISDEXAMFETAMINE DIMESYLATE</td>
<td>73,736</td>
<td>2,337,536</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MORPHINE SULFATE</td>
<td>72,890</td>
<td>4,389,732</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIAZEPAM</td>
<td>67,557</td>
<td>2,969,951</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PREGABALIN</td>
<td>58,234</td>
<td>4,369,183</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACETAMINOPHEN WITH CODEINE</td>
<td>51,001</td>
<td>2,386,879</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Utilizing the PDMP

- Red flags:
  - Inconsistent use vs. prescribed
  - Multiple/overlapping prescriptions
  - Dramatic changes in dose
  - Frequent early refills
  - Concurrent opiate and benzo prescribing
Utilizing the PDMP: WI Act 266 (2015)

- **April 1, 2017**
- Before prescribing monitored drug
- Exceptions -
  - Hospice
  - 3 days or less prescribed
  - Drug administered directly
  - Emergency situation prevents review of PDMP
  - PDMP not operational, technical issue – must notify CSB
- Act 266 – opiate CME prior to license renewal
8. PAIN MANAGEMENT PRIOR TO SURGERY AFFECTS RESULTS

- Avoid opiates for chronic pain prior to surgery
- Preop opiate use:
  - Higher complication rates
  - More postoperative narcotics
  - Lower satisfaction rates after surgery
- Chronic dosing will not address acute postsurgical pain
- Pain will be perceived as more, but should not last longer
9. BEWARE OF BENZODIAZEPINES

- AVOID OPIATES + BENZOS
- 3x increase respiratory depression and annual mortality
- Neither demonstrates effectiveness more than 2 months
- Have patient chose, wean the other
- Concurrent use needs clearly documented rationale
- Similar effects with alcohol
Avoid Opiates + Benzos

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Increase annualized mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 morphine mg equivalents (MME)</td>
<td>880%</td>
</tr>
<tr>
<td>100 MME + benzodiazepines</td>
<td>2640%</td>
</tr>
<tr>
<td>200 MME</td>
<td>2400%</td>
</tr>
<tr>
<td>200 MME + benzodiazepines</td>
<td>7200%</td>
</tr>
</tbody>
</table>
10. AVOID OXYCODONE

- No more effective than other oral opioids
- More qualities that promote addiction to a greater degree
- 2x euphoria of equivalent doses of oral morphine, hydrocodone
- Harder to d/c treatment

Wightman et al, 2012
AVOID OXYCODONE

- More abused
- 16 million >12 yrs age – lifetime nonmedical use of oxycodone
- Illicit value $1/mg ($0.15/mg if acetaminophen added)
- Most frequently encountered pharmaceutical Rx by law enforcement
- 2x as potent as morphine

Natl Survey on Drug Use and Health, 2014
AVOID OXYCODONE

- Meta-analysis
- RCTs examining abuse liability
- 9 studies
- Oxycodone
  - High subjectiveness attractiveness
  - Increased reinforcing characteristics
  - Increased abuse liability profile
- Increased vs. oral morphine and oral hydrocodone

Wightman et al, 2012
AVOID OXYCODONE

- “the use of oxycodone is discouraged”
- Should not be considered first-line
- Indications
  - Intolerance of other opioids
  - Evaluated for increased risk of abuse

Zachy 2008, Schoedel 2011
11. OPTIMAL TREATMENT OF CHRONIC PAIN – FIRST EVALUATE

- Targeted history/examination – signs of abuse
- Nature/intensity of pain – baseline, challenge credibility
- Current/past treatment, response
- Co-existing diseases
- Effect of pain on function
- Substance abuse history (self and family)
- Psychiatric disorders – bipolar, ADHD, depression
- Medical indication for opioids documented
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.

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

drugabuse.gov
12. OPTIMAL TREATMENT OF CHRONIC PAIN – TRIAL OF OPIOIDS

- Initiation is a trial, NOT a commitment
- Objective goals – symptoms and function – prior to start
  - 30% improvement for success
- Agree on goals before treatment
- Not met after trial – wean/discontinue opioids
13. OPTIMAL TREATMENT OF CHRONIC PAIN – RISK/ BENEFIT

- Consider and start and with every refill
- Reassess risks/benefits
- Wean/discontinue with increased risk
- Risk of imminent danger or diverted – stop and treat for withdrawal
OPTIMAL TREATMENT OF CHRONIC PAIN – RISK/BENEFIT

- Exceptions to immediate cessation:
  - Unstable angina
  - Pregnancy
    - 1st trimester - miscarriage
    - 3rd trimester - preterm labor
OPTIMAL TREATMENT OF CHRONIC PAIN – Ongoing risk assessment

- Review of the Prescription Drug Monitoring Program
- Periodic urine drug testing - at least yearly
- Periodic pill counts - at least yearly
- Violation review
Opiate/Opioid Metabolism

- Codeine → Hydrocodone → Dihydrocodeine
- Heroin → 6-AM → Morphine → Hydromorphone
- Oxycodone → Oxymorphone
<table>
<thead>
<tr>
<th>Drug</th>
<th>Half-life (hr)</th>
<th>Metabolites</th>
<th>Concentrations above the cutoff will screen positive for</th>
</tr>
</thead>
<tbody>
<tr>
<td>morphine</td>
<td>1.5 - 6.5</td>
<td>normorphine, <strong>hydromorphone</strong> (&lt;2.5%)</td>
<td>Opiates</td>
</tr>
<tr>
<td>codeine</td>
<td>1 - 4</td>
<td>morphine, <strong>hydrocodone</strong> (&lt;11%), norcodeine</td>
<td>Opiates</td>
</tr>
<tr>
<td>oxycodone</td>
<td>4 - 12</td>
<td><strong>oxymorphone</strong>, noroxycodone</td>
<td>Oxycodone</td>
</tr>
<tr>
<td>oxymorphone</td>
<td>3 - 6</td>
<td>6-hydroxy-oxymorphone</td>
<td>Oxycodone</td>
</tr>
<tr>
<td>hydrocodone</td>
<td>3.5 - 9</td>
<td><strong>hydromorphone</strong>, norhydrocodone, <strong>dihydrocodeine</strong></td>
<td>Opiates</td>
</tr>
<tr>
<td>hydromorphone</td>
<td>3 - 9</td>
<td>hydromorphol</td>
<td>Opiates</td>
</tr>
</tbody>
</table>

* **bolded** metabolites are identical to pharmaceutically available drugs
# Urine Drug Screening

<table>
<thead>
<tr>
<th>Medication Used</th>
<th>Time detected in Urine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>48 hours</td>
</tr>
<tr>
<td>Heroin (detected as morphine)</td>
<td>48 hours</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>2-4 days</td>
</tr>
<tr>
<td>Methadone</td>
<td>3 days</td>
</tr>
<tr>
<td>Morphine</td>
<td>48-72 hours</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>2-4 days</td>
</tr>
</tbody>
</table>

Healthpartners.com
14. OPTIMAL TREATMENT OF CHRONIC PAIN – INFORMED CONSENT

- Adverse effects of treatment
  - Addiction
  - Overdose
  - Death
- Treatment agreement
  - Behaviors required of patient to keep them safe from adverse effects
15. INITIAL OPIOID TREATMENT - SHORT ACTING OPIOIDS

- Start low, go slow
- Titrate dose with short acting – acute and chronic
- Consider long acting as majority of dose
  - If stabilized on short acting
  - Chronic therapy
- No indication for extended release treatment for acute pain
16. INITIAL OPIOID TREATMENT – LOWEST EFFECTIVE DOSE

- Lowest effective dose, shortest duration
- Convert to morphine milligram equivalents (MME) for risk assessment
- 50 MME - additional precautions
- 90 MME - no evidence for higher doses
- Must have appropriate documentation to go higher
Opioid Dose Calculator

Web-based Opioid Dose Calculator now available - completely FREE!

Works on mobile devices such as smart phones and tablets, and on your PC and Mac!

To use the web-based Opioid Dose Calculator for use on your smart phone, tablet, PC, or Mac, click on the link below:

Web-based Opioid Dose Calculator

- No download needed!
- Enter doses in real time - the total MED will be instantly displayed.
- Supports the following mobile devices: iPhones, iPads, Android phones, Android tablets (iOS and Android platforms).
- Also works on most current web browsers (Explorer, Firefox, Safari, etc.) on your PC and Mac.
- To save for offline use, follow the instructions contained in the web-based calculator.
<table>
<thead>
<tr>
<th>Opioid (oral or transdermal):</th>
<th>mg per day:*</th>
<th>Morphine equivalents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Fentanyl transdermal (in mcg/hr)</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Methadone†</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Morphine</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>40</td>
<td>60</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Tapentadol</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Tramadol</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>60</strong></td>
<td></td>
</tr>
</tbody>
</table>
17. AVOID METHADONE

- Variable metabolism and sensitivity
- Days to steady state (accumulation)
- Drug interactions
- Stronger respiratory depressant
- Prolonged QTc effect
- Increased risk overdose and death
- Use only with extensive training/experience – MAT program
18. OPIOIDS AND ILLICIT DRUG USE

- Increase abuse, overdose, death
- Strongly discouraged
- Clear and compelling justification
19. INITIAL OPIOID TITRATION

- Re-evaluation 1-4 weeks
- Chronic therapy: 3 months or less
20. HOME NALOXONE

- Indications for use:
  - History of overdose (should be contraindication to prescribe)
  - Opioid dose > 50 MME/day
  - Clinical depression
  - Other measured risk (behaviors, family history, PDMP, UDS)
- 0.4 IM/intranasal, repeat if needed
- Can be prescribed to family members
- Available without prescription in Wisconsin
HOME NALOXONE

- Wisconsin Act 200 (2014)
- Standing naloxone order – trained WI Pharmacists
- Request by individual, family member, friend
- Screened by pharmacist, pharmacy tech
  - Chronic opioids > 3 months
  - Medication assisted treatment
  - 90 MME/day or higher
  - Medical comorbidities
21. THE RESPONSIBILITIES OF PRESCRIBING

- Must care for complications
- Assess for behaviors of opiate use disorder
- Assist with addiction treatment
  - Providing directly
  - Referring to treatment center
- Discharging a patient for opioid use disorder alone not acceptable
# DAST-10 Questionnaire

These questions refer to the past 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you used drugs other than those required for medical reasons?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2. Do you abuse more than one drug at a time?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>3. Are you always able to stop using drugs when you want to? (If never use drugs, answer “Yes.”)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>4. Have you had &quot;blackouts&quot; or &quot;flashbacks&quot; as a result of drug use?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>5. Do you ever feel bad or guilty about your drug use? If never use drugs, choose “No.”</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>6. Does your spouse (or parents) ever complain about your involvement with drugs?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>7. Have you neglected your family because of your use of drugs?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>8. Have you engaged in illegal activities in order to obtain drugs?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
22. DISCONTINUING TREATMENT

- Not effective:
  - Decrease 10% weekly
  - Discontinue at 5-10 MME

- Increased risk:
  - Decrease 25% weekly
  - Discontinue at 5-10 MME
  - Clonidine 0.2 mg oral twice daily
  - Tizanidine 2 mg oral three times daily

- Imminent risk of overdose, addiction, or diversion
  - Stop immediately, treat for withdrawal
POCKET GUIDE: TAPERING OPIOIDS FOR CHRONIC PAIN

Follow up regularly with patients to determine whether opioids are meeting treatment goals and whether opioids can be reduced to lower dosage or discontinued.

cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf
Opioid Taper Tips

- Who should taper?
  - Requests dose reduction
  - No meaningful improvement in pain/function (at least 30%)
  - > 50 MME with no benefit
  - Opioids with benzodiazepines
  - Signs of opiate use disorder
  - Early warning signs for overdose: confusion, sedation, slurred speech
Opioid Taper Tips

- Adjust the rate and duration of the taper based on response
  - Don’t reverse the taper
  - Pause or slow and treat withdrawal
- When reach smallest available dose
  - Extended interval between doses
  - Stop when taken less than once daily
- Address increased overdose risk if revert to original dose
<table>
<thead>
<tr>
<th>Symptom</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restlessness, sweating or</td>
<td>Clonidine 0.1-0.2 mg orally every 6 hours or transdermal patch 0.1-0.2 mg</td>
</tr>
<tr>
<td>tremors</td>
<td>weekly (If using the patch, oral medication may be needed for the first 72</td>
</tr>
<tr>
<td></td>
<td>hours during taper. Monitor for significant hypotension and anticholinergic</td>
</tr>
<tr>
<td></td>
<td>side effects.</td>
</tr>
<tr>
<td>Nausea</td>
<td>Anti-emetics such as ondansetron or prochlorperazine</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Loperamide or anti-spasmodics such as dicyclomine</td>
</tr>
<tr>
<td>Muscle pain, neuropathic</td>
<td>NSAIDs, gabapentin or muscle relaxants such as cyclobenzaprine, tizanidine</td>
</tr>
<tr>
<td>pain or myoclonus</td>
<td>or methocarbamol</td>
</tr>
<tr>
<td>Insomnia</td>
<td>Sedating antidepressants (e.g. nortriptyline 25 mg at bedtime or mirtazapine</td>
</tr>
<tr>
<td></td>
<td>15 mg at bedtime or trazadone 50 mg at bedtime). Do not use benzodiazepines</td>
</tr>
<tr>
<td></td>
<td>or sedative-hypnotics.</td>
</tr>
</tbody>
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GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

cdc.gov, Mar 2016
1. Non-opioid treatment preferred – chronic pain
2. Establish goals of treatment before starting
3. Review risks, benefits and responsibilities before starting
4. Initiate treatment with immediate release medication
5. Prescribe lowest effective dose
6. Acute pain – 3 days typical, 7 days max

cdc.gov, Mar 2016
7. Evaluate risk of opiate-related harms - start/periodically
8. Re-evaluate benefits and harms - 1-4 weeks, at least every 3 mos.
9. Utilize PDMP at start, at least every 3 mos.
10. Urine drug screen at start, at least annually
11. Avoid opiates and benzodiazepines
12. Offer or arrange evidence based treatment if opiate use disorder is diagnosed

cdc.gov, Mar 2016
CAN WE MAKE A DIFFERENCE?

- FLO RIDA
- 2010
  - Regulated pain clinics
  - No dispensing of prescription opioids from offices
  - Established PDMP
New laws and enforcement reverse trends in oxycodone prescribing and related deaths in Florida

- Oxycodone prescriptions fell by 24%
- Deaths fell by 52% after years of increases

MORE PROOF!

- **NEW YORK**
  - 2010: PDMP before prescribing opiates
  - 75% drop in patients with multiple prescribers

- **TENNESSEE**
  - 2012: PDMP before prescribing opiates
  - 36% decline in patients with multiple prescribers

- **OREGON**
  - Established PDMP, Medicaid pre-auth high-dose methadone, naloxone education and distribution, provider education
  - 38% decrease prescription opioid overdose
  - 58% decrease methadone overdose
THE OPIOID EPIDEMIC : WI

- Heroin, Opiate, Prevention and Education (HOPE) Agenda
  - John Nygren WI Assemblyman
  - 17 pieces of legislation
  - ID to pick up prescriptions (199), drug disposal programs (198), pilot programs for treatment for underserved populations (195)

legis.wisconsin.gov
Special considerations – our patients

- Reproductive plan review
- Risk of neonatal abstinence
- Pre-pregnancy consultation
  - Chronic pain
  - Maternal - Fetal Medicine
  - Neonatology
- Effective contraception
Conclusion

- The United States is currently experiencing an unprecedented crisis in opiate use disorders.
- Although there is no easy fix, we can contribute to the solution.
- Progress is made through responsible management of acute and chronic pain.
- Patient and provider education is key to optimal pain management while also minimizing unnecessary opiate prescribing.
References


References