Southern Oregon Opioid Prescriber Toolkit

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Jackson Care Connect

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Western Oregon Advanced Health

Regional CCO Collaborative For Safer Opioid Prescribing

Southern Oregon Opioid Prescriber Toolkit

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MYTH	VS	TRUTH
1 **Opioids are effective long-term treatments for chronic pain.**		While evidence supports short-term effectiveness of opioids, there is insufficient evidence that opioids control chronic pain effectively over the long term, and there is evidence that other treatments can be effective with less harm.
2 **There is no unsafe dose of opioids as long as opioids are titrated slowly.**		Daily opioids dosages close to or greater than 90 MED/day are associated with significant risks, and lower dosages are safer.
3 **The risk of addiction is minimal.**		Up to one quarter of patients receiving prescription opioids long term in a primary care setting struggles with addiction. Certain risk factors increase susceptibility to opioid-associated harms: history of overdose, history of substance use disorder, higher opioid dosages, or concurrent benzodiazepine use.

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This toolkit has been prepared through the collaborative efforts of all four Coordinated Care Organizations (CCOs) serving Southwestern Oregon.

Mission statement

The primary purpose of the Regional CCO Collaborative provider workgroup is to:

1. Implement opioid related benefit changes successfully at CCOs across the region.
2. Change prescribing practices through outreach, education, and resource delivery.
3. Support providers that are treating patients with pain.

ASSESS HARMS OF OPIOID THERAPY

Long-term opioid therapy can cause harms ranging in severity from constipation and nausea to opioid use disorder and overdose death. Certain factors can increase these risks, and it is important to assess and follow-up regularly to reduce potential harms.

1. **ASSESS.** Evaluate for factors that could increase your patient's risk for harm from opioid therapy such as:
   - Personal or family history of substance use disorder
   - Anxiety or depression
   - Pregnancy
   - Age 65 or older
   - COPD or other underlying respiratory conditions
   - Renal or hepatic insufficiency

2. **CHECK.** Consider urine drug testing for other prescription or illicit drugs and check your state's prescription drug monitoring program (PDMP) for:
   - Possible drug interactions (such as benzodiazepines)
   - High opioid dosage (≥50 MED/day)
   - Obtaining opioids from multiple providers

3. DISCUSS. Ask your patient about concerns and determine any harms they may be experiencing such as:
   - Nausea or constipation
   - Feeling sedated or confused
   - Breathing interruptions during sleep
   - Taking or craving more opioids than prescribed or difficulty controlling use

4. **OBSERVE.** Look for early warning signs for overdose risk such as:
   - Confusion
   - Sedation
   - Slurred speech
   - Abnormal gait

If harms outweigh any experienced benefits, work with your patient to reduce dose, or taper and discontinue opioids and optimize nonopioid approaches to pain management.

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How to approach an opioid taper/cessation

ISSUE	RECCOMENDED LENGTH OF TAPER	DEGREE OF SHARED DECISION MAKING ABOUT OPIOID TAPER	INTERVENTION/SETTING
Substance use disorder	No taper, immediate referral	None- provider choice alone	**Intervention:** *Detoxification* with medication assisted treatment (buprenorphine or methadone), Naloxone rescue kit **Setting:** Inpatient or Outpatient Buprenorphine (OBOT)
Diversion	No taper*	None- provider choice alone	Determine need based on actual use of opioids, if any.
At risk for immediate harms	Weeks to months	Moderate- provider led & patient views sought	**Intervention:** Supportive care, Naloxone rescue kit **Setting:** Outpatient taper **Option:** Buprenorphine (OBOT)
Therapeutic failure	Months	Moderate- provider led & patient views sought	**Intervention:** Supportive care, Naloxone rescue kit **Setting:** Outpatient taper **Option:** Buprenorphine (OBOT)
At risk for future hamrs	Months to years	Moderate- provider led & patient views sought	**Intervention:** Supportive care, Naloxone rescue kit **Setting:** Outpatient taper **Option:** Buprenorphine (OBOT)

** If diverting, then patient isn't taking opioid, taper not needed*

M. Weimer, DO

Key Concepts for Tapering Opioid Medications

Establish a Relationship

- A relationship with your patient is key to patient engagement and buy-in. Anecdotally, patients who reported a positive relationship with their provider and care team were more likely to engage in non-opioid and non-medication therapies for pain management. Please refer to "The Art of Difficult Conversations" document for techniques on developing a relationship with your patient.
- If a patient is new to you, or if you haven't prescribed their pain medications in the past, it may be appropriate to introduce the idea of tapering at the first visit and begin the actual taper at a follow-up visit.

Set Expectations

- Shared decision-making should occur, when possible. Please refer to "How to Approach an Opioid Taper/Cessation" for more information. Shared decision-making engages the patient, creates accountability for self-care, and allows the provider to determine or influence available choices.
- Discuss the possible symptoms of withdrawal patients may experience. Short term increases in pain are common during the tapering process. This is usually temporary and once a reduced baseline dose is achieved, patients are likely to report an improvement in their experience of pain. Other common withdrawal symptoms are listed below:

Symptoms of Opioid Withdrawal

Early Symptoms	Late Symptoms
› Agitation	› Abdominal cramping
› Anxiety	› Diarrhea
› Muscle aches	› Dilated pupils
› Increased tearing	› Goose bumps
› Insomnia	› Nausea
› Runny nose	› Vomiting
› Sweating	
› Yawning	

- Reframing the tapering scenario offers support, validation and hope to patients while tapering their medication. Some strategies to reframe the experience may be:
    - Ask your patient to keep a journal of their experience. This serves to track the progression of symptoms over time and creates an opportunity to support your patient through their experience. Review together at each visit and note when progress has been made (i.e. when symptoms begin to decline)
    - Normalize the experience of withdrawal symptoms through discussion. Explain "these symptoms are normal because it means your body is readjusting to the new dose, which means we are making progress and moving in the right direction" (share Phases of Withdrawal document)
- Set a goal and identify what is important to your patient. This can help keep patients goal-oriented and engaged in the tapering process. Goal setting can also be used to create a support network outside of the provider team, such as a close friend or family member.
- Maintain current prescribing best practices and processes throughout tapering process, including risk management strategies. This should include, but is not limited to, PDMP check and UDS screens.

Source: Pain Treatment Guidelines, Oregon Pain Guidance (OPG) May 2016

Key Concepts for Tapering Opioid Medications

Challenges Experienced When Tapering

- The slower the taper, the less short-term discomfort for the patient. Offering choices to the patient for tapering speed can help the patient manage their experience and engage in working towards the common goal: reducing risk while maintaining or improving function.
- With increased pain during taper there may be a temporary reduced level of functioning. However, patients should improve in their function and experience of pain as the taper progresses and their body adjusts.
- If patients are experiencing many adverse effects during the taper process, it is important to re-evaluate the increment of dose reduction and frequency of reduction. It may be appropriate to make smaller incremental changes or make changes less often (i.e. move every two week adjustments to every four weeks).
- Opioid Use Disorder (OUD) may become apparent during the tapering process. It is important for primary care clinicians to be able to offer or successfully connect patients to evidence-based treatment for this chronic condition. Please contact your local CCO for more information on community providers.
- It may be appropriate to "pause" a taper; however, doses should not be increased once a taper has begun. Increasing the dose after a patient has begun tapering is counterproductive to the goal of reducing risk and prolongs the patient's tapering experience.
- Withdrawal symptoms are common during tapering; however, duration and severity will likely vary from patient to patient depending on a host of factors. There are several non-controlled adjuvant medications that may be prescribed to attenuate these symptoms and support patients through their taper. The list below includes medications used to manage common withdrawal symptoms. Duration and dosing should be tailored to each patient.

OPIOID WITHDRAWAL ATTENUATION COCKTAIL

Acute Withdrawal

Clonidine 0.1mg QID x anticipated length of withdrawal. (Check BP and watch for hypotension.)

Diarrhea: Loperamide 4mg then 2mg QID. May have opioid effects at high doses.
Alternatively, consider Hycosamine 0.125mg q 4-6 hrs PRN

Myalgias: Ibuprofen 400mg po QID or Acetaminophen 325mg po Q6hrs

Anxiety: Hydroxyzine 25mg po TID

Insomnia: Trazodone 50-100mg po QHS

Nausea: Ondansetron 8mg po BID x anticipated length of withdrawal. (Check QTc)

Anticipated Withdrawal as a Part of a Planned Taper

Anxiety: Gabapentin Escalating Dose to 1200mg/day. Start loading one month prior to planned taper.

Clonidine 0.1mg QID x anticipated length of withdrawal. (Check BP and watch for hypotension.)

Diarrhea: Loperamide 4mg then 2mg QID

Myalgias: Ibuprofen 400mg po QID or Acetaminophen 325mg po Q6hrs

Anxiety: Hydroxyzine 25mg po TID

Insomnia: Trazodone 50-100mg po QHS

Nausea: Ondansetron 8mg po BID x anticipated length of withdrawal. (Check EKG for QTc interval)

Source: Pain Treatment Guidelines, Oregon Pain Guidance (OPG) May 2016

THE ART OF DIFFICULT CONVERSATIONS

It is common for the provider/healthcare team to experience challenging conversations with patients as safety guidelines in the area of chronic pain and prescription opioids are implemented. Some topics that may elicit fear in patients and therefore potential discord may include:

- Discussing controlled substance client/clinic agreements.
- Discussing community, state, and national guidelines for safe-prescribing practices.
- Informing new patients that opioids or other controlled substances will not be prescribed and/or increased.
- Informing patients that opioids will be discontinued and/or tapered.
- Discussing the dangers and side effects of the medication.

It is understandable and predictable for patients to express strong feelings when they are presented with information such as the need to reduce or eliminate opioids. Pain medications can become a patient's primary coping strategy for dealing with physical, emotional, psychological and post-traumatic pain. Delivering a message about reducing or stopping such medications can be triggering and even terrifying for a patient and the patient's family. In such situations, patient's emotions are commonly first expressed in the form of anger directed toward the prescribing provider and healthcare team. When facing a highly emotional patient, it is helpful to consider what may be underlying the strong emotional expression. Often underneath the heightened emotional response such as anger, there is fear, grief, panic, sadness, and/or a belief that living without prescription opioids is impossible. Being curious and understanding about what may be beneath a highly emotional expression does not mean one should not take action in the service of safety; however, treading lightly and following the recommendations below will make for a more positive outcome.

Value Identification

Prior to engaging in potentially challenging conversations, it is advisable to spend time reflecting on the core values and principles that you are upholding in the difficult conversation. For example, it may be in the service of practicing safe medicine, being in alignment with your colleagues, the medical board and/or community, state, and national safe opioid prescribing guidelines. When you are in alignment with your values and the healthcare team believes that the change is in the patient's best interest, the difficult conversations are often more manageable and rewarding.

Realistic Expectations

When asking a patient to do something they may be afraid to do or that they do not want to do, they may leave the appointment highly distressed, very angry, and/or inconsolably sad. It is common for providers and the healthcare team to feel that if a patient leaves in such a highly agitated way, this indicates that the outcome of the appointment was a failure. Reconsider this belief. When a provider or healthcare team member asks a patient to make a change that is guided by core principles and values and a belief that it is in the patient's best interest to make the change, then the state the patient is leaving in can be considered a natural part of the patient's therapeutic process, and a positive step toward the individual's overall health and well-being.

Willingness to Feel Uncomfortable

Difficult conversations often bring about discomfort for patients, their families, providers, and healthcare team members. When we model our willingness to be uncomfortable to our patients, it helps the process. Consider saying to yourself before engaging in such a conversation, "I am willing to be uncomfortable having this conversation because it is in the service of my value of safety and best-practice medicine." It can be helpful to notice your own sympathetic nervous system activation (e.g., rapid, shallow breathing; clenching fists or jaw), and then engage in an activity to activate your parasympathetic nervous system (e.g., slowing down your exhale and softening your hands or jaw). Just as these situations can be highly triggering for our patients, they can be highly triggering for providers and the healthcare team, as well. These conversations go much more smoothly when providers or healthcare team members can identify which types of patients and situations trigger them the most and develop an intervention strategy to notice the trigger and proceed calmly and effectively with delivering effective patient care.

Relationship as a Resource

It is important not to underestimate the relationship between the patient and the provider or healthcare team as a resource. Most patients genuinely care for their providers and/or healthcare team and want to work collaboratively with them. Often, genuinely communicating with patients that you will stick by their side through the changes can be one of the most powerful tools. Patients often fear their providers or healthcare team will abandon them, ask them to make changes too quickly, not listen to their fears, and or "fire" them from their practice. Proactively quashing such fears and acknowledging that the fear is real to them will go a long way toward reducing those fears.

Belief and Confidence

Expressing the belief in the patient's ability to make the change is one of the most valuable tools for creating positive clinical outcomes such as removing or reducing opioids. You may think the patient knows this; however, it is highly advisable to overtly tell the patient, even over multiple appointments, and even if it feels redundant or if you don't completely believe that your patient will be able to make such changes. Believing the patient can change is critical to the success of the process. Over time, as you see your patient making such changes and actually increasing functioning and quality of life, you will be more confident in your patient's abilities and it will be easier to relay your belief in them.

Resources

Difficult Conversations: Real life examples, Helpful Hints, and Tools - www.oregonpainguidance.org/clinical-tools
Motivational Interviewing Resources - www.motivationalinterviewing.org

Opioid Tapering Flow Sheet

START HERE

Consider opioid taper for patients with opioid MED > 90 mg/d or methadone > 30 mg/d, aberrant behaviors, significant behavioral/physical risks, lack of improvement in pain and function.

1. Frame the conversation around tapering as a safety issue.
2. Determine rate of taper based on degree of risk.
3. If multiple drugs involved, taper one at a time (e.g., start with opioids, follow with BZPs).
4. Set a date to begin and set a reasonable date for completion. Provide information to the patient and establish behavioral supports prior to instituting the taper. See OPG guidelines.

OPIOID TAPER

Opioids

Basic principle: For longer-acting drugs and a more stable patient, use slower taper. For shorter-acting drugs, less stable patient, use faster taper.

1. Use an MED calculator to help plan your tapering strategy. Methadone MED calculations increase exponentially as the dose increases, so methadone tapering is generally a slower process.
2. Long-acting opioid: Decrease total daily dose by 5–10% of initial dose per week.

   Short-acting opioids: Decrease total daily dose by 5–15% per week.
3. See patient frequently during process and stress behavioral supports. Consider UDS, pill counts, and PDMP to help determine adherence.
4. After ¼ to ½ of the dose has been reached, with a cooperative patient, you can slow the process down.
5. Consider adjuvant medications: antidepressants, gabapentin, NSAIDs, clonidine, anti-nausea, anti-diarrhea agents.

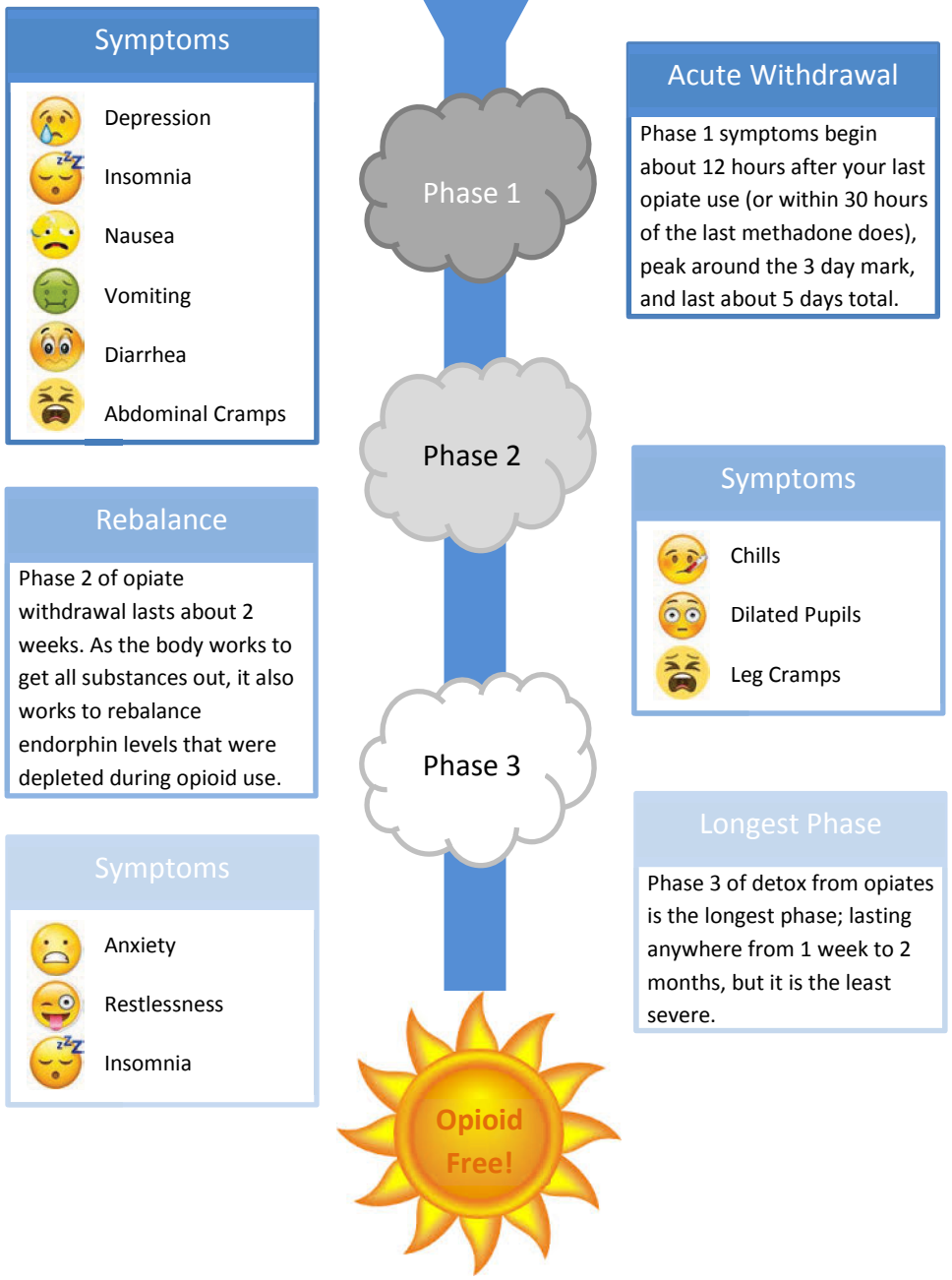
MED for Selected Opioids

Opioid	Approximate Equianalgesic Dose (oral and Transdermal)
Morphine (reference)	30mg
Codeine	200mg
Fentanyl transdermal	12.5mcg/hr
Hydrocodone	30mg
Hydromorphone	7.5mg
Methadone Chronic	4mg
Oxycodone	20mg
Oxymorphone	10mg
Tapentodol	75mg
Tramadol	300mg

Morphine Equivalent Dosing (MED) Calculator:
agencymeddirectors.wa.gov/mobile.html

Opiate Withdrawal

These are the 3 phases of withdrawal most people experience while detoxing from opiates.



What to expect when detoxing from opiates

Phase One

This is the phase right after you reduce your dose or stop taking the medications, about 12 to 30 hours after your last use. You can experience any of the following symptoms: depression, nausea, cramps, diarrhea, and insomnia. At this point, your body is reacting to the immediate absence of the drug it has become used to. It is the physical phase where you will go through most of the physical pain. This phase could last 5 days to a week. You should start to feel better as you move into phase two.

Phase Two

At this point, your body is going to start working out most of the toxins that you have built up over the time period of using the medication .The less time you have been on the drug and the less you have used, the easier this stage may be. Phase two can last about two weeks. As your body works to get rid of all the toxins, it also works to balance the natural substances in your body (endorphins) that were reduced while you used opiates. Symptoms that might be experienced at this phase include chills, sweating, goose bumps, dilated pupils, leg cramps, and restless leg syndrome.

Phase Three

This phase can be the most difficult for some people. Phase three is generally the longest, but people who have successfully tapered off of opiates say it is often the least severe phase. The symptoms here can be more psychological than physical but there will still be some physical pain and discomfort. Symptoms here might include anxiety, restlessness, and insomnia.

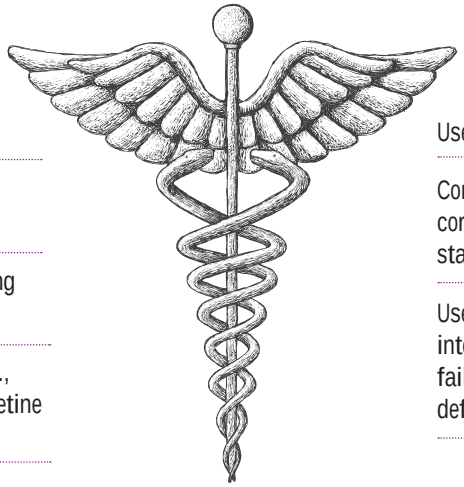
Adapted from https://addictionresource.com/drugs/morphine/withdrawal/

NONOPIOID TREATMENTS FOR CHRONIC PAIN

PRINCIPLES OF CHRONIC PAIN TREATMENT

Patients with pain should receive treatment that provides the greatest benefit. Opioids are not the first-line therapy for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. Evidence suggests that nonopioid treatments, including nonopioid medications and nonpharmacological therapies can provide relief to those suffering from chronic pain, and are safer. Effective approaches to chronic pain should:

- Use nonopioid therapies to the extent possible
- Identify and address co-existing mental health conditions (e.g., depression, anxiety, PTSD)
- Focus on functional goals and improvement, engaging patients actively in their pain management
- Use disease-specific treatments when available (e.g., triptans for migraines, gabapentin/pregabalin/duloxetine for neuropathic pain)



- Use first-line medication options preferentially
- Consider interventional therapies (e.g., corticosteroid injections) in patients who fail standard non-invasive therapies
- Use multimodal approaches, including interdisciplinary rehabilitation for patients who have failed standard treatments, have severe functional deficits, or psychosocial risk factors

NONOPIOID MEDICATIONS

MEDICATION	MAGNITUDE OF BENEFITS	HARMS	COMMENTS
Acetaminophen	Small	Hepatotoxic, particularly at higher doses	First-line analgesic, probably less effective than NSAIDs
NSAIDs	Small-moderate	Cardiac, GI, renal	First-line analgesic, COX-2 selective NSAIDs less GI toxicity
Gabapentin/pregabalin	Small-moderate	Sedation, dizziness, ataxia	First-line agent for neuropathic pain; pregabalin approved for fibromyalgia
Tricyclic antidepressants and serotonin/norephinephrine reuptake inhibitors	Small-moderate	TCAs have anticholinergic and cardiac toxicities; SNRIs safer and better tolerated	First-line for neuropathic pain; TCAs and SNRIs for fibromyalgia, TCAs for headaches
Topical agents (lidocaine, capsaicin, NSAIDs)	Small-moderate	Capsaicin initial flare/ burning, irritation of mucus membranes	Consider as alternative first-line, thought to be safer than systemic medications. Lidocaine for neuropathic pain, topical NSAIDs for localized osteoarthritis, topical capsaicin for musculoskeletal and neuropathic pain

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

CS263451 April 27, 2016

RECOMMENDED TREATMENTS FOR COMMON CHRONIC PAIN CONDITIONS

Low back pain

Self-care and education in all patients; advise patients to remain active and limit bedrest

Nonpharmacological treatments: Exercise, cognitive behavioral therapy, interdisciplinary rehabilitation

Medications

- First-line: acetaminophen, non-steroidal anti inflammatory drugs (NSAIDs)
- Second-line: Serotonin and norepinephrine reuptake inhibitors (SNRIs)/tricyclic antidepressants (TCAs)

Migraine

Preventive treatments

- Beta-blockers
- TCAs
- Antiseizure medications
- Calcium channel blockers
- Non-pharmacological treatments (Cognitive behavioral therapy, relaxation, biofeedback, exercise therapy)
- Avoid migraine triggers

Acute treatments

- Aspirin, acetaminophen, NSAIDs (may be combined with caffeine)
- Antinausea medication
- Triptans-migraine-specific

Neuropathic pain

Medications: TCAs, SNRIs, gabapentin/pregabalin, topical lidocaine

Osteoarthritis

Nonpharmacological treatments: Exercise, weight loss, patient education

Medications

- First-line: Acetamionphen, oral NSAIDs, topical NSAIDs
- Second-line: Intra-articular hyaluronic acid, capsaicin (limited number of intra-articular glucocorticoid injections if acetaminophen and NSAIDs insufficient)

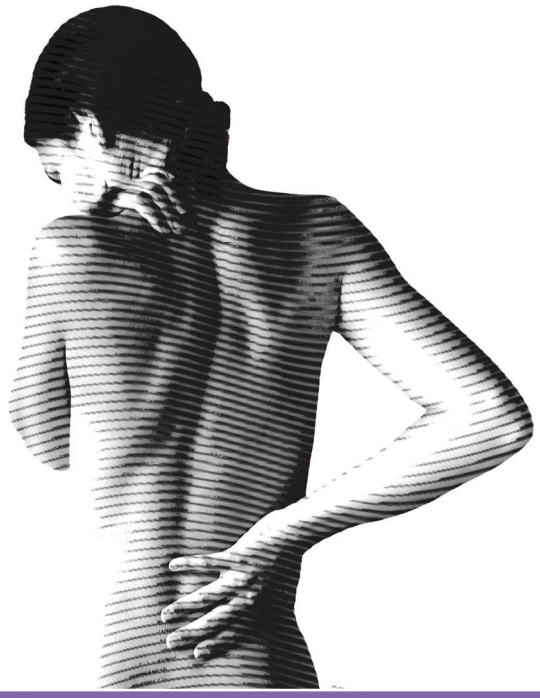
Fibromyalgia

Patient education: Address diagnosis, treatment, and the patient's role in treatment

Nonpharmacological treatments: Low-impact aerobic exercise (e.g., brisk walking, swimming, water aerobics, or bicycling), cognitive behavioral therapy, biofeedback, interdisciplinary rehabilitation

Medications

- FDA-approved: Pregabalin, duloxetine, milnacipran
- Other options: TCAs, gabapentin



Pain Management Modalities

	Service	Self-Referral And/or Prior Authorization	CCO Notes Based on coverage within OHP Prioritized List
Physical Health Benefits	Acupuncture	PA*	*AC- PA required *JCC- covered, No PA *PHJC-PA Required WOAH-Initial evaluation with contracted provider covered without PA. Must be referred by PCP
	Osteopathic Manipulation	SR, PA	AC- PA required JCC- covered diagnosis paired with CPT code PH- PA unless done by PCP WOAH-No auth if done by PCP. Initial evaluation with PCP referral covered, ongoing treatment needs PA from treating provider.
	Chiropractic	SR, PA	AC- PA required JCC-No PA for evaluation. PA required for treatment. PHJC-PA Required WOAH- PCP or back pain clinic referral required, PA for ongoing treatment
	Massage	PA	AC- May be accessible through rehab or chiropractic services. PA required JCC-Accessible through chiropractic services PHJC- May be accessible through rehab or chiropractic services. PA Required WOAH- May be accessible through PT or Back Pain Clinic
	Physical Therapy	PA	Hydrotherapy may be accessed through physical therapy or gym membership AC- PA required JCC- Evaluation and first visit covered without PA. Ongoing treatment requires PA. Evaluation and 5 visits (combined) for not covered diagnosis with PA. PH-Evaluation and first visit covered without PA. Ongoing treatment requires PA. WOAH-Initial evaluation covered without PA. PT will request PA for ongoing therapy.
	Occupational Therapy	PA	AC- PA required JCC- Evaluation and 5 visits (combined) for not covered diagnosis with PA. PH- Evaluation and first visit covered with no PA. Ongoing treatment requires PA. WOAH- Evaluation with no PA. OT will request PA for ongoing treatment.
	Nutrition Counseling	SR	AC-Accessible through dietician. No PA required for first 5 visits. JCC- available through YMCA program *PH- PA required *WOAH-RD available with PA. Classes through BAH Community Ed, Dietary support group (TOPS) through weight mgmt program
Mental Health and Addictions	Cognitive Behavioral Therapy/ Acceptance and Commitment Therapy	SR	AC- Please contact member's Mental Health Provider; Options (Josephine), JCMH (Jackson), Curry Community Health (Curry) JCC- Please contact behavioral health department at 503-416-3404 for authorization and coverage requirements PH-Accessible through Options or New Pathways Moving through Chronic Pain or through clinic-based behavioral health WOAH-CBT through Coos Health and Wellness; Curry residents through Curry Community Health
	Counseling (A&D or Mental Health)	SR	AC- A&D services through contracted Providers. MH services, please contact member's Mental Health Provider. No PA required JCC- Please contact behavioral health department at 503-416-3404 for authorization and coverage requirements PH-A&D services through Choices Counseling, MH through Options WOAH- Mental Health through Coos Health and Wellness; Substance use treatment through Adapt; Curry residents through Curry Community Health

Flexible Services	Self-Management Program	SR	Josephine County- New Pathways (CBT/Movement) All Counties- Living Well with Chronic Pain
	Exercise/ Yoga	SR, PA*	AC- YMCA, Private Health Clubs JCC-YMCA, no PA *PH-Flexible service request required for gym membership WOAH-Bay Area Hospital Community programs, health clubs participating in WOAH Weight Management program
Medication Benefits	**Medication** **(Rx required for coverage)**	**Formulary Or Non-formulary**	**CCO Notes** **Based on coverage within OHP Prioritized List and CCO formulary drug list**
	NSAIDs/Acetaminophen	F	
	Salon-Pas Patches	F*	*JCC-
	Anti-Convulsants, TCAs	F*	*Lyrica req PA
	Topical Analgesics	F*	*JCC-some topicals are NF

CCO Contact Information		
AllCare Health	Pharmacy Services AllCare Customer Service	(541) 471-4106
Jackson Care Connect	Rachel Vossen, Pharm.D. Autumn Chadbourne Provider Relations Specialist	(503) 416-3403 (503) 416-4705
Primary Health of Josephine County	Deana Floyd Pharmacy Services Chris Burnham Member Services, Authorizations	(541) 471-4208
Western Oregon Advanced Health	WOAH Pharmacy Services WOAH Customer Service	(541) 269-0388 (541) 269-7400

Key	
SR	Self-referral
PA	Prior Authorization
F	Formulary (covered medication)
NF	Non-formulary (not covered medication)
AC	AllCare Health
JCC	Jackson Care Connect
PH	Primary Health of Josephine County
WOAH	Western Oregon Advanced Health
PCP	Primary Care Provider

CCO Formulary Drug Lists:
AllCare: https://providers.allcarehealth.com/Formularies.aspx
Jackson Care Connect: http://www.jacksoncareconnect.org/for-providers/drug-list
Primary Health: http://www.primaryhealthjosephine.com/memberResources.html#fndtn-panel6
Western Oregon Advanced Health: http://www.woahcco.com/wp-content/uploads/2014/12/WOAH-Formulary-2016-Printable_Revision_ByClass.pdf

CCO Variances may exist-please contact the CCO for more information.

Last updated: 10/25/2016

OPIOID TAPERING AGREEMENT FOR CHRONIC, NON-CANCER PAIN

Patient Information	
Patient Name:	
Member ID:	
Date of Birth:	
Phone:	

Prescriber Information	
Prescriber Name:	
NPI:	
Office Phone:	
Office Fax:	

Provider review

1. This patient is currently being treated for active cancer related pain and taper is not indicated. ☐Yes ☐No
2. I have met with the patient and established a three month taper plan* to ≤90 MED. ☐Yes ☐No

   OR this patient was not able to taper to ≤90 MED and needs an additional 3 months to taper. ☐Yes ☐No
3. I have reviewed the Oregon Prescription Drug Monitoring Program database for this patient. ☐Yes ☐No
4. I have shared/created the taper plan with other opioid prescribers involved in patient's care. ☐Yes ☐No

***Please note: If no taper plan is received, member's coverage of opiates will be restricted per CCO policies.**

Opioid Tapering Plan (please contact our clinical pharmacists if you require additional assistance)

Short Acting:	
Current Daily Dose:	
Target Daily Dose:	

Long-Acting:	
Current Daily Dose:	
Target Daily Dose:	

Additional Notes:

Prescriber's Signature: Date:

Tapering Assistance and opioid related questions: CCO Clinical Pharmacist Contact Information

AllCare CCO: Mark Kantor, RPh	541-471-4106	(f) 541-471-4128
Jackson Care Connect: Rachel Vossen, PharmD	503-416-3403	(f) 503-416-1318
Primary Health: Bill Kennon, RPh	541-471-4208	(f) 541-956-5460
Western Oregon Advanced Health: Caryn Mickelson, PharmD	541-269-4558	(f) 541-269-7147

General opioid taper guidelines (adapted from resources below):

- Gradual tapers can often be completed anywhere in the range of 2 weeks to 6 months. Slower tapers may be necessary for patients who have been on high-dose opioids for longer periods.
- Do not reverse the taper; it must be unidirectional. The rate may be slowed or paused while monitoring for and managing withdrawal symptoms.
- The decision to first taper long or short acting opioids should be based on the type of pain the patient has (intermittent vs constant), their total daily dose of opioids, and patient preference.
- Start with a taper of ≤10% of the original dose per week and assess the patient's functional and pain status at each visit.
- During opioid tapers, we suggest that you see the patient every 2-4 weeks.
- Patients on fentanyl patches should be transitioned to a different long-acting opioid, then tapered according to the long-acting guideline. IMPORTANT: reduce dose to account for cross-tolerance.
- Multiple non-opioid medications are available to treat withdrawal symptoms (ie clonidine, anti-emetics).
- Tapering plan may be reassessed if pain/function deteriorate or withdrawal symptoms persist- if the dosing schedule needs to be adjusted, you will need to submit a taper plan modification.
- **Do not treat withdrawal symptoms with benzodiazepines or additional opioids.**

Opioid Alternative Pain Management Options

These are suggested alternatives and this is not an all-inclusive list. There may be specific authorization requirements or restrictions for alternative treatments. *If you have questions regarding specific opioid pain alternatives, please contact the CCO directly.*

- **Alternative medications:** NSAIDs, gabapentin, amitriptyline, nortriptyline, acetaminophen, topical agents.
- **Counseling:** Available to all patients for mental health, pain management, and alcohol and drug abuse.
- **Massage therapy:** *Subject to authorization requirements*
- **Physical/Occupational therapy:** *Subject to authorization requirements*
- **Chiropractic manipulation:** *Where available, Subject to authorization requirements*
- **Acupuncture:** *Where available, Subject to authorization requirements*

CCO variances may exist. Please refer to CCO information or contact the representative for more information.

Additional Resources:

- Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49.
- Tapering Opioids For Chronic Pain. http://www.cdc.gov/drugoverdose/prescribing/resources.html
- Interagency Guideline on Prescribing Opioids for Pain. Washington State Agency Medical Directors' Group. http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf
- Weimer, M et al. Guideline for Safe Chronic Opioid Therapy Prescribing for Patients with Chronic Non-Cancer Pain. http://www.ohsu.edu/gim/epiclinks/opioidresources/opioidguidelines.htm
- Pain Treatment Guidelines. Oregon Pain Guidance. http://professional.oregonpainguidance.org/wp-content/uploads/sites/2/2014/04/OPG_Guidelines_2016.pdf

References:

- Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49.
- Califf RM, Woodcock J, Ostroff S. A Proactive Response to Prescription Opioid Abuse. New England Journal of Medicine. February 4, 2016: Special Report. DOI: 10.1056/NEJMsr1601307
- Interagency Guideline on Prescribing Opioids for Pain. Washington State Agency Medical Directors' Group.
- Weimer, M et al. Guideline for Safe Chronic Opioid Therapy Prescribing for Patients with Chronic Non-Cancer Pain. OHSU. 2013
- Pain Treatment Guidelines. 2016. Oregon Pain Guidance.

Additional Resources:

CDC Guideline for Prescribing Opioids for Chronic Pain
http://www.cdc.gov/drugoverdose/prescribing/guideline.html

CDC Opioid Guideline Resources
http://www.cdc.gov/drugoverdose/prescribing/resources.html

Oregon Pain Guidance
http://professional.oregonpainguidance.org

OHSU Guideline for Safe Chronic Opioid Therapy Prescribing for Patients with Chronic Non-Cancer Pain
http://www.ohsu.edu/gim/epiclinks/opioidresources/opioidguidelines.htm

Turn the Tide Rx- the Surgeon General's call to end the opioid crisis.
http://turnthetiderx.org/

Opioids for Chronic Pain: JAMA Patient Page
http://jamanetwork.com/journals/jama/fullarticle/2503507

Oregon Prescription Drug Monitoring Program: Information, sign-up, and Provider Portal
http://www.orpdmp.com

Data Dashboard: Prescribing and Overdose Data for Oregon:
https://public.health.oregon.gov/PreventionWellness/SubstanceUse/Opioids/Pages/data.aspx

Regional CCO Collaborative For Safer Opioid Prescribing

AllCare Health
740 SE 7th St,
Grants Pass, OR 97526
888-460-0185
https://www.allcarehealth.com

Jackson Care Connect
33 N. Central Ave, Suite 320
Medford, OR 97501
855-722-8208
http://www.jacksoncareconnect.org/

Primary Health of Josephine County
1867 Williams Hwy, Ste 108
Grants Pass, OR 97527
800-471-0304
http://www.primaryhealthjosephine.org/

Western Oregon Advanced Health
290 South 4th Street
Coos Bay, OR 97420
800-264-0014
http://www.woahcco.com/