Frequently Asked Questions (FAQs)

DMHC OPIOID TRAINING

NAMM California
Part of OptumCare®

1. What is Vivitrol and how can it be used in Opioid treatment?

It is long acting injectable Naltrexone and is FDA approved for the prevention of relapse of opioid or alcohol dependence. It is administered deep IM on a once per month basis. For example, it can be used for someone who has confirmed heroin addiction and has failed a methadone treatment program.

2. What is the age category of Opioid overdose?

The highest rate of death from opioid overdose is between age 20 and 60. However, seniors are at risk of opioid overdose; especially considering their multiple comorbidities mood and increased risk of drug-drug interactions.

3. How do you calculate morphine milligram equivalents (MME) for total daily dose of opioids?

There is a MME Calculator app available on CDC website which you can easily download by visiting the CDC website at https://www.cdc.gov/drugoverdose/prescribing/app.html

4. Can pregnant women be detoxed?

Pregnant women with opioid use disorder have been treated with Methadone since the 1970s but now Buprenorphine is the treatment of choice as neonatal withdrawal syndrome is less severe. Medically assisted detoxification is not usually indicated as recidivism is higher than with MAT (Medically Assisted Treatment).

5. When must I consult CURES??

- The first time a patient is prescribed, ordered, administered, or furnished a controlled substance, unless one of the exemptions in the MBC website link below apply.
- Within the twenty-four hour period, or the previous business day, before prescribing, ordering, administering, or furnishing a controlled substance, unless one of the exemptions in the MBC website link below apply.
- Before subsequently prescribing a controlled substance, if previously exempt.
- At least once every four months if the controlled substance remains a part of the patient's treatment plan.

Follow this link to the Medical Board of California (MBC) website to see what exemptions are there to consulting CURES: https://www.mbc.ca.gov/Licensees/Prescribing/CURES/Mandatory_Use.aspx

6. Many of the patients are being managed by pain management, so do I have the legal obligation to check CURES every time they come in even if I don't write them the prescription?

It is the prescribing clinician's responsibility to check CURES as they are managing the patients. If you are not the prescriber then it would be reasonable to check CURES periodically (ideally every 4 months) so that you know what is going on with the patient in pain management.

7. Do drug treatment facilities have good outcomes?

It depends on how you define good outcomes. Drug dependency or addiction is a chronic disease that is relapsing by nature. Outcomes are improved when there is a longitudinal approach to care instead of episodic care. Currently, most treatment begins with a period of detoxification followed by intensive group therapy integrating a 12-step behavioral approach to recovery. The MAT approach when combined with a traditional behavioral treatment program decreases the relapse rate for opioid addicted patient.

8. Is it safer sometimes to send the patients to detox environment or can you gradually taper them off sustained release morphine preparations over period of time?

It is safer to detox an opioid dependent patient in the in-patient setting if they are physically or mentally unstable (have multiple comorbidities) or if they are at high risk of relapse.

9. How do you deal with patient on Soma and Meloxicam?

Patients who takes Soma (Carisoprodol) for muscle relaxation can abuse this drug. It has a similar effect on endorphin receptors as alcohol. It has been used traditionally in the treatment of acute muscle spasm but is probably not a very effective drug for chronic pain. There is no drug interaction between Soma and Meloxicam. The combination of Soma plus opioids increases the risk of opioids.

10. Why are patients in a methadone clinic not tapered off and always kept on the same dose?

Maintenance is the goal of both Methadone and Buprenorphine treatment strategies. Relapse on heroin or other illicit drugs are increased with trials of Methadone taper.

11. With regard to opioids and benzos as high risk; is it any dose of benzos that is a concern?

Patients who are on high doses of both opioids and benzodiazepine are at higher risk for sedation, respiratory depression and overdose death I recommend a slow taper of the benzodiazepine (first) in conjunction with a behavioral-cognitive approach to managing anxiety or insomnia.

12. What are the consequences for the provider who prescribes opioids and benzos?

By taking the following precautionary measures, you can significantly reduce the risk of facing any unfavorable consequences:

- ✓ utilizing the CURES report every four months
- ✓ having controlled substance abuse agreement signed by your patient
- ✓ performing urine drug screening either in your office and/or ordering in a laboratory
- ✓ identifying patients with opioid use disorder and tapering those that are appropriate
- ✓ working closely with your office staff, physical therapists, and clinical care partners to support this process

13. Is the Opioid Risk Tool (ORT) a sufficient Risk Assessment Tool?

Yes, it is a sufficient and validated risk assessment tool with 10 questions that assess the risk of abusing opioids.

14. How do you handle a patient on Norco and UDS shows presence of THC, or other illegal substance like cocaine?

If a patient is not being upfront and an illegal substance like cocaine comes out in a drug screen, then this is very likely someone with opioid use disorder and/or multi substance addiction. See **Question 24** for comments about THC in the urine drug screen.

15. Are there any recommended interdisciplinary pain programs that are available in the Riverside area?

Please reach out to your Pain specialist in your area to learn what resources and programs are available.

16. State of California requires all prescribers to complete 12 CME hours of pain management, since this lecture does not provide any CME credits, are there any resource lectures that do count for CME?

Please check with your specialty society for available resources that offer CME credits. You can also look for this information online on the California Medical Board website. Other sources for CME include programs sponsored by the American Society of Addiction Medicine and the PAIN week organization.

17. There is a lot of push back and resistance from patients when you try to adjust their medicine, and often times they refuse pain management putting a provider in a compromisable situation. What should you do when you encounter such situation?

Patient resistance to changing their opioid dose is usually founded on fear of increased pain and/or loss of control in their life. As clinicians, guiding a "forced" taper should be limited to those who have clear aberrant drug use or are experiencing medical complications from the opioids. It is recommended to reassure patients that the taper process is a joint, planned, interactive process with the goal to minimize discomfort and to improve quality of life. Few opiate dependent patients know that long term use of opioids increases their sensitivity to pain. Thus, one should engage the patient in the conversation of risks and benefits. You can also counsel that long-term use of opioids is also associated with increased risk of depression and memory loss. If a plan can still not be established, then a referral to an Addiction Medicine specialist is indicated.

18. Are opioids not good drugs for fibromyalgia?

Yes, opioids are not very effective for treating fibromyalgia.

19. Is Tramadol good alternative as a weak opioid?

No, it is not a good alternative for the management of chronic pain. Tramadol has the additional problem of increasing the seizure threshold and its efficacy is not greater than nonsteroidal anti-inflammatory agents.

20. Where we can get the contract for the patients to sign when using opioids?

There are several boilerplate contracts that can easily be found online. *(You can also refer to the resources links provided in the **Opioid Presentation** deck available on the Care Dojo site).*

21. What do we do with the 52 years old active heroin addict, who is also on chronic opioid treatment, and refuses to accept decreased doses?

The patient needs to be advised of their risks of continued use. They should be referred to the addiction medicine specialist or a medically supervised detoxification treatment program.

22. What does MAT stands for?

It stands for **Medication Assisted Treatment**. Methadone, Naltrexone, and Buprenorphine are all medication assisted treatments for opioid use disorder.

23. Can you calculate daily morphine equivalent dose in patients on Fentanyl patch?

A 100 mcg (0.1 mg) Fentanyl patch is equivalent to 30 mg of Morphine (oral), i.e. 30 MME. When switching opioids, it is safer to underestimate the equivalent opioid dose then increase based on the clinical response.

24. If patients are on opioids and test positive for marijuana, what should we do?

It is recommended you take a full substance abuse history. If the patient is determined to have opioid use disorder, then the presence of additional unexpected prescription or recreational drugs is problematic. Referral for treatment may be indicated. If the patient is at low risk, marijuana intake is limited and effective for treating patient symptoms, then the clinician may consider continuing opioids with this in mind. The Controlled Substances Agreement should be amended to reflect this change. Laws in your state about recreational use of Marijuana apply.

25. Is higher dose gabapentin useful in tapering patient off of opioids?

Gabapentin is not effective for tapering off of opioids. It can be helpful for the treatment of neuropathic pain. The FDA has recently issued a warning about the concurrent use of gabapentinoids combined with opioids causing respiratory depression, especially in the elderly or patients with respiratory comorbidities.

26. Are we obligated to continue narcotics while waiting for records if abuse is suspected?

If you suspect opioid abuse you are not required to prescribe opioids. In this case you should get a records release from the patient for the prior prescriber, check the CURES report, consider doing a Urine Drug Screen in office, and take a substance abuse history before prescribing opioids.

27. Do you need to have a printed copy of CURES in the chart for every 3 months?

You should always have the CURES report to review every 4 months. Your staff can scan the document into your electronic health record.

28. Will CBD prescription use enter our practice?

We don't have much data about the efficacy of CBD for treatment of acute or chronic pain.

29. What if patients have a negative urine test, but they are on Hydrocodone?

Verify with the patient how often they are taking their medication and how often they miss their dose. Finally ask when their last dose was. If they claim adherence to their medication, then you can suspect they are diverting their medication. This could be an indication to immediately stop the medication. The Controlled Substances Agreement has been violated.

30. What are urine metabolites of Hydrocodone?

A urine metabolite of Hydrocodone is Hydromorphone and might suggest a False Positive test. The presence of Hydromorphone in a urine drug screen, could also represent an unexpected result especially if the concentration is relatively high compared to Hydrocodone.

31. What if patient violates pain contract or has failed urine test?

It depends on the patient. If a patient has a high risk of opioid use disorder and fail the urine test then a referral to addiction medicine and/or treatment program may be indicated. The patient can also be referred to Pain Management or Addiction Medicine. You could facilitate a pain medicine or addiction specialist appointment and prescribe enough opioids to get to that appointment date. Note that some unexpected urine test results may be explained for reasons other than aberrant use.

32. If a colleague who signed the original controlled substance pain management agreement leaves the practice, do you absolutely have to establish another agreement signed by the new physician assuming care? What should be the standard protocol in our practice?

Assuming the leaving colleague was a part of your practice, it is recommended you at least review the controlled substances agreement with the patient. You could also have the patient sign a new agreement. This will decrease the chances of agreement violations as some patients have little understanding of the details. Make sure the patient has a signed copy of the agreement for their use.

33. Patient on Norco and testing positive for other narcotics meds, what is the practice obligation to fill the meds?

Recall that Hydromorphone is a metabolite of Hydrocodone and quantify the concentrations of both compounds. An expected result would be a high concentration of Hydrocodone and a lower concentration of Hydromorphone. There is no obligation, per se, to continue prescribing opioids, but there are risks of not providing enough medication to get the patient into a program or another provider. These risks include: precipitating opioid withdrawal, disruption of the doctor-patient relationship, patient looking to other riskier sources of opioids (Heroin, Fentanyl, or other prescription opioids) and their associated risk of overdose.

34. Can we copy the cure results into plan column of visit notes instead of scanning in the chart?

It is recommended you keep the CURES report separate from your visit notes. It is a best practice to keep them in the confidential document section of the chart. It is easy to find and easy to compare to prior CURES reports.