

OKLAHOMA OPIOID PRESCRIBING GUIDELINES

Note: These guidelines do not replace clinical judgment in the appropriate care of patients. They are not intended as standards of care or as templates for legislation, nor are they meant for patients in palliative care programs or with cancer pain. The recommendations are an educational tool based on the expert opinion of numerous physicians and other health care providers, medical/nursing boards, mental and public health officials, and law enforcement personnel in Oklahoma and throughout the United States.^{1, 2, 3}

Opioid Treatment for Acute Pain

1. Health care providers are encouraged to consider non-pharmacological therapies and/or non-opioid pain medications. Opioids should only be used for treatment of acute pain when the severity of the pain warrants that choice.
2. By Oklahoma law, it is mandatory that providers check the Oklahoma Prescription Monitoring Program (PMP) prior to prescribing and every 180 days prior to authorizing refills for opiates, synthetic opiates, semi-synthetic opiates, benzodiazepines, or carisoprodol. More frequent checks of the PMP are recommended.
3. When opioids are started, providers should prescribe the lowest possible effective dose. Prescribe no more than a short course; most patients require opioids for no more than three days.
4. Avoid prescribing opioids to patients currently taking benzodiazepines and/or other opioids.
5. Patients should be counseled to store medications securely, never to share them with others, and to dispose of medications when the pain has resolved.
6. Long-acting or extended-release opioids should not be prescribed for acute pain.
7. Providers should provide screening, brief intervention, and referral to treatment, if indicated.
8. Continued opioid use should be evaluated carefully, including assessing the potential for abuse, if pain persists beyond the anticipated period of acute pain.
9. In general, health care providers should not provide replacement prescriptions for opioids that have been lost, stolen, or destroyed.

Opioid Treatment for Chronic Pain

1. Alternatives to opioid treatment should be tried, or previous attempts documented, before initiating opioid treatment for chronic pain.
2. By Oklahoma law, it is mandatory that providers check the Oklahoma Prescription Monitoring Program (PMP) prior to prescribing and every 180 days prior to authorizing refills for opiates, synthetic opiates, semi-synthetic opiates, benzodiazepines, or carisoprodol. More frequent checks of the PMP are recommended.
3. A comprehensive evaluation should be performed before initiating opioid treatment for chronic pain.
4. The health care provider should screen for risk of abuse or addiction before initiating opioid treatment.
5. Patients should be counseled to store medications securely, never to share them with others, and to dispose of medications when pain has resolved.
6. Long-acting or extended-release opioids are associated with an increased risk of overdose death, and should only be prescribed by health care providers familiar with their indications, risks, and need for careful monitoring.
7. A written treatment plan should be established that includes measurable goals for reduction of pain and improvement of function.

8. The patient should be informed of the risks, benefits, and terms for continuation of opioid treatment, ideally using a written and signed treatment agreement. Consider co-prescribing naloxone for patients with increased risk of opioid overdose.
9. Opioids should be initiated as a short-term trial to assess the effects of opioid treatment on pain intensity, function, and quality of life. The trial should begin with a short-acting opioid medication.
10. During the titration period, regular visits for evaluation of progress toward goals should be scheduled and the PMP should be checked more frequently.
11. Continuing opioid treatment should be a deliberate decision that takes into consideration the risks and benefits of chronic opioid treatment for that patient. Patients and health care providers should periodically reassess the need for continued opioid treatment, weaning whenever possible. A second opinion or consultation may be useful in making that decision.
12. Opioid treatment should be tapered or gradually discontinued if adverse effects outweigh benefits or if aberrant, dangerous, or illegal behaviors are demonstrated. Care should be taken when tapering opioid treatment, particularly in patients on higher dosages, the elderly, and patients who are pregnant. Abrupt discontinuation of opioids should be avoided.
13. Health care providers should consider consultation for patients with complex pain conditions, serious co-morbidities, mental illness, or a history or evidence of current drug addiction or abuse.
14. In general, health care providers should not provide replacement prescriptions for opioids that have been lost, stolen, or destroyed.
15. Health care providers should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.



Oklahoma Society of Interventional Pain Physicians | Oklahoma Board of Nursing

Resources

1. **Centers for Disease Control and Prevention. (2016).** *CDC Guideline for Prescribing Opioids for Chronic Pain.* Retrieved from <https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>. Accessed July 8, 2016.
2. **Oklahoma State Department of Health. (2013).** *Oklahoma Emergency Department (ED) and Urgent Care Clinic (UCC) Opioid Prescribing Guidelines.* Retrieved from https://www.ok.gov/health2/documents/UP_Oklahoma_ED-UCC_Guidelines.pdf. Accessed July 8, 2016.
3. **Oklahoma State Department of Health. (2014).** *Opioid Prescribing Guidelines for Oklahoma Health Care Providers in the Office-Based Setting.* Retrieved from https://www.ok.gov/health2/documents/UP_Oklahoma_Office_Based_Guidelines.pdf. Accessed July 8, 2016.

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