
Identifying Patients:

1. Determine if patient is experiencing chronic or acute pain and establish a diagnosis supported by diagnostic studies. If patient is experiencing acute pain, refer to the Safe Prescribing for Acute Pain Toolkit.
2. Review medical history, including records from previous providers before prescribing (Check CURES prior to prescribing Schedule II-IV medications and every four months thereafter as long as the medication is part of the patients’ treatment).
3. Determine if patient is exhibiting signs of Opioid Use Disorder (OUD). Use these Tips for Assessing for Opioid Use Disorder to help.
4. Assess patient’s risk of future opioid misuse or abuse using validated screening tools such as DIRE or SBIRT.
5. Have patient fill out a pre-visit questionnaire to identify changes in functional or behavioral factors that would affect the treatment plan.

Once you have identified the patient’s pain management status, review the relevant best practices below.

Statement on Co-prescribing Naloxone: Co-prescribing Naloxone is strongly recommended with any opioid prescription to prevent opioid overdose and begin a conversation with patients regarding the risks involved in opioid therapy.

Under California law, as of 2019 prescribers are required to offer naloxone to patients considered to be at high risk of overdose including patients on 90 Morphine Milligram Equivalent (MME) per day, patients prescribed benzodiazepines along with opioids, and patients that present to prescribers as having an increased risk of overdose. Prescribers are also required to provide education on overdose prevention and the use of naloxone for the treatment of OUD.

If your patient has or may have Opioid Use Disorder...

- Utilize communication strategies to avoid the stigmatizing language strongly associated with Opioid Use Disorder.
- Evaluate the risks and benefits of continued chronic opioid treatment.
- Strongly consider treatment for OUD that includes Medication Assisted Treatment (MAT).
- Educate patient on the evidence supporting short-term and long-term benefits of tapering off opioids and transitioning to non-opioid pain management alternatives.
- Refer patients with OUD for MAT when necessary:
  - The Alameda and Contra Costa County MAT Induction Resource List can help you find places to send patients for Buprenorphine Induction. The Buprenorphine Treatment Practitioner Locator can help you find individual x-waivered clinicians.
  - The UCSF Clinician Consultation Center operates a Substance Use Warmline which offers free and confidential clinician-to-clinician telephone consultation focusing on substance use evaluation and management for primary care clinicians.
- For assistance with referring patients for MAT, you may also call your county substance use helpline. Alameda County: 1-844-682-7215; Contra Costa County: 1-800-846-1652.
- Educate patients on the merits of MAT for the treatment of OUD.
- Co-prescribing Naloxone is particularly important to consider for patients with OUD due to their increased risk of overdose.

If patient is already engaged in long-term opioid pain reduction therapy...

- Assess functional improvements on opioids (with a validated tool such as PEG), and compare results to baseline function and pain.
- Use patient communication strategies to avoid stigmatizing language, and more effectively discuss transitioning to non-opioid alternatives.
- Educate patient on the evidence supporting short-term and long-term benefits of tapering off opioids and transitioning to non-opioid pain management alternatives.
- Continue co-prescribing Naloxone with any long-term opioid prescription.
- Consider using Patient Agreement contracts as a tool to discuss risks and responsibilities of continued opioid therapy.
- Consider periodic urine toxicology monitoring to assess for adherence to prescribed medications and for other substance use at least yearly.
- Continually reassess for worrisome behaviors and side effects.
- Track conditions that increase risks of opioid therapy such as age, cognitive status, respiratory status, other prescriptions, and personal/family history of addiction.
- Be aware of Medical Board of California and Centers for Disease Control guidelines on high-risk MME dosages and evaluate risks and benefits of continuing opioid therapy at greater than 50 MME per day.
- Use extreme caution with concomitant prescription of opioids with benzodiazepines

Prior to considering initiating long-term opioid therapy...

- Perform a physical exam to derive baseline function and pain.
- Educate patients on the evidence supporting the benefits of using non-pharmacological pain management alternatives.
- Be aware that clinical trials show that opioids are not more effective in controlling chronic pain than non-opioid modalities.
- Create a plan of treatment with the patient that incorporates non-opioid interventions as much as possible.
- Consider starting with a few days’ supply while documenting, then bring patient back for in-depth discussion and history review at follow-up appointment.
- Consider using Patient Agreement contracts as a tool to discuss risks and responsibilities of opioid therapy.
- Track conditions that increase risks of opioid therapy such as age, cognitive status, respiratory status, and other prescriptions.
- Discuss an opioid therapy exit plan with patients.
- Conduct a urine toxicology screen prior to initiating opioid therapy.
- If prescribing opioids, use the lowest possible dose and work to reduce the dose prescribed.

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Important Information for all Clinicians:

- Effective October 2, 2018, physicians are required to consult the CURES database (California’s Prescription Drug Monitoring Database [PDMD]) prior to prescribing Schedule II, III, or IV controlled substances to a patient for the first time and at least once every four months thereafter if that substance remains part of the patient’s treatment.
  - CURES Mandatory Use Reference Sheet
  - CURES Advisory Memo
- CDC Checklist (MME thresholds are to be considered general guidelines. Each patient's treatment should be individualized)

March 2019. The information in this document is current as of publication. Please consult the Medical Board of California or your local medical society for information on current laws and policies.