St. Vincent's Health East
Birmingham, Alabama
October 2, 2018

Safe Use of Opioids

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Where discoveries are delivered.℠

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Goals

1. Review use of Opioids
2. Review Opioid Epidemic
3. Review Opioid Guidelines and Mandates

Disclosures

P & T Committee Optium RX

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The US treats pain with opioids

- > 1 in 3 adults in US took an opioid in 2015 National Institute on Drug Abuse 2017
  ≈ 50% non-cancer pain ≈ 30% for post op pain ≈ 20% cancer GBI Research Opioids to Market 2017
- US prescribed 70% of the world's supply of opioids in 2014
  - 99% of hydrocodone
  - 51% of morphine
  - 73% of oxycodone
  - 53% hydromorphone

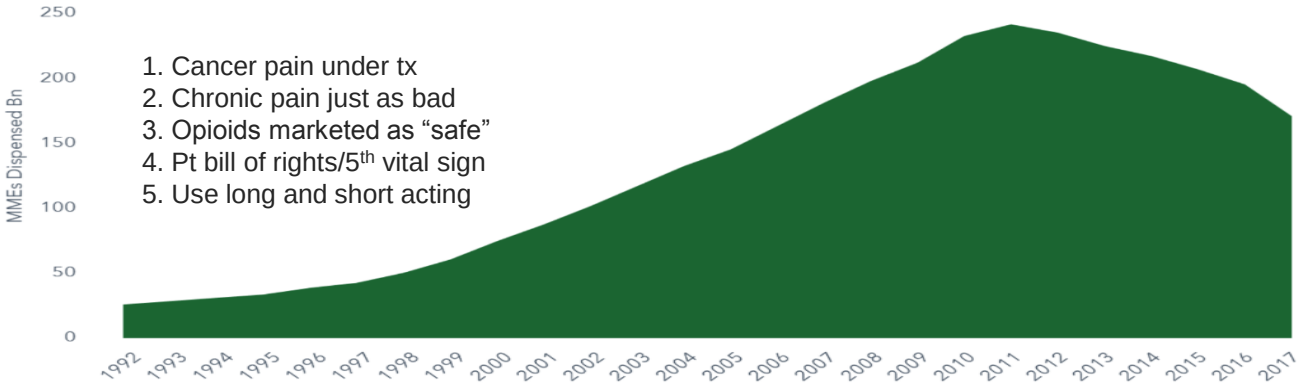
  International Narcotics Control Board. Statistical information on narcotic drugs 2011
- 4x higher than in Europe in 2015
- AL highest in the nation CDC 2016
- AL 4th and 1st Congressional District Ranked 1st and 5th in US American Journal of Public Health July 2018

  (166 prescriptions per 100 people)

1. WA sets soft limit
2. DEA makes hydrocodone Schedule II
3. CDC guidelines
4. States and Insures establish opioid restrictions
5. ? Federal response

1. Cancer pain under tx
2. Chronic pain just as bad
3. Opioids marketed as "safe"
4. Pt bill of rights/5th vital sign
5. Use long and short acting

Prescription opioid volume peaked in 2011 at 240 billion milligrams of morphine equivalents and have declined by 29% to 171 billion



Source: IQVIA "SMART – Launch Edition", Dec 2017

Chart notes: Prescription counts are adjusted for length of prescriptions and re-aggregated. Prescriptions referred to as 90-day are calculated based on transactions with 84 days supply or more to include medicines with up to one week fewer treatment days. Prescriptions for 84 days supply or more or factored by three, and those under 84 days unchanged.

Report: Medicine Use and Spending in the U.S.: A Review of 2017 and Outlook to 2022, Apr 2018

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How effective are opioids

- Evidence supports only short-term use for any kind of pain
- Effective for acute pain (?) end of life
- ↑ cardiovascular events, endocrine abnormalities, fx, sleep disorders, cognitive impairment, immune suppression, hyperalgesia and tolerance
- ↑ risk in pts with mental health issues and advanced dz
- Pts taking opioids have worse pain, higher health care utilization, and lower activity JPain 2006; 7:281-289 Pain 2006;125:172-179
- Recovery rate from industrial injury 4x greater in individuals not using opioids Clin J Pain 2010; 26:763-769
- **1 in 550** die a median of 2.6 years after 1st opioid prescription Frieden and Houry, NEJM, 2016
- **1 in 32** die when dose > 200 MME Frieden and Houry, NEJM, 2016
- Gateway drug to illicit drugs

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How have opioids affected health care?

- 72,000 overdoses in US 40% are prescription opioids
- 20% of the decline of males in the labor force due to opioid abuse Brookings Paper on Economic Activity 2017
- > 115 die in US daily from opioid overdoses NCHS Data Brief 2017
- > 50% prescription opioids are used by pts with mental health disorders *J Am Board Fam Med*. 2017
- ≈ 500 start heroin use each day and within 12 m ≈ 40% of new heroin users have become dependent on heroin JAMA Psychiatry 2018
- 24% of medication-related malpractice claims involved opioids (5% of prescriptions)
- 15% of claims, the physician "behaved in an inappropriate way”
- Retrospective review (2006 to 2015) “showed that a physician gave no explanation at all for writing an opioid prescription in 29% of the cases.”
  Annals of Internal Medicine Sept 2018

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Opioids and Surgery

Opioids worsen long term outcome after spine surgery Spine, 2018

- 425 pts
- 44% reported preop opioid use
- Compared to non-opioid users, preoperative use resulted in increased LOS, longer ICU stays, increased risk of daily opioid use, and greater disability 2 years later

Assc of Opioid-Related Adverse Drug Events Among Surgical Pts JAMA Surgery 2018

- 21 acute care hospitals 135, 379 patients
- 14 386 (10.6%) ORADEs
- Surgical and endoscopic procedures from 2013 - 2015
- Risks: older, male, white, and sicker
- Assc with significantly worse clinical and cost outcomes

inpt mortality, discharge to another care facility, prolonged stay, high cost of hospitalization, and 30-day readmission

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Preoperative Opioid Use Is Associated with Higher Readmission and Revision Rates in Total Knee and Total Hip Arthroplasty JBJS July 18

- Assc of preoperative opioid use with 30-d readmission/ early revision rates
- 324,154 patients
- Opioid-naïve TKA patients lower revision rate than did those with >60 days of preoperative opioid use (1-year 1.07% vs 2.14%; 3-year 2.58% vs 5.00%)
- Opioid-naïve THA patients (1-year: 0.38% vs 1.10%;3-year: 1.24% vs 2.99%)
- 30-day readmission rate after TKA or THA was significantly lower for patients with no preoperative opioid use compared with those with >60 days of preoperative opioid use (TKA: 4.82% vs 6.17%; THA: 3.71% vs 5.85%)

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Opioids worsen outcome after orthopedic surgery Cozowicz C et al. Pain, 2018

- 1,035,578 lower joint arthroplasties, 220,953 spine fusions.
- Compared to lower quartile opioid dose, high dose associated with increase odds of DVT (50%), postoperative infection (50%), urinary complications (23%), GI and respiratory complications (15%), increased length of stay (12%), costs (6%)

- Preop COT is a risk factor for complications, readmission, adverse events, and increased costs after one- or two-level PLF Spine 2018
- Filling opioid prescriptions prior to ACL surgery were 10x more likely to be filling prescriptions 5 m after surgery American Orthopaedic Society for Sports Medicine 2017
- Patients who used opioids prior to TKA obtained less pain relief from the operation JBJS 2017

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Increased Rates of New Persistent Opioid Use After Minor and Major Surgery JAMA Surg.2017

- 36,177 US adults: 1 of 13 common elective surgical procedures categorized as either minor or major
- The 2 groups showed similar rates of new persistent opioid use (5.9% in the minor group vs 6.5% in the major group)
- “Persistent opioid use may be less associated with **postsurgical pain** than addressable patient-level factors”
- Risk factors: preoperative pain and mood disorders, substance abuse, and preoperative tobacco use

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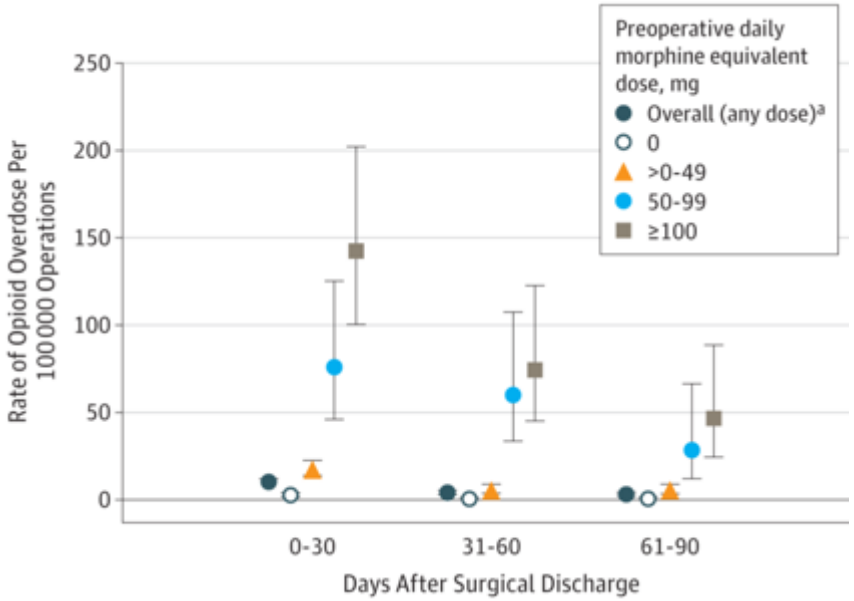
Prescription Opioid Analgesics Commonly Unused After Surgery A Systematic Review AMA Surg. August 2017

- Review of 6 studies, 810 pts orthopedic, thoracic, obstetric, and general surgical procedures
- 67% to 92% of pts reported unused opioids
- 42% to 71% opioid tablets unused
- Most pts stopped due to adequate pain control
- 16% to 29% opioid-induced adverse effects
- 73% to 77% reported opioids were not stored in locked containers
- All studies reported low rates of anticipated or actual disposal



JAMA. 2018;320(5):502-504.

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Post-Surgical Pain Management Guidelines

Johns Hopkins Post-Surgical Pain

https://www.solvethecrisis.org/best-practices

- ***Microdiscectomy (one level)***
- ***Preop*** 1g PO Acetaminophen / 300 mg PO Gabapentin ***Intraop:*** IV Ketorolac 15-30 mg one time (at conclusion of surgery)
-
- ***Postop inpatient if admitted***
- ***Inpatient postop standing orders:***
- Acetaminophen 1g PO q8hrs, Ketorolac 15-30 mg IV q6-8 hrs. Or Ibuprofen (NSAIDs) 400 mg q8 hrs, Lidoderm patch
- ***Inpatient Postop narcotics prn only:***
-
- ***Postop discharge standing orders:***
- Acetaminophen / Ibuprofen (NSAIDs) / Lidoderm
-
- ***Postop discharge narcotics prn only:***
  - ***Prescribe ONE only***
- Oxycodone 5 mg PO q6-8 hrs. Prn for 2 days, q12hrs prn = 10-15 pills
- Dilaudid 2 mg PO q 6-8 hrs. Prn for 2 days, q12hrs prn = 10-15 pills
- Tramadol 50 mg q 6 hrs. Prn for 2 days, q12hrs prn = 10-15 pills

Defining Optimal Length of Opioid Pain Medication Prescription JAMA Sept 2017

- Recommend length of prescription:
  - 4 - 9 days for general surgery procedures
  - 4 - 13 days for women's health procedures
  - 6 -15 days for musculoskeletal procedures

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Recommendations/Counseling Patients

- **Write prescriptions in smaller amounts**
- Tell pts not to advertise to others that they have opioids and to keep them medications secure
- SET EXPECTATIONS: “Some pain is normal. You should be able to walk and do light activity, but may be sore for a few days. This will gradually get better.”
- SET NORMS: “Half of patients who have this procedure take under 10-15 pills.”
- NON-OPIOIDS: “Take acetaminophen and ibuprofen around the clock, and use the stronger pain pills only as needed for breakthrough pain.”
- APPROPRIATE USE: “These pills are for pain from your surgery, and should not be used to treat pain from other conditions
- ADVERSE AFFECTS: “We are careful about opioids because they have been shown to be addictive, cause you harm, and even cause overdose if used incorrectly or abused.”
- SAFE DISPOSAL "Disposing of these pills prevents others, including children, from accidentally overdosing. You can take pills to an approved collector (including police stations), or mix pills with kitty litter in a bag and throw them in the trash.”

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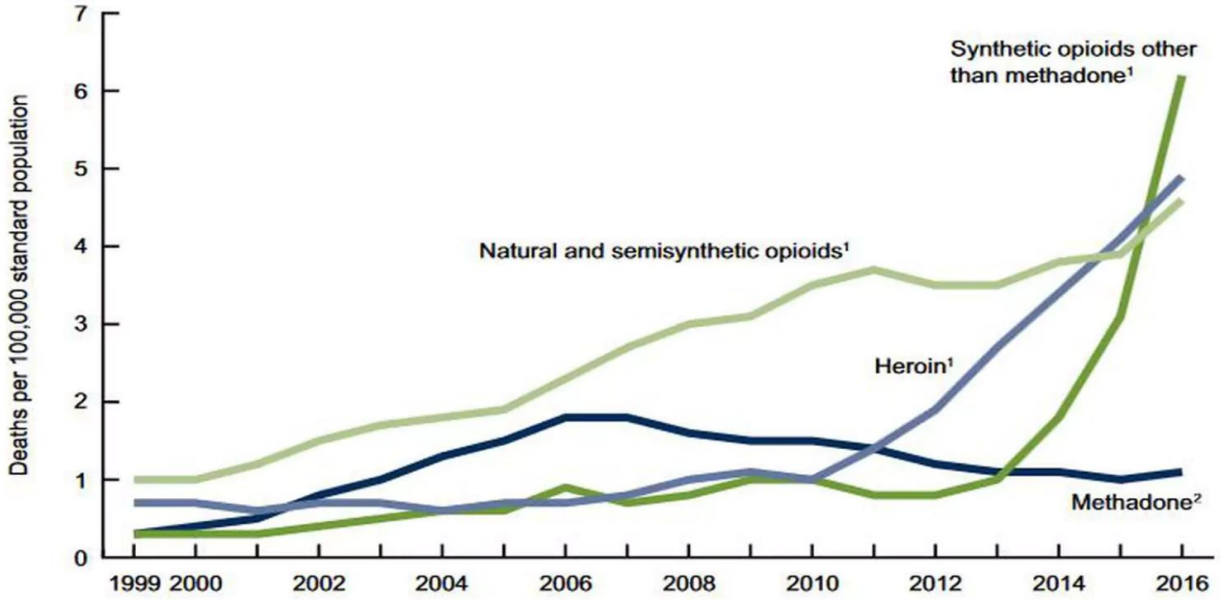
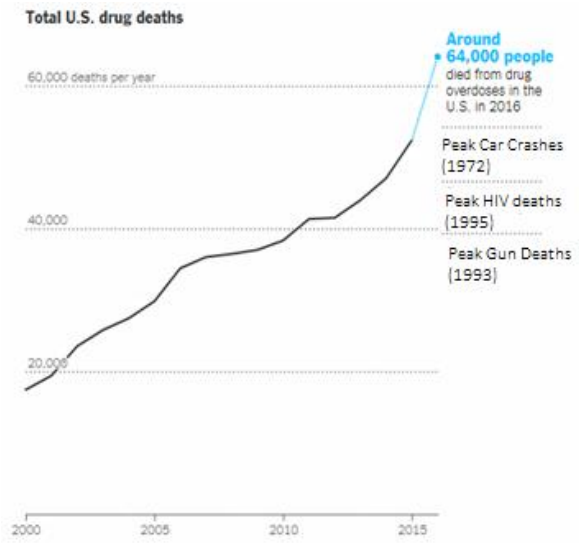
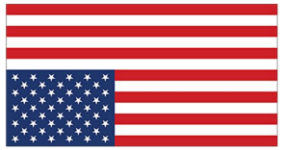
http://michigan-open.org



JAMA. 2017;318(23):2295-2296

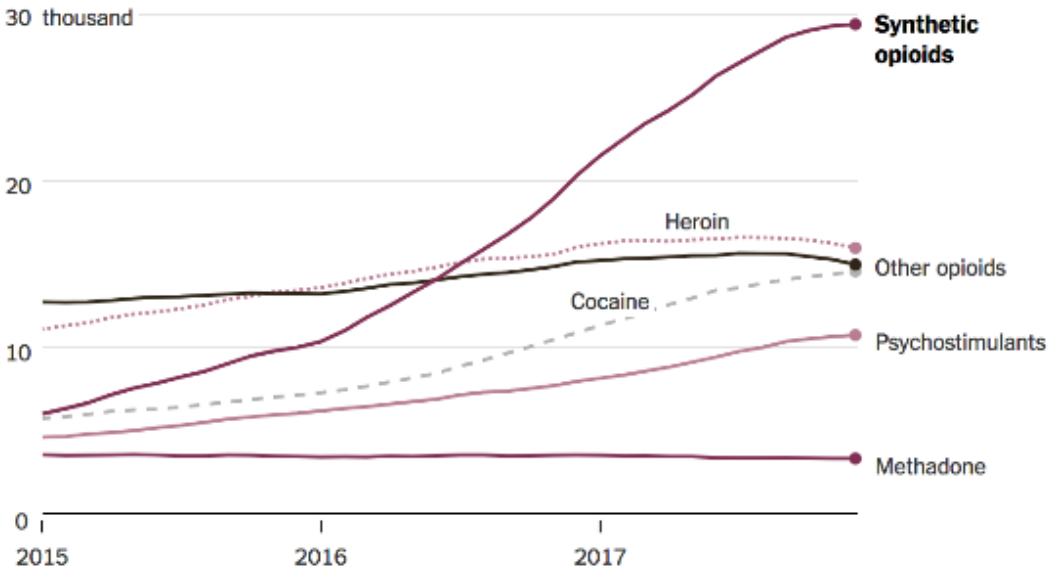


https://www.nytimes.com/interactive/2017/09/02/upshot/fentanyl-drug-overdose-deaths.html



Synthetic Opioids Are Driving Up the Overdose Rate

Overdose deaths in thousands in preceding 12 months



Note: These numbers are adjusted to account for some death investigations that are not completed. Some deaths involve more than one drug.

By The New York Times | Source: The Centers for Disease Control and Prevention

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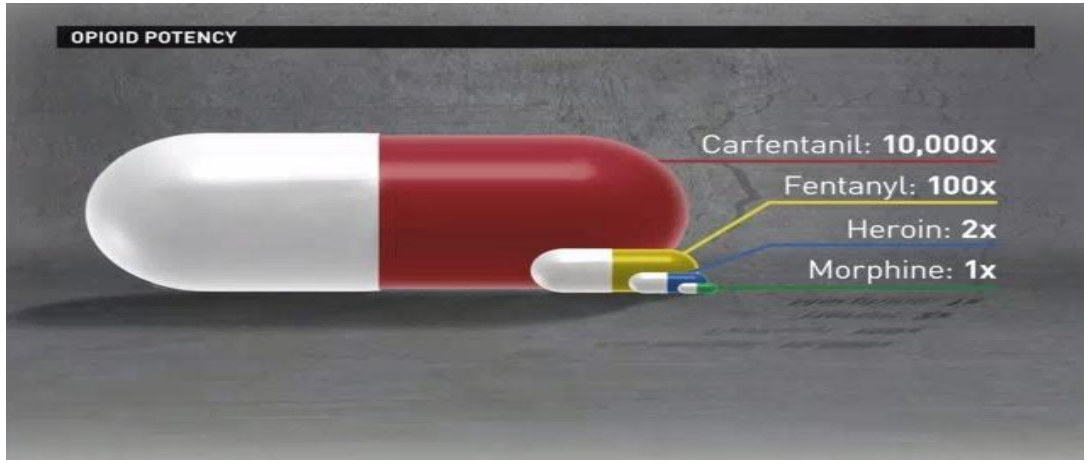
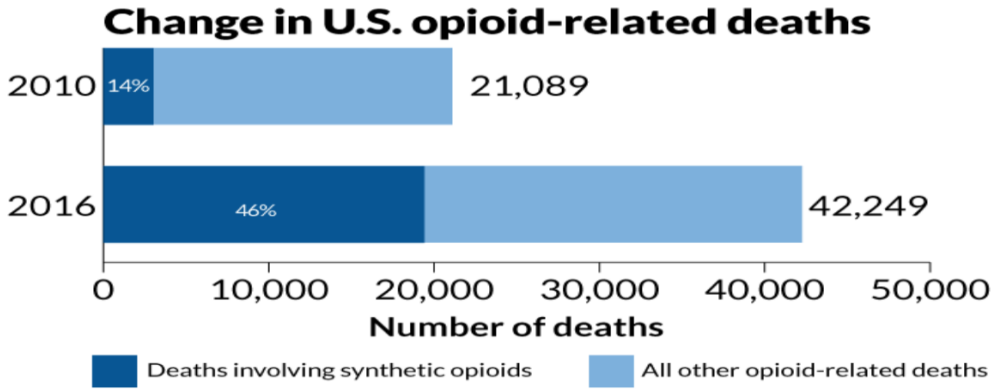
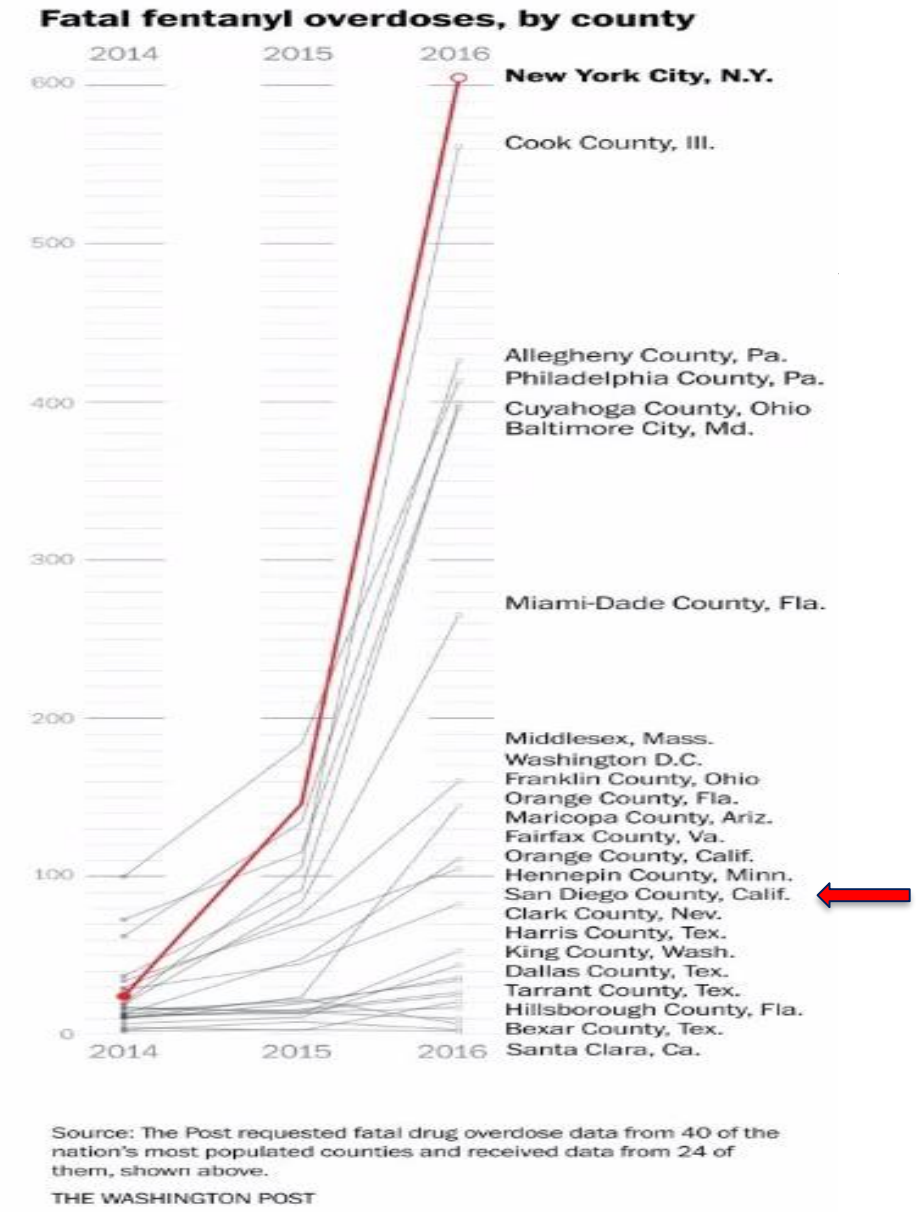
Non Pharmaceutical Fentanyl





National Vital Statistic System's 2018



Source: The Post requested fatal drug overdose data from 40 of the nation's most populated counties and received data from 24 of them, shown above.

THE WASHINGTON POST

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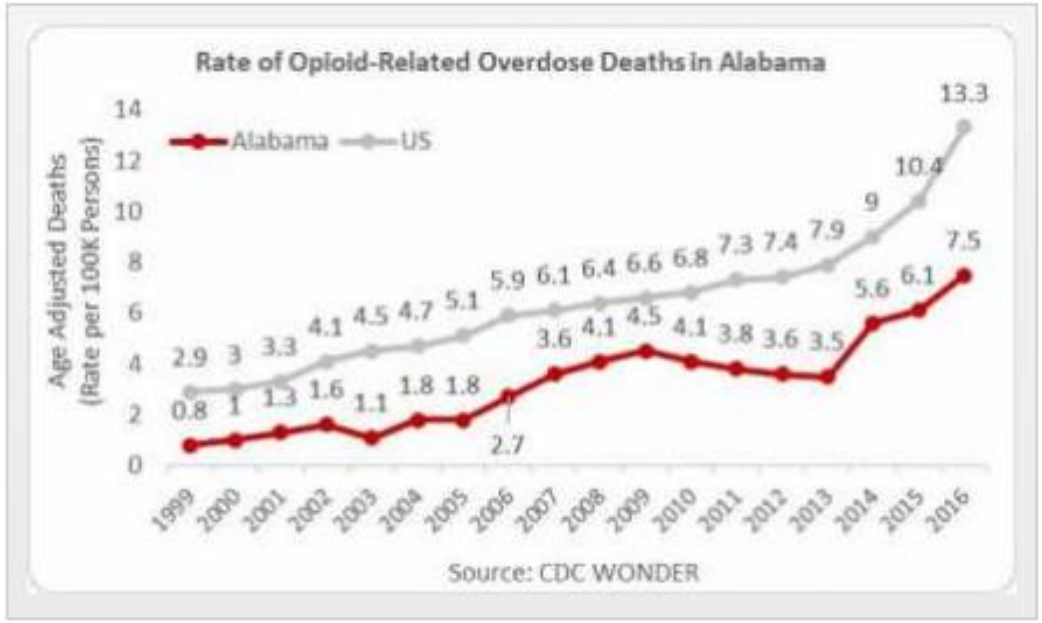
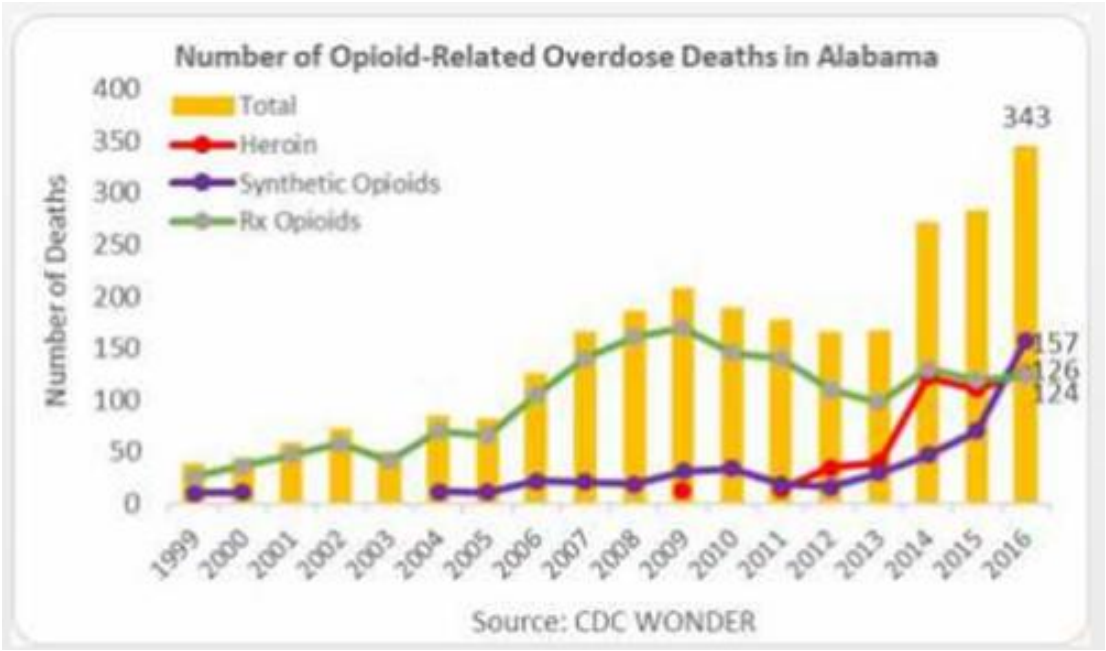
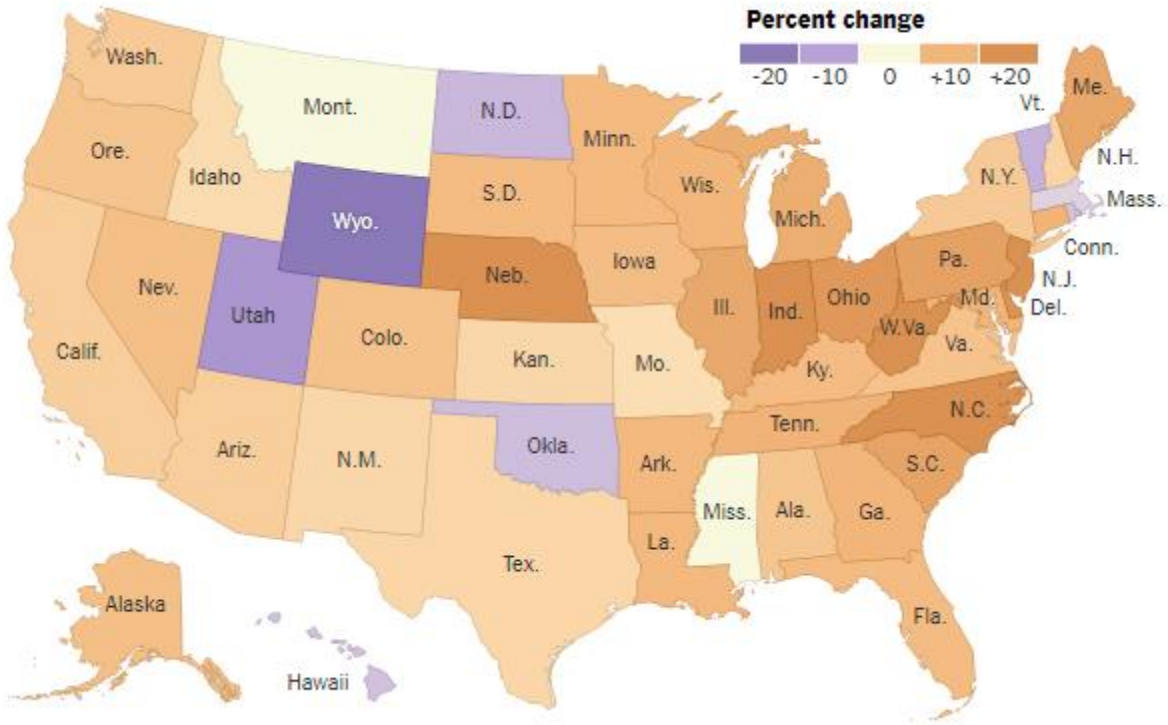




Change in Overdose Deaths Last Year



Source CDC NYT Aug 2018

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New Demographics

- Number of minors hospitalized for opioid poisonings, overdoses doubled (most common 12-17 and 1-5) Peds 2018
- Death rate from opioids is rising most steeply among Black Americans (incr 40% in 2016) CDC 2018
- Black American youth 12-17 were more likely than whites to have used opioids in the past year SAMSHA 2018
- Older black Americans saw the sharpest increase in overdose death rates (? Survive heroin in the 70's) NIDA
- Native Americans had the highest death rate from opioids CDC

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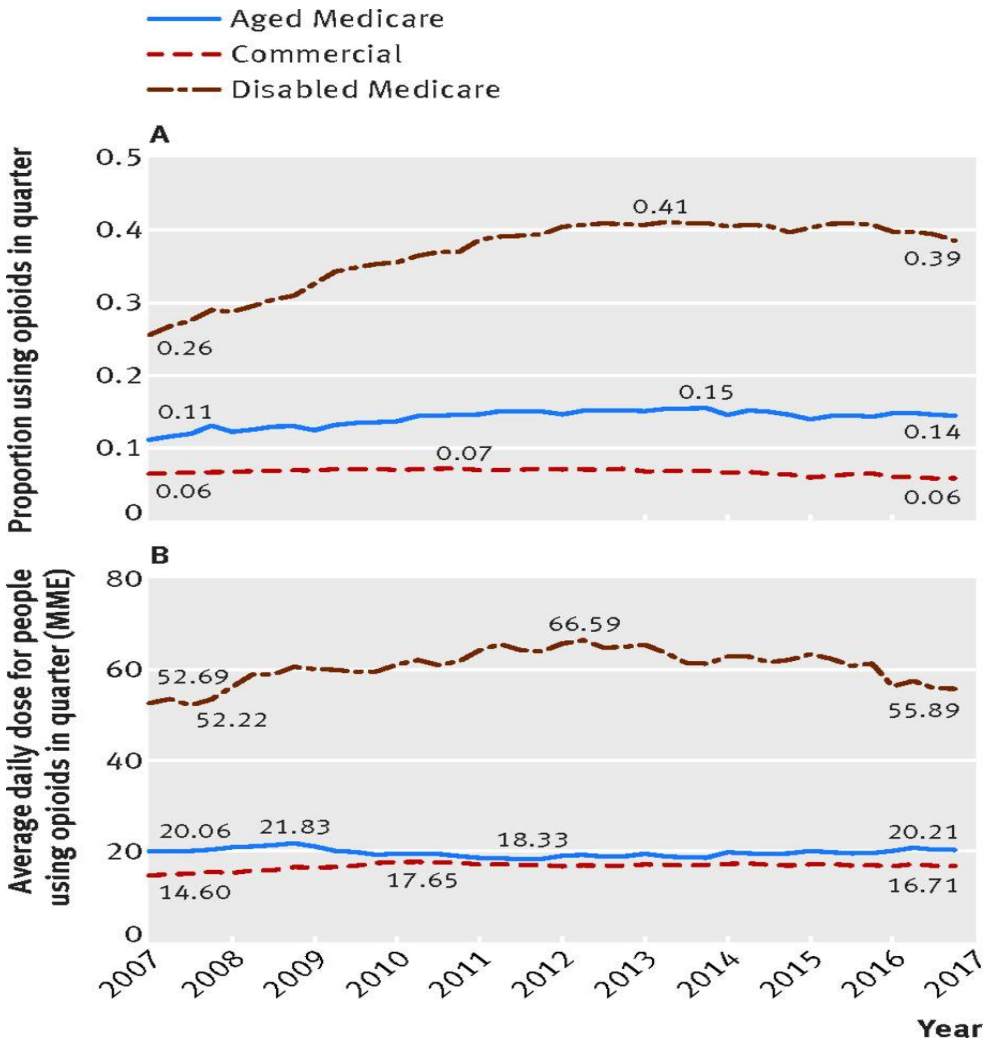
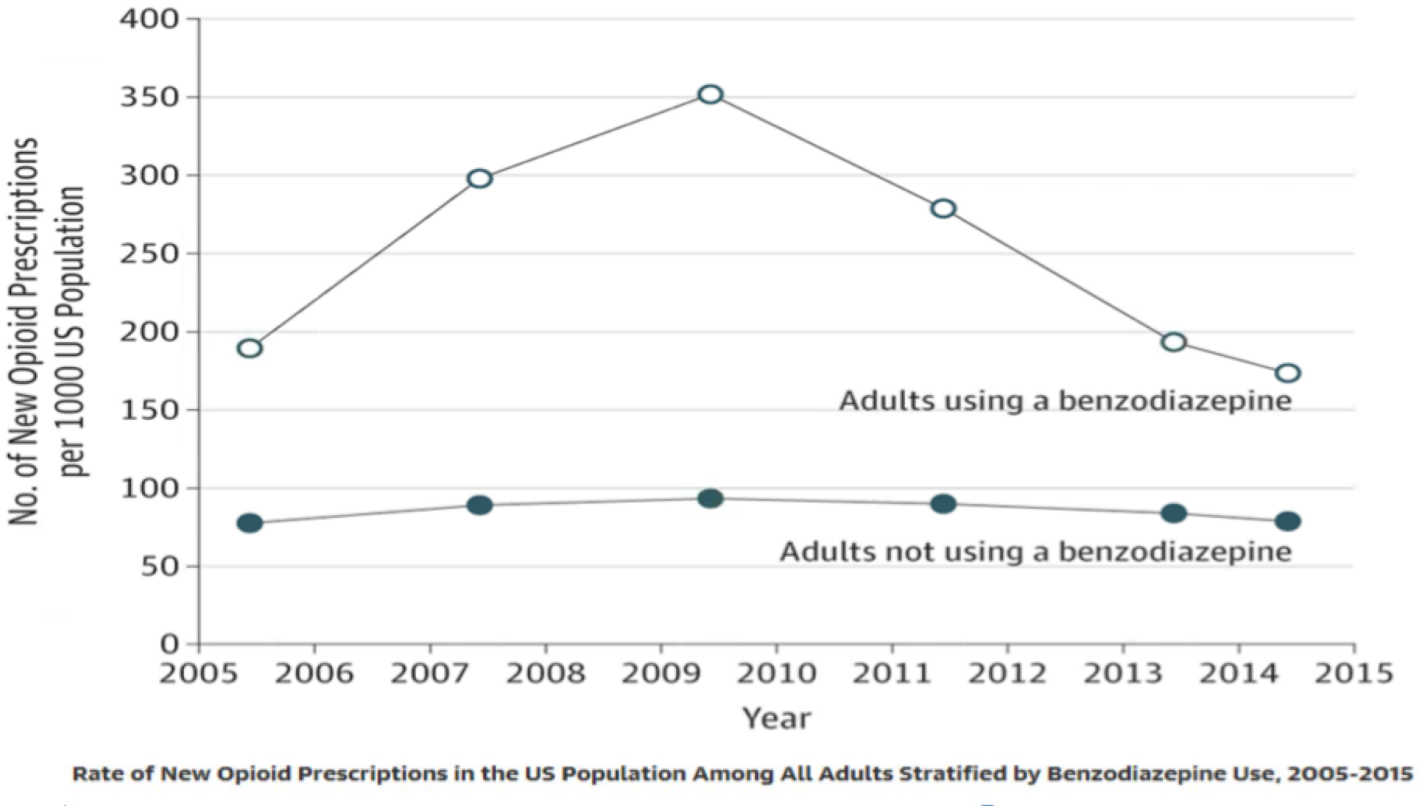
Adjusted time trends in opioid use by beneficiary type, 2007-16.



Molly Moore Jeffery et al. BMJ 2018;362:bmj.k2833

Physician Prescribing of Opioids to Patients at Increased Risk of Overdose From Benzodiazepine Use in the US



Rate of New Opioid Prescriptions in the US Population Among All Adults Stratified by Benzodiazepine Use, 2005-2015

JAMA Psychiatry 2018

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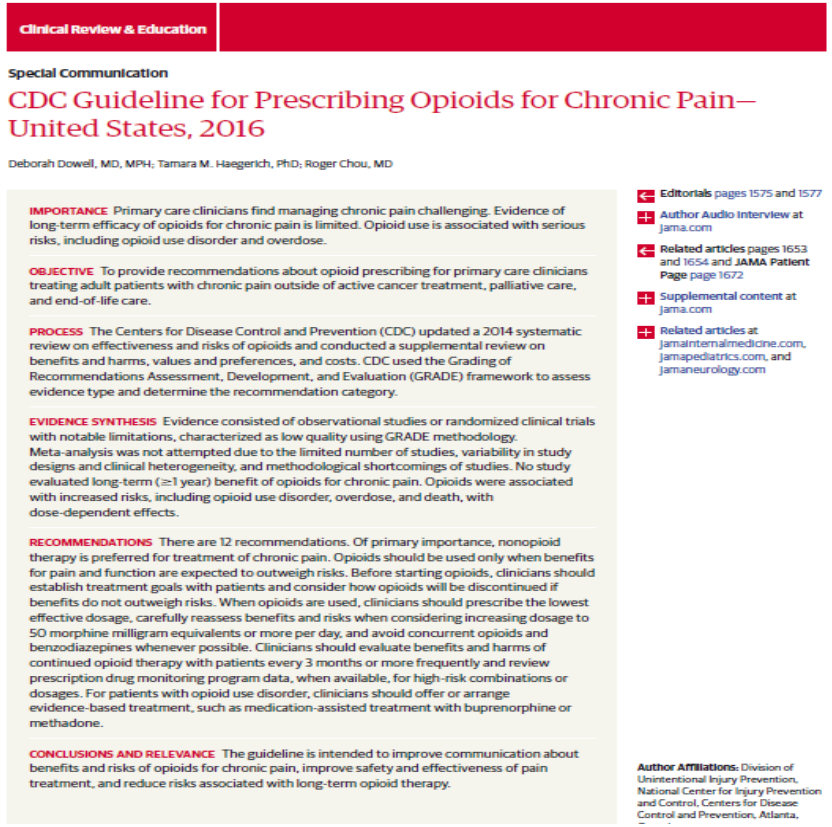
CDC Guidelines for Prescribing Opioids for Chronic Pain
12 Recommendations


Clinical Review & Education

Special Communication

CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016

Deborah Dowell, MD, MPH; Tamara M. Haegerich, PhD; Roger Chou, MD

IMPORTANCE Primary care clinicians find managing chronic pain challenging. Evidence of long-term efficacy of opioids for chronic pain is limited. Opioid use is associated with serious risks, including opioid use disorder and overdose.

OBJECTIVE To provide recommendations about opioid prescribing for primary care clinicians treating adult patients with chronic pain outside of active cancer treatment, palliative care, and end-of-life care.

PROCESS The Centers for Disease Control and Prevention (CDC) updated a 2014 systematic review on effectiveness and risks of opioids and conducted a supplemental review on benefits and harms, values and preferences, and costs. CDC used the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework to assess evidence type and determine the recommendation category.

EVIDENCE SYNTHESIS Evidence consisted of observational studies or randomized clinical trials with notable limitations, characterized as low quality using GRADE methodology. Meta-analysis was not attempted due to the limited number of studies, variability in study designs and clinical heterogeneity, and methodological shortcomings of studies. No study evaluated long-term (≥1 year) benefit of opioids for chronic pain. Opioids were associated with increased risks, including opioid use disorder, overdose, and death, with dose-dependent effects.

RECOMMENDATIONS There are 12 recommendations. Of primary importance, nonopioid therapy is preferred for treatment of chronic pain. Opioids should be used only when benefits for pain and function are expected to outweigh risks. Before starting opioids, clinicians should establish treatment goals with patients and consider how opioids will be discontinued if benefits do not outweigh risks. When opioids are used, clinicians should prescribe the lowest effective dosage, carefully reassess benefits and risks when considering increasing dosage to 50 morphine milligram equivalents or more per day, and avoid concurrent opioids and benzodiazepines whenever possible. Clinicians should evaluate benefits and harms of continued opioid therapy with patients every 3 months or more frequently and review prescription drug monitoring program data, when available, for high-risk combinations or dosages. For patients with opioid use disorder, clinicians should offer or arrange evidence-based treatment, such as medication-assisted treatment with buprenorphine or methadone.

CONCLUSIONS AND RELEVANCE The guideline is intended to improve communication about benefits and risks of opioids for chronic pain, improve safety and effectiveness of pain treatment, and reduce risks associated with long-term opioid therapy.

Editorials pages 1575 and 1577
Author Audio Interview at jama.com
Related articles pages 1653 and 1654 and JAMA Patient Page page 1672
Supplemental content at jama.com
Related articles at jamainternalmedicine.com, jamapediatrics.com, and jamaneurology.com

Author Affiliations: Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta,

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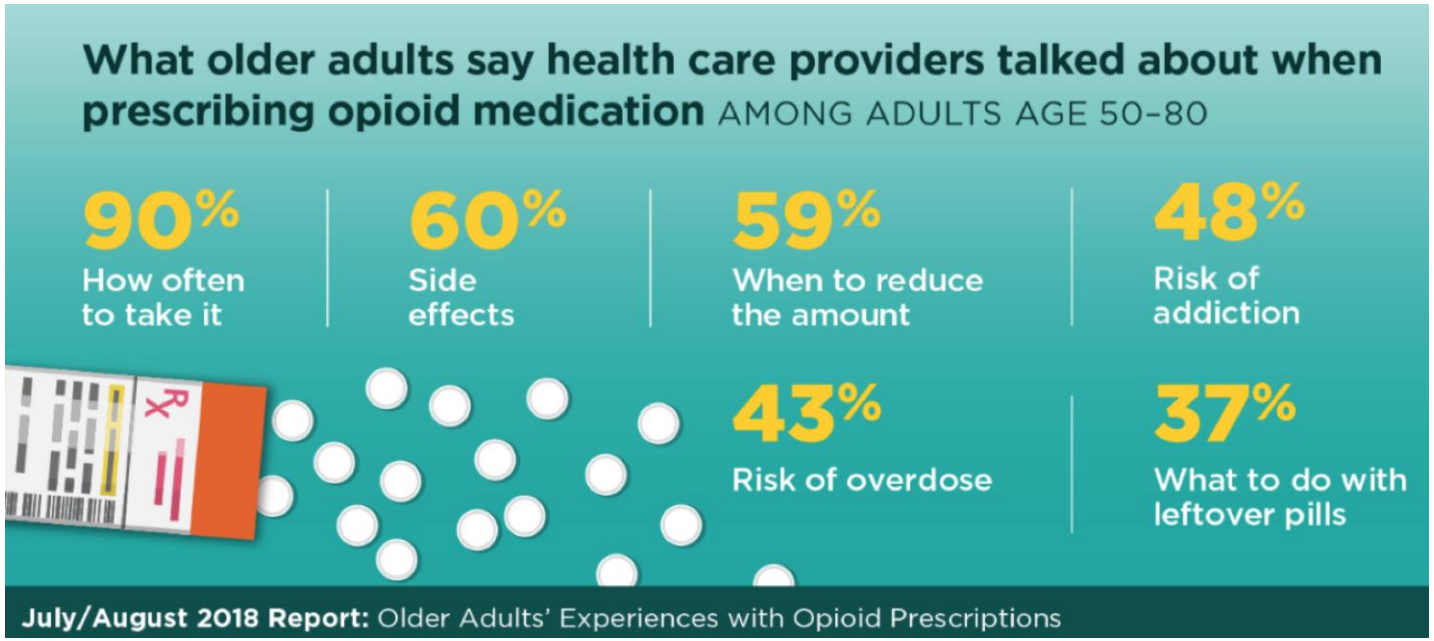
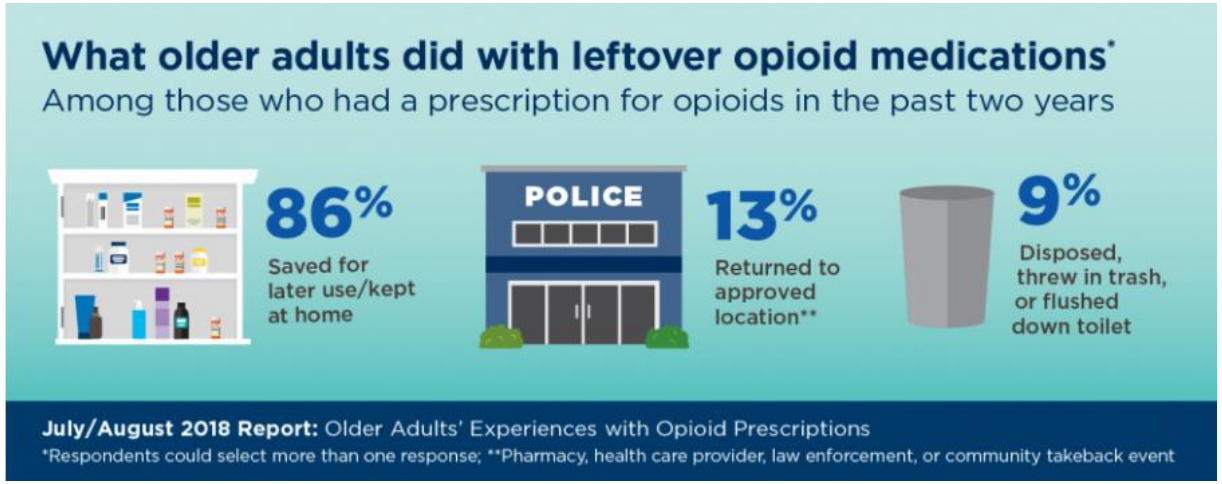
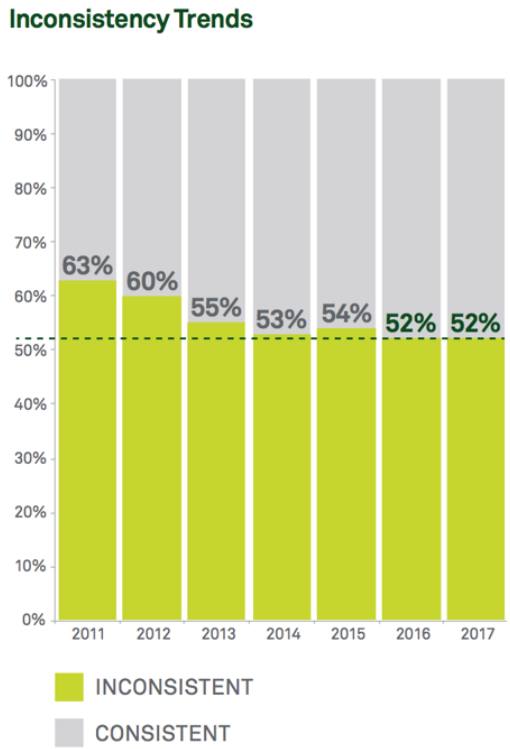

What older adults say health care providers talked about when prescribing opioid medication AMONG ADULTS AGE 50-80
90% How often to take it
60% Side effects
59% When to reduce the amount
48% Risk of addiction
43% Risk of overdose
37% What to do with leftover pills
Rx
July/August 2018 Report: Older Adults' Experiences with Opioid Prescriptions

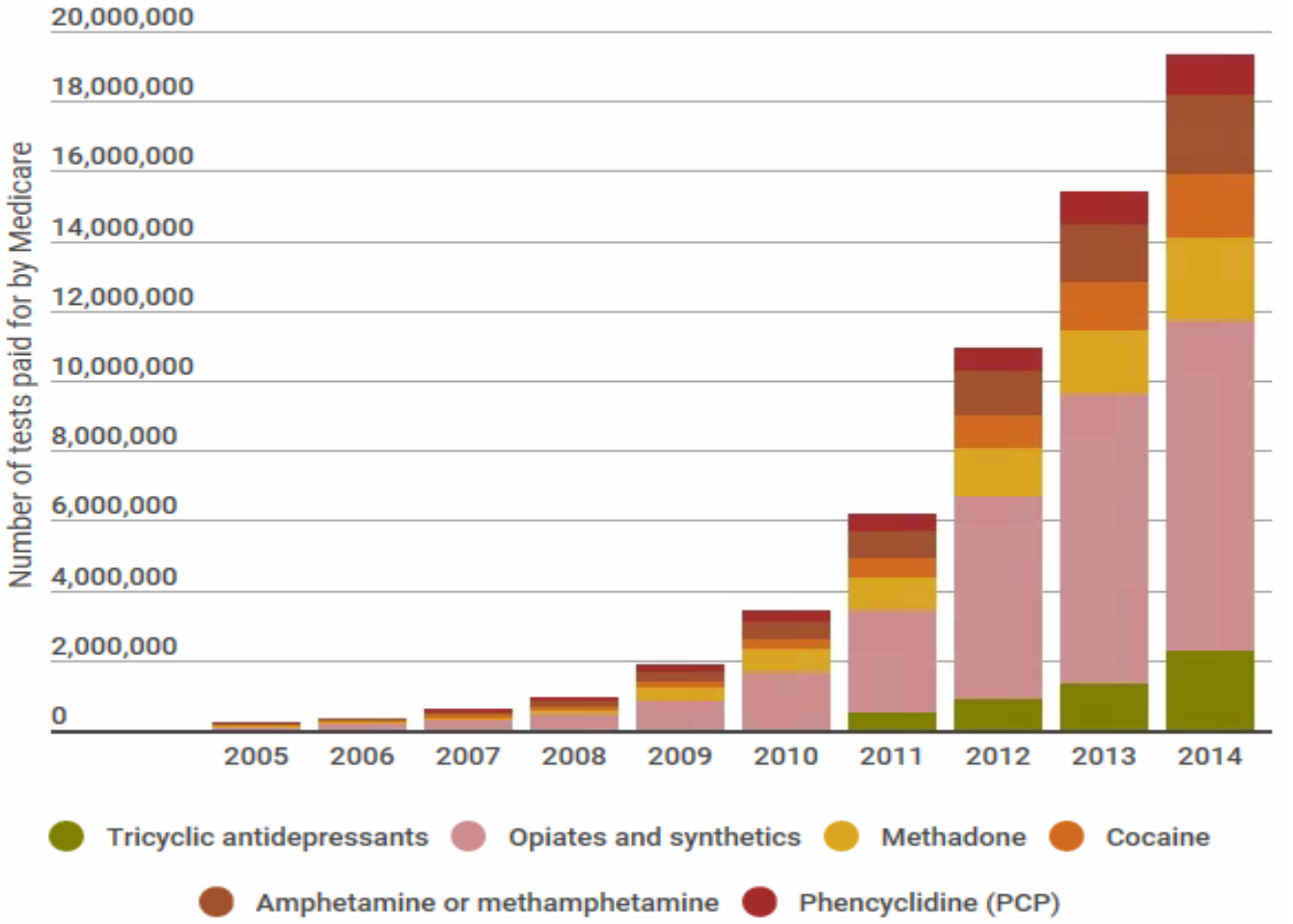

What older adults did with leftover opioid medications*
Among those who had a prescription for opioids in the past two years
86% Saved for later use/kept at home
POLICE
13% Returned to approved location**
9% Disposed, threw in trash, or flushed down toilet
July/August 2018 Report: Older Adults' Experiences with Opioid Prescriptions
*Respondents could select more than one response; **Pharmacy, health care provider, law enforcement, or community takeback event



Quest Diagnostics

www.QuestDiagnostics.com

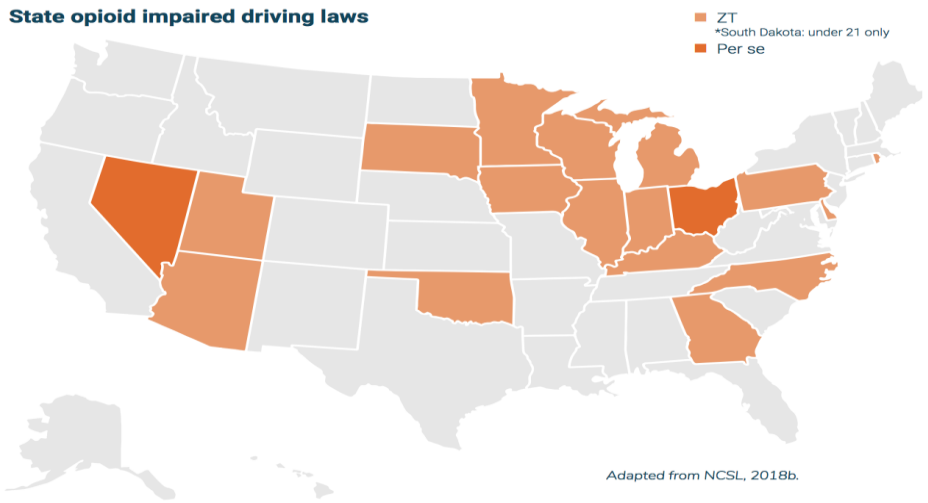
Urine Tests To Detect And Quantify A Variety Of Drugs Have Grown Explosively



Source: CodeMap

Advise to patients on opioids and driving

- FDA's prescribing advice for OxyContin says only "Warn patients not to drive or operate dangerous machinery unless they are tolerant to the effects of OxyContin and know how they will react to the medication"



Adapted from NCSL, 2018b.

Driving Under the Influence of Drugs (DUID) is illegal in every state.	***Zero Tolerance laws*** prohibit driving with any amount of specified drugs in the body.	***Per se laws*** prohibit driving with an amount of a drug above a specified per se limit, similar to the 0.08 or 0.05 BAC per se laws for alcohol.
DUID has two requirements: an officer must observe signs that the driver is impaired and the impairment must be linked to a drug. Opioids can impair, so DUID laws apply to opioids.	As of April 2018, 16 states have zero tolerance laws for some or all opioids. South Dakota's zero tolerance law applied only to drivers under the age of 21. (NCSL, 2018d)	As of April 2018, Nevada and Ohio had per se laws applying to some opioids. (NCSL, 2018d)

DUI DOESN'T JUST MEAN BOOZE

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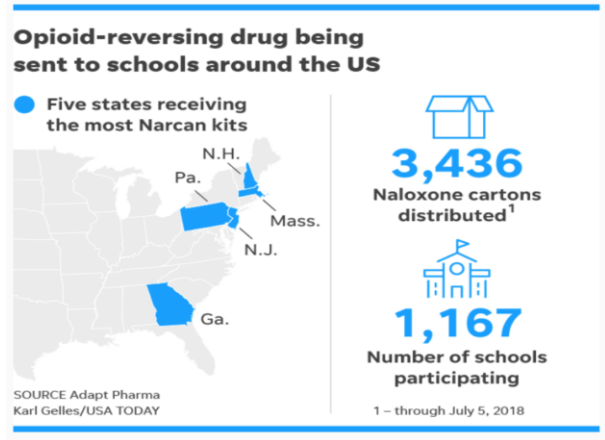
Naloxone Legislation

- All states have passed access legislation
  Drug Alcohol Depend 157, 112-120
- 40 states passed overdose Good Samaritan laws when reporting overdose
- >150,000 lay people received training and kits, and reversing >26,000 overdoses MMWR 2015
- Access laws assoc with a 11% ↓ in deaths
  National Bureau of Economic Research 2016
- Did not ↑ in non-medical use of prescription painkillers
- 8000 prescriptions filled each day per AMA



(h) Physicians should consider co-prescribing naloxone in patients deemed to be appropriate by the clinical determination of the treating physician

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What happens after Naloxone use?

Massachusetts Department of Health

- 12,192 give naloxone by EMS from 7/2013 to 1/2016
- 6.5% died the day given
- 10% died within a year
- 40% died outside of the hospital (> 50% in the 1st month)
- Only 5% of overdose survivors received MAT

- Scott G. Weiner, Annual Conference of the American College of Emergency Physicians 2017

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

HHS OIG Data Brief • OEI-02-17-00250

Opioids in Medicare Part D: Concerns about Extreme Use and Questionable Prescribing

Key Takeaways:

- ✓ *One in three Medicare Part D beneficiaries received a prescription opioid in 2016*
- ✓ *About 500,000 beneficiaries received high amounts of opioids*
- ✓ *Almost 90,000 beneficiaries are at serious risk; some received extreme amounts of opioids, while others appeared to be doctor shopping*
- ✓ *About 400 prescribers had questionable opioid prescribing patterns for beneficiaries at serious risk*

Exhibit 2: Most Common Opioids in Part D, by Number of Prescriptions, 2016

* Tablets also contain 325 mg of acetaminophen.
Source: OIG analysis of Medicare Part D data, 2017

Two Groups of Beneficiaries at Serious Risk of Opioid Misuse or Overdose:

1. Beneficiaries who received extreme amounts of opioids—i.e., an average daily MED greater than 240 mg for 12 months.
2. Beneficiaries who appeared to be doctor shopping—i.e., received a high amount of opioids (an average daily MED greater than 120 mg for 3 months) *and* had four or more prescribers and four or more pharmacies.

Exhibit 4

Beneficiaries who appear to be DOCTOR SHOPPING received high amounts of opioids and had ≥4 prescribers and ≥4 pharmacies

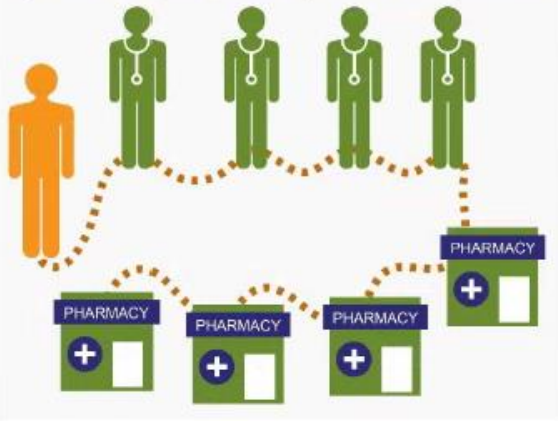

Exhibit 3: Average Daily MED

* CDC Guidelines for Prescribing Opioids for Chronic Pain, March 2016

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Published July 2017

CMS makes changes to opioid proposal following criticism

- Withdrew hard edit for > 90 MED due to pushback
- Current recommendation is to have pharmacist document conversation and agreement with prescriber if > 90 MED
- CMS official said this would “fit within the current workflow of what the pharmacist is already doing to verify the prescriptions, speaking with the pt and the prescriber.”
- Pharmacists may fill doses between 90 - 200 MED for CA, hospice, palliative or long term care pts
- Allows Medicare drug benefit plans to require pts at risk of addiction to use only selected prescribers or pharmacies
- 7d limit for first prescription

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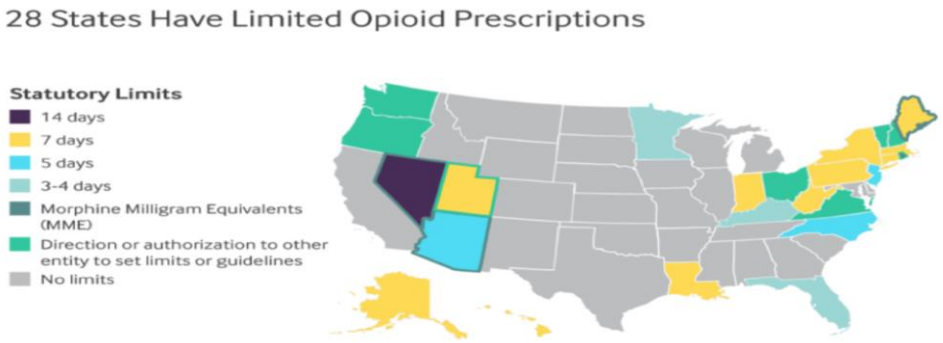
Government response



- MA 1st to establish a 7d in 2016.
- By 2018, 28 states mandate some type of guidance, limit, or requirement related to prescribing
- Most are quantity limits but some have MME
- Most limit 1st time scripts to 3-14 days and PDMP query
- April 2018, CMS rule to limit Part D to 90 mg of morphine and 7 days for 1st fill
- Aug 2018, Medicare updated policy to emphasize that providers are to review opioid use as a routine component of IPPE "Welcome to Medicare" visit and the Initial and Subsequent Annual Wellness Visits.
- CARA 2.0 (The Comprehensive Addiction and Recovery Act) has a 3 d limit, requires PDMP review, and changes requirement to first get pt consent to release addiction tx records

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FDA: Immediate-Release Opioids Now Under REMS

- July 2012, FDA approved the Extended-Release and Long-Acting (ER/LA) Opioid Analgesic Risk Evaluation and Mitigation Strategy (ER/LA REMS) to ensure that the benefits of ER and LA opioid
- FDA Education Blueprint for Health Care Providers Involved in the Treatment and Monitoring of Patients with Pain September 2018
- Raises the number of individual products subject to the opioid REMS from 62 to 347
- Cover all "providers who are involved in the management of patients with pain" -- not just those writing prescriptions

https://www.fda.gov/downloads/Drugs/DrugSafety/InformationbyDrugClass/UCM620249.pdf

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The Opioid Crisis Response Act of 2018

$7.9 billion for the CDC, the Department of Health and Human Services, and other agencies

1. Medicaid payments for large (inpt) treatment facilities.
2. Permit more healthcare providers to prescribe MAT and encourages the development of nonaddictive painkillers.
3. Crack down on illicit opioids shipped to the U.S. from other countries.
4. Bill dropped a measure that would've reduced drugmakers' responsibility to pay for a higher share of Medicare drug costs, despite heavy lobbying from the pharmaceutical industry

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CURES 2.0
MANDATORY USE
BEGINS OCTOBER 2, 2018

The Controlled Substance Utilization Review and Evaluation System (CURES) was certified for statewide use by the Department of Justice (DOJ) on April 2, 2018. Therefore, the mandate to consult CURES prior to prescribing, ordering, administering, or furnishing a Schedule II–IV controlled substance becomes effective on October 2, 2018. Visit www.mbc.ca.gov/CURES for detailed information regarding CURES 2.0.

Note: The phrase "controlled substance" as used in this guide refers to a Schedule II, Schedule III, or Schedule IV controlled substance.

WHEN MUST I CONSULT CURES?

- The first time a patient is prescribed, ordered, administered, or furnished a controlled substance, unless one of the exemptions on back 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 on back 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.

ARE THERE ANY PROTECTIONS FOR PRESCRIBERS?

- There is no private cause of action for a prescriber's failure to consult CURES.
- For complete information on the mandatory requirement to consult CURES, please read HSC § 11165.4.
- If you have any further questions, please seek legal counsel.

> "First time" is defined **as the initial occurrence in which a health care** practitioner intends to prescribe, order, administer, or furnish **a controlled substance** to a patient and has not previously prescribed a **controlled substance to** the patient.
>
> *— Health and Safety Code (HSC), § 11165.4(a)(1)(B)*

HOW CAN I GET HELP WITH CURES?

For general assistance with CURES, including training and CURES usage support, contact the California DOJ at (916) 210-3187 or CURES@doj.ca.gov. For Direct Dispensing assistance, contact Atlantic Associates, Inc. at (800) 539-3370 or cacures@aainh.com.

Consumers | Applicants | Licensees | About Us

CURES: Preparing for the New Duty-to-Consult Requirement

Join the California Medical Association (CMA) for a free webinar.

CMA, in collaboration with the California Department of Justice and Medical Board of California, offers this webinar to present the new duty to consult mandate and requirements imposed by the law when checking CURES. Attendees will also receive an overview of the registration process and key features of the CURES database.

Webinar Information and Registration
Date: Wednesday, August 22, 2018
Time: 12:15 PM - 1:15 PM

Schedule I

Schedule I drugs, substances, or chemicals are defined as drugs with no currently accepted medical use and a high potential for abuse. Some examples of Schedule I drugs are:

heroin, lysergic acid diethylamide (LSD), marijuana (cannabis), 3,4-methylenedioxymethamphetamine (ecstasy), methaqualone, and peyote

Schedule II

Schedule II drugs, substances, or chemicals are defined as drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence. These drugs are also considered dangerous. Some examples of Schedule II drugs are:

Combination products with less than 15 milligrams of hydrocodone per dosage unit (Vicodin), cocaine, methamphetamine, methadone, hydromorphone (Dilaudid), meperidine (Demerol), oxycodone (OxyContin), fentanyl, Dexedrine, Adderall, and Ritalin

Schedule III

Schedule III drugs, substances, or chemicals are defined as drugs with a moderate to low potential for physical and psychological dependence. Schedule III drugs abuse potential is less than Schedule I and Schedule II drugs but more than Schedule IV. Some examples of Schedule III drugs are:

Products containing less than 90 milligrams of codeine per dosage unit (Tylenol with codeine), ketamine, anabolic steroids, testosterone

Schedule IV

Schedule IV drugs, substances, or chemicals are defined as drugs with a low potential for abuse and low risk of dependence. Some examples of Schedule IV drugs are:

Xanax, Soma, Darvon, Darvocet, Valium, Ativan, Talwin, Ambien, Tramadol

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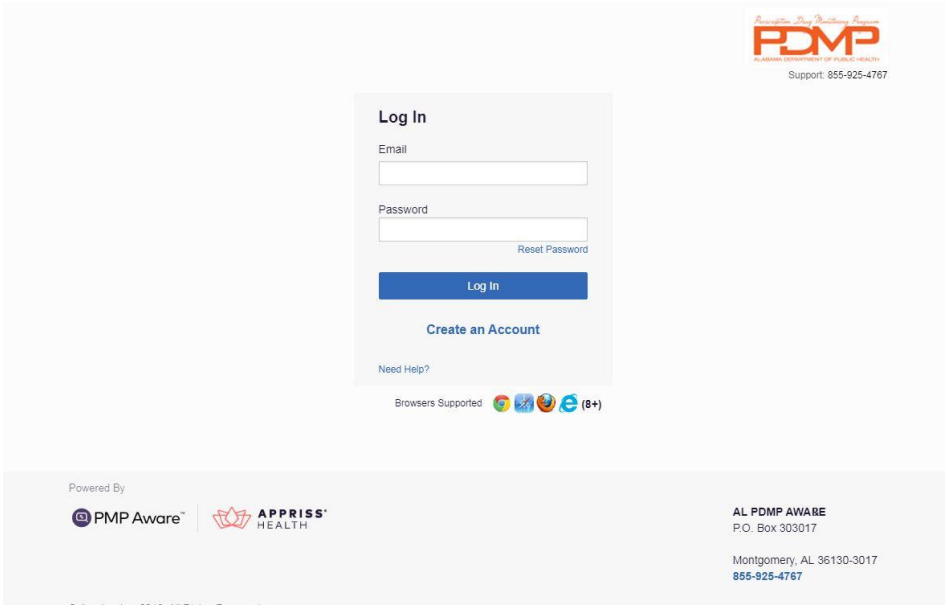
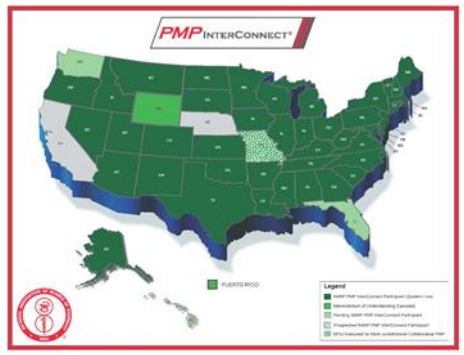
Do you know your password?





ALABAMA BOARD OF MEDICAL EXAMINERS
ADMINISTRATIVE CODE
CHAPTER 540-X-4

When prescribing a patient controlled substances of more than 30 MME per day, physicians shall review that patient's prescribing history through the PDMP at least two (2) times per year, and each physician is responsible for documenting the use of risk and abuse mitigation strategies in the patient's medical record.

Physicians shall query the PDMP to review a patient's prescribing history every time a prescription for more than 90 MME per day is written, on the same day the prescription is written.

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Association Between Prescription Drug Monitoring Programs and Nonfatal and Fatal Drug Overdoses: A Systematic Review Ann Int Med 2018

Meta analysis of 17 articles: **Uncertain if PDMP makes a difference**

- Low-strength evidence from 10 showed ↓ in fatal overdoses with PDMP
- Program features associated with a ↓ in overdose deaths included mandatory provider review, provider authorization to access PDMP data, frequency of reports, and monitoring of nonscheduled drugs
- 3 of 6 showed ↑ in heroin overdoses after PDMP implementation

- Review of 20,000 surgery pts - Surgeons prescribed more opioid after hydrocodone schedule changed from III to II JAMA Surg Aug 2018
- Requirement to review PDMP for pts undergoing Elective Surgery did not change dose in NH JAMA Surg Aug 2018

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Commercial Payer Limits

Express Scripts

- Limit pts new to opioid tx to 7-days for their 1st script
- Default prescription will be for short-acting opioids
- Long-acting opioids for a 1st time user, requires PA
- PA necessary for continuing opioid tx beyond the initial 7 days

Cigna

- Cigna has goal to reducing opioid use 25% by 2019
- OxyContin is no longer covered

Aetna

- Reduce “inappropriate opioids prescribing” by 50%

Walmart

- New scripts to 7 days
- Require EPCS
- Provide power to dispose of unused opioids

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Recommendations for Treating Acute Pain in Patients Receiving Medicated-Assisted Treatment (MAT) for Opioid Use Disorder

Methadone – opioid agonist; daily liquid dispensed only in specialty regulated clinics

Naltrexone –opioid antagonist; daily pill or monthly injection

Buprenorphine –opioid agonist/ antagonist; daily dissolving tablet, cheek film, or 6-month implant under the skin

	Minimal to No Pain	Moderate to Severe Pain
University of Michigan Health System	Continue bup-nx and contact provider	Cancel surgery
	Consider adding NSAIDS or acetaminophen	Coordinate with bup-nx provider to stop bup-nx ≥5 d, transition to short-acting opioids before surgery
	If off bup-nx ≥5 d, treat with regular opioids	If off bup-nx ≥5 d, use opioid analgesics for pain
		Consider adjuncts—acetaminophen, NSAIDs, gabapentin/pregabalin, alpha-2 agonist, low-dose ketamine infusion
		Consider regional anesthesia
		Return to bup-nx provider for reinduction
Boston Medical Center	Continue bup-nx and contact provider and consider	Hold bup-nx on the day of the surgery
	Adding NSAIDs and acetaminophen	Give single-dose ER/LA before the surgery and continue ER/LA opioid to address baseline pain control
	Dividing bup-nx dose q6–8 h	Use PCA with no basal dose or IR/SA opioid analgesic for breakthrough pain
	Increasing bup-nx dose	Return to bup-nx provider within a week for consideration to reinduce bup-nx
	Adding short-acting opioid analgesics	
University of Kentucky Health care	Continue bup-nx and contact provider	Continue bup-nx and contact provider
	Consider adjuncts—acetaminophen/NSAIDs, opioids up to 3 d if necessary	Consider acute pain consult for potential PCA or regional modality
	Consider dividing bup-nx dose every 6–8 h	Admit in close observation unit to assess analgesia
	If off bup-nx, consider adjunct therapy with acetaminophen/NSAIDS or opioids	Continue opioid therapy for postoperative pain after discharge

Abbreviations: bup-nx, buprenorphine–naloxone; ER/LA, extended release/long acting; NSAIDs, nonsteroidal anti-inflammatory drugs; PCA, patient-controlled analgesia.

Anesth Analg. 2018 Aug;127(2):539-547

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Bad News

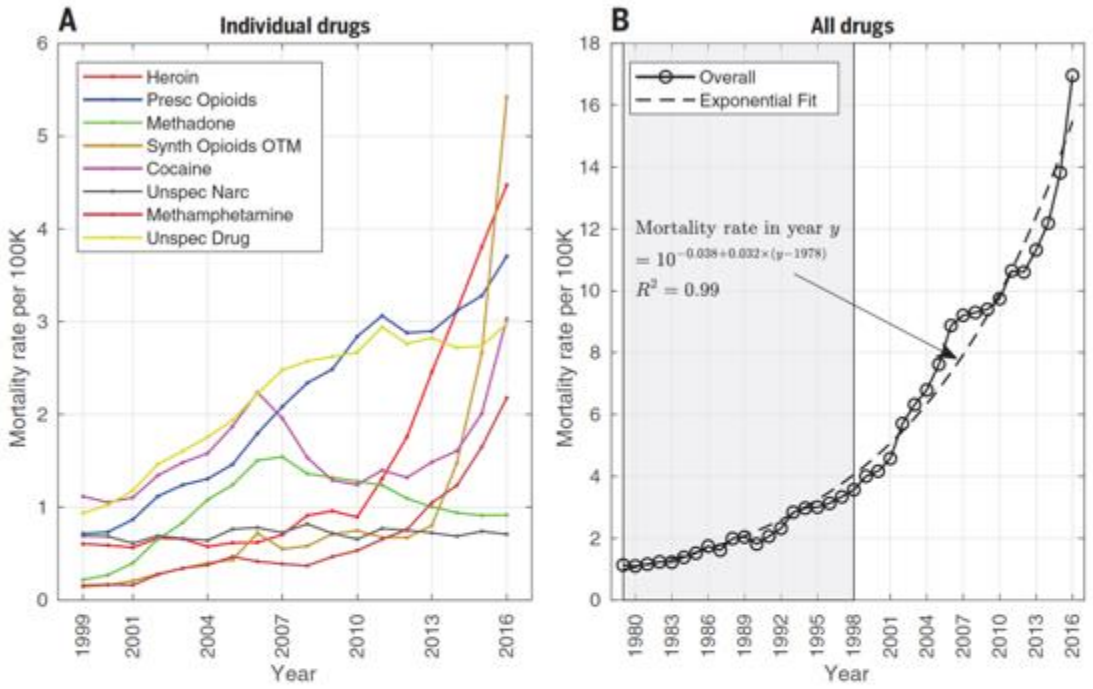


Fig. 1. Mortality rates from unintentional drug overdoses. (**A** and **B**) Mortality rates for (A) individual drugs and (B) all drugs. Detailed data for individual drugs are only available from 1999 to 2016, although additional data for all drugs are available since 1979 (this area is grayed out). The exponential equation and fit are shown for all drugs. (Synth Opioids OTM: synthetic opioids other than methadone. This category includes fentanyl and its analogs.)

http://science.sciencemag.org/content/sci/361/6408/eaau1184.full.pdf

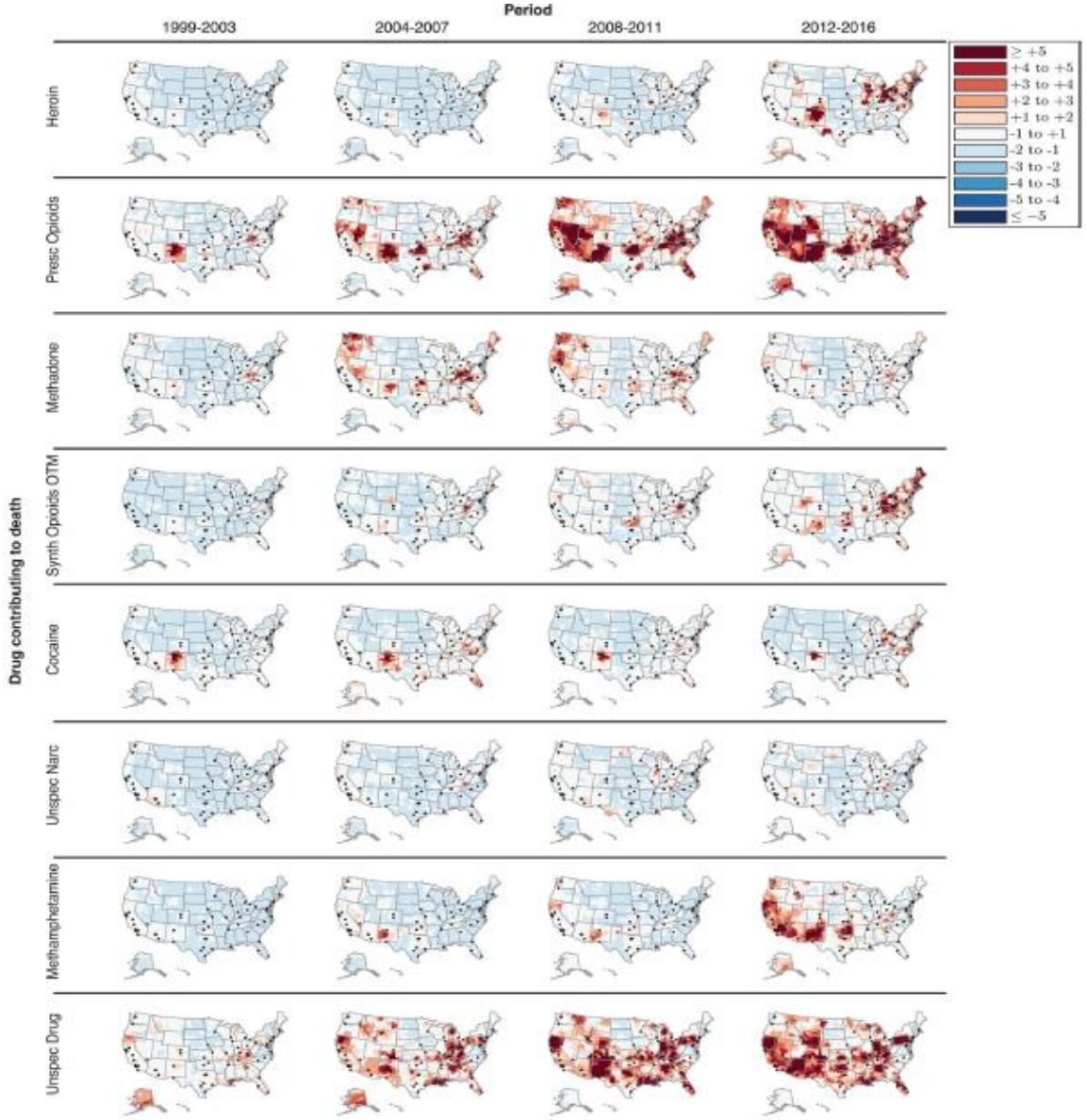
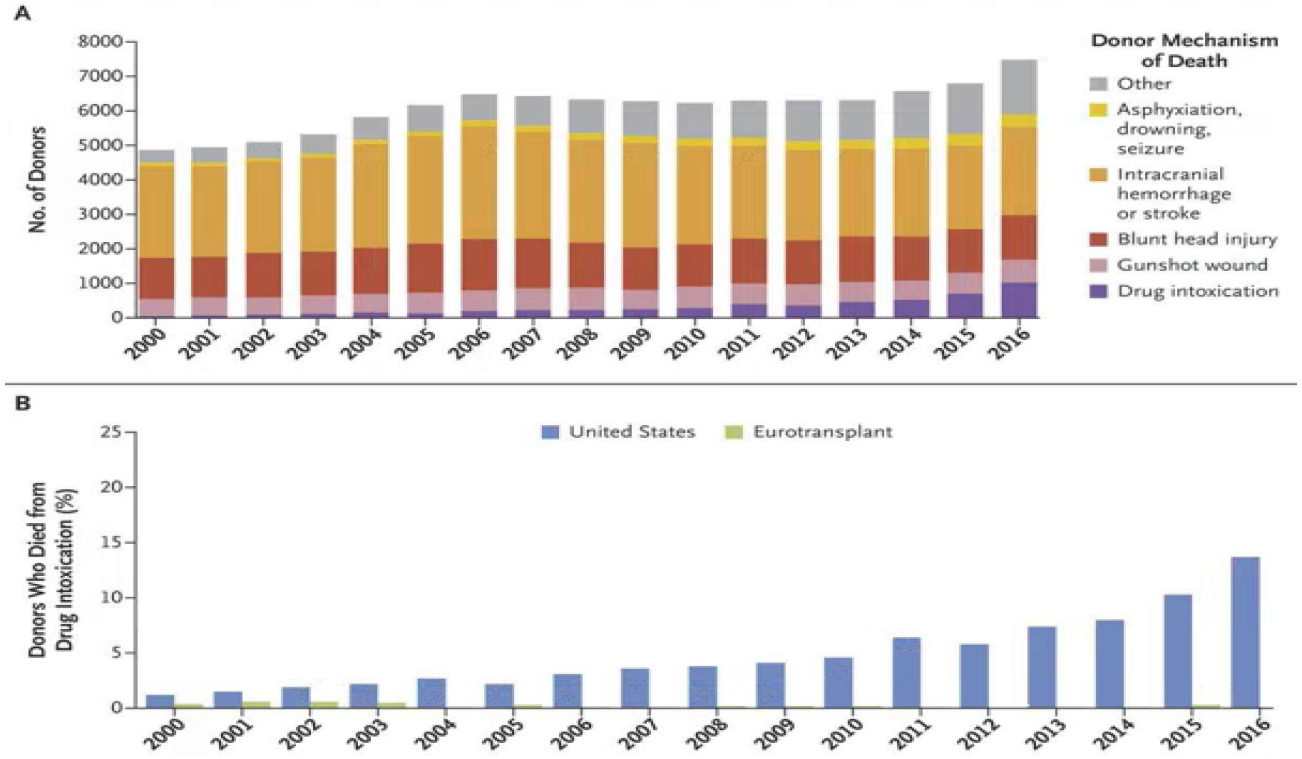


Fig. 3. Geospatial hotspot analysis by drug and period. The Gi* statistics are standardized using pooled statistics across all drugs and periods. The various shades of red and blue indicate pooled standard deviations above and below the pooled mean, respectively, as shown in the legend. The small black circles indicate major cities with populations greater than 300,000 people. None of the regions were less than 2 pooled standard deviations below the pooled average. (Synth Opioids OTM: synthetic opioids other than methadone. This category includes fentanyl and its analogs.)

Good News ?



N Engl J Med 2018; 378

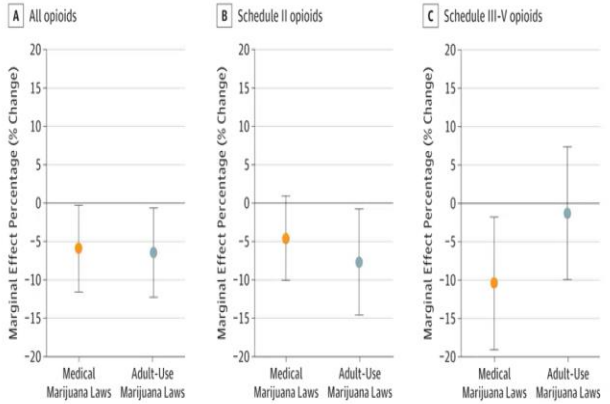
Table 2. Daily Doses Prescribed for Opioids Using "Any Medical Cannabis Law" (MCL) Policy Variable, by Opioid Type[a]

Opioid Type, With MCL in Effect	Coefficient (95% CI)	Percentage Change	*P* Value
Hydrocodone	−1.404 (−2.895 to 0.087)	−10.5	.06
Oxycodone	0.039 (−0.105 to 0.182)	4.4	.59
Fentanyl	−0.133 (−0.272 to 0.006)	−8.5	.06
Morphine	−0.246 (−0.478 to −0.015)	−14.1	.04
Methadone	0.006 (−0.063 to 0.075)	0.8	.87
Other opioid	−0.472 (−1.241 to 0.296)	−6.0	.22

[a] There were 306 observations for each type of drug. Ordinary least-squares regression coefficients from models in which the dependent variables are total opioid prescriptions. Percentage changes from the average "no MCL" state level of prescribing are in parentheses. Data are aggregated to all prescriptions in opioid category by state and year. Variables included in all models but not shown here: whether state has adopted legal recreational cannabis, whether the state has an operational electronic prescription drug monitoring program, Herfindahl index of physician market competition, percentage of the population below the poverty line; percentage of population enrolled in Medicare, percentage of Medicare in Medicare Advantage plans, total state population; a time trend, and state fixed effects.

Daily Doses Prescribed for Opioids Using "Any Medical Cannabis Law" (MCL) Policy Variable, by Opioid Type[a]

JAMA Intern Med. 2018



Association Between Medical and Adult-Use Marijuana Laws and Medicaid-Covered Opioid Prescribing Rate

Analysis of the CMS State Drug Utilization Data, 2011-2016.[19] Opioid prescribing rate was measured by the number of Medicaid-covered prescriptions for opioids on a quarterly, per-1000-Medicaid-enrollees basis and was population-weighted. Error bars indicate 95% CIs clustered at the state level. Orange dots indicate prescribing rates under medical marijuana laws; gray dots, rates under adult-use marijuana laws.Rates and 95% CIs are also presented in eTables 3, 5, and 6 in the Supplement.

JAMA Intern Med. 2018

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