Controlled Prescriptions: Questions and Answers

This section of the toolkit provides helpful prescribing tips and patient answers.

Safe Pain Medicine Prescribing in Emergency Departments:

Controlled Prescriptions: Questions and Answers

April 2014
Roneet Lev, MD

As physicians we feel the responsibility to be the ultimate patient advocate, the safety net, the one doctor who can fix things when no one else can. We are always there, 24/7, ready to solve problems. If patients can't get their prescriptions from their clinic, we are there to help. If the psychiatrist can't be reached and the patients need their medications, we are there. If medications are stolen, we are there.

Unfortunately, sometimes when we write prescriptions we are harming patients, not helping them. Prescription Drug Abuse is an epidemic with 105 lives lost per day nationwide according to the Centers of Disease Control. All of these deaths are preventable.

We prescribe 10 times more pills now than we did 10 years ago. There is a high street value for many of the controlled substances, and diversion of medications is a serious problem. We need to follow the Goldilocks rule: not too much, not too little, but just right. The quantities of pills need to help, without leftover for potential diversion or waste.

It is much harder to say no to patients than to say yes. The "Yes" doctors are quickly identified as the "candy man" in the community. The "Yes" emergency departments are the "candy land." Word gets out quickly.

Hopefully this article will help you to say "No," to do it in a nice way, and to realize that you are helping your patient with your decision. You are the ultimate patient advocate, and that is why you must prescribe safely.

These are general recommendations based on my experiences and those of my colleagues. I chair the prescription drug abuse medical task force in San Diego, with California ACEP, and work with the medical and community at large to curb the prescription drug abuse epidemic. You may like some suggestions and not others. That's not a problem. With time and practice you will develop the best language that works for you.

Helpful Prescribing Tips:

- CURES is your friend. It is a valuable tool, like checking old records. It makes you a better doctor. I had a patient who said, "I don't have a doctor." I checked CURES, and they did have a doctor. "Oh, that's not my doctor, that's just my pain doctor." You will also find out when patients really need a prescription and couldn't get it. CURES will help you prescribe smarter.

- There are many patient advocates who are appalled by the number of prescriptions that we write for. We generally hear the complaints when we do not give prescriptions that patients are demanding. However, there are an equal number of people who are angry that doctors are over-prescribing. "I can't believe that the doctor gave me 30 Percocet after a simple cyst was removed!" I have seen a prescription of Vicoprofen given after a dental cleaning! The prescription was given to the wife of a prescription drug abuse advocate. Now it is a permanent exhibit in the anti-drug lectures.

- Opioid withdrawal is uncomfortable, but not dangerous. New patients who present to the pain specialist are not immediately given whatever meds they state they need. The specialist first does research - CURES report, drug screen, reviews old records - and it may be 2 weeks before the patient is placed on a regular regimen. Do not feel badly if you are sending a patient home without a pain prescription in someone who has already received one in the past month from a different provider.

- Chronic Pain Medication refill principles are really the same for all patients. The underlying diagnosis does not matter - cancer, sickle cell anemia, spinal stenosis, fibromyalgia. If the patient has prescriptions from other doctors, then the ED should not be giving more prescription.

- Benzodiazepine withdrawal, unlike opioid withdrawal can be dangerous. Xanax is a frequently requested medication. However the half-life is short and abuse potential is high. According to the San Diego Coroner report, the deaths from Xanax equal the deaths from oxycodone. If you need to prescribe a benzodiazepine, give ativan or librium.

- For alcohol withdrawal, there is no point in writing a prescription for librium if the patient plans on continuing to drink. Ask the patient what his or her intention is. If they want to try and stop, then by all means, write a prescription. The alcohol treatment programs recommend that you write the prescription "prn", so if your patient goes to a treatment program it can be given as needed instead of round the clock. Usually no more than 10 pills are needed.

- If a patient already has pain pills at home, they usually do not need more pills from you. A patient with a kidney stone or humerus fracture, who already is on Percocet for back pain, usually does not need extra pills. Treat the acute pain in the ED/Urgent Care Centers, but the patient may not need another prescription.

- Patients on chronic pain medications should have a pain contract with their doctor. Chronic pain means needing opioids for 3 months or more. The Medication Agreement states that medications will not be refilled in the emergency department/urgent care centers, that lost prescriptions will not be refilled, and that the patient should make appointments with his or her doctor before he or she runs out of their medication. Having such a patient come to the ED for a prescription is like a child asking the mother for permission to go out after the father said no. (For my kids this is a crime with the highest level of punishment). You are not helping the patient by filling such a prescription.

- Patients should not mix opioids and benzodiazepines. Patients should not mix opioids with illegal drugs. Pain specialists as part of their practice make patients choose between opioids and benzodiazepines. There are unfortunate patients who have a legitimate pain condition, but refuse to stop abusing meth or heroin, and therefore the clinics will not refill pain prescription. Giving a controlled prescription to a patient who is a known addict is a DEA violation and can jeopardize your license.

- Don't prescribe Soma (Carisoprodol). This is a highly abused medication that is suppose to work as a muscle relaxant, but in fact is metabolized to meprobamate, a horse tranquilizer that is no longer available in Canada, Sweden, and Norway. If you are prescribing a muscle relaxant, use Flexeril (cyclobenzaprine) instead. Soma is part of the "Holy Trinity": Oxycodone, Xanax, and Soma. Some pharmacies have a red flag warning to call a physician for a written justification for all patients on the "Holy Trinity." It's much easier to just not write for Soma than to fill out paperwork explaining why the patient needs it.

- In a hurry? Don't want confrontation? It is a lot easier to say "yes" and just give a few pills. It is much harder to say "no", look at CURES and check prior records. How bad can a few pills be? A few pills can mean continued addiction, drug diversion, avoiding getting help, and even death. The yes doctor is the "candy man." You need to follow the well know rule of medicine: "Physician do no harm".

Helpful Patient Answers

PATIENT COMPLAINT: "Back Pain or Headache with multiple previous visits."

PROVIDER ACTION: "Listen carefully; get a full history, physical, and medication history."

Don't make the mistake of jumping to conclusions because the patient is there again and again for the same complaint. Don't start rolling your eyes and label the patient a "drug seeker."

The first thing to do is to treat this patient like any other patient. EMTALA mandates that even if a patient presents with a chronic condition, you need to do a full screening to make sure the patient does not have an emergency medicine condition. Sit down, take a good history and include a very detailed medication history. Do a thorough physical examination. Check the old chart. Do your homework even more than you would a different patient. See if something was missed on previous visits.

I am sure you have seen a patients like this example. Chief complaint: "headache," and the nurses said "he is here all the time - he just wants drugs." I smiled, thanked them for the heads up, put blinders on to what was implied, and took the time to do a careful assessment. This patient was in hospital a month ago for headache with a negative work up. There was an explanation of why the admitting team did not think an LP was warranted. Teaching point - someone didn't want to do a test that = I have to do it. And of course, this man had meningitis. Not just any meningitis, but TB meningitis. We all know that revisits to the ED/urgent care centers are opportunities to find the real diagnosis.

PATIENT REQUEST: "Can I have something for pain?"
This is a common request from many patients with various chief complaints.

PROVDIER ANSWER: "Yes, let me check your medical record for the best choice."
You will generally offer pain medications to many patients before they even ask. You may not need the part about "let me check your records." Even with patients who are drug seeking, you will often want to offer pain relief, even if it is a non-opioid choice. Then go to the chart, to CURES, and do some research for the best plan.

PATIENT REQUEST: A patient requests a pain prescription when medical records or CURES show that they already receive a prescription from a different provider.

PROVIDER ANSWER: "I will treat your pain now, but your doctor needs to write for any additional prescriptions."
"I see that you already have prescriptions from Dr. X. For your safety all of your pain medications need to be regulated by a single doctor and pharmacy." **Although I cannot write for a pain prescription, I can certainly help with your pain today."**

Usually that does the trick. However if you need, you can use the following lines:

"These medications are controlled by the DEA, which has strict rules for both the doctor and the patient. You have to get any new prescriptions from your doctor or clinic."

"**We practice safe medicine and therefore all prescriptions and care should be coordinated with your doctor."**

And finally, you can simply say**, "I am sorry, we follow the safe prescribing guidelines, which means all your narcotic prescriptions have to come from one doctor and one pharmacy."**

PATIENT COMMENT: "But my doctor is out of town, my insurance changed, I couldn't get an appointment"

PROVIDER ANSWER: "I'm sorry that happened. We can help you with your pain in the emergency department/urgent care center, but for your safety you will need to contact your doctor for any additional prescriptions."
Like with talking to small children, try to avoid the word, "no", and make statements in the positive.

Look at the CURES report. You will see if the patient has received medications from the same clinic on a monthly basis. If this is the case, then it should be part of their pain contract not to get additional prescription from the ED/Urgent Care Center. If the patient is doctor shopping, then you should not be part of that.

"Your doctor would want us to honor the pain contract, so I would want to follow your doctor's recommendations."

I have had a patient tell me "But I made sure I did not sign the contract, so that I can get more medication." Well... just because she didn't sign it doesn't mean we should not be following the pain contract.

PATIENT COMPLAINT: "None of the other medicines work for me"
Patients frequently say, "I tried ibuprofen", "I tried Vicodin", and "Those don't work for me. What I really need is Dilaudid 2 mg IV with Benadryl 50 mg and Phenergan."

PROVIDER ANSWER - "Can you please tell me how you take the prescription?"
There are some reasonable patients who really tried the ibuprofen and Vicodin, but you need to find out exactly how they used it.

You need to ask: **"Tell me how are you taking your medication."** Find out the dose and the timing.

You will be surprised how many patients used 400 mg of ibuprofen twice a day and it was not enough. Or they took one pill of Vicodin last night and now 8 hours later they are in the ED/Urgent Care Center with pain again without taking anything in between.

Depending on the description of how the medications are being taken, your answer could be: "**That's the right dosing**, good job, you should continue." Or "**That's not quite giving the medications a chance to work**. Let's try having you take the medication with a good dose. If you take Vicodin 4 times a day and add ibuprofen 4 times a day, you can alternate and have something to take 8 times a day. The combination works well."

The unreasonable patient will give you a vague answer like: "I have tried it in the past, so I know it doesn't work," or "I am allergic to everything." This is a red flag for you to check CURES and old records. The answer is: **"I need to review your records to find out what the best options are."** Go to the records, do the research, find out the allergies and what they received before, and return with a plan.

PATIENT COMPLAINT: "My prescriptions were lost"
Patients will come to the ED/Urgent Care Centers and ask for a refill of a prescription because they lost it. We have heard all the reasons: "I forgot them on the bus," "My back pack was stolen," " I flushed them down the toilet because I thought I didn't need them," "they fell in the pool," and "I lost them at Disneyland."

PROVIDER ANSWER: "I can give you something for pain now, but it is best for your doctor to coordinate any additional prescription."
If the patient says that the prescriptions were stolen, then the answer is easy:
"Did you file a police report?" These are highly abused medications that are sold illegally. If a prescription were stolen then the DEA or police would want to know about it.

With a lost or stolen prescription, you need to listen to the story and use your judgment. Pain Agreements state that patients should not lose their medications and keep them safe. Some pain agreements allow for one lost prescription a year. The primary care doctor should be aware of the missing prescription. It is probably best to have lost or stolen prescriptions refilled by the primary care provider who can take account of all the prescriptions. Check a CURES report and see if there is a bigger problem.

Make sure that you document on the patient's discharge instructions and in your dictation: **"Please obtain all pain medications from single doctor or clinic. No refills will be provided by the emergency department/urgent care center."** This should be a message for doctors coming after you that the patient has received information on safe prescribing.

PATIENT QUESTION: "I need some codeine for my cough."

Phenergan with codeine cough syrup is a highly abused medication. There are cultures that put this medication in their drink and sip it all day. There have been pharmacies in some parts of town that received a fine for excessive loads of Phenergan with codeine. I've seen funny hidden camera videos showing pharmacy techs sneaking sips of codeine while at work.

PROVIDER ANSWER: "The best medicine for your cough is an inhaler."
"The inhaler opens your lungs and gets the junk out. A cough syrup just prevents the cough reflex and keeps the junk in. That's why I don't prescribe the cough syrup and use the inhaler instead".

PATIENT QUESTION: "My tooth hurts."

PROVIDER ANSWER: "Would you like a shot to stop the pain?'

One of my favorite patients is a dental patient, and not because my husband is a dentist. It's because these are the most grateful patients. Do a dental block with Marcaine and get 100% relief for 6 hours. When I ask "Do you want a shot like the dentist for your pain that will numb up your tooth?" Patient with true dental pain will say: "Anything, just get rid of the pain." You should never give an IM injection of Dilaudid for dental pain. If the patient is "scared" of a shot (dental block), then you can offer a couple Vicodin in the ED/urgent care and check a CURES report to see if you should be writing a prescription or not.

PATIENT QUESTION: "I know my rights!"
There are patients who are angry no matter what we do or how nice we are. They threaten to sue you and want to talk to a manager.

PROVIDER ANSWER: "I am happy to refer you to our manager."
Remember that you are on stage when you talk to patients. Your conversation is not just for the patient, but also for the big audience of other patients and staff who are listening in on the interesting loud interaction. The listeners want to root for you.

I have used the same language to one patient who is so thankful that someone took the time to explain the dangers of the medications, and another who gets angry and called administration.

If you are referring the patient to hospital administration, hopefully they understand and are educated about safe prescribing. If not, you should provide some educational background and refer them to the various web sites that explain the prescription drug abuse epidemic and safe prescribing. (CaliforniaACEP.org or SanDIegoSafePrescribing.org).

There are several lines you can use in difficult situations:

"I am sorry you feel this way, and I am happy to refer you to our manager."
"This is the same treatment I give my own family."

PATIENT MEDICATION HISTORY: " Vicodin, Ambien, Xanax, Soma, Neurontin, ..."

PROVIDER ANSWER: "I see that your medications have some drug interactions."
I am sure you have reviewed patient medication lists that go on for pages. Use this as an opportunity to alert the patient to polypharmacy or for opioid and sedative interactions. A patient may present with a fall, but the fall is because of all the medications.
"Wow, that's a long list of medications!"
"I see from the list that you are taking pain medications and anxiety medications together. That could be a dangerous combination."
"I don't want to make changes to your medications, but you should discuss this with your doctor, and at least do not take the oxycodone and xanax at the same time."
"You seem very sleepy from these medications."

"Could it be that you fell down because of your medications?"
One family member of a patient I saw agreed with my explanation and said, "We don't want a Michael Jackson."

PATIENT PRESENTATION: Abdominal pain with multiple negative work ups.
PROVIDER ANSWER: "How often do you use marijuana?"

The first thing to do is a good history, physical, and make sure that a different diagnosis has not been overlooked. After that, think marijuana.

Marijuana these days is not the marijuana of the 1970s. California marijuana can have 25% THC or more, while in the 70's marijuana was 3% THC. There is a new surge of chronic abdominal pain patients who have had multiple CT scans, endoscopies, colonoscopies, and ultrasounds, all with negative results, but with a history of daily marijuana use. The treatment for THC associated cyclic vomiting syndrome is to get off the marijuana, and not to get more and more Dilaudid. Treating marijuana toxicity with opioids is creating a second addiction on top of the first one. This is difficult to explain to patients, because they were told marijuana helps nausea rather than causing it. If you can convince the patient to stop marijuana for several months (not just a few days), they will be grateful later.

PATIENT PRESENTATION: Musculoskeletal pain in a Patient who is in recovery.

PROVIDER ANSWER: "You did such a good job being clean, it's not a good idea to trade one drug for another."
You see patients in recovery that is proud of their recovery, but have a new pain condition. They understand addiction. Explain to them that using Motrin and Tylenol and limiting opioids will help them prevent a new addiction.

PATIENT COMPLAINT: Pain

PROVIDER DISCHARGE INSTRUCTION: "I will give you a prescription for Norco. Please realize that this is a medication that can be abused. Keep it secure, take it only as prescribed, and do not drive if not fully alert."

The prescription drug abuse advocates request that physicians warn their patients about the seriousness of controlled medications. A quick warning in the ED can go a long way.

PATIENT PRESENTATION: Clear Doctor Shopping

PROVIDER ANSWER: "I am concerned as your medications can be addicting. Would you like me to refer you to someone who can help with this?"

As with everything, you have to use your judgment. Most patients who are in the ED/Urgent Care Center are not ready to admit that they have an addiction, but sometime their family members are around and realize that there is a problem. **Use family and friends to highlight a prescription problem.**

This is the language recommended for the primary care provider when they need to discontinue opioid treatment because of prescription drug abuse: **"The medication no longer appears to be as beneficial as it once was. As the benefits of the opioids no longer outweigh the risks, we need to discontinue this approach and together find a safer and more effective means of dealing with your pain".**

Some patients have very overt doctor shopping and you may want to contact the DEA. Getting the DEA involved can force patients into court mandated drug rehab and save someone's life.

Words at a Glance

PATIENT	PROVIDER ANSWER
Anything	**Remember you are on stage. Your words not just for the patient, but for the staff and patients who are also listening.**
Can I have something for pain?	**"Yes, let me check your medical record for the best choice"**
The medicines don't work	**"Can you please tell me how you take the prescription?"**
Lost Rx Rx from other Sources	**I can give you something for pain now, but it is best for your doctor to coordinate any additional prescription".**
Stolen Rx	**Did you file a police report?**
Patient with chronic pain	**"Your doctor would want us to honor the pain contract, so I would want to follow your doctor's recommendations".**
I need codeine cough syrup	**"The best medicine for your cough is an inhaler.**
Dental Pain	**"Would you like a shot to stop the pain?'**
Abdominal Pain with negative work ups	**"How often do you use marijuana?"**
Previous Recovery History	**"You did such a good job being clean, it's not a good idea to trade one drug for another".**
Opioids and Sedatives	**"I see that your medications have some drug interactions"**
Clear Doctor Shopping	**"I am concerned as your medications can be addicting. Would you like me to refer you to someone who can help with this?"**
Angry Patient	**"I am sorry you feel this way. I will try to treat your pain now, but your doctor needs to coordinate any further prescriptions."**

Further Suggestions

Medscape has a free CME program on "Managing Pain Patients Who Abuse Prescription Drugs." This has video examples of how a primary care provider talks to his patient. You will need a Medscape username and password. www.medscape.org/viewarticle/770440

If you have further tips and suggestions that should be included in the next version of this document, please contact Roneet Lev via email at roneet@cox.net.