

CDC Guidelines for Prescribing Opioids for Chronic Pain

Centers for Disease Control and Prevention

The Epidemic

Misuse, addiction and deaths related to opioid use have become a growing problem over the past decade +, with Michigan being no exception.

- Since 1999, deaths involving PRESCRIPTION opioids have quadrupled
 - **Nationally**, between 1999-2014; 165,000 deaths from overdose
 - 2014: 14,000 + deaths related to prescription opioid use.

Michigan

“Prescriptions for individual dosage units of the most addictive drugs increased from 180 million in 2007 to 745 million in 2014.” – BCBS of Michigan

There was also an increase in the number of controlled substances prescribed by approximately 4 million, in the past 10 years.

Where we rank

- 10th in the nation, per capita prescribing rates of opioid pain relievers.
- 16th in the nation for overdose deaths.

Blue Cross Blue Shield Blue Care Network of Michigan

Guideline for prescribing opioids for chronic pain

With Opioid abuse becoming a national crisis, there was a need for development of clear and consistent guidelines for prescribing.

- **Primary Audience:** Primary Care Providers, Nurse Practitioners, Physician Assistants.
 - **Use:** Treating patients 18 + years of age for chronic pain

**Does not include active cancer treatment, palliative care, and end-of-life care*

12 Recommendations; 3 categories

- Determining when to initiate or continue opioids for chronic pain
- Opioid selection, dosage, duration, follow-up, and discontinuation
 - Assessing risk and addressing harms of opioid use

**These are only intended as an overview of the guideline and full recommendations should be reviewed before prescribing opioids for chronic pain.*

Determine whether to initiate or continue opioids for chronic pain

As taken directly from the Centers for Disease Control and Prevention

Recommendation #1

Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain.

Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient.

If opioids are used, they should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy, as appropriate.

Effective non-pharmacologic therapies: Exercise and Cognitive Behavioral Therapy

Effective non-opioid medications: acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), anticonvulsants, antidepressants

Recommendation #2

Establish realistic goals for patients treatment and pain before beginning opioid therapy.

- Discuss how/when opioid therapy will be discontinued if does not prove beneficial.
- This includes continuing opioid therapy ONLY if there is clinically meaningful improvement in patient condition.

Recommendation #3

Discuss risks and potential benefits of opioid therapy both before beginning treatment and periodically throughout treatment period.

Opioid selection, dosage, duration, follow-up and discontinuation

As taken directly from the Centers for Disease Control and Prevention

Recommendation #4

When beginning therapy, immediate-release opioids should be prescribed instead of extended-release/long acting opioids.

Recommendation #5

When beginning opioid treatment, start with the lowest effective dosage.

- Use caution with any dose
- Start low, go slow- reassess pain and function
 - Increase frequency of follow-ups
- Before/when increasing dosage (especially to >90 MME/day) discuss other pain treatment therapies

Recommendation #6

Opioid treatment for acute pain often leads to long term opioid use; for acute pain treatment with opioids, low dosage with a short duration of time should be considered, if possible.

- 3 days or less will often be sufficient; more than 7 days will rarely be needed.
 - avoid prescribing additional opioids “just in case”.
-

Recommendation #7

Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation.

- Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently.
- If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Assessing Risk and Addressing Harms of Opioid Use

As taken directly from the Centers for Disease Control and Prevention

Recommendation #8

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms.

- Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (>50 MME/day), or concurrent benzodiazepine use, are present.
- Avoid prescribing opioids to patients with sleep-disordered breathing when possible.
 - During pregnancy, carefully weigh risks and benefits with patients.
- Use additional caution with renal or hepatic insufficiency, aged >65 years.
 - Ensure treatment for depression is optimized.

Recommendation #9

Clinicians should review the patient's history of controlled substance prescriptions using state PDMP- **MICHIGAN AUTOMATED PRESCRIPTION SYSTEM (MAPS)** data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him/her at high risk for overdose

- Review PDMP data before beginning opioid therapy and periodically throughout course of therapy
-

Recommendation #10

When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy

- Consider urine drug testing at least annually to assess for prescribed medications use and illicit drugs.

Recommendation #11

Avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

- Offer evidence-based psychotherapies for anxiety: cognitive behavioral therapy, specific anti-depressants approved for anxiety, other non-benzodiazepine medications approved for anxiety
 - Coordinate care with mental health professionals.
-

Recommendation #12

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.

- Discuss concerns with your patient and provide an opportunity for patient concerns.
 - Assess for OUD using DSM-5 criteria.

Tools and Resources

Additional resources available for providers and patients:



IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

- 1 Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
- 2 Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
- 3 Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

Posters
Fact Sheets
Checklists

Education on Epidemic

<https://www.cdc.gov/drugoverdose/index.html>

Online provider training series:

<https://www.cdc.gov/drugoverdose/training/index.html>

Full CDC guidelines for prescribing opioids for chronic pain :

<https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

- 4 When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
- 5 When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day.
- 6 Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
- 7 Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

- 8 Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present.
- 9 Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
- 10 When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
- 11 Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
- 12 Clinicians 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.

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

Prescription Drug Monitoring Programs

As the guideline suggests, the use of a PDMP is a crucial part in responsible prescribing methods.

Michigan's newly redone PDMP was recently relaunched with some very effective additions.

MAPS Update

May 4th, 2017

Presented by

Haley Winans, Analyst

Bureau of Professional Licensing

BPL-MAPS@Michigan.gov | 517-373-1737

Bureau of Professional Licensing

- Established in July 2015
- 10 Occupational Licensing/Regulation Boards
- 25 Health Professional Licensing/Regulation Boards
- Boards are advisory and determine sanctions
- License and regulate over 758,000 individuals
- 3 Divisions: Licensing, Investigations & Inspections, and Legal Affairs/Enforcement
- Drug Monitoring Section: Administers Michigan Automated Prescription System (MAPS) and investigates overprescribing, over dispensing, and drug diversion
 - BPL notifies DHHS, Michigan Association of Health Plans, and BCBS when licensees are suspended as the result of an investigation and are believed to have a significant opioid-addicted population



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MAPS Background

- Established in 2003
- Contains over 120 million records
- Data maintained for 5 years
- Required reporting of CS Schedule 2-5 from:
 - Prescribers who dispense CS Schedule 2-5
 - Pharmacists (dispensers)
 - Veterinarians



MAPS Reporting Requirements

- Board of Pharmacy Rule 338.3162b outlines prescription information that must be reported to MAPS. Information includes:
 - Patient identification number
 - If under age 16, all zeroes shall be submitted
 - If patient is an animal, positive identification of the animal's owner
 - Quantity
 - National Drug Code (NDC)
 - Prescription issue date
 - Prescription fill date
 - Estimated day supply
 - Prescription number
 - Prescriber DEA number
 - Dispenser DEA number
- Accuracy in reporting is extremely important, as MAPS is a tool used by health professionals, law enforcement and regulatory agencies, and benefit plan managers
 - **Ex: Correct prescriber DEA number of who issued prescription**



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MAPS Replacement Project

- MAPS replaced with new system software
 - Vendor: Appriss Health's PMP AWARe
- 6 month project started in October 2016
- Successfully launched and implemented on April 4, 2017
- All users of the old system are required to create a new account with MAPS through the PMP AWARe software
- Will continue to seek feedback from Stakeholders



Registration

When you go to the site and register for the first time, please have the following information for reference:

- DEA Registration ID (#)
- License ID (#)
- Controlled Substance License ID (#) – if applicable
- National Provider Identifier (NPI)



PMP AWARxE Preview

Help PMP AWARxE

Log In

Email

Password [Reset Password](#)

[Login](#) [Create an Account](#)



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PMP AWARxE Preview

Registration Process

Create an Account

[Registration Process Tutorial](#)



[Get Adobe Acrobat Reader](#)

Email

Password

Password Confirmation

Save and Continue



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PMP AWARxE Preview

Registration Process

Select your User Roles

- ▶ Healthcare Professional
- ▶ Law Enforcement
- ▶ Other

Save and Continue

- Once user role is chosen, user will be prompted to enter identification criteria, including but not limited to: DEA number, DOB, professional license number, address, phone number
- Delegate users required to enter supervisor email(s) used to register. Supervisor is required to approve Delegate users in their own account.

Delegate

I am a delegate for... *

...the following people

email: + Add...

Submit Your Registration



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PMP AWA_Rx_E Preview

The screenshot displays the PMP AWA_Rx_E dashboard. At the top, there is a navigation bar with links for Home, RbSearch, User Profile, Help, and Log Out. Below this is a secondary navigation bar with Home, Dashboard, and Announcements. The main content area is titled "My Dashboard" and is divided into several sections:

- Patient Alerts:** A table listing patient alerts with columns for Patient Full Name, DOB, Alert Date, and Alert Letter. The table contains five rows, with the third row for "BOB TESTPATIENT" highlighted in green and marked as "new".
- Announcements:** A box containing a message for physicians dated 11/09/2015, with the text "Test message for only Physicians".
- Quick Links:** A section with a single link for "Google".
- Recent Requests:** A table listing recent requests with columns for Patient Name, DOB, Request Date, and Delegate. It contains six rows of data.
- Delegates:** A table listing delegates with columns for Delegate Name, Status, and Request Date. It contains two rows of data.



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PMP AWARxE Preview

[User Profile](#) [My Profile](#) [Delegate Management](#) [Password Reset](#) [Log Out](#)

My Profile

Name: [Redacted] Employer DEA(s): [Redacted]
DOB: [Redacted] Employer: [Redacted]
Primary Contact: [Redacted] Employer Phone: [Redacted]
Professional License #: [Redacted] Type: LPN Role: Prescriber Delegate - Licensed

Add a Healthcare Specialty [Browse All](#)
Search by keyword (e.g. Allergy, Internal, Sports, Clinical)
[Designate Primary Specialty](#)

Animate Interface
Time Zone: UTC

Email: [Redacted]
Change Email: [Redacted]
Re-enter Email: [Redacted]

Supervisors:
I am a delegate for...
...the following people email: [Redacted] + Add...
[Redacted]
State of Michigan : P: 517-373-1737 F:
611 W Ottawa, ; Lansing, MI 48933

[Save Changes](#)

- Delegate users able to add additional supervisors or remove, and Supervisors are able to manage their Delegate users



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PMP AWARxE Preview

Home RxSearch User Profile Help Log Out PMP AWARxE

RxSearch Patient Request Bulk Patient Search Requests History MyRx Patient Alerts

Patient Request

Supervisor Select

Patient Rx Request Tutorial Get Adobe Acrobat Reader

Patient Info	Patient Location	PMP Interconnect Search
First Name* <input type="checkbox"/> Partial spelling <input type="text"/>	City <input type="text"/>	
Last Name* <input type="checkbox"/> Partial spelling <input type="text"/>	State/Province State Select <input type="text"/>	
DOB* mm/dd/yyyy <input type="text"/>	Zip Code <input type="text"/>	
Prescription Fill Dates		
From* No earlier than 2 years from today <input type="text" value="01/17/2016"/>		
To* <input type="text" value="01/17/2017"/>		

Search



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PMP AWARxE Preview

[Home](#)
[Data](#)
[RxSearch](#)
[Insight](#)
[Admin](#)
[Settings](#)
[User Profile](#)
[Help](#)
PMP AWARxE

[RxSearch](#)
[Patient Request](#)
[Bulk Patient Search](#)
[Requests History](#)
[Requests Processing](#)
[MyRx](#)
[Patient Alerts](#)

Patient Report [Refine Search](#)

Report Prepared: 09/13/2016

Date Range: 09/13/2015–09/13/2016



▶ **John Doe**

▼ **PATIENT ALERTS**

SUSPECTED PRESCRIBER/PHARMACY SHOPPER

Please note that this person has received controlled substances prescriptions written by **1** prescribers and had them filled at **1** pharmacies during the past **3** months. This equals or exceeds the threshold of **1** prescribers and **1** pharmacies and while there may be a valid reason for this, it also may be indicative of the practice of prescriber and/or pharmacy shopping.

PATIENT'S COUNTS
 Prescribers: 1
 Pharmacies: 1
 Time Frame: 3 Months

ALERT THRESHOLDS
 Prescribers: 1
 Pharmacies: 1

Alert Disclaimer Text Limits Set: 1 & 1 in 3 months

Summary

Prescriptions:9 Prescribers:4 Pharmacies:3 Private Pay:5 Active Daily MME:0.0

▼ Prescriptions

Filled	ID	Written	Drug	QTY	Days	Prescriber	Rx #	Pharmacy *	Refills	MME/D	Pynt Type	PMP
06/22/2016	1	06/21/2016	ACETAMINOPHEN-COD #3 TABLET	3.0	3	Ap Doc	JD1528588	Appri (1119)	-1	4.5	Private Pay	DO



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PMP AWARxE Preview

The screenshot displays the 'Bulk Patient Search' interface within the PMP AWARxE system. At the top, a navigation bar includes links for Home, RxSearch, User Profile, Help, and Log Out, along with the system name 'PMP AWARxE'. Below this, a secondary menu highlights 'Bulk Patient Search' among other options like Patient Request, Requests History, MyRx, and Patient Alerts.

The main section is titled 'Bulk Patient Search' and features a 'Supervisor Select' dropdown menu. Underneath, users are prompted to 'Enter Patients by' and can choose between 'Manual Entry' and 'File Upload'.

Manual Entry: This section includes input fields for 'First Name*', 'Last Name*', 'Date of Birth*' (with a 'mm/dd/yyyy' placeholder), and 'Zip Code'. An 'Add +' button is positioned to the right of the Zip Code field.

OR

File Upload: This section includes a 'Sample file' link, a 'Choose a file' button, a 'Choose File' button, and a 'Clear' button. A 'Validate Format' button is located below these options.

Name Grouping: This section has a 'Group Name*' input field.

Prescription Fill Dates: This section includes a 'From*' field with the text 'No earlier than 2 years from today' and a date input field containing '01/17/2016'. It also has a 'To*' field with a date input field containing '01/17/2017'.

PMP Interconnect Search: This section is currently empty.

At the bottom left, there is a 'Bulk Search History' link with a right-pointing arrow. At the bottom right, there is a 'Search' button.



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PMP AWARxE Preview

Home | RxSearch | User Profile | Help | Log Out | PMP AWARxE

RxSearch | Patient Request | Bulk Patient Search | Requests History | My Rx | Patient Alerts

My Rx

Prescriptions Written	DEA Numbers
from* No earlier than 2 years from today <input type="text" value="mm/dd/yyyy"/>	<input checked="" type="checkbox"/> <input type="text"/>
to* <input type="text" value="mm/dd/yyyy"/>	
Generic Drug Name (Optional) <input type="text"/>	



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Questions?

For technical assistance, please contact Appriss' customer first center at:

- 844-364-4767

For policy or administrative assistance, please contact MAPS support team:

- 517-373-1737 or BPL-MAPS@Michigan.gov



Thank You

Special thank you to all our Stakeholders who have been involved and engaged with our team as we transitioned MAPS to Appriss Health's PMP AWARxE platform.



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Bureau of Professional Licensing MAPS Frequently Used Websites

MAPS software was replaced with Appriss Health's PMP AWARxE software, effective April 4, 2017. This frequently used website sheet is a quick reference list of important links and information about the new software.

PMP AWARxE: <https://michigan.pmpaware.net>

- This new site allows licensed professionals (and their delegates) to access data. This is the same site that law enforcement and benefit plan managers use to request data from MAPS.

PMP Clearinghouse: <https://pmpclearinghouse.net>

- This site allows licensed professionals who dispense and pharmacies to submit data (controlled substances that have been dispensed) to MAPS.

MAPS – BPL/LARA website: www.michigan.gov/mimapsinfo

- Information about MAPS, laws, requirements, reports, quick links, and communication, including feature guides and tutorials on how to register and use the new MAPS, PMP AWARxE software, can be found on this site.

Technical Application Support:

- Appriss Customer First Support: **1-844-364-4767**
- Appriss Email Support:
PMP AWARxE: <https://apprisspmp.zendesk.com/hc/en-us/requests/new>
PMP Clearinghouse: <https://apprisspmpclearinghouse.zendesk.com/hc/en-us/requests/new>

MAPS Policy and Administrative Support:

- MAPS Team: **517-373-1737**
- MAPS Email: BPL-MAPS@michigan.gov