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.

Blue Cross Blue Shield Blue Care Network of Michigan

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

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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.

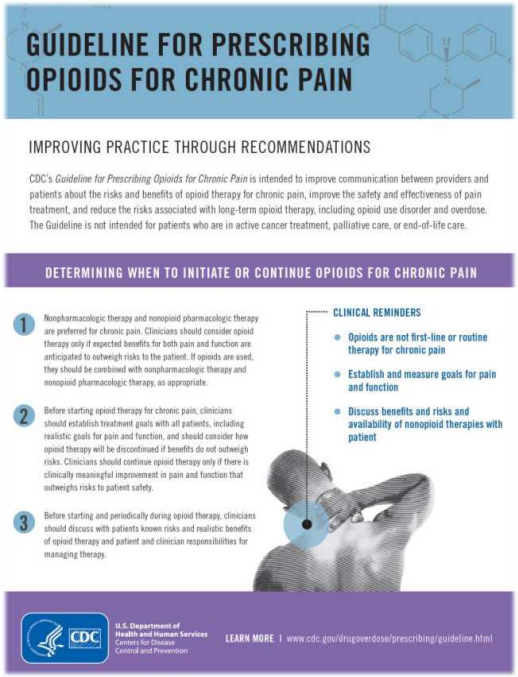
- Offer evidence-based psychotherapies for anxiety: cognitive behavioral therapy, specific anti-depressants approved for anxiety, other non-benzodiazepine medications approved for anxiety
- Coordinate care with mental health professionals.

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



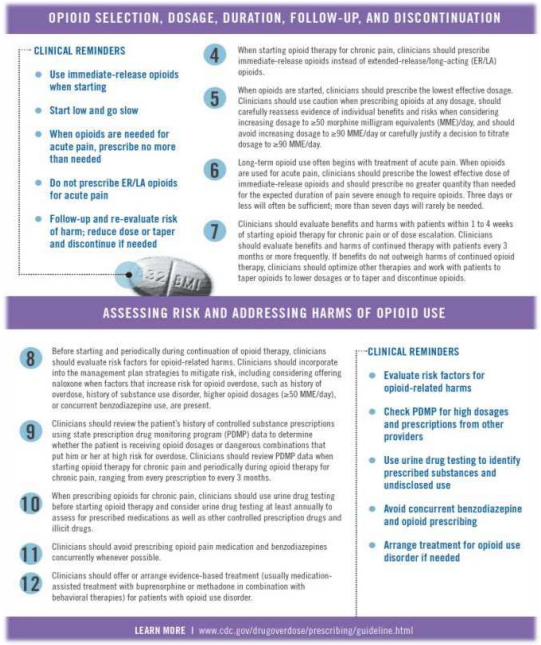
Additional resources available for providers and patients:

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



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.

LICENSING AND REGULATORY AFFAIRS
CUSTOMER DRIVEN. BUSINESS MINDED.

MAPS Update

May 4th, 2017

Presented by
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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

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**

MAPS Replacement Project

- MAPS replaced with new system software
  - Vendor: Appriss Health's PMP AWARxE
- 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 AWARxE 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 Indentifier (NPI)

PMP AWARxE Preview

PMP AWARxE Preview

PMP AWARxE Preview

- 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.

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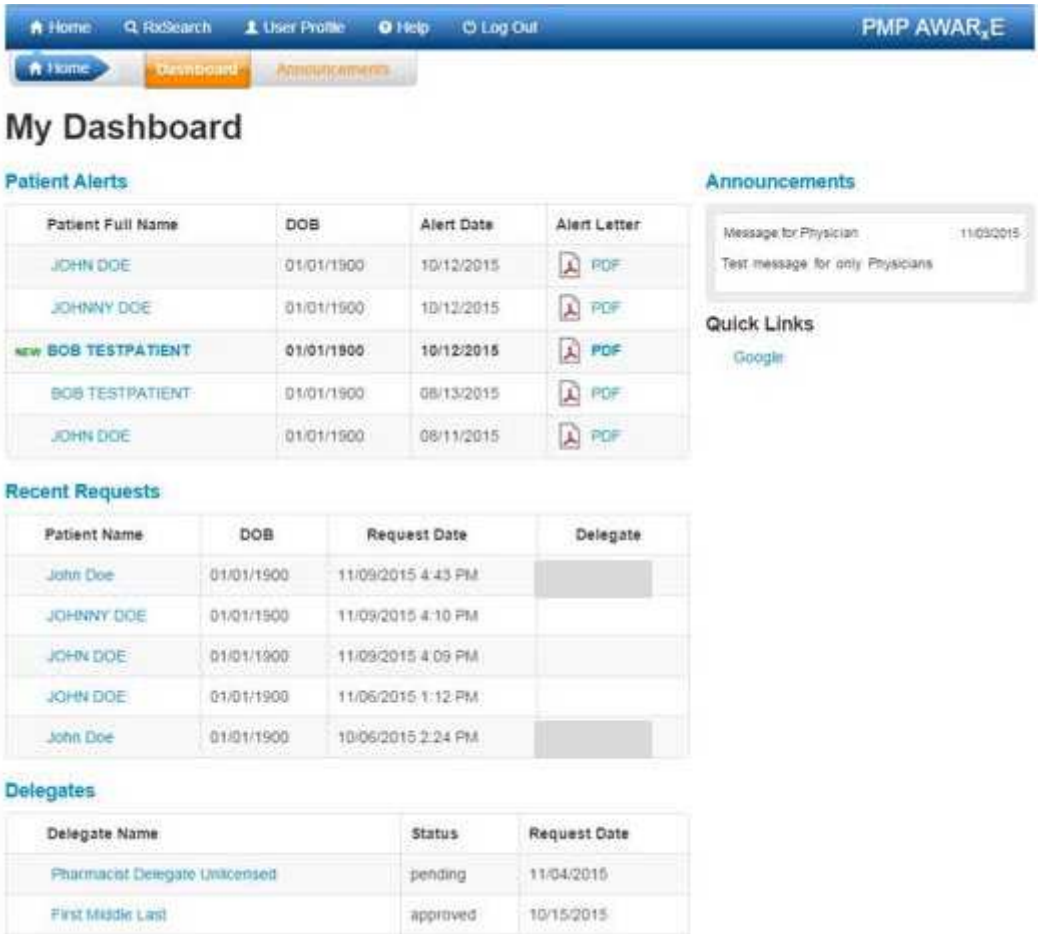
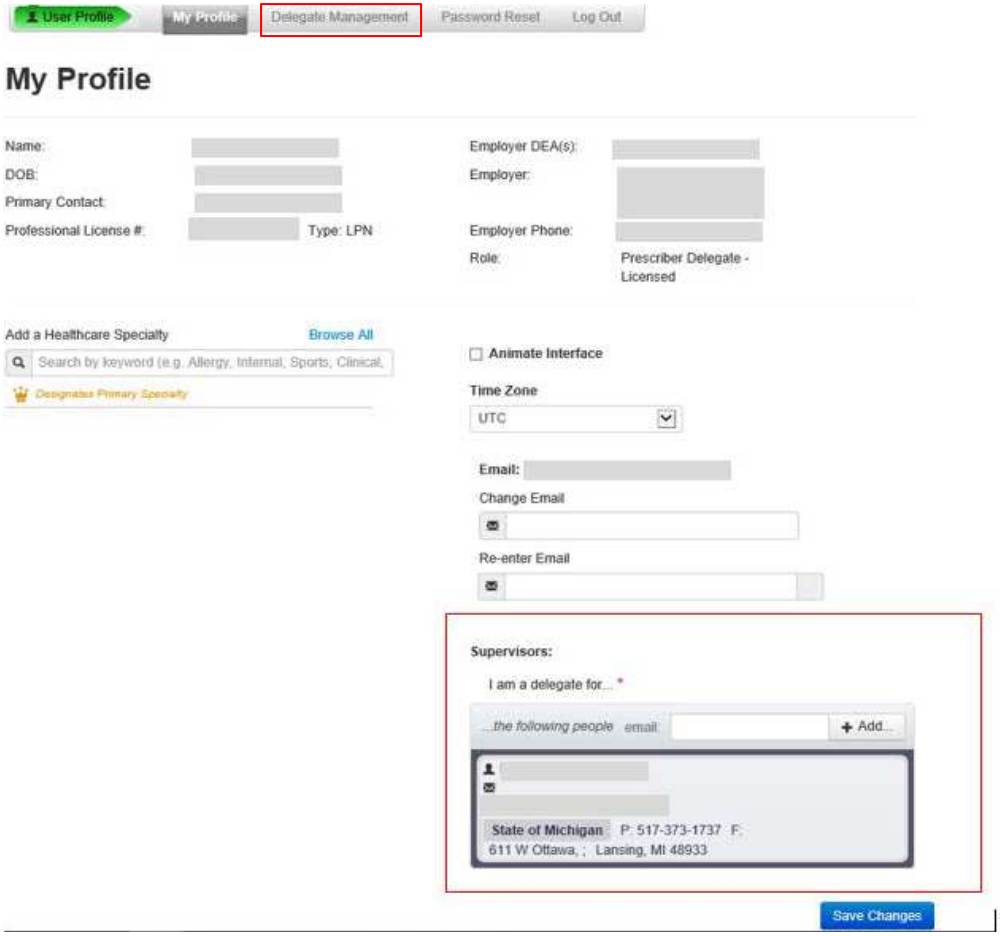
PMP AWARxE Preview

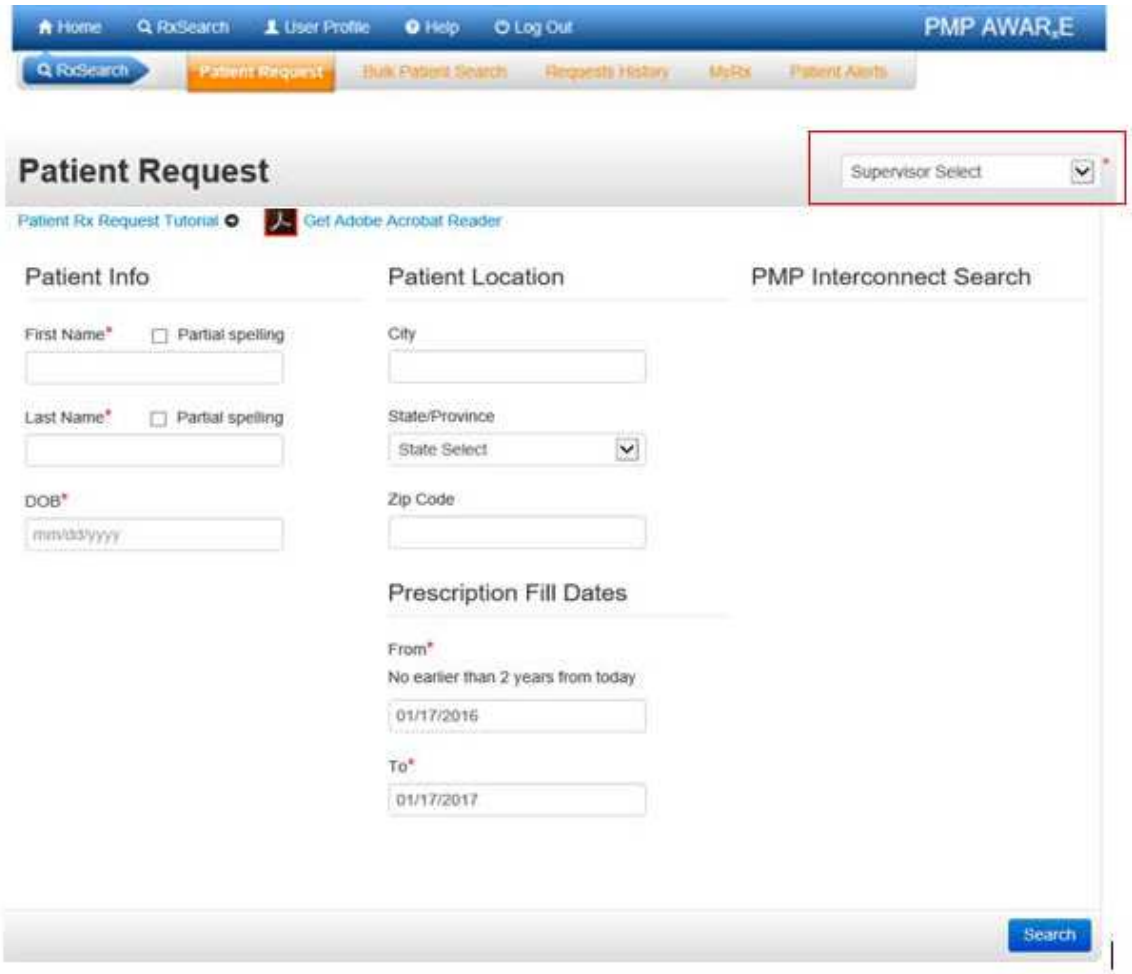


PMP AWARxE Preview



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

PMP AWARxE Preview



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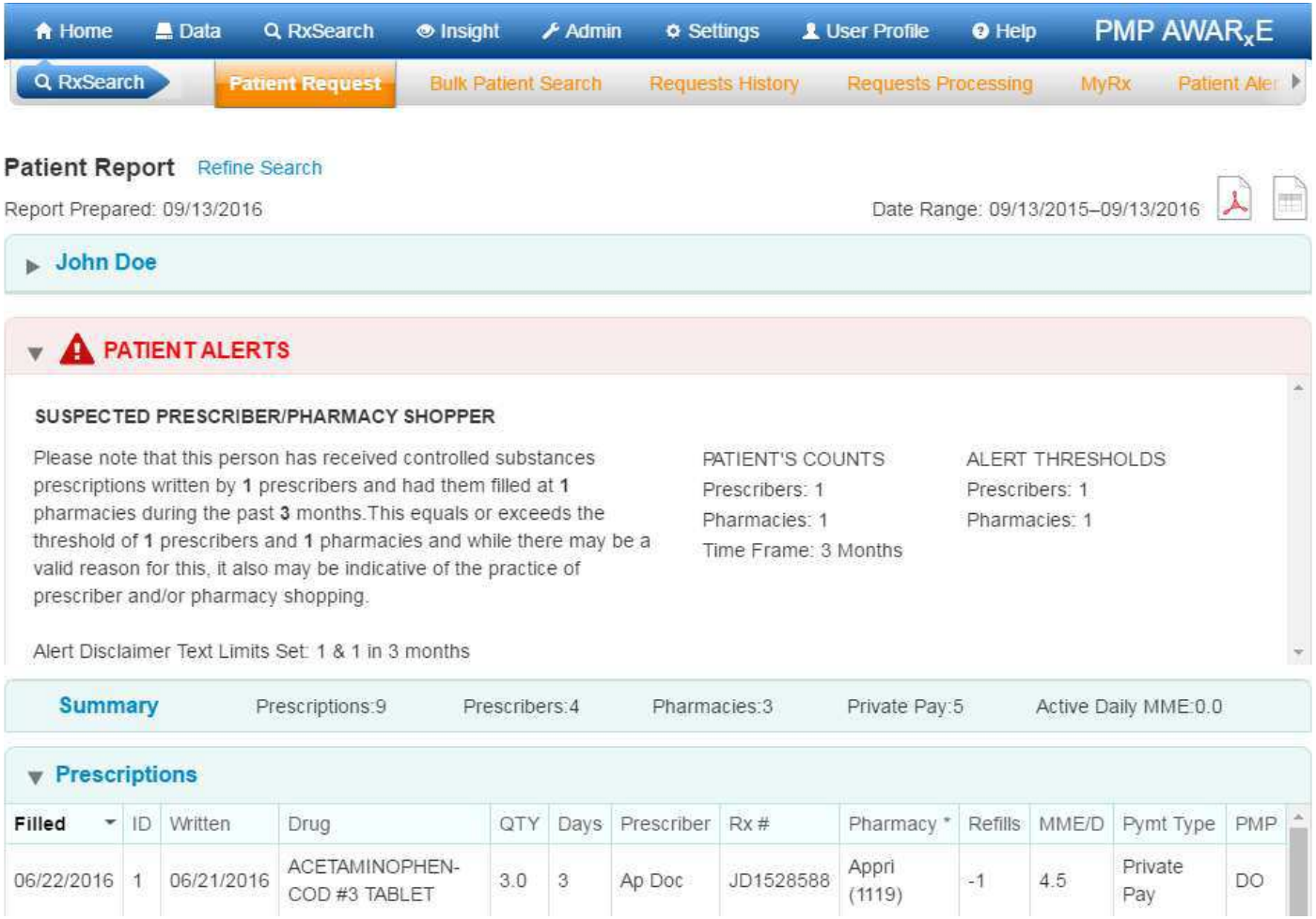

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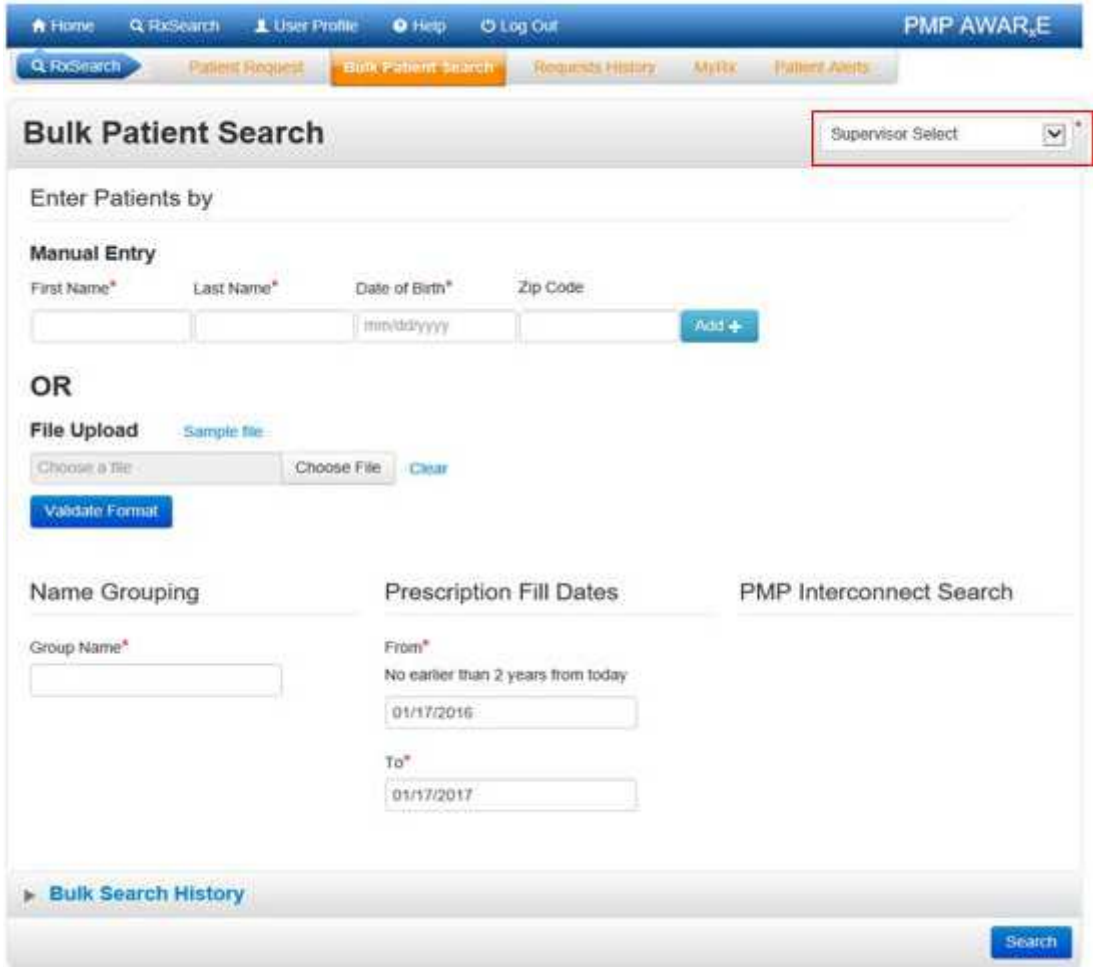

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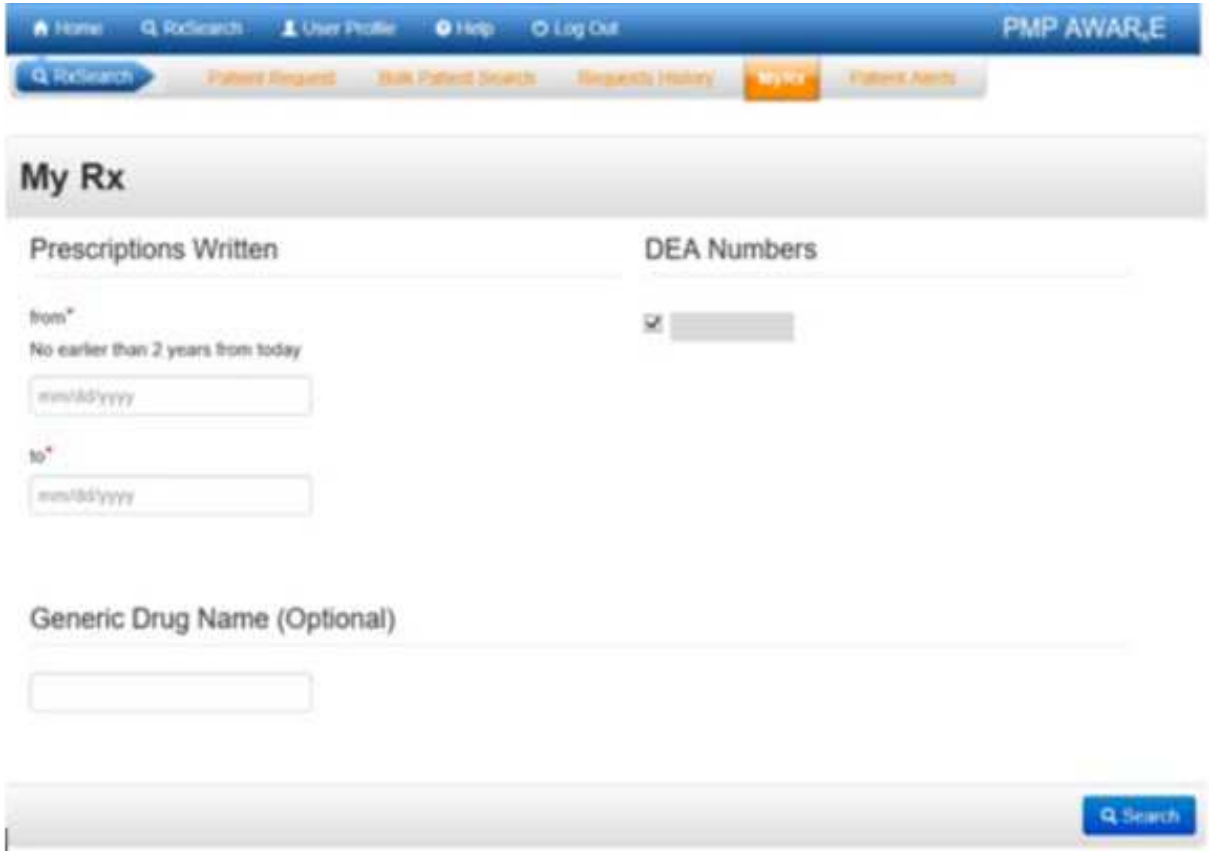

Questions?

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.

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

Updated 04/18/2017