



CO*RE COLLABORATION FOR REMS EDUCATION

PRESENTS

OPIOID PRESCRIBING:

Safe Practice, Changing Lives

UPDATED IN 2017

CHAPTER 1

WELCOME



BIO: Annette Carron, DO

Annette T. Carron, DO, CMD, FACOI, FAAHPM is Director of Geriatrics and Palliative Care at Botsford Hospital in Farmington Hills, MI. Dr. Carron is also an Assistant Clinical Professor, of Internal Medicine at Michigan State University College of Osteopathic Medicine.

DISCLOSURE:

Dr. Carron has nothing to disclose.





NO CO*RE PARTNER HAS ANY CONFLICTS OF INTEREST TO REPORT (APPENDIX 2)

FACULTY ADVISORY PANEL



David Bazzo, MD
UC SAN DIEGO



Ron Crossno, MD
KINDRED AT HOME



Kate Galluzzi, DO
PHILADELPHIA COLLEGE
OF OSTEOPATHIC MEDICINE



Carol Havens, MD
KAISER PERMANENTE



Randy Hudspeth, APRN
PRACTICE CONSULTANT



Cathy Judd, PA-C
PARKLAND HEALTH



Ed Salsitz, MD
MT. SINAI BETH ISRAEL



Seddon Savage, MD
DARTMOUTH COLLEGE



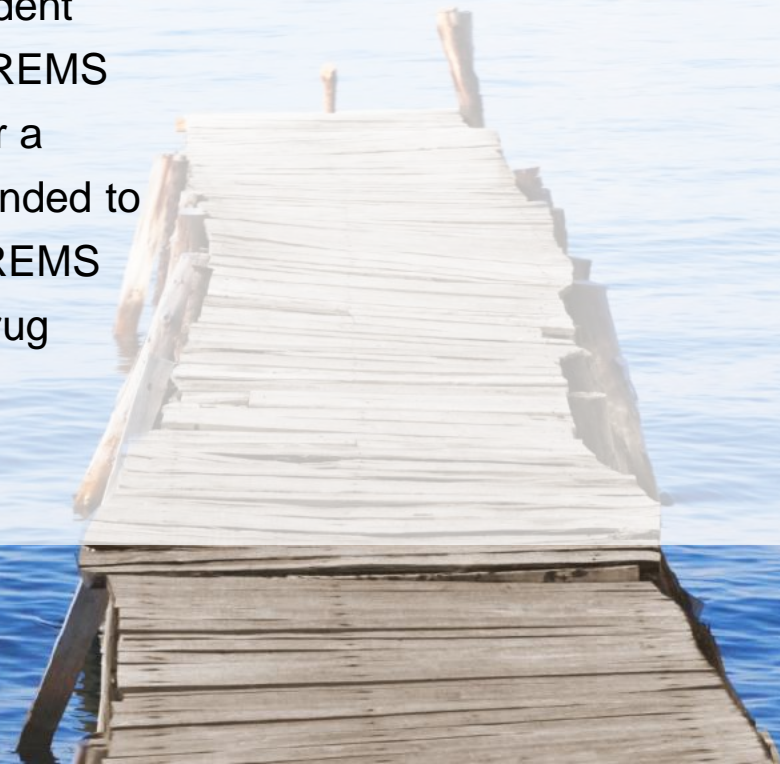
Barb St. Marie, ANP
UNIVERSITY OF IOWA

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ACKNOWLEDGEMENT

Presented by **American Osteopathic Association**, a member of the Collaborative on REMS Education (CO*RE), 11 interdisciplinary organizations working together to improve pain management and prevent adverse outcomes.

This educational activity is supported by an independent educational grant from the ER/LA Opioid Analgesic REMS Program Companies. Please see [this document](#) for a listing of the member companies. This activity is intended to be fully compliant with the ER/LA Opioid Analgesic REMS education requirements issued by the US Food & Drug Administration.



PRODUCTS COVERED BY THIS REMS



BRAND NAME PRODUCTS

- Arymo ER morphine sulfate ER tablets
- Avinza® morphine sulfate ER capsules
- Belbuca® buprenorphine buccal film
- Butrans® buprenorphine transdermal system
- Dolophine® methadone hydrochloride tablets
- Duragesic® fentanyl transdermal system
- Embeda® morphine sulfate/naltrexone ER capsules
- Exalgo® hydromorphone hydrochloride ER tablets
- Hysingla® ER hydrocodone bitartrate ER tablets
- Kadian® morphine sulfate ER capsules
- MorphaBond® morphine sulfate ER tablets
- MS Contin® morphine sulfate CR tablets
- Nucynta® ER tapentadol ER tablets
- Opana® ER oxymorphone hydrochloride ER tablets
- OxyContin® oxycodone hydrochloride CR tablets
- Targiniq™ ER oxycodone hydrochloride/naloxone hydrochloride ER tablets
- Troxyca ER oxycodone hydrochloride/naltrexone capsules
- Vantrela ER hydrocodone bitartrate ER tablets
- Xtampza ER oxycodone ER capsules
- Zohydro® hydrocodone bitartrate ER capsules

GENERIC PRODUCTS

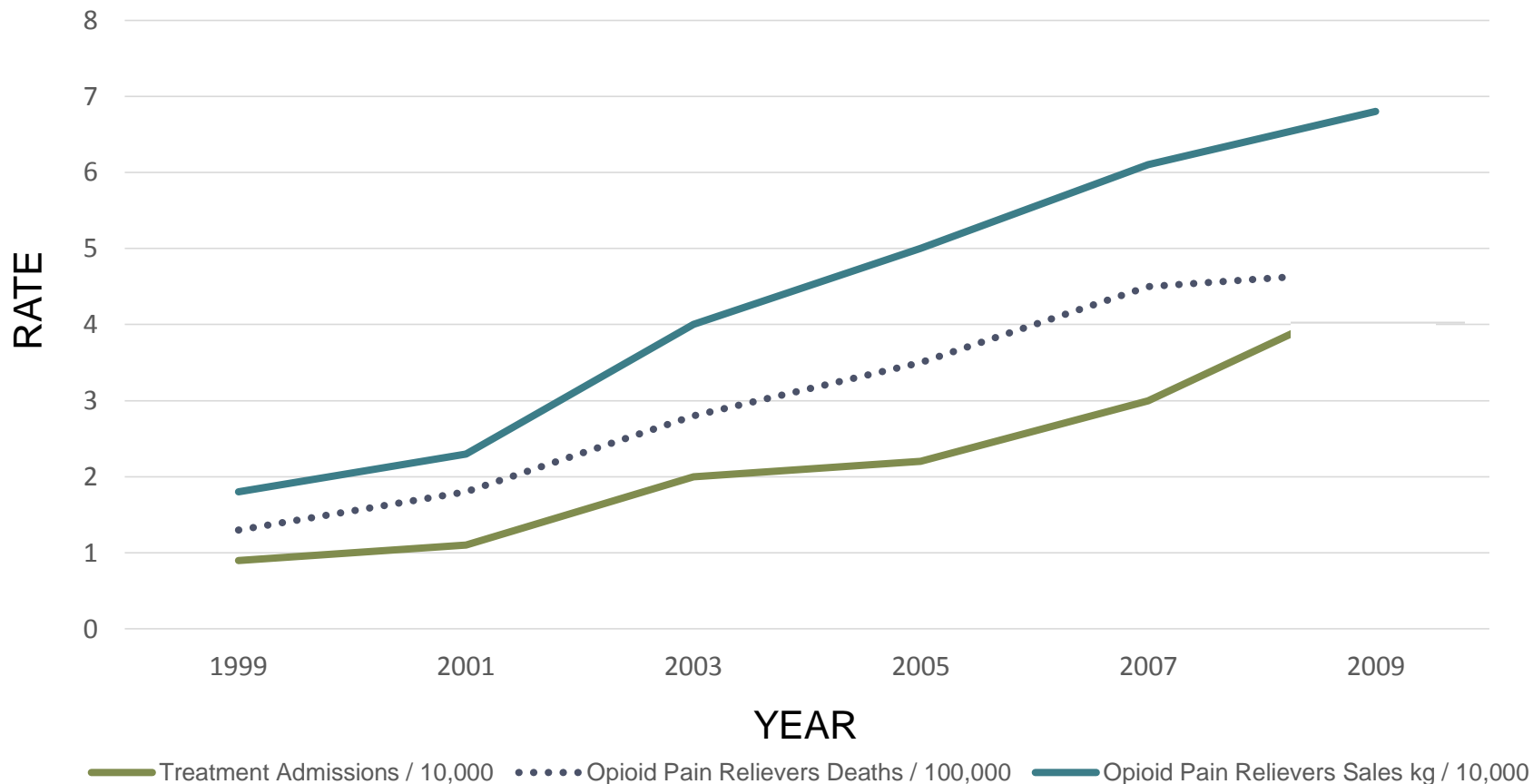
- Fentanyl ER transdermal systems
- Methadone hydrochloride tablets
- Methadone hydrochloride oral concentrate
- Methadone hydrochloride oral solution
- Morphine sulfate ER tablets
- Morphine sulfate ER capsules
- Oxycodone hydrochloride ER tablets

CHAPTER 2

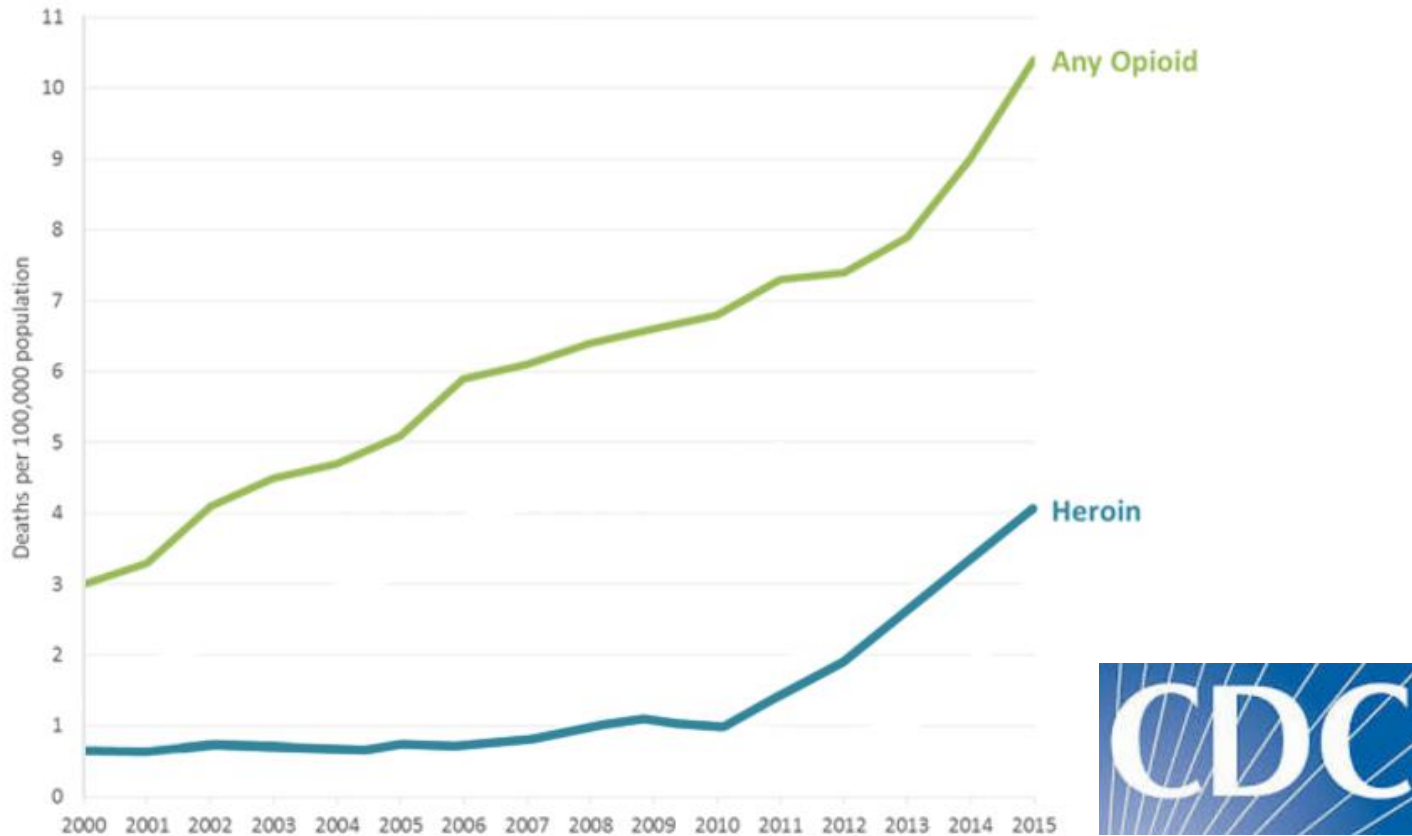
WHY ARE WE HERE?



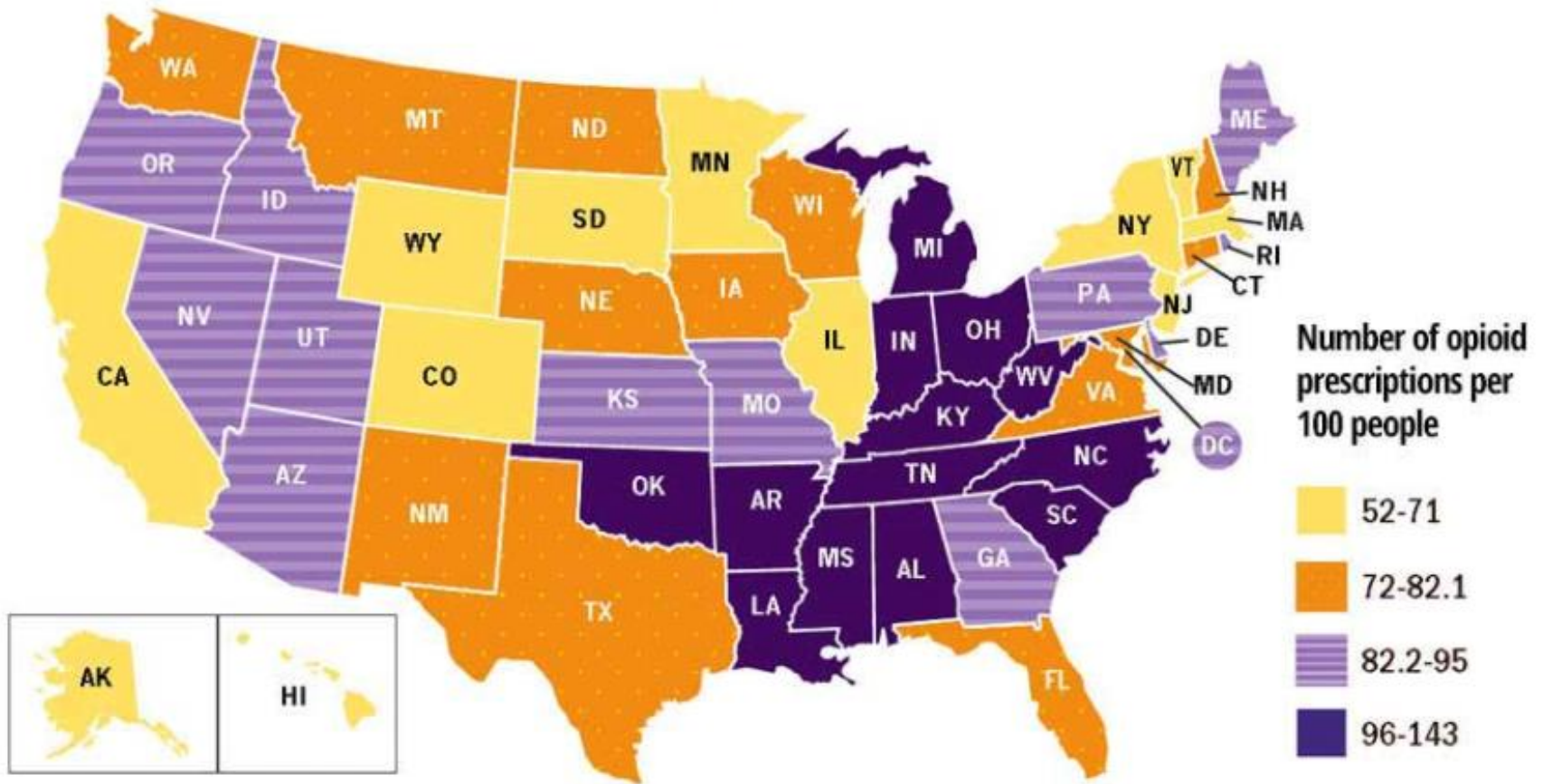
OPIOID DEATHS, TREATMENT ADMISSIONS AND PRESCRIBING



OVERDOSE DEATHS INVOLVING OPIOIDS, U.S., 2000-2015

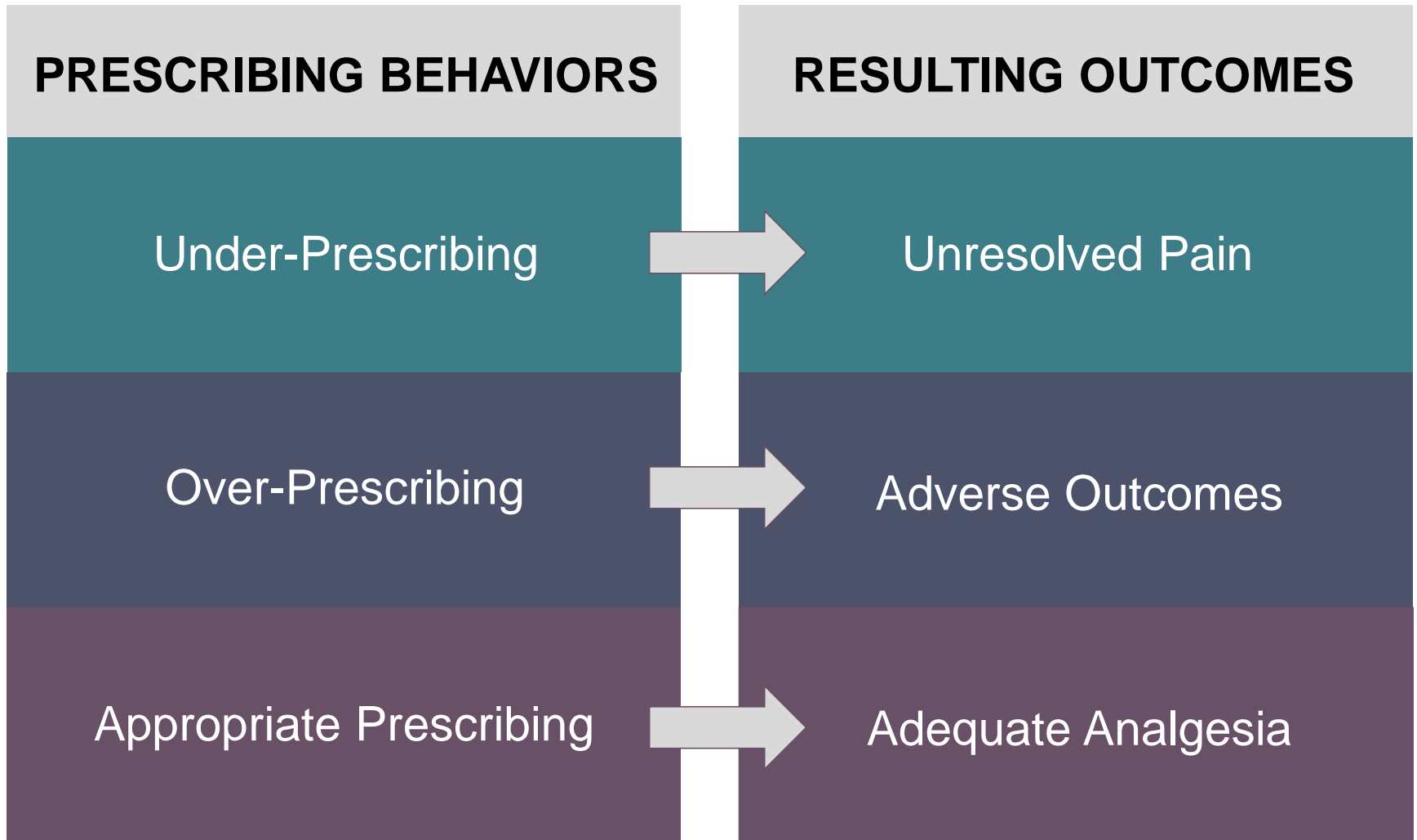


PRESCRIBING PATTERNS – WE PLAY A ROLE



SOURCE: IMS, National Prescription Audit (NPA™), 2012.

OPIOID PRESCRIBING - THE PENDULUM SWINGS



BENEFITS VS. RISKS

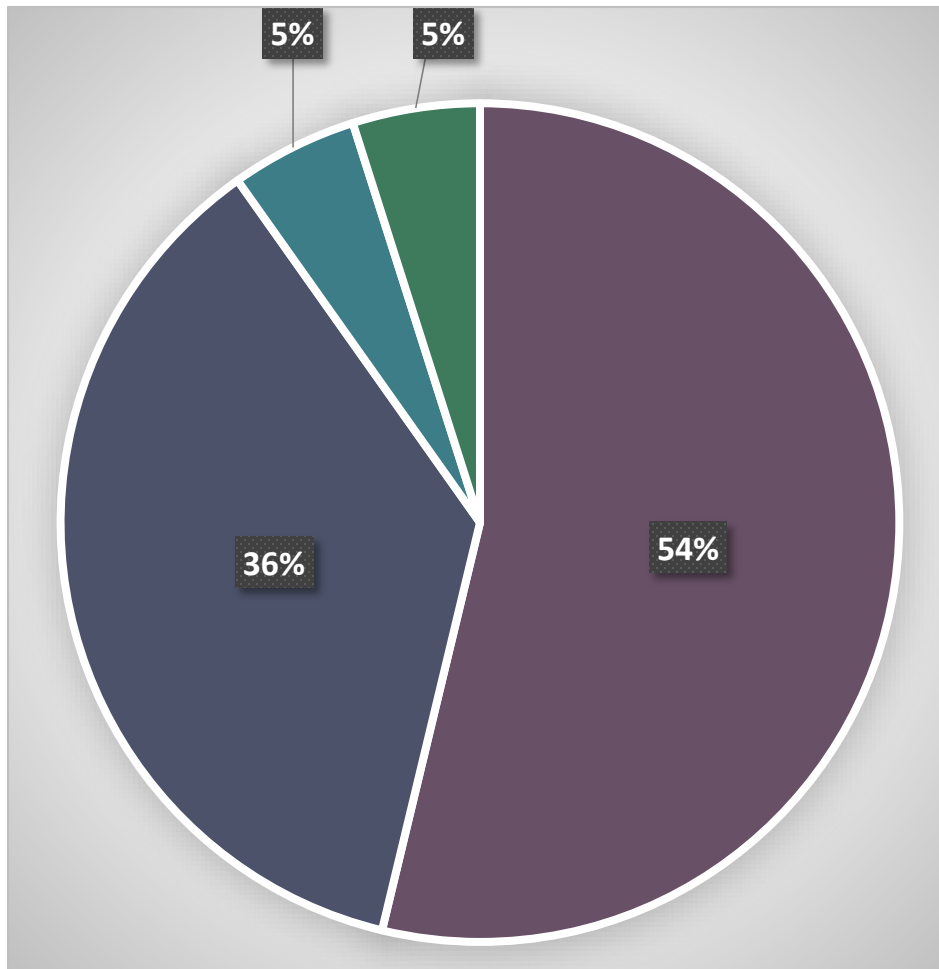
BENEFITS

- Analgesia
 - Adequate pain control
 - Continuous, predictable (with ER/LAs)
- Improved function
- Quality of life





RISKS

- Overdose, especially as ER/LA formulations contain more opioids than Immediate Release
- Life-threatening respiratory depression
- Abuse by patient or household contacts
- Misuse, diversion, and addiction
- Physical dependence and tolerance
- Interactions with other meds and substances
- Risk of neonatal opioid withdrawal syndrome
- Inadvertent exposure/ingestion by household contacts especially children

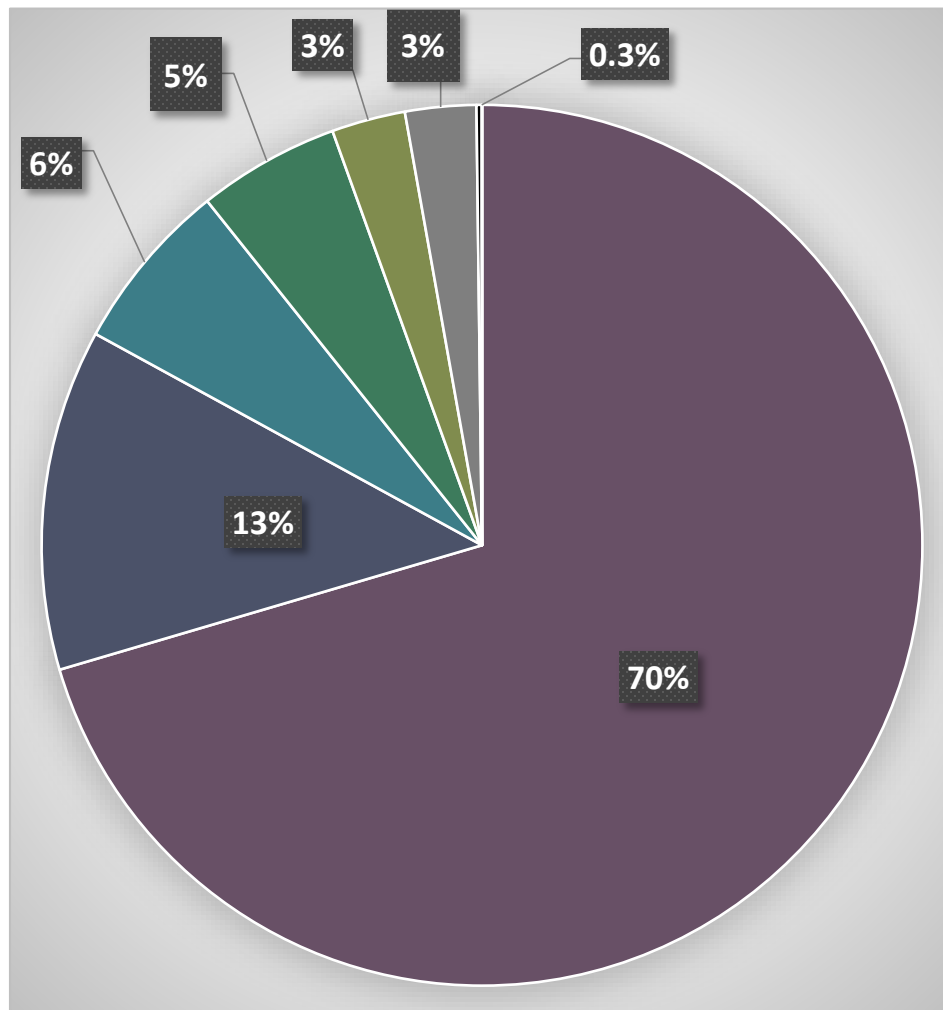
SOURCE OF MOST RECENT RX OPIOIDS AMONG PAST-YEAR MISUSERS 2015



Source where pain relievers were obtained for most recent misuse among 12.5 million people aged 12 or older who misused prescription pain relievers in the past year: percentages, 2015

-  54% - Given by, bought from, or taken from a friend or relative
-  36% - Through a prescription or stolen from healthcare provider
-  5% - Bought from a dealer or stranger
-  5% - Some other way

FIRST SPECIFIC DRUG ASSOCIATED WITH INITIATION OF ILLICIT DRUG USE 2013



2.8 million initiates of illicit drugs

- 70.3% - Marijuana
- 12.5% - Pain Relievers
- 6.3% - Inhalants
- 5.2% - Tranquilizers
- 2.7% - Stimulants
- 2.6% - Hallucinogens
- 0.3% - Sedatives and Cocaine

THE FEDERAL PLAYERS

Many agencies involved



WE ARE HERE
BECAUSE OF ...





- On July 9, 2012, the Food and Drug Administration (FDA) approved a Risk Evaluation and Mitigation Strategy (REMS) for extended-release (ER) and long-acting (LA) opioid medications
- First time FDA has ever used accredited CE/CME as part of a REMS

Misuse, abuse, diversion, addiction, and overdose of opioids has created a serious public health epidemic in the U.S.

When prescribed well and used as prescribed, opioids can be valuable tools to effectively treat pain.

This course does not advocate for or against the use of Immediate Release (IR) or Extended-Release/Long-Acting (ER/LA) opioids. Our purpose is to provide proper education about safe prescribing practices along with effective patient education.

LEARNING OBJECTIVES



Accurately assess patients with pain for consideration of an opioid trial



Establish realistic goals for pain management and restoration of function



Initiate opioid treatment (IR and ER/LA) safely and judiciously, maximizing efficacy while minimizing risks



Monitor and re-evaluate treatment continuously; discontinue safely when appropriate



Counsel patients and caregivers about use, misuse, abuse, diversion, and overdose



Educate patients about safe storage and disposal of opioids



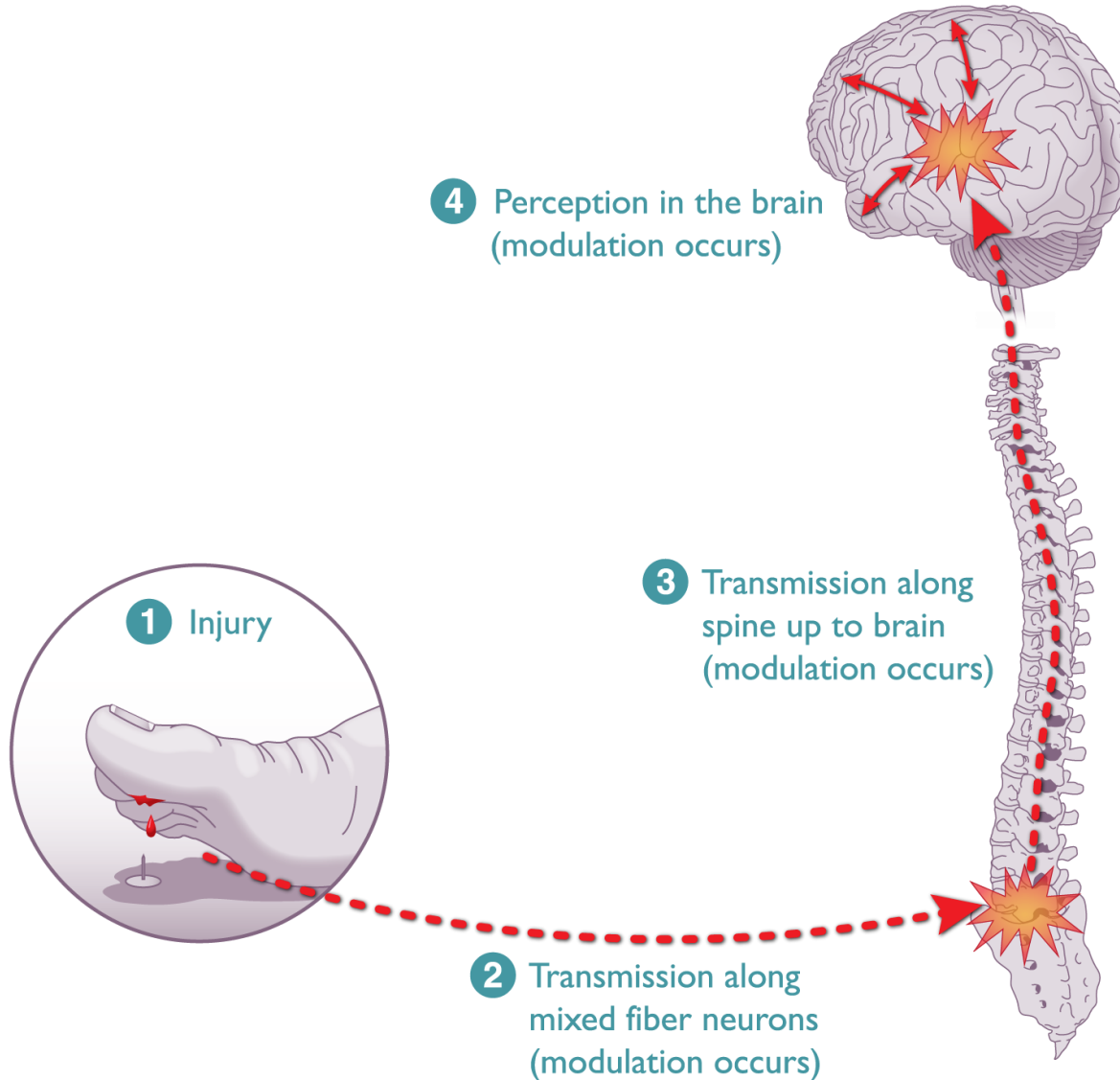
Demonstrate working knowledge and ability to access general and specific information about opioids, especially those used in your practice

You and Your Team *can* have an immediate and positive impact on this crisis while also caring for your patients appropriately.

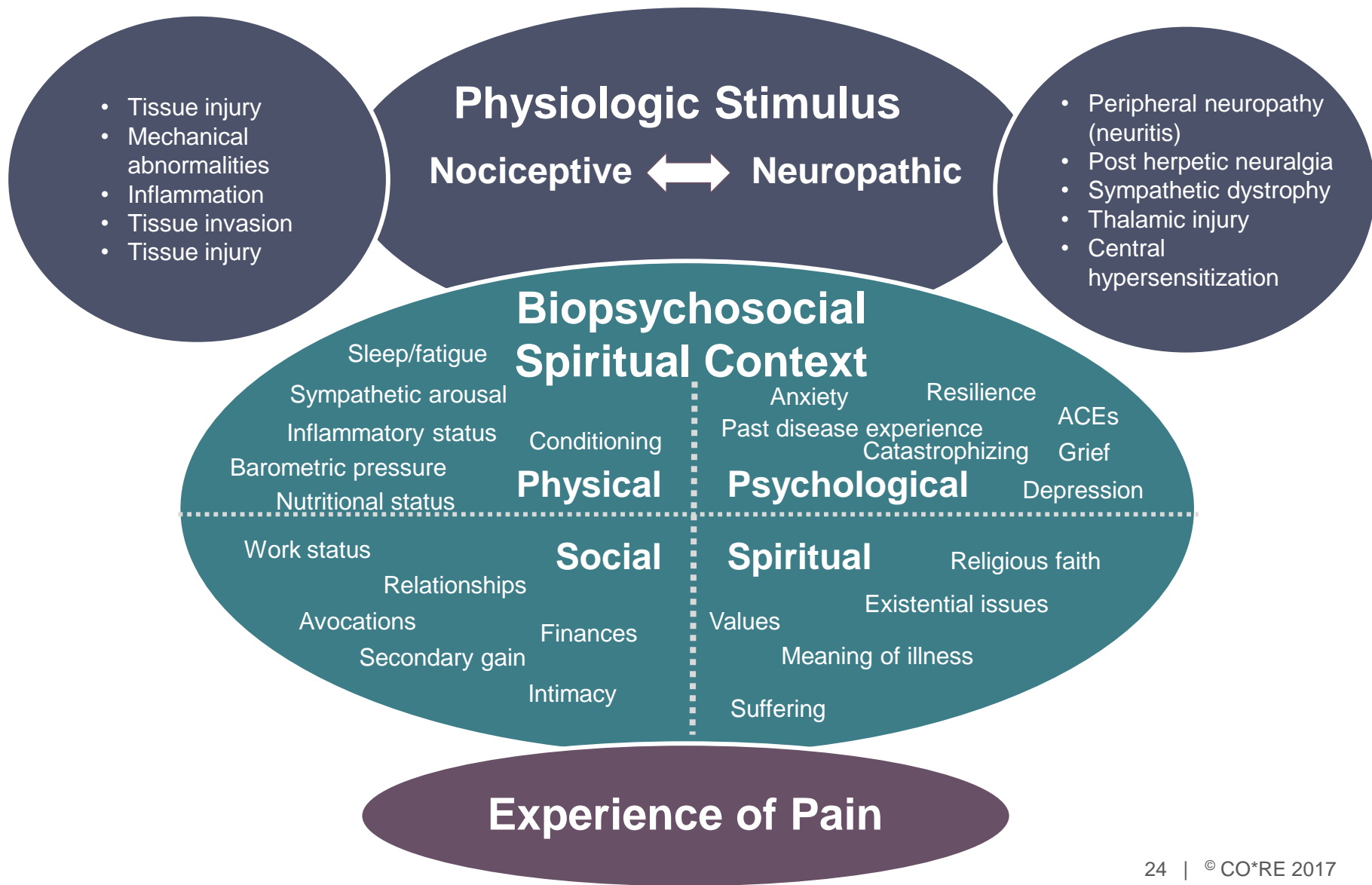
CHAPTER 3

PAIN

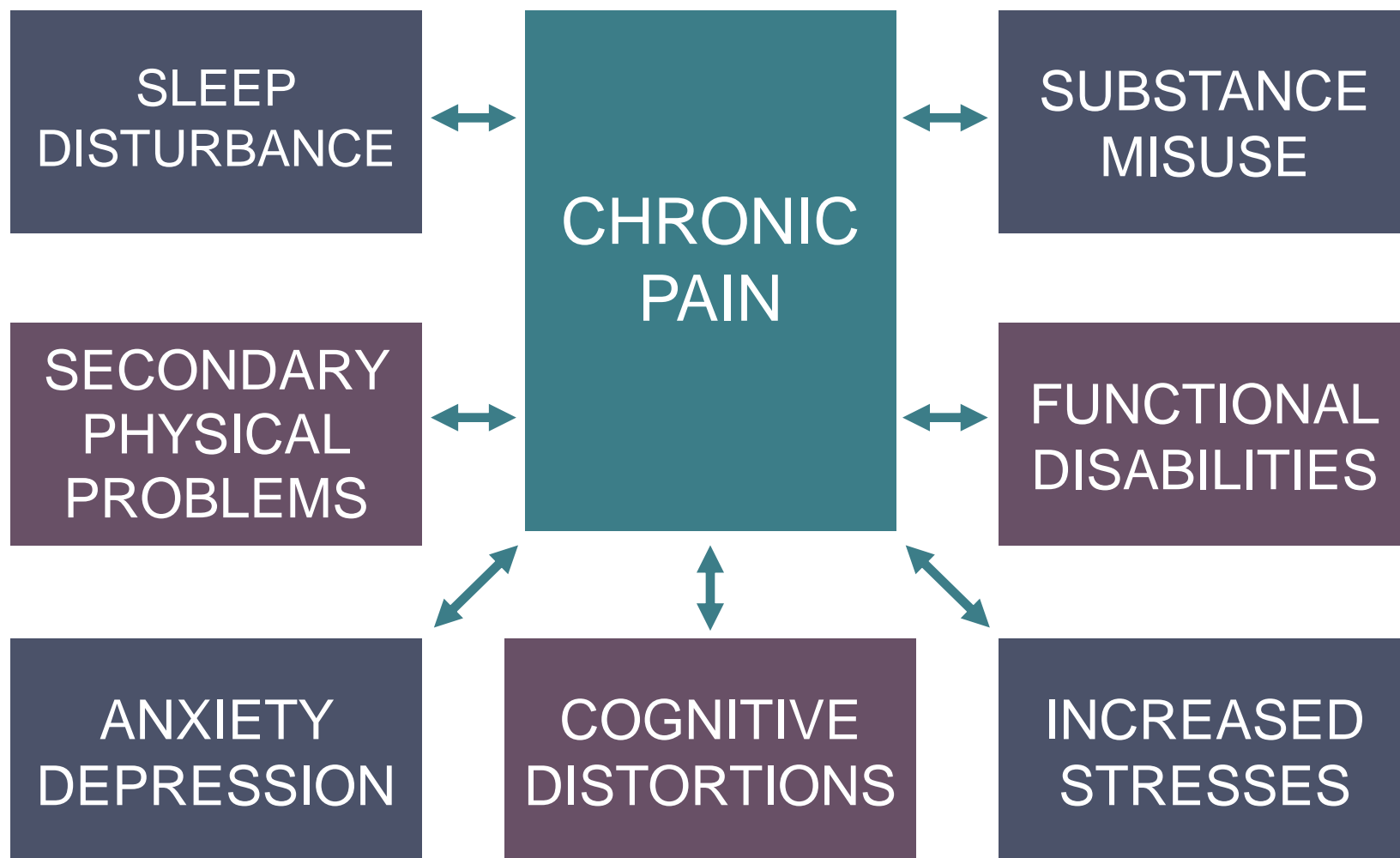
THE NEUROPSYCHOBIOLOGY OF PAIN



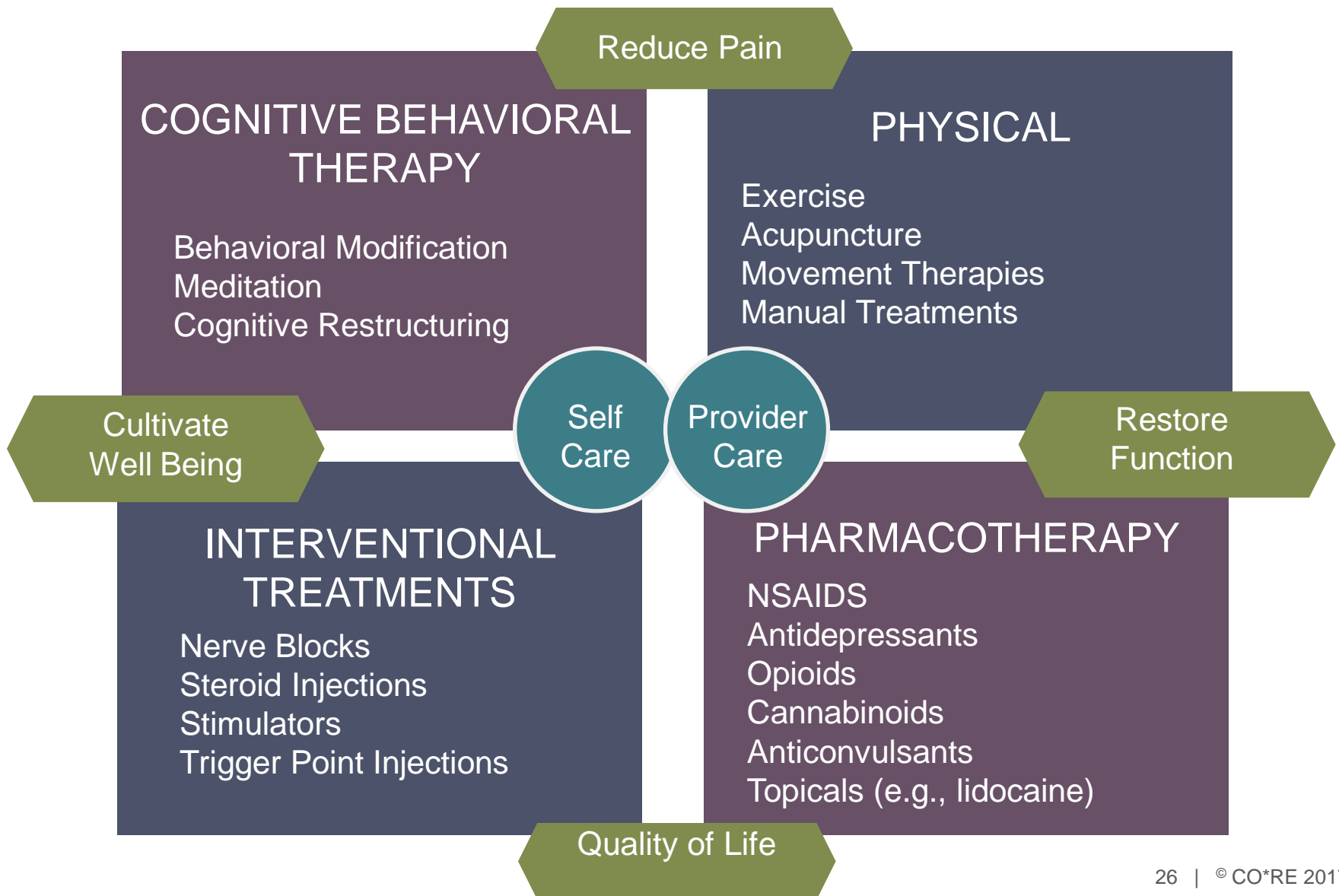
UNDERSTANDING PAIN



THE IMPACT OF PAIN



PAIN MANAGEMENT GOALS AND TREATMENT OPTIONS: A MULTI-MODAL APPROACH





- Explain neurophysiology of pain processing to patients
- When patients understand, their concerns are validated
- Pain has biological, psychological, social, and spiritual components

CHALLENGE: THE EARLY REFILL



RED FLAG: Is this misuse? Abuse?

Your patient requests an early refill for the second time in six months.
Took extra medications for headache and again for toothache.
Prescription is for lower back pain.

Action:

Evaluate potential misuse. Confirm patient's understanding of each medication's dosage, time of day, and maximum daily dose. Ask him/her to repeat these instructions back to you. Avoid clinical terms such as "prn". Review treatment goals and expectations. Select and document a therapy plan that is compatible with patients' individual needs, is safe, effective and balanced. Screen for risk with Current Opioid Misuse Measure (COMM) and, if indicated, refer to addiction specialist for treatment.

CHAPTER 4

ASSESSMENT

PAIN ASSESSMENT

DESCRIPTION OF PAIN



Location



Intensity



Quality



Onset/
Duration



Variations/
Patterns/Rhythms

WHAT RELIEVES THE PAIN?

WHAT CAUSES OR INCREASES PAIN?

EFFECTS OF PAIN ON PHYSICAL, EMOTIONAL, AND PSYCHOSOCIAL
FUNCTION

PATIENT'S CURRENT PAIN AND FUNCTION

TREATMENT HISTORY

NON-PHARMACOLOGIC STRATEGIES AND EFFECTIVENESS

PHARMACOLOGIC STRATEGIES AND EFFECTIVENESS

PAST USE



CURRENT USE

- Query state Prescription Drug Monitoring Program (**PDMP**) to confirm patient report

DOSAGE

- For opioids currently prescribed: opioid, dose, regimen, and duration
 - Important to determine if patient is **opioid tolerant**

GENERAL EFFECTIVENESS

PAST MEDICAL HISTORY

ILLNESS RELEVANT TO (1) EFFECTS OR (2) METABOLISM OF OPIOIDS

1. Pulmonary disease, constipation, nausea, cognitive impairment
2. Hepatic, renal disease

ILLNESS POSSIBLY LINKED TO SUBSTANCE USE DISORDER (SUD):

- Hepatitis
- HIV
- Tuberculosis
- Cellulitis
- STIs
- Trauma/Burns
- Cardiac Disease
- Pulmonary Disease

OBTAIN A COMPLETE HISTORY OF CURRENT AND PAST SUBSTANCE USE

RISK FACTORS FOR OPIOID ABUSE

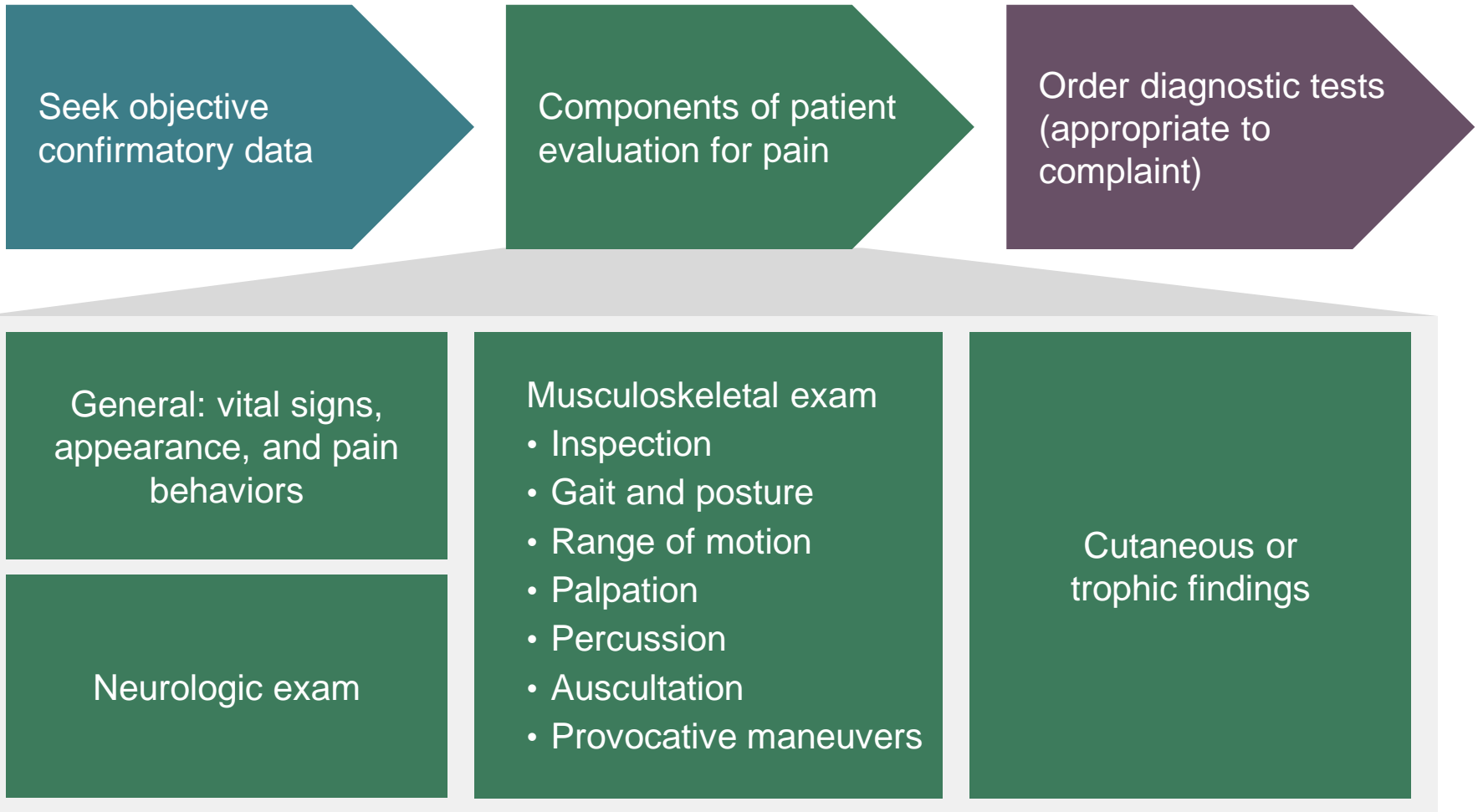
- Controlled medications: prescribed or non-prescribed
- Alcohol and tobacco
- History of sexual abuse
- Family history of substance abuse and psychiatric disorders
- Age (16-45 YO)

Substance abuse history does not prohibit treatment with ER/LA opioids but may require additional monitoring and expert consultation/referral

SOCIAL HISTORY

Employment, cultural background, social network, marital history, legal history, and other behavioral patterns

PHYSICAL EXAM AND ASSESSMENT



RISK ASSESSMENT TOOLS

TOOL	# OF ITEMS	ADMINISTERED BY
PATIENTS CONSIDERED FOR LONG-TERM OPIOID THERAPY		
ORT Opioid Risk Tool	5	patient
SOAPP [®] Screener and Opioid Assessment for Patients with Pain	24, 14, & 5	patient
DIRE Diagnosis, Intractability, Risk, and Efficacy score	7	clinician
CHARACTERIZE MISUSE ONCE OPIOID TREATMENT BEGINS		
PMQ Pain Medication Questionnaire	26	patient
COMM Current Opioid Misuse Measure	17	patient
PDUQ Prescription Drug Use Questionnaire	40	clinician
NOT SPECIFIC TO PAIN POPULATIONS		
CAGE-AID Cut Down, Annoyed, Guilty, Eye-Opener tool, Adapted to Include Drugs	4	clinician
RAFFT Relax, Alone, Friends, Family, Trouble	5	patient
DAST Drug Abuse Screening Test	28	patient
SBIRT Screening, Brief Intervention, and Referral to Treatment	Varies	clinician

OPIOID RISK TOOL (ORT)

Mark each box that applies		Female	Male	
1 Family history of substance abuse				
Alcohol	<input type="checkbox"/>	1	<input type="checkbox"/>	3
Illegal drugs	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Prescription drugs	<input type="checkbox"/>	4	<input type="checkbox"/>	4
2 Personal Hx of substance abuse				
Alcohol	<input type="checkbox"/>	3	<input type="checkbox"/>	3
Illegal drugs	<input type="checkbox"/>	4	<input type="checkbox"/>	4
Prescription drugs	<input type="checkbox"/>	5	<input type="checkbox"/>	5
3 Age between 16 and 45 yrs				
	<input type="checkbox"/>	1	<input type="checkbox"/>	1
4 Hx of preadolescent sexual abuse				
	<input type="checkbox"/>	3	<input type="checkbox"/>	0
5 Psychologic disease				
ADD, OCD, bipolar, schizophrenia	<input type="checkbox"/>	2	<input type="checkbox"/>	2
Depression	<input type="checkbox"/>	1	<input type="checkbox"/>	1

ADMINISTER

 On initial visit

 Prior to opioid therapy

SCORING (RISK)

 0-3: low

 4-7: moderate

 ≥8: high

Scoring Totals:

SCREENER AND OPIOID ASSESSMENT FOR PATIENTS WITH PAIN (SOAPP)[®]



Identifies patients as high, moderate, or low risk for misuse of opioids prescribed for chronic pain

HOW IS SOAPP[®] ADMINISTERED?

Usually self-administered in waiting room, exam room, or prior to an office visit

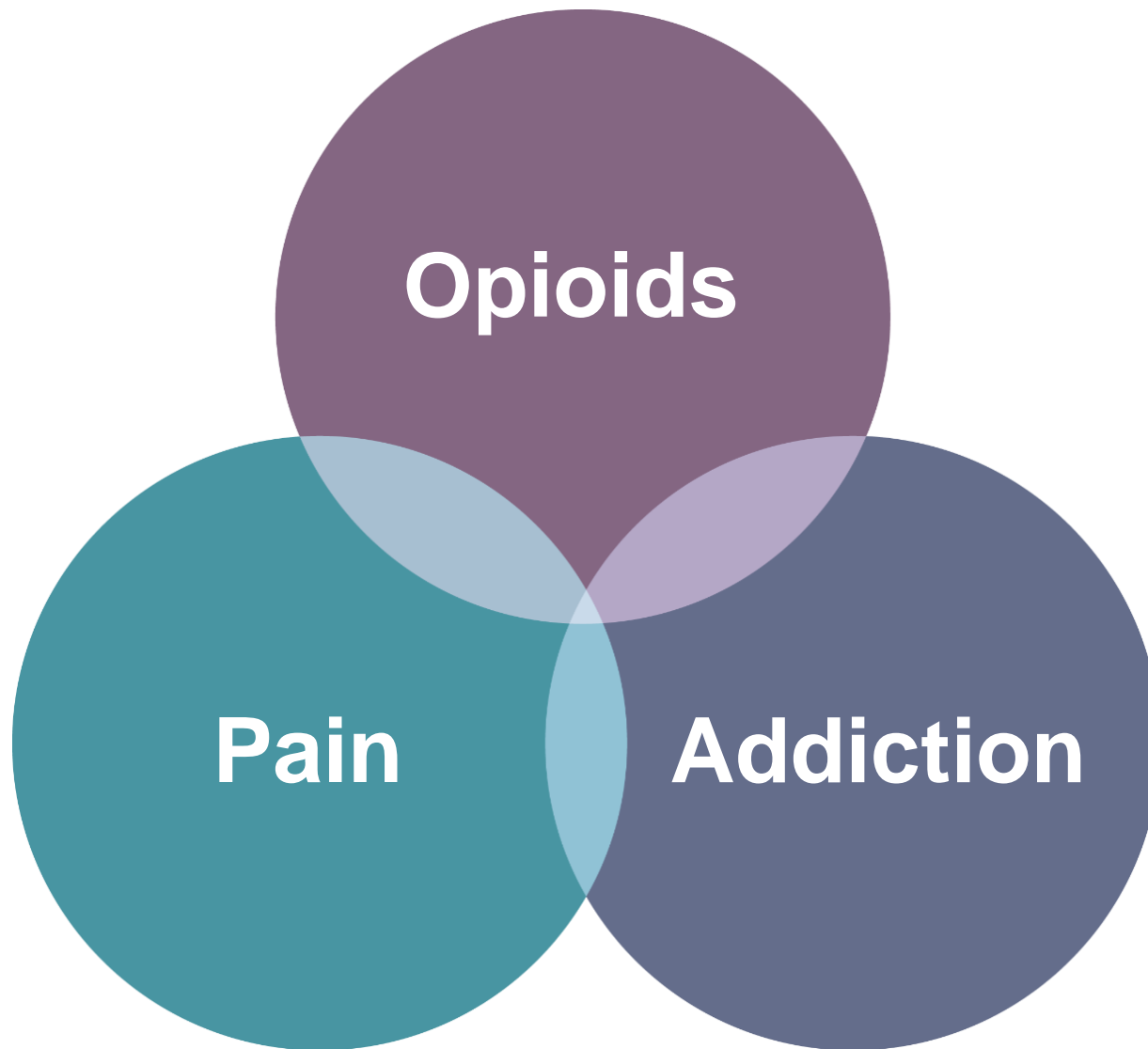
May be completed as part of an interview with a nurse, physician, or psychologist

Prescribers should have a completed and scored SOAPP[®] while making opioid treatment decisions

SOAPP®: 4 FORMATS AVAILABLE TO ASSESS MISUSE RISK CO*RE

SOAPP® 1.0 24Q VERSION (ORIGINAL)	14Q VERSION	5Q (SHORT-FORM) VERSION	SOAPP-R 24Q VERSION (REVISED)
24 questions (14 used to score tool)	14 questions*	5 questions*	24 questions
Add ratings for 14 "screening" questions	Add ratings for each question		
Score ≥12: high risk 8-11: moderate risk <8: low risk	Score ≥12: high risk 8-11: moderate risk <8: low risk	Score ≥4: increased risk	Score ≥22: high risk 10-21: moderate risk ≤9: low risk
<10 min. to complete 10 "unscored" questions provide background	<8 min. to complete	<5 min. to complete	<10 min. to complete

*Questions from SOAPP V.1.0 Patients rate all questions on scale of 0-4



Opioids

WHAT IS THE RISK FOR MY PATIENT?

- Risk of opioid use disorder in patients on chronic opioid therapy (COT) for chronic non-cancer pain (CNCP) is up to 30%
- Always highest with past history of substance use disorder (SUD) or psychiatric comorbidity
- Recognize that patient needs and patterns shift with age

PAIN AND ADDICTION

PAIN – 5 A'S

Analgesia

Activities/Function

Aberrant Behavior

Adverse Effects

Affect

ADDICTION – 5 C'S

Control, loss of

Compulsive use

Craving drug

Continued use

Chronic problem

RISK AND PAIN ASSESSMENT TOOL BOXES



PAIN ASSESSMENT TOOL BOX

- Pain Assessment Tools (BPI, etc.)
- Functional Assessment (SF 36, PPS, geriatric assessment, etc.)
- Pain intensity, Enjoyment of life, General activity (PEG)

RISK ASSESSMENT TOOL BOX

- PDMP
- UDT
- Risk Assessment Tools (ORT or SOAPP®)

Mental Health Tools (PHQ9, GAD7, etc.)

CONSIDER A TRIAL OF AN OPIOID?



POTENTIAL BENEFITS ARE LIKELY TO OUTWEIGH RISKS

FAILED TO ADEQUATELY RESPOND TO NON-OPIOID & NONDRUG INTERVENTIONS

PAIN IS MODERATE TO SEVERE

INITIATE TRIAL OF IR OPIOIDS

WHEN TO CONSIDER A TRIAL OF AN OPIOID



60-YR-OLD WITH CHRONIC DISABLING OA PAIN

- Non-opioid therapies not effective
- No psychiatric/medical comorbidity or personal/family drug abuse history
 - High potential benefits relative to potential risks
 - Could prescribe opioids to this patient in most settings with routine monitoring

30-YR-OLD WITH FIBROMYALGIA AND RECENT ALCOHOL USE DISORDER

- High potential risks relative to benefits (opioid therapy not first line for fibromyalgia)
- Requires intensive structure, monitoring, and management by clinician with expertise in both addiction & pain

Not a good candidate for opioid therapy



INITIATING OPIOIDS: CDC GUIDELINE (2016)



- Begin with IR
- Prescribe the lowest effective dosage
- Use caution at any dosage, but particularly when
 - Increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day and carefully justify a decision to titrate dosage to ≥ 90 MME/day
- For acute pain, prescribe lowest effective dose of IRs, no more than needed
- Re-evaluate risks/benefits within 1 - 4 weeks of initiation or dose escalation
- Re-evaluate risks/benefits every 3 months; if benefits do not outweigh harms optimize other therapies, work to taper and discontinue
- Link to the Guideline:
<https://www.cdc.gov/drugoverdose/prescribing/providers.html>

Cancer pain, hospice, and palliative care patients are not covered by CDC Guideline

INFORMED CONSENT

When initiating a trial of opioid analgesic therapy, confirm patient understanding of informed consent to establish:

ANALGESIC AND
FUNCTIONAL GOALS OF
TREATMENT

EXPECTATIONS

POTENTIAL RISKS

ALTERNATIVES TO
OPIOIDS

HOW TO MANAGE

- Common Adverse Effects (AEs) (e.g., constipation, nausea, sedation)
- Risks (e.g., abuse, addiction, respiratory depression, overdose)
- AEs with long-term therapy (e.g., hyperalgesia, low testosterone, irregular menses or sexual dysfunction)

PATIENT-PRESCRIBER AGREEMENT (PPA)

Document signed by both patient and prescriber at time an opioid is prescribed

CLARIFY TREATMENT PLAN AND GOALS OF TREATMENT WITH PATIENT, PATIENT'S FAMILY, AND OTHER CLINICIANS INVOLVED IN PATIENT'S CARE

ASSIST IN PATIENT EDUCATION

DISCUSS MEDICATION SAFE HANDLING, STORAGE, AND DISPOSAL

DOCUMENT PATIENT AND PRESCRIBER RESPONSIBILITIES

PATIENT PROVIDER AGREEMENT (PPA)

REINFORCE EXPECTATIONS FOR APPROPRIATE AND SAFE OPIOID USE

- One prescriber
 - Consider one pharmacy
 - Safeguard
 - Do not store in medicine cabinet
 - Keep locked (medication safe)
 - Do not share or sell
 - Instructions for disposal when no longer needed
 - Prescriber notification for any event resulting in a pain medication prescription
- Follow-up
 - Monitoring
 - Random UDT and pill counts
 - Refills
 - Identify behaviors for discontinuation
 - Exit strategy

ROUTINELY MONITOR PATIENT ADHERENCE TO TREATMENT PLAN

- Recognize and document aberrant drug-related behavior
 - In addition to patient self-report also use:
 - State PDMPs
 - UDT
 - Positive for non-prescribed drugs
 - Positive for illicit substance
 - Negative for prescribed opioid
- Family member or caregiver interviews
- Monitoring tools such as the COMM, PADT, PMQ, or PDUQ
- Medication reconciliation (e.g., pill counts)



PADT=Pain Assessment and Documentation Tool

ADDRESS ABERRANT DRUG-RELATED BEHAVIOR

Behavior outside the boundaries of agreed-on treatment plan:

Unsanctioned dose escalations or other noncompliance with therapy on 1 or 2 occasions

Unapproved use of the drug to treat another symptom

Openly acquiring similar drugs from other medical sources

Multiple dose escalations or other noncompliance with therapy despite warnings

Prescription forgery

Obtaining prescription drugs from nonmedical sources

Any of these behaviors merit **investigation**, proceed with caution

Adequately **DOCUMENT**
all patient interactions,
assessments, test results,
and treatment plans.



- Conduct a comprehensive and pain-focused history and physical
- Assess for risk of abuse and for mental health issues
- Determine if a therapeutic trial is appropriate
- Establish realistic goals for pain management and function
- Document **EVERYTHING**

CHALLENGE: THE DELAYED SURGERY



RED FLAG:

Patient may be stalling to continue an opioid regimen

Ms. Jones says she needs opioids to manage her pain until she can have surgery. She reports continued delays in getting to surgery. You phone the surgeon and discover that no date has been set and that she has cancelled several appointments.

Action:

Set a time limit and expectation. Offer non-pharmacologic methods and non-opioid interventions for pain management. Communicate with the surgeon and advise patient to make appointment with surgeon for discussion of treatment plan.



CHAPTER 5

MANAGEMENT

MONITORING AND DISCONTINUING



PART 1

MONITORING

OPIOID SIDE EFFECTS

- Respiratory depression – most serious
- Opioid-Induced Constipation (OIC) – most common
- Sedation, cognitive impairment
- Falls and fractures
- Sweating, miosis, urinary retention
- Hypogonadism
- Tolerance, physical dependence, hyperalgesia
- Addiction in vulnerable patients



Prescribers should report serious AEs to the FDA:

www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf

or 1-800-FDA-1088

OPIOID-INDUCED RESPIRATORY DEPRESSION

Chief hazard of opioid agonists, including ER/LA opioids

- If not immediately recognized and treated, may lead to respiratory arrest and death
- Greatest risk: initiation of therapy or after dose increase

Manifested by reduced urge to breathe and decreased respiration rate

- Shallow breathing
- CO₂ retention can exacerbate opioid sedating effects

Instruct patients/family members to call 911

Managed with

- Close observation
- Supportive measures
- Opioid antagonists
- Depending on patient's clinical status

MORE LIKELY TO OCCUR

- In elderly, cachectic, or debilitated patients
 - **Contraindicated** in patients with respiratory depression or conditions that increase risk
- If given concomitantly with other drugs that depress respiration
- Patients who are opioid-naïve or have just had a dose increase

REDUCE RISK

- Proper dosing and titration are essential
- **Do not overestimate** dose when converting dosage from another opioid product
 - Can result in fatal overdose with first dose
- Instruct patients to swallow tablets/capsules whole
 - Dose from cut, crushed, dissolved, or chewed tablets/capsules may be fatal, particularly in opioid-naïve individuals

WHEN TO MOVE FROM IR TO ER/LA OPIOIDS

PRIMARY REASONS

- Maintain stable blood levels (steady state plasma)
- Longer duration of action
- Multiple IR doses needed to achieve effective analgesia
- Poor analgesic efficacy despite dose titration
- Less sleep disruption

OTHER POTENTIAL REASONS

- Patient desire or need to try a new formulation
- Cost or insurance issues
- Adherence issues
- Change in clinical status requires an opioid with different pharmacokinetics
- Problematic drug-drug interactions



CONSIDERATIONS FOR CHANGE FROM IR TO ER/LA OPIOIDS

DRUG AND DOSE SELECTION IS CRITICAL

Some ER/LA opioids or dosage forms are only recommended for **opioid-tolerant** patients

- ANY strength of transdermal fentanyl or hydromorphone ER
- Certain strengths/doses of other ER/LA products (check drug prescribing information)

MONITOR PATIENTS CLOSELY FOR RESPIRATORY DEPRESSION

Especially within 24-72 hours of initiating therapy and increasing dosage

INDIVIDUALIZE DOSAGE BY TITRATION BASED ON EFFICACY, TOLERABILITY, AND PRESENCE OF AEs

Check ER/LA opioid product PI for minimum titration intervals

Supplement with IR analgesics (opioids and non-opioid) if pain is not controlled during titration

OPIOID TOLERANCE

If opioid tolerant caution should still be used at higher doses

Patients considered opioid tolerant are taking at least

- 60 mg oral morphine/day
- 25 mcg transdermal fentanyl/hour
- 30 mg oral oxycodone/day
- 8 mg oral hydromorphone/day
- 25 mg oral oxymorphone/day
- An equianalgesic dose of another opioid

Still requires caution when rotating a patient on an IR opioid to a different ER/LA opioid



**FOR 1 WEEK
OR LONGER**

IMPORTANT

DEFINITION

Change from an existing opioid regimen to another opioid with the goal of improving therapeutic outcomes or to avoid AEs attributed to the existing drug (e.g., myoclonus)



RATIONALE

Differences in pharmacologic or other effects make it likely that a switch will improve outcomes

- Effectiveness and AEs of different mu opioids vary among patients
- Patients show incomplete cross-tolerance to new opioid
 - Patient tolerant to first opioid can have improved analgesia from second opioid at a dose lower than calculated from an Equianalgesic Dosing Table (EDT)

EQUIANALGESIC DOSE TABLES (EDT)

Many different versions:

PUBLISHED

ONLINE

ONLINE INTERACTIVE

SMART-PHONE APPS



Vary in terms of:



EQUIANALGESIC
VALUES

WHETHER RANGES ARE
USED

Which opioids are included: May or may not include transdermal opioids, rapid-onset fentanyl, ER/LA opioids, or opioid agonist-antagonists



EXAMPLE OF AN EDT FOR ADULTS

DRUG	Equianalgesic Dose		Usual Starting Doses	
	SC/IV	PO	PARENTERAL	PO
Morphine	10 mg	30 mg	2.5-5 mg SC/IV q3-4hr (1.25-2.5 mg)	5-15 mg q3-4hr (IR or oral solution) (2.5-7.5 mg)
Oxycodone	NA	20 mg	NA	5-10 mg q3-4 (2.5 mg)
Hydrocodone	NA	30 mg	NA	5 mg q3-4h (2.5 mg)
Hydromorphone	1.5 mg	7.5 mg	0.2-0.6 mg SC/IV q2-3hr (0.2 mg)	1-2 mg q3-4hr (0.5-1 mg)

MU OPIOID RECEPTORS AND INCOMPLETE CROSS-TOLERANCE

MU OPIOIDS BIND TO MU RECEPTORS

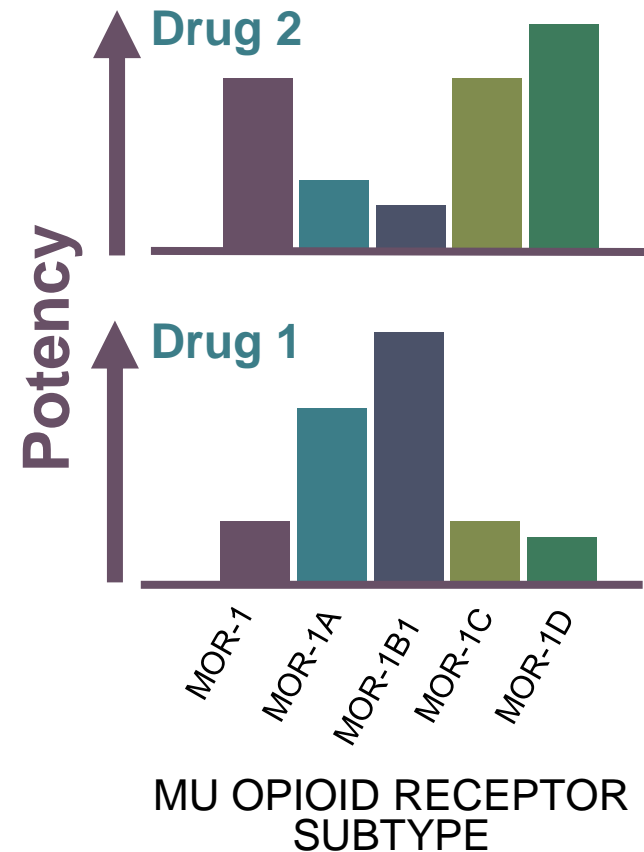
MANY MU RECEPTOR SUBTYPES:

Mu opioids produce **subtly different** pharmacologic response based on distinct activation profiles of mu receptor subtypes

MAY HELP EXPLAIN:

Inter-patient variability in response to mu opioids

Incomplete cross-tolerance among mu opioids



GUIDELINES FOR OPIOID ROTATION

REDUCE CALCULATED EQUIANALGESIC DOSE BY 25%-50%*

SELECT % REDUCTION BASED ON CLINICAL JUDGMENT

CLOSER TO 50% REDUCTION IF PATIENT IS

- Receiving a relatively high dose of current opioid regimen
- Elderly or medically frail

CLOSER TO 25% REDUCTION IF PATIENT

- Does not have these characteristics
- Is changing route of administration

Calculate equianalgesic dose of new opioid from EDT



*75%-90% reduction for methadone

IF SWITCHING TO METHADONE:

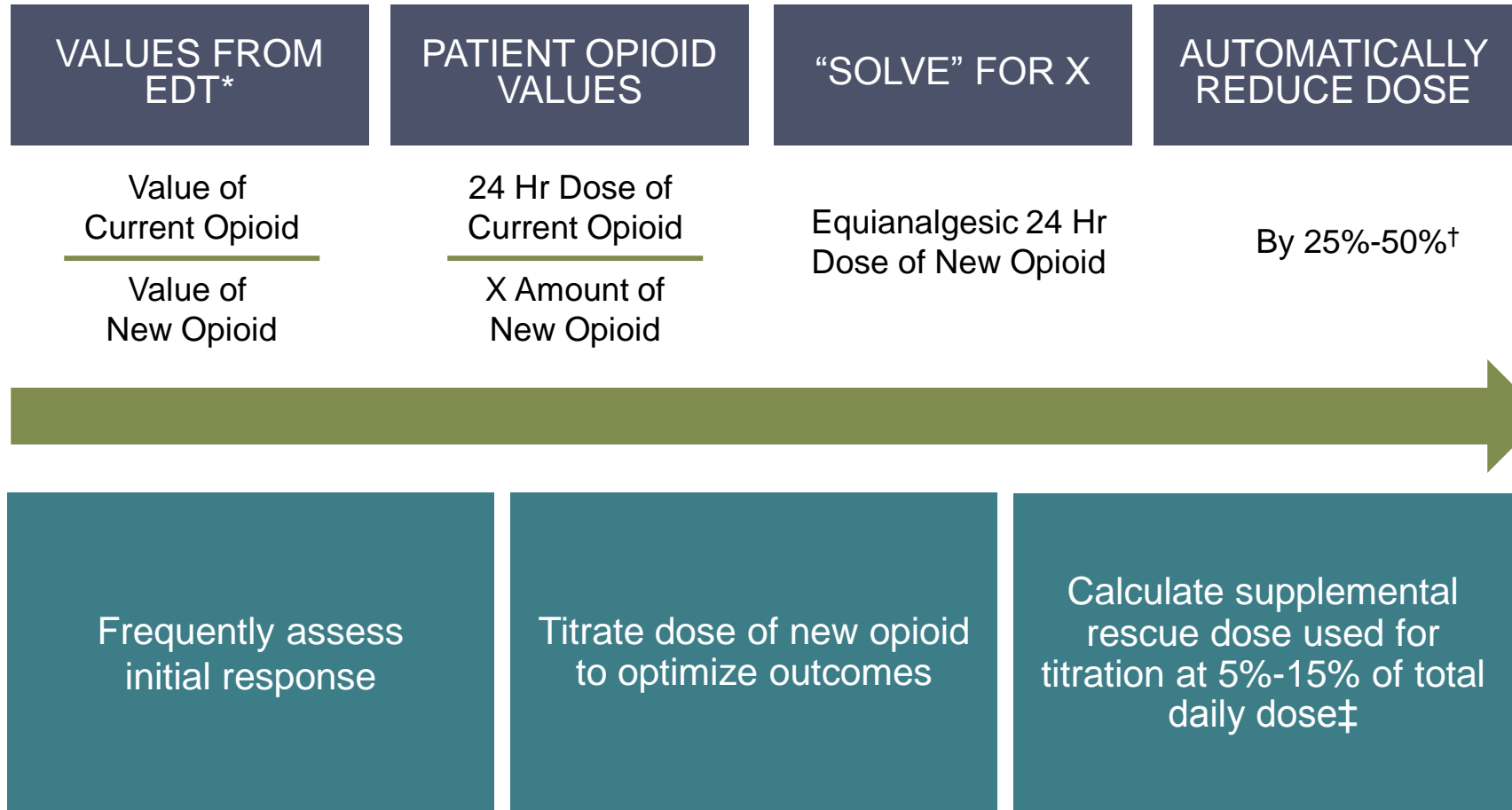
- Standard EDTs are less helpful in opioid rotation to methadone
- In opioid tolerant patients, methadone doses should **not** exceed 30-40 mg/day upon rotation
 - Consider inpatient monitoring, including serial EKG monitoring
- In opioid-naïve patients, methadone should **not** be given as an initial drug

IF SWITCHING TO TRANSDERMAL:

- **Fentanyl**, calculate dose conversion based on equianalgesic dose ratios included in the PI
- **Buprenorphine**, follow instructions in the PI



GUIDELINE FOR OPIOID ROTATION: SUMMARY



* If switching to transdermal fentanyl, use equianalgesic dose ratios provided in PI

† If switching to methadone, reduce dose by 75%-90%

‡ If oral transmucosal fentanyl used as rescue, begin at lowest dose irrespective of baseline opioid

BREAKTHROUGH PAIN (BTP)

PATIENTS ON STABLE ATC OPIOIDS MAY EXPERIENCE BTP

- Disease progression or a new or unrelated pain
 - Target cause or precipitating factors
- Dose for BTP: using an IR is 5%-15% of total daily opioid dose, administered at an appropriate interval
- Never use ER/LA for BTP

CONSIDER ADDING

- PRN IR opioid trial based on analysis of benefit versus risk
 - Risk for aberrant drug-related behaviors
 - High-risk: only in conjunction w/ frequent monitoring & follow-up
 - Low-risk: w/ routine follow-up & monitoring
- Non-opioid drug therapies
- Non-pharmacologic treatments

BE READY TO REFER

SUBSTANCE USE DISORDER

SAMHSA substance
abuse treatment
facility locator

[https://findtreatment.samhsa.gov/locator/
home](https://findtreatment.samhsa.gov/locator/home)

SAMHSA mental
health treatment
facility locator

[https://findtreatment.samhsa.gov/locator/
home](https://findtreatment.samhsa.gov/locator/home)

HIGH-RISK/COMPLEX PATIENTS

Refer to pain management, check state regulations for requirements

SAMHSA = Substance Abuse and Mental Health Service Administration

RATIONALE FOR URINE DRUG TESTING (UDT)



- Urine testing is done **FOR** the patient not **TO** the patient
- Help to identify drug misuse/addiction
- Assist in assessing and documenting adherence

UDT FREQUENCY IS BASED ON CLINICAL JUDGMENT
AND STATE REGULATIONS

TYPES OF UDT METHODS

Be aware of what you are testing and not testing

IMMUNOASSAY (IA) DRUG PANELS

- Either lab-based or point of care
- Identify substance as present or absent according to cutoff
- Many do not identify individual drugs within a class
- Subject to cross-reactivity and variability



GC/MS OR LC/MS

- Identify the presence and quantity of substance(s)
- Identify drugs not included in IA tests
- When results are contested

GC/MS=gas chromatography/mass spectrometry - LC/MS=liquid chromatography/mass spectrometry

SPECIFIC WINDOWS OF DRUG DETECTION

How long a person excretes drug and/or metabolite(s) at a concentration above a cutoff

DETECTION TIME OF DRUGS IN URINE

Governed by various factors; e.g., dose, route of administration, metabolism, fat solubility, urine volume and pH

For most drugs it is 1-3 days

Chronic use of lipid-soluble drugs increases detection time; e.g., marijuana, diazepam, ketamine

INTERPRETATION OF UDT RESULTS

POSTIVE RESULT



Demonstrates recent use

- Most drugs in urine have detection times of 1-3 days
- Chronic use of lipid-soluble drugs: test positive for ≥ 1 week

Does not diagnose

- Drug addiction, physical dependence, or impairment

Does not provide enough information to determine

- Exposure time, dose, or frequency of use

NEGATIVE RESULT



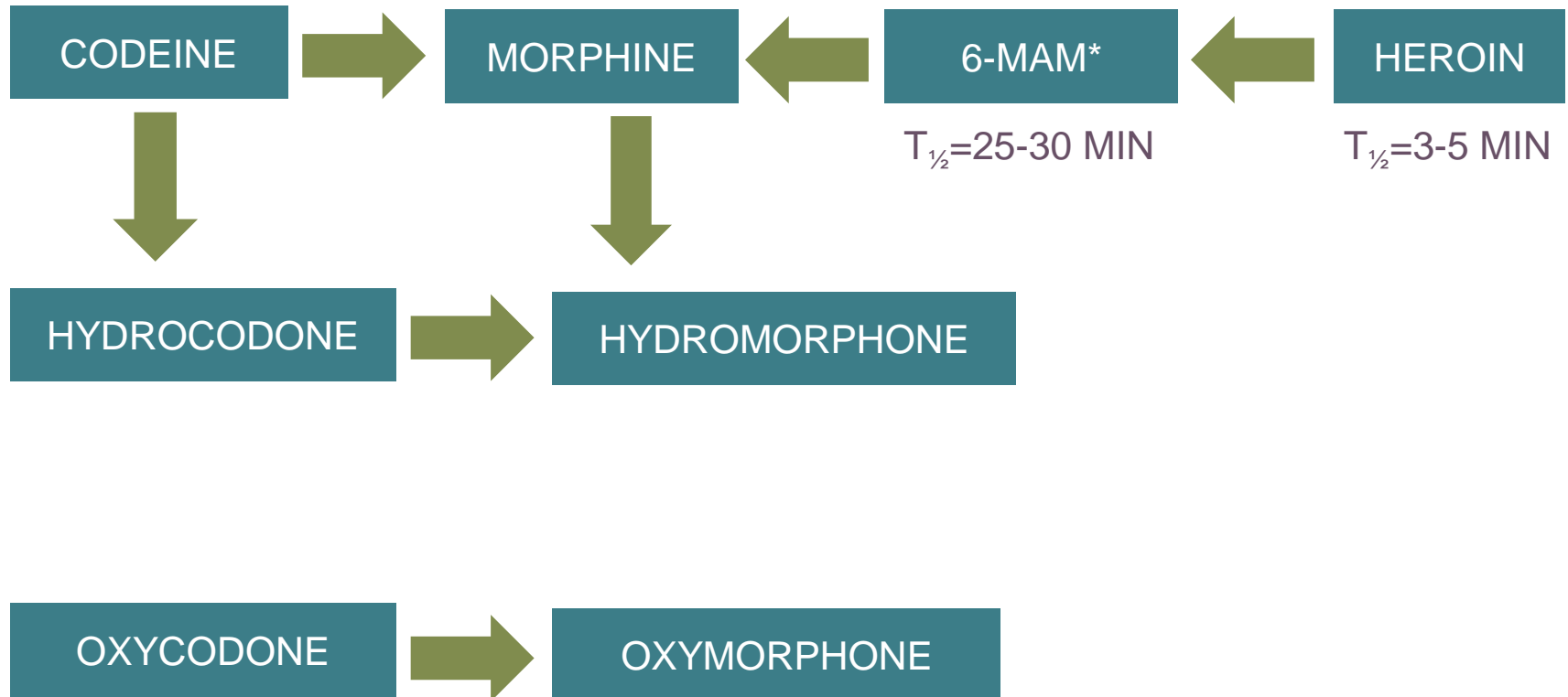
Does not diagnose diversion

- More complex than presence or absence of a drug in urine

May be due to maladaptive drug-taking behavior

- Binging, running out early
- Other factors: e.g., cessation of insurance, financial difficulties

EXAMPLES OF METABOLISM OF OPIOIDS



*6-MAM=6-MONOACETYLMORPHINE

CHALLENGE: THE OFFENDED PATIENT



RED FLAG:

You decide not to request routine risk assessment for fear of creating conflict

Mrs. Lane and her family have been your patients for years. She has chronic headache and back pain treatment. When you ask her to take a UDT, she becomes upset and accuses you of not trusting her. You decide against further risk assessments because you are concerned about damaging the relationship.

Action:

Require all patients receiving opioids to follow a treatment plan and adhere to defined expectations. Create office policy for performing UDT for patients receiving opioids beyond two weeks. Practice universal precautions. Explain to patient that you must meet the standards of care that include evaluation of risk in all patients, use of PPAs, and other tools.



PART 2

DISCONTINUING

REASONS FOR DISCONTINUING OPIOIDS

PAIN LEVEL
DECREASES IN
STABLE PATIENTS

INTOLERABLE AND
UNMANAGEABLE
AEs

NO PROGRESS
TOWARD
THERAPEUTIC
GOALS

MISUSE

- 1 or 2 episodes of increasing dose without prescriber knowledge
- Sharing medications
- Unapproved opioid use to treat another symptom (e.g., insomnia)

ABERRANT BEHAVIORS

- Use of illicit drugs or unprescribed opioids
- Repeatedly obtaining opioids from multiple outside sources
- Prescription forgery
- Multiple episodes of prescription loss
- Diversion

TAPER DOSE WHEN DISCONTINUING

- Minimize withdrawal symptoms in opioid-dependent patient, consider medications to assist with withdrawal
- May use a range of approaches from slow 10% dose reduction per week to more rapid 25%-50% reduction every few days
- If opioid use disorder or a failed taper, refer to addiction specialist or consider opioid agonist therapy
- Counseling and relaxation strategies needed





- Establish informed consent and PPA at the beginning
- Educate the whole team: *patients, families, caregivers*
- Refer if necessary
- Anticipate opioid-induced respiratory depression and constipation
- Follow patients closely during times of dose adjustments
- Periodically evaluate functional outcomes
- Discontinue opioids slowly and safely

CHALLENGE: IS THIS A LAB ERROR?



RED FLAG:

The questionable Urine Drug Test

Donald has been prescribed oxycodone for six months to treat back pain. His UDT at six months comes back negative in all areas. He tells you that he is taking his meds.

Action:

Do not discharge the patient as the first action. Contact the lab and discuss the test and any metabolite or specimen integrity issues. Ask: Is this the right lab test? Repeat the UDT and document everything. Discuss with the patient.

CHALLENGE: PATIENTS WHO ARE NOT WHO THEY APPEAR



RED FLAG:

Patient wants to control their pill mg dose and taper plan

Tom has back pain. He is managed by taking oxycodone (40 mg BID) but wants to decrease his dose when he can, thus he requests only 20 mg pills. He often brings in unused meds to show how he is trying to reduce his dose. He resists any change.

Action:

Do not allow patient to taper on their own. Create an endpoint for the taper. See patient once a week with a seven-day supply for the tapering until they are off opioids. Document teaching, patient's comments about the plan, UDT, pill counts, non-pharmacological modalities for pain management, and their adherence to this plan.

CHAPTER 6

SPECIAL POPULATIONS

OLDER ADULTS

RISK FOR RESPIRATORY DEPRESSION

- Age-related changes in distribution, metabolism, excretion; absorption less affected

MONITOR

- Initiation and titration
- Concomitant medications (polypharmacy)
- Falls risk, cognitive change, psychosocial status
- Reduce starting dose to 1/3 to 1/2 the usual dosage in debilitated, non-opioid-tolerant patients
- Start low, go slow, but GO
- Patient and caregiver reliability/risk of diversion



ROUTINELY INITIATE A BOWEL REGIMEN

KNOW THE REPRODUCTIVE PLANS AND PREGNANCY STATUS OF YOUR PATIENTS

- 40% of women with childbearing potential are prescribed opioids
- Opioid exposure during pregnancy causes increased risk for fetus
- Most women do not know they are pregnant in first few weeks
- Therefore all women of childbearing age are at risk
- No adequate nor well-controlled studies of opioids for pain in pregnancy

THE PREGNANT PATIENT

Potential risk of opioid therapy to the newborn is neonatal opioid withdrawal syndrome

GIVEN THESE POTENTIAL RISKS, CLINICIANS SHOULD:

- Counsel women of childbearing potential about risks and benefits of opioid therapy during pregnancy and after delivery
- Encourage minimal/no opioid use during pregnancy, unless potential benefits outweigh risks to fetus
- Refer to a high risk OB/Gyn who will ensure appropriate treatment for the baby

- If chronic opioid therapy is used during pregnancy, anticipate and manage risks to the patient and newborn

- If using opioids on a daily basis, consider methadone or buprenorphine





JUDICIOUS USE OF IR FOR BRIEF THERAPY

SAFETY AND EFFECTIVENESS OF MOST ER/LA OPIOIDS UNESTABLISHED

- Pediatric analgesic trials pose challenges
- Transdermal fentanyl approved in children aged ≥ 2 yrs
- Oxycodone ER dosing changes for children ≥ 11 yrs

ER/LA OPIOID INDICATIONS ARE PRIMARILY LIFE-LIMITING CONDITIONS

WHEN PRESCRIBING ER/LA OPIOIDS TO CHILDREN:

- Consult pediatric palliative care team or pediatric pain specialist or refer to a specialized multidisciplinary pain clinic

CHALLENGE: VULNERABILITY IN CO-DEPENDENT OLDER ADULTS



RED FLAG:

Questionable family diversion

78-year-old Thelma comes into clinic, accompanied by grandson, who is in the exam room with you and Thelma. Thelma says her oxycodone 10 mg tablets q 4 hours is no longer working for her back pain. She asks for more medicine. You ask grandson to leave the exam room so you can examine her privately.

Action: Based on exam findings and her request for more medication:

- UDT and PDMP check
- Discuss whether or not it is possible her grandson, or another family member, might be using her medications.
- Patient education: Do not give opioids to another person. Store in secure place – locked. Let you know if medications are not secure or if she feels any pressure about sharing medications.

CHAPTER 7

KNOW YOUR FEDERAL AND STATE LAWS

FEDERAL AND STATE REGULATIONS

Comply with federal and state laws and regulations that govern the use of opioid therapy for pain



FEDERAL

- Code of Federal Regulations, Title 21 Section 1306: rules governing the issuance and filling of prescriptions pursuant to section 309 of the Act (21 USC 829)

www.deadiversion.usdoj.gov/21cfr/cfr/2106cfrt.htm

- United States Code (USC) - Controlled Substances Act, Title 21, Section 829: prescriptions

www.deadiversion.usdoj.gov/21cfr/21usc/829.htm

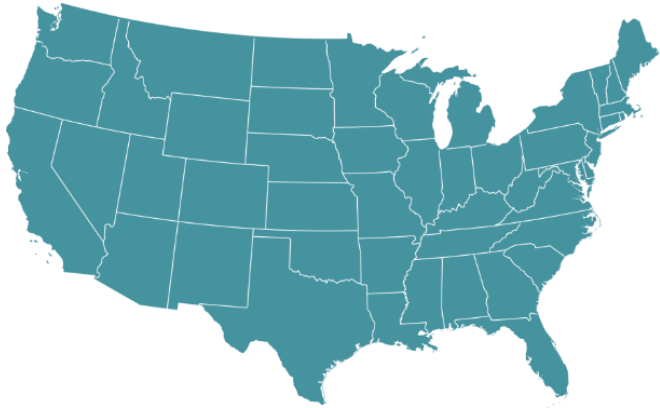


STATE

- Database of state statutes, regulations, and policies for pain management

www.medscape.com/resource/pain/opioid-policies

www.painpolicy.wisc.edu/database-statutes-regulations-other-policies-pain-management



NOT ALL FEDERALLY
LICENSED FACILITIES
REPORT TO PDMPs

[Link to state PDMP sites](#)

INDIVIDUAL STATE LAWS DETERMINE

- Who has access to PDMP information
- Which drug schedules are monitored
- Which agency administers the PDMP
- Whether prescribers are required to register with the PDMP
- Whether prescribers are required to access PDMP information in certain circumstances
- Whether unsolicited PDMP reports are sent to prescribers
- Bordering states may be available
- Designated surrogates may have access

PDMP BENEFITS

Provides full accounting of prescriptions filled by patient

RECORD OF A PATIENT'S CONTROLLED SUBSTANCE PRESCRIPTIONS

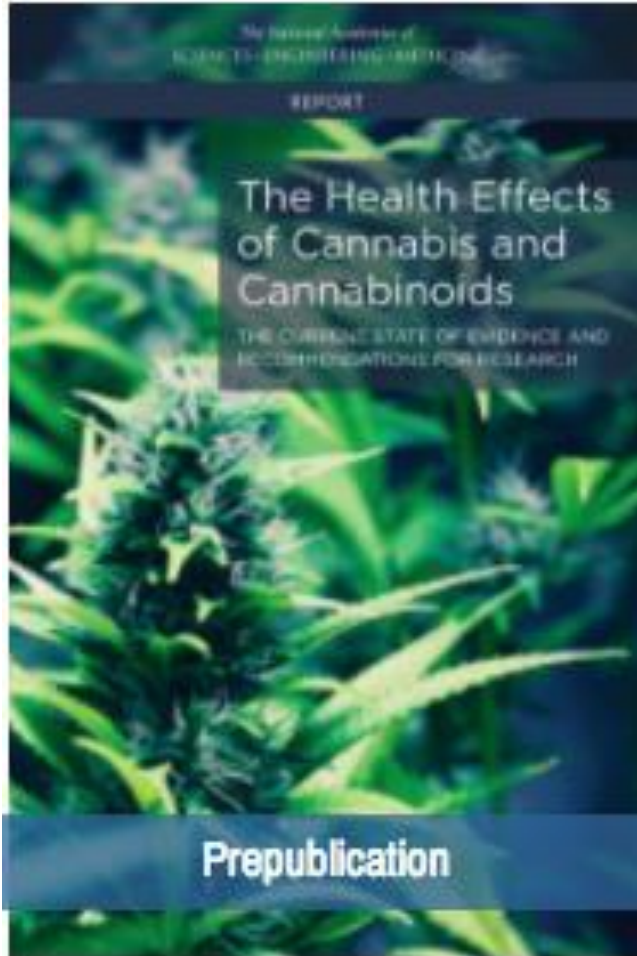
- Some are available online 24/7
- Opportunity to discuss with patient



PROVIDE WARNINGS OF POTENTIAL MISUSE/ABUSE

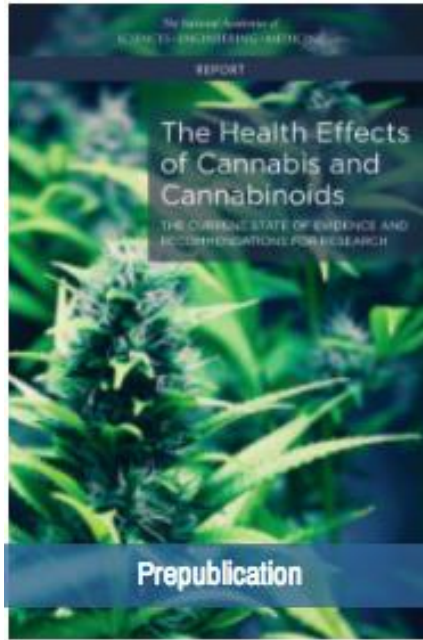
- Existing prescriptions not reported by patient
- Multiple prescribers/pharmacies
- Drugs that increase overdose risk when taken together
- Patient pays with cash (vs insurance) for controlled meds

CANNABIS



- DEA Schedule 1 (“high abuse potential”) yet state laws and regulations vary
- There is evidence that cannabis or selective cannabinoids (cannabidiol) are effective for chronic pain treatment in adults
- More research is needed
- Concern for high risk groups: children, adolescents, pregnant women

CONSIDERATIONS FOR CLINICIANS



- Use available scientific evidence, advise patients
 - Inform about potential effects; AEs mostly mild and well tolerated (cough, anxiety)
 - Screen for potential misuse/abuse, diversion
- Set treatment goals, use PPA
- Encourage patients to keep notes, discuss with them
- Document everything
- Regular re-evaluation
- Consider periodic UDTs
- Discontinue if not helpful moving toward goals
- Edibles are the fastest growing delivery system
- No well controlled studies on the combined use of opioids and cannabis



CHAPTER 8

**COUNSELING PATIENTS
AND CAREGIVERS**

USE PATIENT COUNSELING DOCUMENT



DOWNLOAD:

www.er-la-opioidrems.com/lwgUI/rems/pdf/patient_counseling_document.pdf

ORDER HARD COPIES:

www.minneapolis.cenveo.com/pcd/SubmitOrders.aspx

Patient Counseling Document on Extended-Release / Long-Acting Opioid Analgesics
Patient Name:
The DOs and DON'Ts of Extended-Release / Long - Acting Opioid Analgesics
DO: <ul style="list-style-type: none"> • Read the Medication Guide • Take your medicine exactly as prescribed • Store your medicine away from children and in a safe place • Flush unused medicine down the toilet • Call your healthcare provider for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.
Call 911 or your local emergency service right away if: <ul style="list-style-type: none"> • You take too much medicine • You have trouble breathing, or shortness of breath • A child has taken this medicine
Talk to your healthcare provider: <ul style="list-style-type: none"> • If the dose you are taking does not control your pain • About any side effects you may be having • About all the medicines you take, including over-the-counter medicines, vitamins, and dietary supplements
DON'T: <ul style="list-style-type: none"> • Do not give your medicine to others • Do not take medicine unless it was prescribed for you • Do not stop taking your medicine without talking to your healthcare provider • Do not cut, break, chew, crush, dissolve, snort, or inject your medicine. If you cannot swallow your medicine whole, talk to your healthcare provider. • Do not drink alcohol while taking this medicine
For additional information on your medicine go to: dailymed.nlm.nih.gov

Patient Counseling Document on Extended-Release / Long-Acting Opioid Analgesics
Patient Name:
Patient Specific Information
Take this card with you every time you see your healthcare provider and tell him/her: <ul style="list-style-type: none"> • Your complete medical and family history, including any history of substance abuse or mental illness • If you are pregnant or are planning to become pregnant • The cause, severity, and nature of your pain • Your treatment goals • All the medicines you take, including over-the-counter (non-prescription) medicines, vitamins, and dietary supplements • Any side effects you may be having
Take your opioid pain medicine exactly as prescribed by your healthcare provider.

EXPLAIN

- Product-specific information about the IR or ER/LA opioid (especially when converting)
- Take opioid as prescribed
- Adhere to dose regimen
- How to handle missed doses
- Notify prescriber if pain not controlled
- Call prescriber for options on side effect management

INSTRUCT PATIENTS/ CAREGIVERS TO

- Read the ER/LA opioid **Medication Guide** received from pharmacy **every time** an ER/LA opioid is dispensed



EXPLAIN

- Inform prescriber of ALL meds being taken
- Warn patients not to abruptly discontinue or reduce dose
- Risk of falls
- Caution with operating heavy machinery and when driving
- Sharing or selling opioids can lead to others' deaths and is against the law

OPIOIDS CAN CAUSE DEATH EVEN WHEN TAKEN PROPERLY

- Signs/symptoms are respiratory depression, gastrointestinal obstruction, allergic reactions



EXPLAIN

- Tell patients and caregivers, medications must be kept in a locked container
- Will periodically assess for benefits, side effects, and continued need for IR/ER/LA opioids
- Need for re-evaluation of underlying medical condition if the clinical presentation changes over time

OPIOIDS SHOULD BE STORED IN A SAFE AND SECURE PLACE

- Away from children, family members, visitors, and pets
- Safe from theft

Opioids are scheduled under Controlled Substances Act and can be misused and abused

Never break, chew, crush, or snort an oral ER/LA tablet/capsule, or cut or tear patches prior to use

- May lead to rapid release of ER/LA opioid causing overdose and death
- If unable to swallow a capsule whole, refer to PI to determine if appropriate to sprinkle contents on applesauce or administer via feeding tube



Use of CNS depressants or alcohol with ER/LA opioids can cause overdose & death

- Use with alcohol may result in rapid release and absorption of a potentially fatal opioid dose – “dose dumping”
- Other depressants include sedative-hypnotics and anxiolytics, illegal drugs



OVERDOSE POISONING, CALL 911

- Person cannot be aroused or awakened or is unable to talk
- Any trouble with breathing, heavy snoring is warning sign
- Gurgling noises coming from mouth or throat
- Body is limp, seems lifeless; face is pale, clammy
- Fingernails or lips turn blue/purple
- Slow, unusual heartbeat or stopped heartbeat



NALOXONE

Naloxone:

- An opioid antagonist administered by injection or intranasally, or IV
- Reverses acute opioid-induced respiratory depression but will also reverse analgesia

What to do:

- Discuss an ‘overdose plan’
- Involve and train family, friends, partners, and/or caregivers
- Check with pharmacy if they are prescribing
- Check expiration dates and keep a viable dose on hand
- In the event of known or suspected overdose, administer naloxone and **call 911**

Available as:

- Naloxone kit (with syringes, needles)
- Injectable
- Nasal spray

Consider offering a naloxone prescription to all patients prescribed IR and ER/LA opioids

ABUSE-DETERRENT FORMULATION/TAMPER RESISTANT (ADF/TR) OPIOIDS

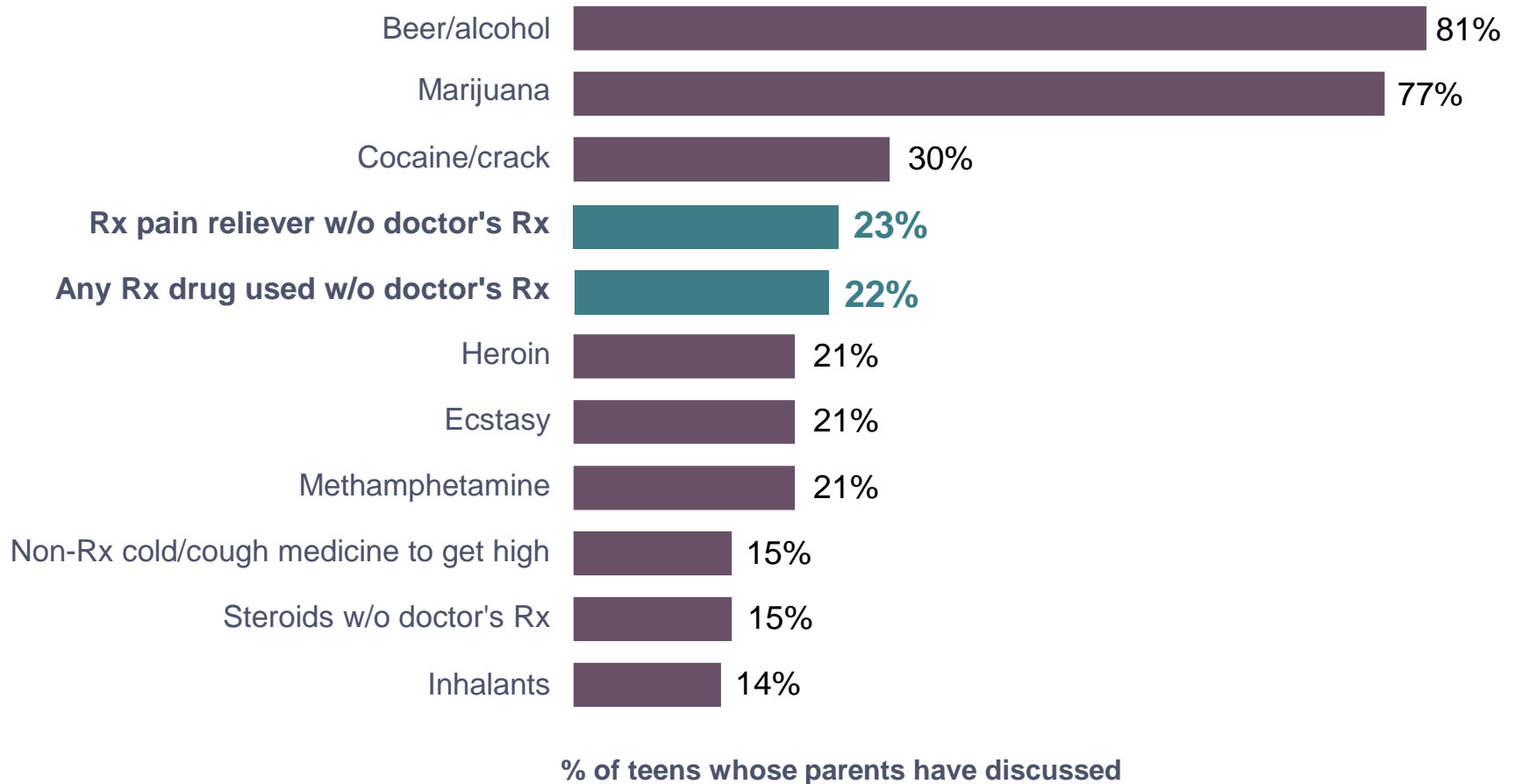


- Response to growing non-medical use problem
- An ER/LA opioid with physical barrier to *deter* extraction
 - Less likely to be crushed, injected, or snorted
- Consider as one part of an overall strategy
- Mixed evidence on the impact of ADF/TR on misuse
- Remember overdose is still possible if taken orally in excessive amounts

SUBSTANCES PARENTS HAVE DISCUSSED WITH TEENS*



*As reported by teens



REMEMBER...

STEP 1: MONITOR

- Note how many pills in each prescription
- Keep track of dosage and refills
- Make sure everyone in the home knows

STEP 2: SECURE

- Keep meds in a safe place (locked cabinet)
- Encourage parents of your teen's friends to secure their prescriptions

STEP 3: DISPOSE

- Discard expired or unused meds
- Consult PI for best disposal



RX OPIOID DISPOSAL

New “Disposal Act” expands ways for patients to dispose of unwanted/expired opioids

DECREASES AMOUNT OF OPIOIDS INTRODUCED INTO THE ENVIRONMENT, PARTICULARLY INTO WATER

Collection receptacles

Call DEA Registration Call Center at **1-800-882-9539** to find a local collection receptacle



Mail-back packages

Obtained from authorized collectors



Voluntarily maintained by:

- Law enforcement
- Authorized collectors, including:
 - Manufacturer
 - Distributor
 - Reverse distributor
 - Retail or hospital/clinic pharmacy
 - Including long-term care facilities

Look for local take-back events

- Conducted by Federal, State, tribal, or local law enforcement
- Partnering with community groups

OTHER METHODS OF OPIOID DISPOSAL

IF COLLECTION RECEPTACLE, MAIL-BACK PROGRAM, OR TAKE-BACK EVENT UNAVAILABLE, THROW OUT IN HOUSEHOLD TRASH

- Take drugs out of original containers
- Mix with undesirable substance
- Place in sealable bag, can, or other container
- Remove identifying info on label



FLUSH DOWN SINK/TOILET IF NO COLLECTION RECEPTACLE,
MAIL-BACK PROGRAM, OR TAKE-BACK EVENT AVAILABLE

- As soon as they are no longer needed
- Includes transdermal adhesive skin patches
 - Used patch (3 days) still contains enough opioid to harm/kill a child
 - Dispose of used patches immediately after removing from skin
- Fold patch in half so sticky sides meet, then flush down toilet
- Do NOT place used or unneeded patches in household trash
 - Butrans (buprenorphine transdermal system)
exception: can seal in Patch-Disposal Unit
provided and dispose of in the trash



CHAPTER 8 – PEARLS FOR PRACTICE



- Use formal tools (PPAs, counseling document) to educate patients and caregivers
- Emphasize safe storage and disposal to patients and caregivers
- Consider co-prescribing naloxone

CHALLENGE: THE DAUGHTER'S PARTY



RED FLAG:

Patients do not safeguard their opioid medications correctly

Your patient's daughter stole her father's opioids from his bedside drawer to take to a "fishbowl party." Her best friend consumed a mix of opioids and alcohol and died of an overdose.

Action:

Always counsel patients about safe drug storage; warn patients about the serious consequences of theft, misuse, and overdose. Tell patients that taking another person's medication, even once, is against the law.

CHAPTER 9

DRUG CLASS CONSIDERATIONS

FOR SAFER USE: KNOW DRUG INTERACTIONS, PK, AND PD

CNS depressants can potentiate sedation and respiratory depression

Some ER/LA products rapidly release opioid (dose dump) when exposed to alcohol
Some drug levels may increase without dose dumping

Use with MAOIs may increase respiratory depression

Certain opioids with MAOIs can cause serotonin syndrome

Can reduce efficacy of diuretics
Inducing release of antidiuretic hormone

Methadone and buprenorphine can prolong QTc interval

Drugs that inhibit or induce CYP enzymes can increase or lower blood levels of some opioids

TRANSDERMAL/TRANSMUCOSAL DOSAGE FORMS

Do not cut, damage, chew, or swallow



Exertion or exposure to external heat can lead to fatal overdose

Rotate location of application

Prepare skin: clip (not shave) hair & wash area with water

Monitor patients with fever for signs or symptoms of increased opioid exposure

Metal foil backings are not safe for use in MRIs

For buccal film products the film should not be applied if it is cut, damaged, or changed in anyway -- use entire film

DRUG INTERACTIONS COMMON TO OPIOIDS

- Concurrent use with other CNS depressants can increase risk of respiratory depression, hypotension, profound sedation, or coma
- Reduce initial dose of one or both agents

- Avoid concurrent use of partial agonists* or mixed agonist/antagonists† with full opioid agonist
- May reduce analgesic effect and/or precipitate withdrawal

- May enhance neuromuscular blocking action of skeletal muscle relaxants and increase respiratory depression

- Concurrent use with anticholinergic medication increases risk of urinary retention and severe constipation
- May lead to paralytic ileus

*Buprenorphine; †Pentazocine, nalbuphine, butorphanol

SPECIFIC CHARACTERISTICS

Know for opioid products you prescribe:

Drug substance

Formulation

Strength

Dosing interval

Key instructions

Use in opioid-tolerant patients

Product-specific safety concerns

Relative potency to morphine

Specific information about product conversions, if available

Specific drug interactions

SUMMARY

Prescription opioid abuse and overdose is a national epidemic.
Clinicians must play a role in prevention.

Assess patients for treatment with IR and ER/LA opioids

Initiate therapy, modify dose, and discontinue use of opioids

Monitor ongoing therapy with IR and ER/LA opioids

Counsel patients and caregivers about the safe use of opioids, including proper storage and disposal

Be familiar with general and product-specific drug information concerning opioids



Our session stops here, but your review continues...

Refer to Appendix 1
for specific drug information on ER/LA opioid analgesic
products

For detailed information, prescribers can refer to prescribing information
available online via DailyMed at

www.dailymed.nlm.nih.gov

or Drugs@FDA at www.fda.gov/drugsatfda

Thank you for completing the post-activity
assessment for this CO*RE session

**Your participation in this assessment allows CO*RE to report
de-identified numbers to the FDA**

A strong show of engagement will demonstrate that clinicians have
voluntarily taken this important education and are committed to
patient safety and improved outcomes

THANK YOU!



THANK YOU!

WWW.CORE-REMS.ORG

Appendix 1. Drug Specific Slides

Morphine Sulfate ER Tablets (Arymo ER)

Capsules 15 mg, 30 mg, 60 mg

Dosing interval

- Every 8 or 12 hours

Key instructions

- Initial dose in opioid-naïve and opioid non-tolerant patients is 15 mg every 8 or 12 hours
- Dosage adjustment may be done every 1 to 2 days.
- Take one tablet at a time, with enough water to ensure complete swallowing immediately after placing in the mouth

Drug interactions

- P-gp inhibitors (e.g. quinidine) can increase the exposure of morphine by about two-fold and increase risk of respiratory depression

Opioid-tolerant

- A single dose of ARYMO ER greater than 60 mg, or total daily dose greater than 120 mg, is for use in opioid-tolerant patients only.

Product-specific safety concerns

- Do not attempt to chew, crush, or dissolve. Swallow whole.
- Use with caution in patients who have difficulty in swallowing or have underlying GI disorders that may predispose them to obstruction, such as a small gastrointestinal lumen.



Morphine Sulfate ER Capsules (Avinza)

Capsules 30 mg, 45 mg, 60 mg, 75 mg, 90 mg, and 120 mg

Dosing interval	<ul style="list-style-type: none">• Once a day
Key instructions	<ul style="list-style-type: none">• Initial dose in opioid non-tolerant patients is 30 mg• Titrate in increments of not greater than 30 mg using a minimum of 3-4 d intervals• Swallow capsule whole (do not chew, crush, or dissolve)• May open capsule & sprinkle pellets on applesauce for patients who can reliably swallow without chewing; use immediately• MDD:* 1600 mg (renal toxicity of excipient, fumaric acid)
Drug interactions	<ul style="list-style-type: none">• Alcoholic beverages or medications w/ alcohol may result in rapid release & absorption of potentially fatal dose• P-gp* inhibitors (e.g., quinidine) may increase absorption/exposure of morphine by ~2-fold
Opioid-tolerant	<ul style="list-style-type: none">• 90 mg & 120 mg capsules for use in opioid-tolerant patients only
Product-specific safety concerns	<ul style="list-style-type: none">• None

* MDD=maximum daily dose; P-gp= P-glycoprotein

Buprenorphine Buccal Film (Belbuca)

75 mcg, 150 mcg, 300 mcg, 450 mcg, 600 mcg, 750 mcg, and 900 mcg

Dosing interval

- Every 12 h (or once every 24 h for initiation in opioid naïve patients & patients taking less than 30 mg oral morphine sulfate eq)

Key instructions

- Opioid-naïve pts or pts taking <30 mg oral morphine sulfate eq: Initiate treatment with a 75 mcg buccal film, once daily, or if tolerated, every 12 h
 - Titrate to 150 mcg every 12 h no earlier than 4 d after initiation
 - Individual titration to a dose that provides adequate analgesia and minimizes adverse reaction should proceed in increments of 150 mcg every 12 h, no more frequently than every 4 d
- When converting from another opioid, first taper the current opioid to no more than 30 mg oral morphine sulfate eq/day prior to initiating Belbuca
 - If prior daily dose before taper was 30 mg to 89 mg oral morphine sulfate eq, initiate with 150 mcg dose every 12 h
 - If prior daily dose before taper was 90 mg to 160 mg oral morphine sulfate eq, initiate with 300 mcg dose every 12 h
 - Titration of the dose should proceed in increments of 150 mcg every 12 h, no more frequently than every 4 d

Buprenorphine Buccal Film (Belbuca) *continued*

Key instructions

- Maximum dose: 900 mcg every 12 h due to the potential for QTc prolongation
- Severe Hepatic Impairment: Reduce the starting and incremental dose by half that of patients with normal liver function
- Oral Mucositis: Reduce the starting and incremental dose by half that of patients without mucositis
- Do not use if the package seal is broken or the film is cut, damaged, or changed in any way

Specific Drug Interactions

- CYP3A4 inhibitors may increase buprenorphine levels
- CYP3A4 inducers may decrease buprenorphine levels
- Benzodiazepines may increase respiratory depression
- Class IA and III antiarrhythmics, other potentially arrhythmogenic agents, may increase risk for QTc prolongation and torsade de pointes

Use in Opioid-Tolerant Patients

- Belbuca 600 mcg, 750 mcg, and 900 mcg are for use following titration from lower doses of Belbuca

Product-Specific Safety Concerns

- QTc prolongation and torsade de pointes
- Hepatotoxicity

Relative Potency: Oral

- Equipotency to oral morphine has not been established.

Buprenorphine Transdermal System (Butrans)

Transdermal System 5 mcg/hr, 7.5 mcg/hr, 10 mcg/hr, 15 mcg/hr, 20 mcg/hr

Dosing interval

- One transdermal system every 7 d

Key instructions

- Initial dose in opioid non-tolerant patients on <30 mg morphine equivalents & in mild-moderate hepatic impairment: 5 mcg/h
- When converting from 30 mg-80 mg morphine equivalents, first taper to 30 mg morphine equivalent, then initiate w/ 10 mcg/h
- Titrate in 5 or 10 mcg/h increments by using no more than 2 patches of the 5 or 10 mcg/h system(s) w/ minimum of 72 h prior between dose adjustments. Total dose from all patches should be ≤ 20 mcg/h
- Maximum dose: 20 mcg/h due to risk of QTc prolongation
- Application
 - Apply only to sites indicated in PI
 - Apply to intact/non-irritated skin
 - Prep skin by clipping hair; wash site w/ water only
 - Rotate application site (min 3 wks before reapply to same site)
 - Do not cut
- Avoid exposure to heat
- Dispose of patches: fold adhesive side together & flush down toilet

Buprenorphine Transdermal System (Butrans)

continued

Drug interactions	<ul style="list-style-type: none">• CYP3A4 inhibitors may increase buprenorphine levels• CYP3A4 inducers may decrease buprenorphine levels• Benzodiazepines may increase respiratory depression• Class IA & III antiarrhythmics, other potentially arrhythmogenic agents, may increase risk of QTc prolongation & torsade de pointe
Opioid-tolerant	<ul style="list-style-type: none">• 7.5 mcg/h, 10 mcg/h, 15 mcg/h, & 20 mcg/h for use in opioid-tolerant patients only
Product-specific safety concerns	<ul style="list-style-type: none">• QTc prolongation & torsade de pointe• Hepatotoxicity• Application site skin reactions
Relative potency: oral morphine	<ul style="list-style-type: none">• Equipotency to oral morphine not established

Methadone Hydrochloride Tablets (Dolophine)

Dosing interval

- Every 8 to 12 h

Key instructions

- Initial dose in opioid non-tolerant patients: 2.5 – 10 mg
- Conversion of opioid-tolerant patients using equianalgesic tables can result in overdose & death. Use low doses according to table in full PI
- Titrate slowly with dose increases no more frequent than every 3-5 d. Because of high variability in methadone metabolism, some patients may require substantially longer periods between dose increases (up to 12 d).
- High inter-patient variability in absorption, metabolism, & relative analgesic potency
- Opioid detoxification or maintenance treatment only provided in a federally certified opioid (addiction) treatment program (CFR, Title 42, Sec 8)

Drug interactions

- Pharmacokinetic drug-drug interactions w/ methadone are complex
 - CYP 450 inducers may decrease methadone levels
 - CYP 450 inhibitors may increase methadone levels
 - Anti-retroviral agents have mixed effects on methadone levels
- Potentially arrhythmogenic agents may increase risk for QTc prolongation & torsade de pointe
- Benzodiazepines may increase respiratory depression

Methadone Hydrochloride Tablets (Dolophine)

continued

Opioid-tolerant

- Refer to full PI

Product-specific safety concerns

- QTc prolongation & torsade de pointe
- Peak respiratory depression occurs later & persists longer than analgesic effect
- Clearance may increase during pregnancy
- False-positive UDT possible

Relative potency: oral morphine

- Varies depending on patient's prior opioid experience

Fentanyl Transdermal System (Duragesic)

12, 25, 37.5*, 50, 62.5*, 75, 87.5*, and 100 mcg/hr
(*These strengths are available only in generic form)

Dosing interval

- Every 72 h (3 d)

Key instructions

- Use product-specific information for dose conversion from prior opioid
- Hepatic or renal impairment: use 50% of dose if mild/moderate, avoid use if severe
- Application
 - Apply to intact/non-irritated/non-irradiated skin on a flat surface
 - Prep skin by clipping hair, washing site w/ water only
 - Rotate site of application
 - Titrate using a minimum of 72 h intervals between dose adjustments
 - Do not cut
- Avoid exposure to heat
- Avoid accidental contact when holding or caring for children
- Dispose of used/unused patches: fold adhesive side together & flush down toilet

Fentanyl Transdermal System (Duragesic), *continued*

Key instructions	Specific contraindications: <ul style="list-style-type: none">• Patients who are not opioid-tolerant• Management of<ul style="list-style-type: none">– Acute or intermittent pain, or patients who require opioid analgesia for a short time– Post-operative pain, out-patient, or day surgery– Mild pain
Drug interactions	<ul style="list-style-type: none">• CYP3A4 inhibitors may increase fentanyl exposure• CYP3A4 inducers may decrease fentanyl exposure• Discontinuation of concomitant CYP P450 3A4 inducer may increase fentanyl plasma concentration
Opioid-tolerant	<ul style="list-style-type: none">• All doses indicated for opioid-tolerant patients only
Product-specific safety concerns	<ul style="list-style-type: none">• Accidental exposure due to secondary exposure to unwashed/unclothed application site• Increased drug exposure w/ increased core body temp or fever• Bradycardia• Application site skin reactions
Relative potency: oral morphine	<ul style="list-style-type: none">• See individual PI for conversion recommendations from prior opioid

Morphine Sulfate ER-Naltrexone (Embeda)

Capsules 20 mg/0.8 mg, 30 mg/1.2 mg, 50 mg/2 mg, 60 mg/2.4 mg, 80 mg, 3.2 mg, 100 mg/4 mg

Dosing interval	<ul style="list-style-type: none">• Once a day or every 12 h
Key instructions	<ul style="list-style-type: none">• Initial dose as first opioid: 20 mg/0.8 mg• Titrate using a minimum of 1-2 d intervals• Swallow capsules whole (do not chew, crush, or dissolve)• Crushing or chewing will release morphine, possibly resulting in fatal overdose, & naltrexone, possibly resulting in withdrawal symptoms• May open capsule & sprinkle pellets on applesauce for patients who can reliably swallow without chewing, use immediately
Drug interactions	<ul style="list-style-type: none">• Alcoholic beverages or medications w/ alcohol may result in rapid release & absorption of potentially fatal dose• P-gp inhibitors (e.g., quinidine) may increase absorption/exposure of morphine by ~2-fold
Opioid-tolerant	<ul style="list-style-type: none">• 100 mg/4 mg capsule for use in opioid-tolerant patients only
Product-specific safety concerns	<ul style="list-style-type: none">• None

Hydromorphone Hydrochloride (Exalgo)

ER Tablets 8 mg, 12 mg, 16 mg, 32 mg

Dosing interval	<ul style="list-style-type: none">• Once a day
Key instructions	<ul style="list-style-type: none">• Use conversion ratios in individual PI• Start patients w/ moderate hepatic impairment on 25% dose prescribed for patient w/ normal function• Renal impairment: start patients w/ moderate on 50% & patients w/ severe on 25% dose prescribed for patient w/ normal function• Titrate in increments of 4-8 mg using a minimum of 3-4 d intervals• Swallow tablets whole (do not chew, crush, or dissolve)• Do not use in patients w/ sulfite allergy (contains sodium metabisulfite)
Drug interactions	<ul style="list-style-type: none">• None
Opioid-tolerant	<ul style="list-style-type: none">• All doses are indicated for opioid-tolerant patients only
Product-specific adverse reactions	<ul style="list-style-type: none">• Allergic manifestations to sulfite component
Relative potency: oral morphine	<ul style="list-style-type: none">• ~5:1 oral morphine to hydromorphone oral dose ratio, use conversion recommendations in individual product information

Hydrocodone Bitartrate (Hysingla ER)

ER Tablets, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg, 100 mg, 120mg

Dosing interval

- Once a day

Key instructions

- Opioid-naïve patients: initiate treatment with 20 mg orally once daily.
- During titration, adjust the dose in increments of 10 mg to 20 mg every 3 to 5 days until adequate analgesia is achieved.
- Swallow tablets whole (do not chew, crush, or dissolve).
- Consider use of an alternative analgesic in patients who have difficulty swallowing or have underlying gastrointestinal disorders that may predispose them to obstruction.
- Take one tablet at a time, with enough water to ensure complete swallowing immediately after placing in the mouth.
- Use 1/2 of the initial dose and monitor closely for adverse events, such as respiratory depression and sedation, when administering Hysingla ER to patients with severe hepatic impairment or patients with moderate to severe renal impairment.

Hydrocodone Bitartrate (Hysingla ER)

continued

Drug interactions	<ul style="list-style-type: none">• CYP3A4 inhibitors may increase hydrocodone exposure.• CYP3A4 inducers may decrease hydrocodone exposure.• Concomitant use of Hysingla ER with strong laxatives (e.g., Lactulose) that rapidly increase GI motility may decrease hydrocodone absorption and result in decreased hydrocodone plasma levels.• The use of MAO inhibitors or tricyclic antidepressants with Hysingla ER may increase the effect of either the antidepressant or Hysingla ER.
Opioid-tolerant	<ul style="list-style-type: none">• A single dose ≥ 80 mg is only for use in opioid tolerant patients.
Product-specific safety concerns	<ul style="list-style-type: none">• Use with caution in patients with difficulty swallowing the tablet or underlying gastrointestinal disorders that may predispose patients to obstruction.• Esophageal obstruction, dysphagia, and choking have been reported with Hysingla ER.• In nursing mothers, discontinue nursing or discontinue drug. QTc prolongation has been observed with Hysingla ER following daily doses of 160 mg.• Avoid use in patients with congenital long QTc syndrome. This observation should be considered in making clinical decisions regarding patient monitoring when prescribing Hysingla ER in patients with congestive heart failure, bradyarrhythmias, electrolyte abnormalities, or who are taking medications that are known to prolong the QTc interval.• In patients who develop QTc prolongation, consider reducing the dose.
Relative potency: oral morphine	<ul style="list-style-type: none">• See individual PI for conversion recommendations from prior opioid



Morphine Sulfate (Kadian)

ER Capsules 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 70 mg, 80 mg, 100 mg, 130mg, 150 mg, 200 mg

Dosing interval	<ul style="list-style-type: none">• Once a day or every 12 h
Key instructions	<ul style="list-style-type: none">• PI recommends not using as first opioid• Titrate using minimum of 2-d intervals• Swallow capsules whole (do not chew, crush, or dissolve)• May open capsule & sprinkle pellets on applesauce for patients who can reliably swallow without chewing, use immediately
Drug interactions	<ul style="list-style-type: none">• Alcoholic beverages or medications w/ alcohol may result in rapid release & absorption of potentially fatal dose of morphine• P-gp inhibitors (e.g., quinidine) may increase absorption/exposure of morphine by ~2-fold
Opioid-tolerant	<ul style="list-style-type: none">• 100 mg, 130 mg, 150 mg, 200 mg capsules for use in opioid-tolerant patients only
Product-specific safety concerns	<ul style="list-style-type: none">• None

Morphine Sulfate (MorphaBond)

ER Tablets 15 mg, 30 mg, 60 mg, 100 mg

Dosing interval	<ul style="list-style-type: none">• Every 8 h or every 12h
Key instructions	<ul style="list-style-type: none">• Product information recommends not using as first opioid• Titrate using a minimum of 1 – 2 d intervals• Swallow tablets whole (do not chew, crush, or dissolve)
Specific Drug interactions	<ul style="list-style-type: none">• P-gp inhibitors (e.g. quinidine) may increase the absorption/exposure of morphine sulfate by about two-fold
Opioid-tolerant	<ul style="list-style-type: none">• MorphaBond 100 mg tablets are for use in opioid-tolerant patients only
Product-specific safety concerns	<ul style="list-style-type: none">• None

Morphine Sulfate (MS Contin)

ER Tablets 15 mg, 30 mg, 60 mg, 100 mg, 200mg

Dosing interval	<ul style="list-style-type: none">• Every 8 h or every 12 h
Key instructions	<ul style="list-style-type: none">• Product information recommends not using as first opioid.• Titrate using a minimum of 1-2 d intervals• Swallow tablets whole (do not chew, crush, or dissolve)
Drug interactions	<ul style="list-style-type: none">• P-gp inhibitors (e.g., quinidine) may increase absorption/exposure of morphine by ~2-fold
Opioid-tolerant	<ul style="list-style-type: none">• 100 mg & 200 mg tablet strengths for use in opioid-tolerant patients only
Product-specific safety concerns	<ul style="list-style-type: none">• None

Tapentadol (Nucynta ER)

ER Tablets 50 mg, 100 mg, 150 mg, 200 mg, 250 mg

Dosing interval	<ul style="list-style-type: none">• Every 12 h
Key instructions	<ul style="list-style-type: none">• 50 mg every 12 h is initial dose in opioid non-tolerant patients• Titrate by 50 mg increments using minimum of 3-d intervals• MDD: 500 mg• Swallow tablets whole (do not chew, crush, or dissolve)• Take 1 tablet at a time w/ enough water to ensure complete swallowing immediately after placing in mouth• Dose once/d in moderate hepatic impairment (100 mg/d max)• Avoid use in severe hepatic & renal impairment
Drug interactions	<ul style="list-style-type: none">• Alcoholic beverages or medications w/ alcohol may result in rapid release & absorption of a potentially fatal dose of tapentadol• Contraindicated in patients taking MAOIs
Opioid-tolerant	<ul style="list-style-type: none">• No product-specific considerations
Product-specific safety concerns	<ul style="list-style-type: none">• Risk of serotonin syndrome• Angio-edema
Relative potency: oral morphine	<ul style="list-style-type: none">• Equipotency to oral morphine has not been established

Oxymorphone Hydrochloride (Opana ER)

ER Tablets 5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg, 30 mg, 40 mg

Dosing interval	<ul style="list-style-type: none">• Every 12 h dosing, some may benefit from asymmetric (different dose given in AM than in PM) dosing
Key instructions	<ul style="list-style-type: none">• Use 5 mg every 12 h as initial dose in opioid non-tolerant patients & patients w/ mild hepatic impairment & renal impairment (creatinine clearance <50 mL/min) & patients >65 yrs• Swallow tablets whole (do not chew, crush, or dissolve)• Take 1 tablet at a time, w/ enough water to ensure complete swallowing immediately after placing in mouth• Titrate in increments of 5-10 mg using a minimum of 3-7 d intervals• Contraindicated in moderate & severe hepatic impairment
Drug interactions	<ul style="list-style-type: none">• Alcoholic beverages or medications w/ alcohol may result in absorption of a potentially fatal dose of oxymorphone
Opioid-tolerant	<ul style="list-style-type: none">• No product-specific considerations
Product-specific safety concerns	<ul style="list-style-type: none">• Use with caution in patients who have difficulty swallowing or underlying GI disorders that may predispose to obstruction (e.g. small gastrointestinal lumen)
Relative potency: oral morphine	<ul style="list-style-type: none">• Approximately 3:1 oral morphine to oxymorphone oral dose ratio

Oxycodone Hydrochloride (OxyContin)

ER Tablets 10mg, 15mg, 20mg, 30mg, 40mg, 60mg and 80 mg

**NEW
DOSING
INFO**

Dosing interval	<ul style="list-style-type: none">• Every 12 h
Key instructions	<ul style="list-style-type: none">• Initial dose in opioid-naïve and non-tolerant patients: 10 mg every 12 h• Titrate using a minimum of 1-2 d intervals• Hepatic impairment: start w/ $\frac{1}{3}$-$\frac{1}{2}$ usual dosage• Renal impairment (creatinine clearance <60 mL/min): start w/ $\frac{1}{2}$ usual dosage• Consider other analgesics in patients w/ difficulty swallowing or underlying GI disorders that predispose to obstruction. Swallow tablets whole (do not chew, crush, or dissolve)• Take 1 tablet at a time, w/ enough water to ensure complete swallowing immediately after placing in mouth
Drug interactions	<ul style="list-style-type: none">• CYP3A4 inhibitors may increase oxycodone exposure• CYP3A4 inducers may decrease oxycodone exposure
Opioid-tolerant	<ul style="list-style-type: none">• For Adults: Single dose >40 mg or total daily dose >80 mg for use in opioid-tolerant patients only
Product-specific safety concerns	<ul style="list-style-type: none">• Choking, gagging, regurgitation, tablets stuck in throat, difficulty swallowing tablet• Contraindicated in patients w/ GI obstruction
Relative potency: oral morphine	<ul style="list-style-type: none">• Approximately 2:1 oral morphine to oxycodone oral dose ratio

Oxycodone Hydrochloride (OxyContin) *continued*

ER Tablets 10mg, 15mg, 20mg, 30mg, 40mg, 60mg and 80 mg

IMPORTANT

Key instructions

For Adults:

- Single dose greater than 40 mg or total daily dose greater than 80 mg are for use in adult patients in whom tolerance to an opioid of comparable tolerance has been established.
- When a dose increase is clinically indicated, the total daily oxycodone dose usually can be increased by 25% to 50% of the current dose.

For Pediatric Patients (11 years and older):

- For use only in opioid tolerant pediatric patients already receiving and tolerating opioids for at least five (5) consecutive days with a minimum of 20 mg per day of oxycodone or its equivalent for at least 2 days immediately preceding dosing with Oxycodon ER. Renal impairment (creatinine clearance <60 mL/min): start w/ ½ usual dosage
- If needed, pediatric dose may be adjusted in 1 to 2 day intervals.
- When a dose increase is clinically indicated, the total daily oxycodone dose usually can be increased by 25% of the current daily dose.

IMPORTANT:

- Opioids are rarely indicated or used to treat pediatric patients with chronic pain.
- The recent FDA approval for this oxycodone formulation was NOT intended to increase prescribing or use of this drug in pediatric pain treatment. Review the product information and adhere to best practices in the literature.

Oxycodone Hydrochloride/Naloxone Hydrochloride (Targiniq ER)

ER Tablets 10 mg/5mg, 20 mg/10mg, 40 mg/20mg

Dosing interval	<ul style="list-style-type: none">• Every 12 h
Key instructions	<ul style="list-style-type: none">• Opioid-naïve patients: initiate treatment w/ 10mg/5mg every 12 h• Titrate using min of 1-2 d intervals• Do not exceed 80 mg/40 mg total daily dose (40 mg/20 mg q12h)• May be taken w/ or without food• Swallow whole. Do not chew, crush, split, or dissolve: this will release oxycodone (possible fatal overdose) & naloxone (possible withdrawal)• Hepatic impairment: contraindicated in moderate-severe impairment. In patients w/ mild impairment, start w/ $\frac{1}{3}$-$\frac{1}{2}$ usual dosage• Renal impairment (creatinine clearance <60 mL/min): start w/ $\frac{1}{2}$ usual dosage
Drug interactions	<ul style="list-style-type: none">• CYP3A4 inhibitors may increase oxycodone exposure• CYP3A4 inducers may decrease oxycodone exposure
Opioid-tolerant	<ul style="list-style-type: none">• Single dose >40 mg/20 mg or total daily dose of 80 mg/40 mg for opioid-tolerant patients only
Product-specific safety concerns	<ul style="list-style-type: none">• Contraindicated in patients w/ moderate-severe hepatic impairment
Relative potency: oral morphine	<ul style="list-style-type: none">• See individual PI for conversion recommendations from prior opioids

Oxycodone Hydrochloride/Naltrexone

ER Capsules 10/1.2mg, 20/2.4mg, 30/3.6mg, 40/4.8mg, 60/7.2mg, 80/9.6mg
Hydrochloride (Troxyca ER)

Dosing interval	<ul style="list-style-type: none">• Every 12 h
Key instructions	<ul style="list-style-type: none">• Opioid-naïve & non-tolerant patient is 10/1.2mg, every 12h• Total daily dose may be adjusted by 20/2.4 mg every 2-3 d• Swallow capsules whole (do not chew, crush, or dissolve); possible fatal overdose, and naltrexone (possible withdrawal)• May open capsule & sprinkle pellets on applesauce for patients who can reliably swallow without chewing, use immediately• Do not administer through NG or G tube
Drug interactions	<ul style="list-style-type: none">• CYP3A4 inhibitors may increase hydrocodone exposure• CYP3A4 inducers may decrease hydrocodone exposure
Opioid-tolerant	<ul style="list-style-type: none">• Single dose >40/4.8mg or total daily dose >80/9.6mg for use in opioid-tolerant patients only
Product-specific safety concerns	<ul style="list-style-type: none">• None
Relative potency: oral morphine	<ul style="list-style-type: none">• See individual product information for conversion recommendations from prior opioid

Hydrocodone Bitartrate (Vantrela ER)

ER Tablets 15 mg, 30 mg, 45 mg, 60 mg, 90 mg

Dosing interval	<ul style="list-style-type: none">• Every 12 h
Key instructions	<ul style="list-style-type: none">• Initial dose in opioid naïve and non-tolerant patient is 15 mg every 12 h. Dose can be increased to next higher dose every 3-7 d• Swallow capsules whole (do not chew, crush, or dissolve)• Mild or moderate hepatic and moderate to severe renal impairment: initiate therapy with ½ recommended initial dose. If a dose <15 mg needed, use alternative options
Drug interactions	<ul style="list-style-type: none">• CYP3A4 inhibitors may increase hydrocodone exposure• CYP3A4 inducers may decrease hydrocodone exposure
Opioid-tolerant	<ul style="list-style-type: none">• A 90 mg tablet, a single dose greater than 60 mg, or a total daily dose >120 mg are for use in opioid-tolerant patients only
Product-specific safety concerns	<ul style="list-style-type: none">• None
Relative potency: oral morphine	<ul style="list-style-type: none">• See individual product information for conversion recommendations from prior opioid

Oxycodone (Xtampza ER)

ER Capsules 9 mg,
13.5 mg, 18 mg, 27 mg,
36 mg

Dosing interval	<ul style="list-style-type: none">• Every 12 h
Key instructions	<ul style="list-style-type: none">• Opioid naïve and non-tolerant, initiate with 9 mg every 12 h• Titrate using a minimum of 1-2 d intervals• Take with same amt of food in order to ensure consistent plasma levels• Maximum daily dose: 288 mg (8 x 36 mg), safety of excipients not established for higher doses• May open capsule & sprinkle pellets on applesauce for patients who can reliably swallow without chewing, use immediately• May also be administered through a NG or G feeding tube• Hepatic impairment: initiate therapy at 1/3 to 1/2 usual dose• Renal impairment: creatinine clearance <60 mL/min, follow conservative approach
Drug interactions	<ul style="list-style-type: none">• CYP3A4 inhibitors may increase hydrocodone exposure• CYP3A4 inducers may decrease hydrocodone exposure
Opioid-tolerant	<ul style="list-style-type: none">• A single dose >36 mg or a total daily dose >72 mg for opioid-tolerant patients only
Product-specific safety concerns	<ul style="list-style-type: none">• None
Relative potency: oral morphine	<ul style="list-style-type: none">• There are no established conversion ratios for Xtampza ER, defined by clinical trials

Naloxone (Narcan)

Dosing interval	<ul style="list-style-type: none">• IM or SQ: onset 2-5 minutes, duration >45 min• IV: onset 1-2 min, duration 45 minutes• IN: onset 2-3 min, duration ~ 2 hours
Key instructions	<ul style="list-style-type: none">• Monitor respiratory rate• Monitor level of consciousness for 3-4 hours after expected peak of blood concentrations• Note that reversal of analgesia will occur
Drug interactions	<ul style="list-style-type: none">• Larger doses required to reverse effects of buprenorphine, butorphanol, nalbuphine, or pentazocine
Opioid-tolerant	<ul style="list-style-type: none">• Assess signs and symptoms of opioid withdrawal, may occur w-i 2 min – 2 hrs• Vomiting, restlessness, abdominal cramps, increased BP, temperature• Severity depends on naloxone dose, opioid involved & degree of dependence
Product-specific safety concerns	<ul style="list-style-type: none">• Ventricular arrhythmias, hypertension, hypotension, nausea & vomiting• As naloxone plasma levels decrease, sedation from opioid overdose may increase

Hydrocodone Bitartrate (Zohydro ER)

ER Capsules 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg

Dosing interval	<ul style="list-style-type: none">• Every 12 h
Key instructions	<ul style="list-style-type: none">• Initial dose in opioid non-tolerant patient is 10 mg• Titrate in increments of 10 mg using a min of 3-7 d intervals• Swallow capsules whole (do not chew, crush, or dissolve)
Drug interactions	<ul style="list-style-type: none">• Alcoholic beverages or medications containing alcohol may result in rapid release & absorption of a potentially fatal dose of hydrocodone• CYP3A4 inhibitors may increase hydrocodone exposure• CYP3A4 inducers may decrease hydrocodone exposure
Opioid-tolerant	<ul style="list-style-type: none">• Single dose >40 mg or total daily dose >80 mg for use in opioid-tolerant patients only
Product-specific safety concerns	<ul style="list-style-type: none">• None
Relative potency: oral morphine	<ul style="list-style-type: none">• Approximately 1.5:1 oral morphine to hydrocodone oral dose ratio

Appendix 2. Detailed Disclosure Information for CO*RE Staff and Faculty

The following individuals disclose no relevant financial relationships:

Faculty Advisory Panel & Reviewer COI

Faculty Advisory Panel	Affiliation
David Bazzo, MD	Clinical Professor of Family Medicine, University of California San Diego, School of Medicine
Ron Crossno, MD	Vice President, Medical Affairs and Chief Medical Officer at Kindred at Home
Katherine Galluzzi, DO	Professor and Chair, Department of Geriatrics, Philadelphia College of Osteopathic Medicine
Carol Havens, MD	Director of Physician Education and Development, Kaiser Permanente, Northern California
Randall Steven Hudspeth PhD, MBA, MS, APRN-CNP, FRE, FAANP	Practice and Regulation Consultant in Advanced Practice Pain Management and Palliative Care
Catherine R. Judd, MS, MPA-C, DFAAPA	Senior Physician Assistant, Parkland Health and Hospital Systems
Barbara St. Marie, PhD, ANP, GNP	Assistant Professor, College of Nursing, University of Iowa
Edwin A. Salsitz, MD, DFASAM	Mount Sinai Beth Israel Medical Center, Division of Chemical Dependency; Assistant Professor, Icahn School of Medicine at Mount Sinai
Seddon R. Savage, MD	Associate Professor, Geisel School of Medicine, Dartmouth College, Director Dartmouth Center on Addiction Recovery and Education

External / Consulting Reviewers	Affiliation
Roberto Cardarelli, DO, MPH	Professor, Department of Family and Community Medicine, University of Kentucky College of Medicine
Marcia Jackson, PhD	CME by Design

The following individuals disclose no relevant financial relationships:

CO*RE Partner Staff COI

Staff Person	Partner Affiliation
Julie Bruno	American Academy of Hospice and Palliative Medicine
Michele McKay Anne Norman	American Association of Nurse Practitioners
Marie-Michele Leger Eric Peterson	American Academy of Physician Assistants
Stephanie Townsell	American Osteopathic Association
Penny Mills, Arlene Deverman, Conner Bellis, Molly Muzuk	American Society of Addiction Medicine
Catherine Underwood Brianna Wixted	American Pain Society
Susan Hogeland Jerri Davis	California Academy of Family Physicians
Mary Ales Kate Nisbet	Interstate Postgraduate Medical Association
Cyndi Grimes, Piyali Chatterjee, Sarah Williams	Medscape
Pam Jenkins Phyllis Zimmer	Nurse Practitioner Healthcare Foundation
Tom McKeithen Chris Larrison	Healthcare Performance Consulting

The following individuals disclose no relevant financial relationships:

CO*RE Operations Organizations

Staff Person	Affiliation
Cynthia Kear	Cynthia Kear, LLC
Katie Detzler	Forefront Collaborative
Robin Heyden Neil Heyden	Heyden Ty, LLC