Patients on Chronic Opioid Therapy for Chronic Non-Cancer Pain Safety Guideline

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Last guideline approval: May 2020

Guidelines are systematically developed statements to assist patients and providers in choosing appropriate health care for specific clinical conditions. While guidelines are useful aids to assist providers in determining appropriate practices for many patients with specific clinical problems or prevention issues, guidelines are not meant to replace the clinical judgment of the individual provider or establish a standard of care. The recommendations contained in the guidelines may not be appropriate for use in all circumstances. The inclusion of a recommendation in a guideline does not imply coverage. A decision to adopt any particular recommendation must be made by the provider in light of the circumstances presented by the individual patient.
Interim Update July 2020

- All patients being prescribed long-term opioids are now required to have a safety review of their care plan every 3 months at a COT monitoring visit. Previously, visit frequency requirements were based on risk stratification (every 3 months for patients in the high-intensity monitoring group, every 6 months for moderate-intensity, and annually for low-intensity). We have updated this guideline to align closely with guidance from the Centers for Disease Control and Prevention and the standards of other Kaiser Permanente regions.

- All monitoring visits must be done in person or by video, with at least one in-person visit per year. Telephone and secure messaging conversations no longer count as COT monitoring visits.

- Urine drug screening (UDS) is based on risk stratification, and is no longer required at every monitoring visit except for patients in the high-intensity monitoring group. UDS is required at least annually for patients in the low-intensity group, at least every 6 months for the moderate-intensity group, and at least every 3 months for the high-intensity group.

Major Changes as of May 2020

- The criteria for high-risk opioid use were expanded. Recently added risk factors include mental health conditions (depression, anxiety, PTSD), medical conditions (e.g., obesity, sleep apnea), alcohol and illicit substance use, and advanced age (65 years or older).

- The previous tool for assessing a patient's risk of opioid use disorder (OUD), the Opioid Risk Tool (ORT), was replaced by the updated ORT-OUD tool, which has higher sensitivity and specificity for predicting OUD and easier scoring.

- Screening for sleep apnea using the Epworth Sleepiness Scale is now recommended as part of the initial COT monitoring visit.

- The DSM-5 criteria have replaced the Substance Use Disorder Symptom Checklist as the preferred tool for diagnosing OUD.

- Recommendations against using buprenorphine, Suboxone, cannabinoids (THC and CBDs) for the treatment of chronic pain have been added.

- The guidance on tapering opioids has been expanded to incorporate the BRAVO protocol and recommendations for the speed of taper based on risk stratification.

- Criteria for when to refer to a pain specialist, Mental Health and Wellness, and Addiction Medicine were updated.

Washington State Law

This guideline is in compliance with the State of Washington regulations WAC 246-919-850–985 on the use of opioids in the treatment of patients with chronic non-cancer pain.
Introduction: Relationship Between Opioid Dose and Risk Levels

The use of chronic opioid therapy for chronic pain is not an evidence-based practice and is without established benefits that outweigh the considerable risks on a population level; therefore, it should occur only in very rare circumstances.

Best practice is to defer use of opioids by employing non-pharmacologic and non-opioid therapies first.

Serious opioid-related risks increase sharply with higher doses.

**Opioid use disorder:** A person taking a relatively low dose of prescribed opioids is 15 times as likely to develop opioid use disorder as a person who has not been prescribed opioids. The risk continues to rise with escalating doses; at high doses (≥ 120 mg MED) of opioids, the person’s risk of developing OUD is 122 times that of a person who has not been prescribed opioids. (Edlund 2014)

![Risk of opioid use disorder](image)

**Opioid overdose:** Similarly, a person taking ≥ 100 mg MED will be 9 times as likely to overdose as a person taking < 20 mg MED. (Dunn 2010) Note that approximately 1 overdose in 7 is fatal.

![Risk of overdose](image)

Use the SmartPhrase `opioidrisks` for additional information on the medical risks of long-term opioid use.
Guideline Scope

Kaiser Foundation Health Plan of Washington has adopted the recommendations of the 2015 Agency Medical Directors’ Group (AMDG) Interagency Guideline on Prescribing Opioids for Pain. The guideline is also in alignment with the National Permanente Medical Group 2019 Practice Recommendations for Improving Appropriate Opioid Prescribing and Reducing Potential for Harm.

This is a safety guideline. The recommendations in this guideline apply to adult patients who are already on chronic opioid therapy (COT) for the treatment of chronic non-cancer pain.

Chronic opioid therapy (COT) is daily or near-daily use of opioids for at least 90 days, often indefinitely. (Chou 2009. Additionally, COT is defined as a minimum 70-day supply of opioids dispensed in the previous 3 calendar months.

Chronic non-cancer pain means a state in which non-cancer pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years (WAC 246-919-850–985).

The Centers for Disease Control and Prevention has found insufficient evidence to determine the long-term benefits of opioid therapy for chronic pain, and has found an increased risk for serious harms related to long-term opioid therapy that appears to be dose-dependent. (CDC 2016)

Outside the scope of this guideline are:
- Indications for opioid prescribing
- Initiation of opioid prescribing
- General recommendations for the treatment of chronic non-cancer pain

For these areas, Kaiser Foundation Health Plan of Washington has adopted the recommendations of the 2015 AMDG Interagency Guideline on Prescribing Opioids for Pain.

This guideline does not apply to patients receiving palliative, hospice, or other end-of-life care.

Expectations for Kaiser Foundation Health Plan of Washington Providers

Using protocols and standard documentation, Kaiser Foundation Health Plan of Washington aims to minimize practice variation in the management of patients on chronic opioid therapy for chronic non-cancer pain, which will improve patient safety, ensure compliance with Washington State law, and ultimately increase both patient and provider satisfaction.

- Patients on COT shall be risk-stratified to the highest appropriate category by the prescribing clinician.
- Patients on COT shall have regular COT monitoring visits that:
  - Occur at a 3-month frequency, and
  - Include standard components.
- Patients on COT shall receive all chronic pain management prescriptions from one physician and one pharmacy wherever possible. Clinicians treating a patient on COT are expected to clarify—both among themselves and with the patient—which clinician holds primary prescribing responsibility. See “Opioid prescribing procedures,” p. 15.
- Physicians prescribing opioids for chronic non-cancer pain shall have a one-time completion of at least 4 hours of continuing medical education relating to this topic. The State of Washington offers an online CME to help physicians comply with statewide rules.
Managing Chronic Opioid Therapy (COT)

Risk stratification, intensity of monitoring, and frequency of visits

The intensity of monitoring is determined by the “patient attributes” in Table 1. Patients should be placed in the highest-intensity group for which they meet at least one of the criteria. For example, patients taking benzodiazepines should be in the high-intensity monitoring group even if they are on a relatively low dose of opioids (< 40 mg MED).

All patients on COT shall have a monitoring visit every 3 months either in person or by video, including at least one in-person visit annually. (Telephone and secure messaging conversations are no longer considered monitoring visits.)

<table>
<thead>
<tr>
<th>Monitoring group</th>
<th>Patient attributes</th>
<th>Monitoring visit and urine drug screening (UDS) frequency</th>
</tr>
</thead>
</table>
| **High-intensity**<sup>1</sup> | • Taking ≥ 90 mg morphine equivalent dose (MED)/day  
  *Note:* For patients taking ≥ 120 mg MED/day, referral to a pain specialist is required.  
  • Taking methadone or fentanyl  
  • Taking sedative-hypnotic drugs (benzodiazepines, Z-drugs),<sup>2</sup> carisoprodol, or muscle relaxers concurrently  
  • Using alcohol or marijuana concurrently<sup>3</sup>  
  • Age 25 years or younger  
  • Age 65 years or older  
  • History of overdose  
  • Legal issues related to substances (e.g., DUI)  
  • ORT score ≥ 8 or ORT-OUD score ≥ 3  
  • Mental health conditions: depression, anxiety, substance use disorder, PTSD  
  • Medical conditions: sleep apnea, cardiac disease, pulmonary disease, severe obesity, renal insufficiency, hepatic insufficiency, osteoporosis, pregnancy, history of falls  
  • Illicit substance use: other opioids, other people’s opioid prescriptions, heroin, illicit use of prescription drugs  
  • Repeated aberrant behaviors, such as:  
    o Frequent early refill requests  
    o Escalating dose without consulting with physician  
    o Multiple emergency room/urgent care presentations for opioid treatment  
    o Getting opioids from multiple prescribers  
    o Lost or stolen medications  
    o Sharing medications with others  
    o Disruptive behavior  
    o Not taking as prescribed | Office or video visit required at least every 3 months.  
  UDS required at least every 3 months. |
| **Moderate-intensity**<sup>1</sup> | • Taking between 40 mg and 89 mg MED/day  
  • Moderate score (4–7) on the ORT or ORT-OUD score ≤ 2  
  • Compliant with pain treatment plan | Office or video visit required at least every 3 months.  
  UDS required at least every 6 months. |
| **Low-intensity** | • Taking < 40 mg MED/day  
  • Low score (0–3) on the ORT or ORT-OUD score ≤ 2  
  • Compliant with pain treatment plan | Office or video visit required at least every 3 months.  
  UDS required at least annually. |

<sup>1</sup>Patients in the moderate- and high-intensity monitoring groups are at increased risk of opioid overdose and death from respiratory depression. Offer **naloxone** as preventive rescue medication for these patients. See “Prescribing naloxone,” p. 15.

<sup>2</sup>See the Benzodiazepine and Z-Drug Safety Guideline and this 2016 FDA Safety Warning on the risks of combining benzodiazepines with opioids.

<sup>3</sup>Per National Permanente Medical Group 2019 Clinician Practice Recommendations for Opioid Prescribing, use of marijuana and/or alcohol is contraindicated while taking opioids. COT should not be initiated in patients currently using alcohol or marijuana, and tapering should be considered in patients using COT concurrently with either of these substances.
The chronic opioid therapy monitoring visit: standard components

Steps listed apply to every COT monitoring visit, except where noted.

Every monitoring visit is an opportunity to improve safety for patients on COT and to consider adjusting the Opioid Care Plan—including tapering or discontinuation of opioid therapy—based on changes in the patient’s conditions or comorbidities.

For a patient’s initial COT monitoring visit (ongoing or new start), use SmartPhrase .opioidvisit, which includes all steps required at the initial visit.

For a patient’s follow-up COT monitoring visits, use either .opioidvisit or .opioidmini, which includes just the steps that are required at all visits.

1. Medical screening, history, and physical exam

Use of opioid medications is contraindicated in patients with
- Known opioid use disorder (see “Recognizing opioid use disorder,” p. 9)
- History of opioid overdose

Screen for medical issues that affect opioid risk (e.g., pulmonary, cardiac, renal or hepatic disease; obstructive sleep apnea [using the Epworth Sleepiness Scale]; pregnancy risk; severe obesity; history of falls). See “Tapering or discontinuing opioid therapy,” p. 10.

Obtain/review patient history.

At the patient’s initial COT monitoring visit, conduct a physical exam.

2. Pain and function assessment

Continuation of COT should be considered only when the benefits outweigh the risks. AMDG defines clinically meaningful improvement in function as an improvement in pain and function of at least 30% as compared to the start of treatment or in response to a dose change.

To assess patients’ ongoing response to COT, use the PEG (Pain/Enjoyment/General function) Tool. available as the SmartPhrase .pegscore. The PEG Tool is also available as a KP HealthConnect documentation flowsheet, review flowsheet, and secure message.

For longitudinal tracking of a patient’s progress towards functional goals, consider using the Oswestry Disability Index (available in KP HealthConnect).

3. Prescription monitoring

Check the patient’s record in the Washington State Prescription Monitoring Program database every time controlled substances are prescribed to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk.
4. Opioid risk assessment (initial visit only)

At the patient’s initial COT monitoring visit, use the updated Opioid Risk Tool (ORT-OUD) to assess the risk of developing opioid use disorder (OUD) when taking long-term opioids. The ORT is a validated tool recommended by the Washington State AMDG. A score of 3 or higher indicates a high risk of developing OUD.

5. Psychological comorbidity screening

Screen the patient for depression, suicidal ideation, alcohol use, drug use, PTSD, and anxiety using the Annual Mental Health Questionnaire. Both sides of the questionnaire—including the additional questions on the second page—are required for patients on COT, regardless of whether the PHQ-2 screen is positive. Screening for mental health issues is part of adult standard care.

6. Urine drug screening (UDS)

UDS provides objective data regarding patients who are managing chronic pain and can be used to directly improve patient safety. For their safety, it is important that patients take opioids as prescribed, and this test helps assess whether they are doing that. UDS should also be ordered when seeing patients already on COT who are new to the health plan and have no record of recent UDS.

UDS is legally required, and its routine use helps to ensure that all patients on COT are treated equitably.

UDS is for medical purposes only. KPWA does not collect samples for use in a court of law or for workplace testing.

Clinicians should have a discussion with the patient before the UDS that includes:
- The purpose of testing
- What will be screened for
- What results the patient expects
- Prescriptions or any other drugs the patient has taken
- Time and dose of last dose of opioids
- Actions that may be taken based on the results of the screen
- Possibility of cost to the patient

Patients should be notified that the results will become part of their permanent medical record. Unexpected UDS results must be discussed with the patient; the care plan should be reevaluated only after unexpected positive and negative results have been confirmed by laboratory testing and after the patient has had the opportunity to discuss the results with the prescribing clinician.

For more detailed information on urine drug screening, see Drug Screening Ordering & Interpretation (staff intranet).

7. Care plan

Use .opioidcareplan at every visit to:
- Ensure the patient’s treatment plan includes all components required by Washington State opioid legislation (https://app.leg.wa.gov/wac/default.aspx?cite=246-919-850). The physician shall use a written agreement that outlines the patient’s responsibilities for opioid therapy. (Note: The legislation does not specify that a paper copy or patient signature is needed.)
- Serve as informed consent and documentation for chronic opioid therapy.
8. Documentation and coding

For a patient’s initial COT monitoring visit (ongoing or new start), use SmartPhrase .opioidvisit, which includes all steps required at the initial visit.

For a patient’s follow-up COT monitoring visits, use either .opioidvisit or .opioidmini, which includes just the steps that are required at all visits.

When documenting an encounter with a patient on COT, providers should include diagnosis codes for both the condition being treated with opioid medications and the long-term opioid treatment itself:

- Diagnosis code for underlying condition, and
- Z79.891 Long-term (current) use of opioid analgesic

When COT monitoring is the main reason for the visit, Z79.891 should be used as the primary diagnosis, with the underlying condition as a secondary diagnosis. Conversely, when managing the underlying condition is the main reason for the visit—for example, when ordering physical therapy for a patient with chronic back pain—providers should document the underlying condition (chronic back pain) as the primary diagnosis, and Z79.891 as a secondary diagnosis.

GHC.17 should be added to the problem list for all COT patients at the initial COT monitoring visit.

In the rare instances that providers are treating a patient with both a health problem requiring opioid therapy and a concurrent opioid use disorder, documentation should be clear that the opioids are being used to treat the indicated health problem and not as a treatment for the opioid use disorder. (For patients with an existing or suspected opioid use disorder, see “Recognizing opioid use disorder.”)
Recognizing opioid use disorder

It is not uncommon for patients on COT to develop opioid use disorder (OUD) during their treatment. Whenever OUD is suspected, use the DSM-5 criteria (below) during a conversation with the patient that ideally includes a family member or other observer, or contact the Mental Health and Wellness Mind Phone (1-888-844-4662) for a consultation if unsure how to proceed.

It is illegal for providers to treat opioid use disorders or opioid withdrawal with opioid medications except under very specific circumstances. In outpatient settings, specific opioid medications may only be used by physicians with a special DEA waiver or by specially regulated opioid treatment programs to treat opioid use disorders. See Pharmacy Suboxone Prescribing on the staff intranet for more information.

DSM-5: Opioid Use Disorder

For patients who are prescribed opioid medications, there is an expectation that they will have therapeutically induced physical dependence. As a result, the criteria for opioid use disorder are amended here to exclude counting tolerance and withdrawal criteria.

Opioid use disorder is a problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least 2 criteria occurring within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain, use, or recover from the effects of opioids.
4.Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

If a patient is not being prescribed opioid medications, these are two additional criteria for diagnosis of opioid use disorder:

10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect, or
    b. Markedly diminished effect with continued use of the same amount of an opioid.
11. Withdrawal, as manifested by either of the following:
    c. The characteristic opioid withdrawal syndrome, or
    d. Opioids (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.

Mild: Presence of 2-3 symptoms
Moderate: Presence of 4-5 symptoms
Severe: Presence of 6 or more symptoms
Tapering and Discontinuing Opioids

General principles

1. Any time the risks of continued opioid therapy are found to outweigh its benefits, opioid medications should be tapered and possibly discontinued. The decision to taper is the provider’s; however, developing the care plan is an opportunity for shared decision-making with the patient and family.

2. Taper planning must be individualized based on the patient’s clinical needs, indication for taper, readiness for taper, and ability to comply with care team’s tapering instructions, and on the provider’s clinical judgement.
   - Determine initial step of taper and document rationale in medical record.
   - Consider referral to Clinical Pharmacist Opioid Taper Program (COMET) for help with dosing complicated tapers.
   - **Do not reverse** a taper. A temporary pause in tapering may be indicated to mitigate side effects.
   - Taper planning should be collaborative to the extent possible between provider and patient/family. Areas for shared decision-making can include tapering rate, choice of which medication to taper first, and any other aspects of planning where patient input is appropriate.
   - Consider using the BRAVO protocol (see below) to support conversations about tapering.

3. Assess the patient’s response to the initial dose reduction in the first 1 to 4 weeks.

4. Reassess taper weekly to monthly based on patient's response, and prior to each subsequent dose reduction.

5. Prescribe naloxone for any patient at risk for overdose.

6. Some special populations, such as pregnant women or patients with mental health comorbidities, may require alternative approaches to opioid tapers.

7. For questions before initiating or during an opioid taper, please see the Referral Criteria, p. 19.
Clinical indications for opioid tapering

Table 2. Clinical indications and methods for individualized tapering of opioid therapy

<table>
<thead>
<tr>
<th>Examples of indications</th>
<th>Taper methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Consider for patients taking high-dose, long-acting opioids for many years, with no aberrant behaviors, who do not have other indications as below.</td>
<td>SLOWEST 2-5% every 4-8 weeks</td>
</tr>
<tr>
<td>• Function and pain are not improved, or</td>
<td>SLOW: Most common method 5-10% every 4-8 weeks</td>
</tr>
<tr>
<td>• Tolerance has developed with long-term opioid prescription, or</td>
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<tr>
<td>• Comorbid conditions or other factors increase risk of complications (see list in .opioidrisks, p. 37), or</td>
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<tr>
<td>• Patient requests taper.</td>
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<tr>
<td>• Medication adverse effects indicate risks are greater than benefits, or</td>
<td>MODERATE 10% per week</td>
</tr>
<tr>
<td>• Morphine equivalent dose exceeds recommended threshold of 90 MED, or</td>
<td></td>
</tr>
<tr>
<td>• Comorbid conditions increase risk of complications, or</td>
<td></td>
</tr>
<tr>
<td>• Pain is resolved.</td>
<td></td>
</tr>
<tr>
<td>• Urine drug screen is consistent with substance abuse concerns, or UDS does not show presence of opioids, or</td>
<td>RAPID 20-50% first dose, then 10-20% per day</td>
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<tr>
<td>• Patient’s behavior suggests possible misuse or diversion of medication. Such behaviors might include:</td>
<td>Refer patient for chemical dependency or addiction counseling. (See Referral Criteria, p. 19.)</td>
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<tr>
<td>o Forging prescriptions</td>
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<tr>
<td>o Stealing or borrowing drugs</td>
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<tr>
<td>o Frequently losing prescriptions</td>
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<tr>
<td>o Aggressive demand for opioids</td>
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<tr>
<td>o Injecting oral/topical opioids</td>
<td></td>
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<tr>
<td>o Unsanctioned use of opioids</td>
<td></td>
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<tr>
<td>o Unsanctioned dose escalation</td>
<td></td>
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<tr>
<td>o Concurrent use of illicit drugs</td>
<td></td>
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<tr>
<td>o Getting opioids from multiple prescribers</td>
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<tr>
<td>o Recurring emergency department visits for chronic pain management</td>
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<tr>
<td>o Non-adherence to opioid treatment plan</td>
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<tr>
<td>o Overdose event</td>
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</tr>
<tr>
<td>• If patient is not at risk of withdrawal and is not currently taking an opioid (e.g., negative UDS, patient states no longer taking), no taper is needed.</td>
<td>TAPER NOT NEEDED Consider mental health support. Provide withdrawal medication if indicated. See Treating opioid withdrawal symptoms, p. 14.</td>
</tr>
<tr>
<td>• Do not resume previous opioid medication.</td>
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</tbody>
</table>
BRAVO Protocol: how to taper patients off of chronic opioid therapy

The BRAVO protocol was developed to help providers implement a compassionate approach to opioid tapering while also maintaining a therapeutic alliance. It is a helpful approach when tapering opioids, especially with complex chronic pain patients.

https://content.tts.org/content/Refresher2018/files/G-09_Lembke.pdf

<table>
<thead>
<tr>
<th><strong>B</strong></th>
<th>Broaching the Subject</th>
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<tbody>
<tr>
<td>• Schedule enough time with your patient to have a discussion on this difficult topic.</td>
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<tr>
<td>• Anticipate the patient’s strong emotional reaction.</td>
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<tr>
<td>• Identify the feelings normalize those feelings and express empathy with the concerns that patient may have.</td>
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<tr>
<th><strong>R</strong></th>
<th>Risk-Benefit Calculator</th>
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<tbody>
<tr>
<td>• When assessing benefits, weigh the patient’s pain relief against their functionality.</td>
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<tr>
<td>• Involve family members for more objective views on a patient's opioid use.</td>
<td></td>
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<tr>
<td>• Track common risks such as tolerance and opioid-induced hyperalgesia.</td>
<td></td>
</tr>
<tr>
<td>• Include all of these factors when discussing reasons for tapering off opioids.</td>
<td></td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th><strong>A</strong></th>
<th>Addiction Happens</th>
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<tbody>
<tr>
<td>• Addiction is defined by the “Four C’s”: out of Control use, Compulsive use, Craving and Continued use.</td>
<td></td>
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<tr>
<td>• Dependence happens when the body relies on a drug to function normally.</td>
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</tr>
<tr>
<td>• Dependence and addiction are not equivalent.</td>
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<thead>
<tr>
<th><strong>V</strong></th>
<th>Velocity Matters – and so Does Validation</th>
</tr>
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<tbody>
<tr>
<td>• Go slowly, take the necessary time to ease your patients down on their doses.</td>
<td></td>
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<tr>
<td>• Let the patient be involved when deciding how much to decrease and at what time.</td>
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<tr>
<td>• It is OK to take breaks in lowering the dosage.</td>
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</tr>
<tr>
<td>• Never go backwards, your patient’s tolerance will increase and progress will be lost.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>O</strong></th>
<th>Other Strategies for Coping with Pain – teach patients these 3 Dialectical Behavioral Therapy (DBT) practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>• STOP: Stop. Take a breath. Observe internal and external experiences and proceed mindfully.</td>
<td></td>
</tr>
<tr>
<td>• Opposite Action Skills: acting opposite to a negative emotional urge in the service or pursuing values goals.</td>
<td></td>
</tr>
<tr>
<td>• Radical Acceptance: accepting reality as it is and not as we wish it to be.</td>
<td></td>
</tr>
</tbody>
</table>
Opioid Tapering Flowchart

Assess benefits & risks of continuing opioids at current dose.

**Risks outweigh benefits**
- Discuss, educate, and offer taper. Assess patient’s readiness.

**Benefits outweigh risks**
- Document risk/benefit assessment.
  - Re-evaluate benefits & risks every 1-3 months.

Ready to start taper? NO
- Meets criteria for opioid use disorder (OUD)?
  - YES: Transition to medication for OUD. Consider E-consult with Addiction Medicine.
  - NO: Re-evaluate benefits & risks every 1-3 months.

YES
- Taper down as tolerated until benefits outweigh risks.
- Offer resources to assist with barriers to readiness, then start slow taper.
- OR: Refer to Pain Team.

Tolerating and willing to continue taper? NO
- Re-evaluate benefits & risks every 1-3 months.

YES
- Patient not tolerating taper: See Treating opioid withdrawal symptoms, below.
- Patient resists further dose reduction: Consider OUD or mental health issue. Consider referral to Mental Health or Addiction Medicine.

Adapted from Health and Human Services. Available at https://content.tts.org/content/Refresher2018/files/G-09_Lembke.pdf
**Treating opioid withdrawal symptoms**

When opioids are rapidly discontinued (see Table 2, above) or stopped immediately, withdrawal symptoms can occur. The typical time course for symptom development depends on the particular opioid used by the patient.

- Short-acting opioids (e.g., heroin or oxycodone): Withdrawal symptoms begin 8–12 hours after last use and peak 48–72 hours after last use.
- Long-acting opioids (e.g., methadone or buprenorphine): Withdrawal symptoms begin more gradually, with a few symptoms in the first 24–48 hours, a peak in symptoms 3–5 days after last use, and some symptoms continuing for up to a few weeks.

While opioid withdrawal is unpleasant, it is not dangerous to patients. Medications for withdrawal symptoms are in Table 3.

<table>
<thead>
<tr>
<th>Target symptoms</th>
<th>Medication</th>
<th>Dosing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension, tremors, sweats, anxiety, restlessness</td>
<td>Clonidine ¹</td>
<td>0.1 mg three times daily as needed</td>
</tr>
<tr>
<td>Anxiety, restlessness</td>
<td>Hydroxyzine ² or Diphenhydramine ²</td>
<td>25 mg every 6 hours as needed</td>
</tr>
<tr>
<td>Insomnia</td>
<td>Hydroxyzine ² or Diphenhydramine ²</td>
<td>25–50 mg daily at bedtime as needed</td>
</tr>
<tr>
<td>Nausea/vomiting</td>
<td>Promethazine ²</td>
<td>25 mg every 6 hours as needed</td>
</tr>
<tr>
<td></td>
<td>Metoclopramide ²</td>
<td>10 mg every 6 hours as needed</td>
</tr>
<tr>
<td>Dyspepsia</td>
<td>Calcium carbonate</td>
<td>500 mg 1–2 tabs every 8 hours as needed</td>
</tr>
<tr>
<td></td>
<td>Mylanta, Milk of Magnesia</td>
<td>Follow package instructions.</td>
</tr>
<tr>
<td>Pain, fever</td>
<td>Acetaminophen (Tylenol)</td>
<td>500 mg every 4 hours (not to exceed 3 g/24 hours)</td>
</tr>
<tr>
<td></td>
<td>Ibuprofen</td>
<td>400 mg every 4 hours as needed</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Loperamide ²</td>
<td>4 mg initially, then 2 mg every loose stool as needed; maximum 16 mg/day</td>
</tr>
<tr>
<td>Muscle spasm</td>
<td>Methocarbamil ²</td>
<td>1,000 mg every 6 hours as needed</td>
</tr>
</tbody>
</table>

¹ Clonidine is not FDA-approved for this use, although evidence supports use in this setting. This guideline recommends clonidine as the first-line agent, as it is effective in many patients. As a non-opioid treatment option, it is readily available statewide and does not have extra restrictions on prescribing. Monitor blood pressure and pulse. Dosing of clonidine depends on whether patient is acutely withdrawing or gradually being tapered.

² These are high-risk medications for the elderly. Please consider alternatives for patients aged 64 and older.
Minimizing Risks When Continuing to Prescribe Opioids

This guideline seeks to balance the appropriate use of opioid therapy in chronic non-cancer pain against its potential harms.

- Opioid therapy is continued only when the expected benefits—such as reduced pain and clinically meaningful improvement in function (as measured with the PEG Tool)—are expected to outweigh the risks of overdose, opioid use disorder, and other opioid-related harms.
- Opioid therapy is prescribed at the lowest necessary dose and for the shortest duration.
- Clinicians who manage patients on COT are skilled and knowledgeable in the principles of opioid prescribing, tapering, and discontinuing opioid medication, and in the assessment and management of risks associated with opioid use, such as the development of opioid use disorder.
- Clinicians who manage patients on COT routinely integrate psychotherapeutic interventions, functional restoration, interdisciplinary treatment as needed and available, and other non-opioid therapies. Pain is a normal sensation. Acceptance of chronic pain and focus on functional goals improves quality of life.
- The Centers for Disease Control and Prevention has found insufficient evidence to determine the long-term benefits of opioid therapy for chronic pain, and has found an increased risk for serious harms related to long-term opioid therapy that appears to be dose-dependent. (Dowell 2016)

Prescribing naloxone as preventive rescue medication

Naloxone is an opioid antagonist that may be used to reverse the symptoms of opioid overdose (including respiratory depression) after a known or suspected opioid overdose. Naloxone does not replace emergency medical care.

Offer to prescribe naloxone as a preventive rescue medication for patients (and their family members) in the moderate- and high-intensity groups—those who are taking opioid therapy ≥ 40 mg MED per day or have other risk factors for opioid overdose as defined in Table 1, p. 5.

The preferred naloxone product at Kaiser Foundation Health Plan of Washington is Narcan nasal spray.

Counsel family members or other personal contacts who are in a position to assist the patient who is at risk of opioid-related overdose.

Resources

Pharmacy patient handout on naloxone nasal spray (staff intranet). Use SmartPhrase .avsnaloxone.

Opioid overdose prevention education: www.stopoverdose.org

Opioid prescribing procedures

Chronic non-cancer pain patients should receive all chronic pain management prescriptions from one physician and one pharmacy whenever possible. Clinicians involved in treating a patient on COT are expected to clarify—both among themselves and with the patient—which clinician holds primary responsibility for prescribing. Cross-coverage by another Primary Care provider is included as an extension of the primary prescribing clinician.

Before writing a prescription:
- Calculate and document the total morphine equivalent dose (MED); doing this can help assess the magnitude of seemingly small incremental dosage changes over time. See “Morphine equivalent dosing,” below.
- Calculate and document the total acetaminophen dose, including prescribed and over-the-counter.

When writing prescriptions, provide explicit directions:
- Provide specific patient instructions (e.g., schedule for taking).
- Avoid range dosing. For example, instead of “1-2 tablets every 4-6 hours,” use “1 tablet every 6 hours.”
- Order medication in multiples of 7 days and include “to last ___ days.”
- Consider setting up refills on Tuesday through Thursday so that they don’t fall on a Monday or Friday, when patients and/or providers are more likely to be on vacation.

Do not initiate extended-release/long-acting opioid medication in opioid-naïve patients.
Do not prescribe extended-release/long-acting opioid medication on an as-needed basis.

- Food and Drug Administration (FDA) labels state that extended-release and long-acting opioid analgesics are indicated “for the management of pain severe enough to require daily, around-the-clock opioid treatment and for which alternative treatments are inadequate.” The labels emphasize first considering potentially less-addictive measures.
- Limitations of use: Due to the greater risks of overdose and death with extended-release formulations, their use should be reserved for patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, are not tolerated, or provide inadequate or insufficient pain management. (FDA news release 2013)
- For patients aged 65 years and older, short-acting opioids are preferable, as metabolism of medications slows with age. (AMDG 2015)

**Morphine equivalent dosing (MED)**

An [electronical MED calculator](#) is available on the Agency Medical Directors’ Group web site.

**Equianalgesic dosing and cross-tolerance**

All conversions between opioids are estimates generally based on “equianalgesic dosing” (ED). Patient response to these EDs can vary widely, due primarily to genetic factors and incomplete cross-tolerance. It is recommended that, after the appropriate conversion dose is calculated, it be reduced by 25–50% to ensure safety.

- Reduce opioid dose by 30–50% to accommodate for unknown cross-tolerance and titrate to goal.
- The wide variation among individuals is multifactorial and poorly understood.
- Incomplete cross-tolerance can lead to greater than anticipated potency in a new opioid, even in the same class of analgesic.
- Monitor clinical response and adverse effects.

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Approximate equianalgesic dose (oral and transdermal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine (reference)</td>
<td>30 mg</td>
</tr>
<tr>
<td>Codeine</td>
<td>200 mg</td>
</tr>
<tr>
<td>Fentanyl transdermal</td>
<td>12.5 mcg/hr</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>30 mg</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>7.5 mg</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>20 mg</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>10 mg</td>
</tr>
<tr>
<td>Tramadol</td>
<td>300 mg</td>
</tr>
</tbody>
</table>

---

1. Agency Medical Directors’ Group (AMDG) 2015.
2. Adapted from Von Korff 2008 and FDA labeling.
Methadone

Additionally, methadone has unique characteristics that make it difficult to translate dose to MED. Methadone exhibits a non-linear relationship due to its long half-life and accumulates with chronic dosing. You may see a dramatic increase in MED depending on the dose. The conversion factors for methadone in the AMDG calculator are based on chronic dosing and as follows:

<table>
<thead>
<tr>
<th>Methadone</th>
<th>Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 20 mg/day</td>
<td>4</td>
</tr>
<tr>
<td>21–40 mg/day</td>
<td>8</td>
</tr>
<tr>
<td>41–60 mg/day</td>
<td>10</td>
</tr>
<tr>
<td>&gt; 60 mg/day</td>
<td>12</td>
</tr>
</tbody>
</table>

Table 5. Methadone conversion factors

Ayonrinde 2000

Approaches that are not recommended

Buprenorphine

Use of buprenorphine (film or patch) or Suboxone (buprenorphine/naloxone) is not recommended for the treatment of chronic pain due to lack of evidence of safety and efficacy. However, patients who are currently taking Suboxone should not be abruptly stopped. Consult with the Pain Team or Addiction Medicine before tapering.

Cannabinoids (THC/CBD)

There is insufficient evidence from high-quality studies to determine that any cannabis-based products are effective in reducing pain in patients with chronic non-cancer pain or in increasing the rates of opioid discontinuation. There is limited low-quality evidence suggesting that cannabis-based products may reduce pain in patients with neuropathic pain, however the effect was minimal to moderate.

Adverse effects of cannabis include higher risk of cognitive impairment, headache, nasopharyngitis, nausea, somnolence, and dizziness. KP National 2019 Clinician Practice Recommendations for Opioid Prescribing advises avoiding using opioids in patients who choose to use marijuana.

Adverse effects of opioids

Serious adverse effects may include:

- **Slowed breathing (respiratory depression) that can cause death.** This is more likely for patients who:
  - Have sleep apnea or chronic lung disease,
  - Are on higher opioid doses,
  - Take more medicine than prescribed,
  - Have renal or hepatic impairment, or
  - Use any of the following at any time while taking prescribed opioids: alcohol, other prescription medicines (such as sleep aids, muscle relaxers, and tranquilizers), or street drugs.
  
  See also “Prescribing naloxone as preventive rescue medication,” p. 15.

- **Sedation (sleepiness and sluggishness)** can cloud patients’ judgment and slow their reaction time, putting them at increased risk for falls and accidents while driving, using tools, or operating heavy equipment. Driving while on opioids may be considered driving under the influence (DUI).

- **Babies born to mothers taking opioids will be dependent on opioids at birth.** Women who are trying to get pregnant should not take opioids. Women who become pregnant while taking opioids should consult with their physician to make a plan regarding their medication.
• **Physical dependence, tolerance, or addiction to opioids.** Patients with *physical dependence* will experience withdrawal if they stop suddenly. Patients with *tolerance* need to take more of the medicine to get the same effect. Patients with *addiction* are not able to control their use of opioids even if they want to, which may result in harmful outcomes. See “Recognizing opioid use disorder,” p. 9.

**Common** adverse effects may include:

- Constipation
- Depression
- Fatigue
- Itching (a side effect and not an allergic reaction)
- Nausea or vomiting
- Decreased sex drive (decreased testosterone)
- Low blood pressure
- Difficulty with urination
- Insomnia
- Increased sensitivity to pain (hyperalgesia)
- Impaired immune system
## Table 6. Referral recommendations for patients on COT for chronic non-cancer pain

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Reason for referral</th>
</tr>
</thead>
</table>
| **Integrated Mental Health Specialist** | - Contact urgently to assess patients with **suicidal ideation**.  
- Can provide short-term therapy:  
  - To help patients develop better coping skills for chronic pain  
  - For mild to moderate depression                                                                 |
| **Mind Phone Consultation**        | - Always an option for recommendations related to diagnostic assessment or mental health medication treatment.                                      |
| **Mental Health & Wellness Referral** | - Primary treatment with psychotherapy (individual or group) for moderate to severe mental health conditions  
- Severe depressive or anxiety disorders which have not responded to trials of two or more SSRI/SNRIs  
- Patients with complex presentation and diagnostic uncertainty (e.g., possible bipolar disorder)  
- Any condition with severe symptoms, elevated suicide risk, and/or psychosis |
| **Addiction Medicine Referral**    | - Co-occurring non-opioid substance use disorder  
- Suspected opioid use disorder with diagnostic uncertainty  
- Urine drug screen positive for alcohol, sedative, cocaine or methamphetamine use  
- Patient request for help with addiction  
- Consideration of a new start of medication treatment for OUD, including methadone, naltrexone, or buprenorphine (Suboxone) treatment  
- Concern about substance use disorder  
- Difficulty adhering to opioid care plan  
- Problematic use of medications other than opioids  
- Taking Suboxone from an outside provider for OUD |
| **Pain Specialist**                | **Pain specialty consultation is required for:**  
- Taking over 120 MED or dose increase to 120 mg MED or higher per day  
Consider pain specialty consultation if any of the following:  
- Taking > 90 mg MED  
- Taking Suboxone from an outside provider for chronic pain  
- Help with tapering/discontinuing opioid medication  
- Taking long-term opioids (more than 1 year)  
- Previous failed attempt to taper  
- Patients on fentanyl or methadone (these tapers can be complex) |

1 Pain specialists may include rheumatologists, neurologists, and anesthesiologists. See [WAC-246-919-945](WAC-246-919-945) for more information.
Preventing Conversion from Acute to Chronic Opioid Therapy: General Principles

There is no evidence to support the use of ever-increasing doses of opioids for non-cancer pain. There is now evidence that this leads to harm. (See National Permanente Medical Group 2019 Practice Recommendations.)

The best way to minimize chronic opioid use is to minimize acute opioid prescribing. Sixty percent of patients who take opioids for 3 months are still taking them 5 years later. (AMDG 2015)

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than that needed for the expected duration of pain severe enough to require opioids. (CDC 2016)

For acute, subacute, and perioperative prescribing, general principles from the AMDG guideline are listed here. Refer to the full AMDG guideline for more detailed recommendations.

**Acute phase** (0–6 weeks post episode of pain or surgery)
- Check the Washington State Prescription Monitoring Program (PMP) before prescribing.
- Don’t prescribe opioids for non-specific back pain, headaches, or fibromyalgia.
- Prescribe the lowest necessary dose for the shortest duration.
- Three days or less will often be sufficient; more than seven days will rarely be needed. (CDC 2016)
- opioid use beyond the acute phase is rarely indicated.
- **Required:** Use the SmartPhrase **.acuteopioidtreatment** for documentation when prescribing or offering an acute opioid prescription.

**Subacute phase** (6–12 weeks post episode of pain or surgery)
- Don’t continue opioids without clinically meaningful improvement in function and pain.
- Screen for comorbid mental health conditions and risk for opioid misuse using validated tools.
- Recheck the PMP and administer a baseline urine drug test if you plan to prescribe opioids beyond 6 weeks.

**Perioperative** (preoperative through time of hospital discharge)
- Refer to the 2018 AMDG Supplemental Guidance on Prescribing Opioids for Postoperative Pain.
- Evaluate thoroughly preoperatively: Check the PMP and assess for risk for over-sedation and difficult-to-control pain.
- Tapering opioids is not required before surgery, but avoid escalating the dose before surgery. Set appropriate expectations with patients that their pain management needs will be met following surgery, with the understanding that they will return to their preoperative dose (or less) following surgery.
- Discharge with acetaminophen, NSAIDs, or very limited supply (2–3 days) of short-acting opioids for some minor surgeries.
- For patients on chronic opioids, taper to preoperative doses or lower within 6 weeks following major surgery.

**Special populations**
- Pregnant women: Counsel women before and during pregnancy about maternal, fetal, and neonatal risks.
- Elderly patients: For older adults, initiate opioids at a 25–50% lower dose than for younger adults.
- Adolescents and children: Avoid prescribing opioids for most chronic pain problems.
- Cancer survivors: Rule out recurrence or secondary malignancy for any new or worsening pain.
Evidence Summary

The Chronic Opioid Therapy Safety Guideline was developed using an evidence-based process, including systematic literature search, critical appraisal, and evidence synthesis.

As part of our improvement process, the Kaiser Permanente Washington guideline team is working towards developing new clinical guidelines and updating the current guidelines every 2–3 years. To achieve this goal, we are adapting evidence-based recommendations from high-quality national and international external guidelines, if available and appropriate. The external guidelines should meet several quality standards to be considered for adaptation. They must: be developed by a multidisciplinary team with no or minimal conflicts of interest; be evidence-based; address a population that is reasonably similar to our population; and be transparent about the frequency of updates and the date the current version was completed.

In addition to identifying the recently published guidelines that meet the above standards, a literature search was conducted to identify studies relevant to the key questions that are not addressed by the external guidelines.

A supplementary literature search and evidence review was conducted in May 2020; no new studies were published after the October 2019 evidence review that would change the guideline recommendations.

External guidelines eligible for adapting

  http://www.agencymeddirectors.wa.gov/Files/FinalSupBreeAMDGPostopPain091318wcover.pdf
- National Permanente Medical Group 2019 Clinical Practice Recommendations for Opioid Prescribing.

Key questions addressed in the KPWA guideline

Question 1. What is the clinical effectiveness and safety of buprenorphine buccal film (Belbucca) for the management of non-cancer chronic pain in opioid-experienced and opioid-naïve adults?

- There is a lack of published randomized controlled trials (RCTs) with long-term follow-up that compared the buprenorphine buccal film to an active comparator (e.g., an analgesic, buprenorphine transdermal patch, or other opioid formulations). The published literature consisted only of the two pivotal short-term RCTs (Rauck 2016, Gimbel 2016) and a long-term follow-up observational study (Hale 2017).
- The two short-term RCTs provide moderate-quality evidence that buccal buprenorphine (BBUP) is more effective than placebo in reducing pain over a 12-week duration in selected naïve or opioid-experienced patients with chronic low back pain. The proportions of responders (patients with ≥ 30% or ≥ 50% pain reduction) were also higher in the BBUP versus the placebo groups in the two studies. The results also indicate that BBUP had good safety and tolerability in both naïve and experienced patients. However, these results have to be interpreted cautiously, as:
  - The trials included patients with moderate to severe low-back pain and excluded those with pain due to other chronic conditions, which may limit generalization of the results.
  - Patients in the opioid-experienced trial were self-selected, as only those who were on opioid (30-60 MSE) and were willing and able to taper their opioid treatment to ≤ 30 mg/d, agreed to participate in the study.
  - BBUP was compared to a placebo and not to an active comparator such as an analgesic or any other buprenorphine preparation.
  - Patients entering the double-blinded randomized phase were those who had successfully achieved an adequate analgesia and good tolerability in the titration phase, which may limit generalization of the results.
  - The 12-week duration of the two trials may be insufficient to determine the long-term efficacy, safety, and tolerability of BBUP.
There is insufficient evidence to determine the long-term safety and efficacy of BBUP in patients with chronic pain.
There is insufficient evidence to determine the comparative safety and efficacy of BBPU versus an active comparator.

Question 2. What is the clinical effectiveness and safety of transdermal buprenorphine (Butrans patch), for the management of non-cancer chronic pain in opioid-experienced and opioid-naïve adults?

- The available evidence from low- to moderate-quality studies suggests that transdermal buprenorphine is modestly more effective than placebo in reducing chronic, moderate to severe low-back, knee, or hip osteoarthritic pain in both opioid-naïve and opioid -experienced patients.
- Moderate-quality evidence from two published noninferiority trials (Karlsson 2009, Conaghan 2011) that directly compared buprenorphine transdermal system (BTDS) versus oral opioid preparations (tramadol in one study and codamol in the other) in patients with osteoarthritis indicates that BTDS is non-inferior to other opioid preparations in reducing pain related to osteoarthritis.
- There is evidence from one equivalence trial (James 2010) that BTDS had similar analgesic efficacy as the sublingual buprenorphine tablets but with fewer side effects (nausea, vomiting and dizziness).
- There is fair evidence from one RCT with an active control (Conaghan 2011) that the use of buprenorphine patch in addition to paracetamol was non-inferior to cocodamol with respect to analgesic efficacy in older patients with hip or knee osteoarthritis.
- Transdermal buprenorphine patches are associated with a high incidence of adverse events that the investigators considered mild to moderate.
- The most frequently reported side effects of BTDS were application site reactions, nausea, vomiting, dizziness, somnolence, and headache in opioid-naïve and opioid-experienced patients.
- Discontinuation rates due to the adverse events ranged between studies from 13-48%.
- No serious BTDS-related adverse events or potential misuse or overdose with BTDS were reported.
- The published trials had an enrichment design, which should be considered when generalizing the results.
- It should be noted that most of the published studies were sponsored by the manufacturers of buprenorphine products and the principal investigators had financial ties to the industry.

Question 3. What is the clinical effectiveness and safety of the off-label use of buprenorphine/naloxone products for the management non-cancer chronic pain in adults?

- There is insufficient published evidence from high-quality RCTs to determine the comparative effectiveness and safety of sublingual buprenorphine and other opioid preparations used for the management of non-cancer chronic pain in adults.
- There is insufficient evidence to determine the maximum dose of sublingual buprenorphine that may be allowed for the management of non-cancer chronic pain in adults.
- There is moderate-quality evidence from one RCT (James 2010) showing that sublingual buprenorphine has an equivalent analgesic effect as BTDS in adults with non-cancer chronic pain, but is associated with more side effects and is less tolerated than BTDS.
- There is insufficient published evidence from high-quality RCTs to determine the comparative effectiveness of buprenorphine-naloxone to other opioid preparations in patients with non-cancer chronic pain in the treatment of chronic pain.
- There is low-quality evidence from one small RCT with limitations (Neumann 2013) and retrospective observational studies suggesting that buprenorphine/naloxone therapy may be effective in reducing chronic pain in patients who are dependent on prescription opioids.
Question 4. What is the association between post-traumatic stress disorder (PTSD), chronic pain, and the risk of developing prescription opioid use disorder?

- There is fair evidence from several observational studies, systematic reviews, and meta-analyses of published observational studies suggesting that there is an association between PTSD and chronic pain. However, there is insufficient evidence to determine that it is a cause-and-effect association. There is also insufficient evidence to determine the temporal association between the two. (Ecker 2018, Fishbain 2017, Giordano 2018, Ravn 2018, Sigveland 2017)
- The published systematic reviews and meta-analyses also provide fair evidence suggesting that the prevalence of PTSD differs between the types of chronic pain experience and that anxiety and depression are related to both PTSD and chronic pain.
- Observational studies and national surveys (including Bilevicius 2018, Hassan 2017, and Meier 2014, among several others) show that the rates of prescribed opioid use and misuse are significantly higher among patients with PTSD compared to those without PTSD.

Question 5. Which PTSD screening tools have been validated for patients with chronic pain?

- There is a lack of published U.S. studies validating the PTSD scales among patients with chronic pain. Only two European studies were identified by the literature search; one small Danish study (Andersen 2018) validated the PTSD-8 scale in chronic pain patients and another study validated the Swedish version of the Posttraumatic Diagnostic Scale (Åkerblom 2017).

Question 6. Does screening adult patients on chronic opioid use for sleep apnea using STOP-Bang or another sleep apnea questionnaire reduce the risk of developing sleep apnea and/or respiratory depression?

- The published literature indicates that chronic opioid use may be associated with central sleep apnea and to a lesser degree with obstructive sleep apnea (Jungquist 2012, Correa 2015, Filiatrault 2016).
- There is low- to moderate-quality evidence from earlier observational studies (Walker 2007, Webster 2008) suggesting a dose-response relationship between opioid dose and the severity of sleep apnea, particularly on central sleep apnea.
- There is insufficient evidence to determine whether STOP-Bang or other instruments are appropriate for screening patients on opioid therapy for sleep apnea. The STOP-Bang questionnaire may not be the appropriate tool to identify risk of total sleep apnea in opioid users. (STOP-Bang is useful for obstructive rather than central sleep apnea.)
- The literature search did not identify any sleep apnea screening tool that has been validated for chronic pain patients on opioid therapy.

Question 7. What is the association between chronic pain and correlates of suicidal ideation in adults with chronic pain and opioid use disorder?

- There is moderate-quality evidence from a systematic review of observational studies (Tang 2006, Casne 2006), and a narrative review (Racine 2018) that chronic pain itself, regardless of its type, is a risk factor for suicidality.
- The evidence on the association between pain characteristics (including type, severity and duration) and suicidality is conflicting.
- The POINT cohort study on the pharmaceutical opioid use and dependence among people living with chronic pain (Campbell 2015) shows the following:
  o A diagnosis of depression and a past suicide attempt were independent risk factors for suicidal ideation.
  o Depression was not a significant predictor for elevating a suicidal risk to an attempt.
  o Poorer pain-coping skills were associated with a suicide attempt in the past 12 months.
  o Pain-specific factors such as type, severity, and duration were not independently associated with lifetime or past-12-month ideation or lifetime attempt.
  o Pain-specific factors for suicide risk were only more important than other risk factors in the past-12-month ideation to action.
  o All published studies were observational, and the results have to be interpreted with caution.
Question 8. Is there evidence that the use of Oswestry Disability Index in addition to the PEG (Pain, Enjoyment of life, General activity) screening tool would add incremental benefit in the assessment of function during routine follow-up of patients with chronic pain?

- The literature search did not identify any study that monitored chronic pain patients with the PEG scale together with the Oswestry Disability Index.

Question 9. What are the benefits of using CBD (cannabidiol) or THC (tetrahydrocannabinol) for chronic pain (monotherapy or in combination with other medications including opioids)?

Question 10. What are the harms of using CBD or THC in combination with opioids in patients with chronic pain?

- The overall evidence on the effectiveness and safety of cannabis/cannabinoids for non-cancer chronic pain is limited due to several factors, including:
  - The small sizes of published RCTs.
  - Risk of bias in the published trials.
  - The limited duration of the studies, which is insufficient to determine long-term benefits and harms.
  - Insufficient data on the doses and types of cannabinoids used.
  - Most studies used placebo as a comparator and did not provide sufficient data on the other analgesics used in conjunction with the cannabinoids and their doses.

- There is insufficient evidence from high-quality studies to determine that any cannabis-based products are effective in reducing pain in patients with non-cancer chronic pain in general.
- There is limited low-quality evidence suggesting that cannabis-based products may reduce pain in patients with neuropathic pain. The effect observed on pain reduction varied between systematic reviews with or without meta-analyses from minimal to moderate (Kansagara 2017, Nugent 2017, Mücke 2018, Stockings 2018).
- There is moderate-quality evidence showing that cannabinoids may have a statistically significant but modest effect on reducing non-cancer chronic pain related to multiple sclerosis compared to placebo. However, it was associated with higher rates of adverse effects and withdrawal from treatment due to adverse events (Nielsen 2018, Stockings 2018).
- Harms associated with cannabis use may outweigh any observed benefit.
- Patients treated with cannabinoids were more likely to withdraw from the studies due to adverse events.
- The most commonly reported adverse events were headache, nasopharyngitis, nausea, somnolence, and dizziness.
- There is insufficient evidence to determine the efficacy and safety of cannabinoids in patients with fibromyalgia.
- There is insufficient evidence to determine the efficacy and safety of cannabinoids in patients with rheumatoid arthritis.
- There is insufficient evidence to determine the long-term safety and efficacy of cannabis in patients with neuropathic or any other non-cancer chronic pain.
- There is insufficient evidence to show that cannabis use reduces prescribed opioid use or increases the rates of opioid discontinuation.
References


Guideline Development Process and Team

**Development process**

This guideline was adapted from externally developed evidence-based guidelines and organizations that establish the community standards for chronic opioid therapy for chronic non-cancer pain. The guideline team reviewed additional evidence using an evidence-based process, including systematic literature search, critical appraisal, and evidence synthesis. For details, see Evidence and References.

This edition of the guideline was approved for publication by the Guideline Oversight Group in May 2020.

**Team**

The following specialties were represented on the development and/or update team: chemical dependency, clinical laboratory, family medicine, mental health and wellness, pain team, patient safety, pharmacy, pharmacy informatics, physical therapy, and urgent care.

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John Maisano, PT, Pain Team
Adriana Marti, PsyD, Psychologist, Pain Team
Kim Painter, MD, Family Medicine
Michael Parchman, MD, Kaiser Permanente Washington Research Institute
Katie Paul, MD, Family Medicine
Mena Raouf, PharmD, BCPS, Pharmacy
Kathryn Ramos, Patient Engagement, Clinical Improvement & Prevention
Nadia Salama, MD, PhD, Clinical Epidemiologist, Clinical Improvement & Prevention
Ann Stedronsky, Clinical Publications, Clinical Improvement & Prevention

**Disclosure of conflict of interest**

Kaiser Permanente requires that team members participating on a guideline team disclose and resolve all potential conflicts of interest that arise from financial relationships between a guideline team member or guideline team member’s spouse or partner and any commercial interests or proprietary entity that provides or produces health care–related products and/or services relevant to the content of the guideline.

Team members listed above have disclosed that their participation on the Chronic Opioid Therapy Safety Guideline team includes no promotion of any commercial products or services, and that they have no relationships with commercial entities to report.
Ada Bugg is a 68 year old female who is here for initiation/monitoring of chronic opioid therapy (COT) for the treatment of opioid dx:17837.

Functional goal: ***

Benefits of COT to patient are: ***

PEG score (required):
Clinically meaningful improvement in function is defined as >= 30% reduction in PEG score as compared to start of treatment or response to dose change

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Pain</td>
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<tr>
<td>Quality of Life</td>
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<td>Function</td>
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Oswestry Disability Index score (optional):

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<tbody>
<tr>
<td>Total Score</td>
<td>27</td>
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Risks of opioids for all patients are dependence, opioid use disorder, respiratory depression, cognitive effects and overdose.

Patient’s specific risk factors are:
- Mental health: {COT Risk Factors Mental Health:24443}
- Medical conditions: {COT Risk Factors Chronic Conditions:24444}
- Illicit substance use: {COT Risk Factors substances:24445}
- Patient risk factors: {COT Risk Factors Patient:24446}
- Aberrant behaviors: {COT aberrant behaviors:24500}

Current side effects from opioids: {OPIOID SIDE EFFECTS:18778}

flowsheet results:

<table>
<thead>
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WA State PMP reviewed: {COT PMP reviewed:24505}
Patient expected UDS findings: ***

### Assessment & Plan

Progress on functional goal: ***
Patient meeting functional goal as outlined in their written opioid care plan: {Y/N:19851}
Care plan is {LOWMEDHIGH:21416} risk (based on higher of dose category or other evaluation)
Patient and I decided that the benefits of opioids are {COT Risk benefit:24447}.

Based on this assessment, care plan is as follows:

**Treatment plan for pain**
1. Movement and body awareness (first line for all chronic pain): {COT Movement and body awareness:24465}
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Patient given written updated opioid care plan AVS (Use .opioidcareplan): {Y/N:19851}
Problem List diagnosis (GHC.17) entered: {Y/N:19851}
Next follow up visit at {COT time interval:24463} as {COT-visit type:24985}.
{Note to clinician: Include diagnosis code “Z79.891 Long-term (current) use of opioid analgesic” and condition being treated.}
Opioid Care Plan updated: ***
Responsible clinician: @ME@

Chronic opioid medication is used to treat: ***
Opioid medications covered under COT plan: ***
Pharmacy: ***

Daily MED: ***
Intensity monitoring: {:17881}
Based on: {:22409}

Current opioid medication sig: ***

Frequency of monitoring/UDS:
{OPIOID MONITORING REQS:18786}

WA State PMP checked: ***
Other information: ***
**Subjective**

Ada Bugg is a 68 year old female who is here for initiation/monitoring of chronic opioid therapy (COT) for the treatment of (opioid dx:17837). The patient has been taking opioids since ***.

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Benefits of COT to patient are: ***

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Drug Use (MyGH) Daily or almost daily -
Access to guns? (Monitoring Tool) 1 -
Access to guns? (MyGH) Yes -
Columbia SRA Overall Score 5 -

Previous consultations and workup: ***
Previous non-medication treatments for pain: ***

MEDICAL HISTORY:
Previous opioids prescribed for pain: {OPIOID MEDS:18781}
Previous history related to opioids: ***
Previous non-opioid medicines prescribed for pain: {COT non-opioid medications:24504}
Current opioid prescriptions: No Active OPIOID Medications on file as of 07/13/2020.

Current benzodiazepine prescription/use NOTE: Benzodiazepine and opioid combination increases risk of overdose by at least three-fold, automatic high-risk care plan: ***
Current skeletal muscle relaxant usage: ***
Current non-opioid medicines for pain: ***
Current Prescriptions:
AMOXICILLIN 125 MG CHEWABLE TABLET
ATENOLOL 25 MG TABLET
MORPHINE ER 30 MG TABLET,EXTENDED RELEASE
MORPHINE ER 30 MG TABLET,EXTENDED RELEASE
METHOCARBAMOL 750 MG TABLET
METHOCARBAMOL 750 MG TABLET
LISINOPRIL 10 MG TABLET
ARIPIPRAZOLE 5 MG TABLET
EPINEPHRINE 0.3 MG/0.3 ML INJECTION, AUTO-INJECTOR

WA State PMP reviewed: {COT PMP reviewed:24505}
Patient expected UDS findings: ***

Objective

There were no vitals taken for this visit.
Physical exam: ***

Assessment & Plan

Progress on functional goal: ***
Patient meeting functional goal as outlined in their written opioid care plan: {Y/N:19851}
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{Note to clinician: Include diagnosis code "Z79.891 Long-term (current) use of opioid analgesic" and condition being treated.}
What is naloxone?
Naloxone is used to temporarily reverse the possible life-threatening effects of overdosing on opioids, including heroin. Naloxone helps a person wake up and keeps them breathing.

Can naloxone harm someone?
Naloxone is safe. If you suspect an opioid overdose, it is safe to use naloxone. If you give naloxone to someone who’s overdosed, the person will wake up and go into withdrawal. Withdrawal is unpleasant, but not life-threatening.

How can I prepare myself to help someone who is having an overdose?
1. Know the signs of an opioid overdose:
   - No response when you yell the person’s name or rub the middle of the chest hard
   - Blue lips or fingertips
   - Slow breathing (less than 1 breath every 5 seconds) or no breathing
   - Clammy, cool skin
   - Choking sounds or a gurgling, snoring noise
2. Read the patient information included in the prescription.

What should I do if I think someone is having an overdose?
2. Lay the person on his or her back to receive a dose of naloxone nasal spray.
3. Remove naloxone nasal spray from the box and open the package.
4. Hold the naloxone nasal spray with your thumb on the bottom of the plunger and your first and middle fingers on either side of the nozzle.
5. Tilt the person’s head back, providing support under the neck with your hand.
6. Gently insert the tip of the nozzle into one nostril until your fingers on either side of the nozzle are against the bottom of the person’s nose.
7. Press the plunger firmly to give the dose of naloxone nasal spray.
8. Remove the naloxone nasal spray from the nostril after giving the dose.
9. Call 911. Give the address and say your family member or friend is not breathing.
10. If the person is not breathing, try rescue breathing:
    - Make sure nothing is in the person’s mouth.
    - Tilt the person’s head back, lift the chin, and pinch the nose shut.
    - Give 1 slow breath every 5 seconds until the person starts breathing.
11. If there is no or hardly any breathing, or the person is unresponsive after 2 to 3 minutes, give another dose of naloxone nasal spray in the other nostril
12. If the person is breathing, put the person on his or her side to prevent choking.
13. Comfort the person until the ambulance arrives.

For questions or concerns: Please contact your doctor or Kaiser Permanente Pharmacy Services Monday through Friday between 9 a.m. and 5 p.m. at 1-855-398-9699
What Should I Know About Taking Opioids and Benzodiazepines together?

Kaiser Permanente is committed to the safety and well-being of our patients. As we learn more about the safety of both opioids and benzodiazepines, we update and improve our guidelines for their use.

Recent studies show that patients are at a higher risk for serious health problems if they use opioids and benzodiazepines together. Because of this safety concern, we are participating in a national effort to help patients find alternatives to using this combination of medicines.

What are some examples of opioids and benzodiazepines?
Opioids are prescription pain medicines and benzodiazepines are medicines often prescribed to treat anxiety or sleep problems. The following table outlines some common examples of opioids and benzodiazepines.

<table>
<thead>
<tr>
<th>Opioid examples</th>
<th>Benzodiazepine examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>Alprazolam</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>Diazepam</td>
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<td>Oxycodone</td>
<td>Clonazepam</td>
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<tr>
<td>Fentanyl</td>
<td>Lorazepam</td>
</tr>
<tr>
<td>Morphine</td>
<td></td>
</tr>
</tbody>
</table>

What can happen if I take these medicines together?
• Breathing can be slowed or stopped (overdose), causing brain damage and death.
• The risk of overdose is four times higher if you are taking both opioids and benzodiazepines together.

What does it mean to be on both opioid and benzodiazepine medicines together?
• Different medicines in either the opioid or benzodiazepine class can stay in the body for different lengths of time. In general, these medicines are mostly eliminated after 24 to 48 hours, but in some cases (like diazepam), it can remain in the body for several days.
• Taking the combination within 1 to 2 days of each other can increase your risk for overdose.

If I don’t take both medicines at the same time, am I still at risk for overdose?
• Yes, many of these medicines last in your body for several hours, or even days, after taking them. Although you are not taking both medicines at the same time, their effects can overlap, which can affect your breathing.

I have been on the same doses of these medicines for years and take them as prescribed. Am I still at risk?
• Yes, overdose is often unpredictable. There are many factors that can increase medicine levels in the body. These include changes in drug metabolism, drug interactions, and fluctuations in kidney or liver function.
• A person’s risk of overdose increases with age. This is because the body’s ability to metabolize and get rid of medicines slows down with age, so medicines stay in the body longer.
• Lung disease or infections can also affect breathing and make a person more sensitive to complications caused by an overdose.
• Any of these factors can increase the risk of overdose, even if doses haven’t changed.

Are there medical conditions that increase the risk of breathing complications with these medicines?
• Yes, here are some examples of medical conditions which can increase risk for breathing problems:
  - Lung disease (like asthma, COPD, emphysema, or chronic bronchitis)
  - Sleep apnea
  - Kidney disease
  - Liver disease
  - History of stroke or other cerebrovascular disease
  - Heart failure
  - Recurrent headaches

What should I do now?
If you’ve been taking these medicines for a long time, do not stop them abruptly.
• Talk to your provider about risks and benefits of each medicine.
• Ask your provider about safer alternatives.
• Ask your provider about naloxone.
  Naloxone is a life-saving medicine that can reverse opioid effects on breathing within 2 minutes, until help arrives.

Other Patient Resources:
• Center for Disease Control and Prevention – Information for Patients www.cdc.gov/drugoverdose/patients/index.html
• Learn about Opioid Overdose at www.stopoverdose.org
What to expect during an opioid taper

What is an opioid taper?
- An opioid taper is when the dose of an opioid medicine is slowly reduced.
- Patients work with their provider team to reach a lower, safer opioid dose or stop the medicine completely.

Why should patients taper opioids?
14. Many studies show that opioid medicines can cause more harm than benefit when used for extended periods of time. Since there are so many risks associated with chronic opioid use (including overdose), it is important to regularly assess how much benefit the medicine is providing.
15. Over time opioids can change the way your brain processes pain signals, which can lead to an increase in pain.
16. Many patients discover that decreasing their opioid dose improves pain control and increases overall function.

What are the long-term risks/ side effects of opioid therapy?
- **Tolerance** – The medicine becomes less effective over time, with patients needing higher doses of opioid to achieve the same level of pain control.
- **Physical dependence** – A person experiences symptoms of withdrawal when her or she stops taking the medicine suddenly or decreases the dose by a large amount.
- **Constipation** – A common side effect of opioid use that can lead to nausea and poor appetite and, less commonly, bowel blockage.
- **Drowsiness** – Another common side effect that can cause falls, broken bones, and motor vehicle accidents.
- **Fatigue, low energy, depression** – These side effects can affect a person’s ability to function and work or do day-to-day activities.
- **Sleep apnea or impaired breathing while sleeping** – Sleep problems contribute to daytime fatigue and poor thinking.
- **Low testosterone levels in men** – This leads to low sex drive, low energy, depressed mood, slower recovery from muscle injuries and decreased bone density (thinning of the bones).
- **Low estrogen and progesterone hormones in women** – This leads to decreased bone density and low energy.
- **Accidental overdose and death** – These risks increase the longer a person is taking opioids.

What symptoms can I expect when tapering or decreasing my opioid medication?
- Some patients doing a slow taper do not experience any new symptoms.
- As their opioid dose is lowered, some patients experience a variety of symptoms that can be uncomfortable at first, but which are not usually dangerous.
- Possible symptoms include problems concentrating, stomach cramps, anxiety or nervous feelings, nausea, diarrhea, sweating, goose bumps, trouble sleeping, watery eyes, fast heartbeat, muscle twitching, runny nose, and short-term increase in pain.
- When patients first start tapering their opioid, they might feel that their pain is more intense or severe, but this will get better with time.
  ** This pain might be the same pain that patients are being treated for, as well as total body, joint, and muscle aches.
  ** The pain associated with withdrawal usually goes away in 1 to 2 weeks.
  ** Patients who reduce their opioids slowly have less pain as they withdraw from their medicine.

When will I start to see withdrawal symptoms and how long do they last?
- Some people will not experience any side effects.
- For patients tapering short-acting opioid medicines, symptoms can start between 8 and 24 hours from the time they start to taper and last from 4 to 10 days.
- For patients tapering long-acting opioid medicines, symptoms can start anywhere from 12 to 48 hours from the time they start to taper and last from 10 to 20 days.
- These timeframes are averages. Some patients might have withdrawal symptoms that start sooner or last longer.

How can I prepare for my opioid taper?
- Get support from family, friends, and the members of your health care team.
- Learn and practice non-drug pain management strategies.
- Work with your health care team to make a plan that will help you manage any withdrawal symptoms, including anxiety and trouble sleeping.
- Stay physically active: Stretch, move, walk, or do other kinds of exercise to reduce the severity of these symptoms.

**What can I do manage to symptoms from opioid taper?**
- Meditate, relax, and practice deep breathing techniques.
- Drink plenty of liquids. (8 to 12 cups of water a day is recommended).
- Use distraction techniques (such as listening to music, watching movies, going for walks).
- Use ice or heat on painful areas.
- Take hot baths for muscle cramps, chills, and to relax.
- Find a quiet, peaceful environment.

**What do I do if symptoms are severe?**
- Contact your care team right away if you are concerned about your symptoms or can’t take care of your day-to-day activities and tasks.
- Do not increase your opioid dose on your own.

**Other Patient Resources:**
- Center for Disease Control and Prevention – Information for Patients
  www.cdc.gov/drugoverdose/patients/index.html

*Remember:* The long-term goal is improved pain control and quality of life while reducing harms of treatment. Your care team is here to help!
Dear @Name@,

Thanks for coming in today. Working together, I am optimistic that we can improve your function and sense of well-being. This plan addresses our treatment of your ***.

GOALS:
- Maximize your health and quality of life
- Increase your level of function and activity
- Decrease the effect of pain on your life
- Minimize the risk of side effects and ensure the safest possible use of opioids
- Personal functional goals: ***

WAYS TO HELP YOU MEET YOUR GOALS:
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No Active OPIOID Medications on file as of 07/13/2020.

Opioids are unlikely to relieve all of your pain. While these medicines are known to be effective for a few days, it's unusual for them to provide significant relief for people suffering from long-term painful health conditions.

It's important for you to know the risks and side effects in taking opioid medicine.

For some people, these medicines are addictive and have serious side effects. Opioids can cause physical dependence that makes it difficult to stop using them if the dose is increased over time.

Serious side effects:
- Accidental overdose, trouble breathing, death. This is more likely if you have sleep apnea or chronic lung disease and/or you are on higher opioid doses; if you take more medicine than you're supposed to; or if you mix opioids with alcohol, other prescription medicines (such as sleep aids, muscle relaxers, or tranquilizers), or street drugs. The risk increases with prolonged use.
- Physical dependence, tolerance, or addiction to opioids. Physical dependence means you will experience withdrawal if you stop suddenly. Tolerance means you need to take more of the medicine to get the same effect. Addiction means you are not able to control your use of opioids even if you want to, which might result in harmful outcomes. As many as 1 in 4 people receiving prescription opioids long term struggles with addiction.
- Sedation (sleepiness and sluggishness). This can cloud your judgment and slow your reaction time. Because of this you are at increased risk for falls and accidents while driving, using tools, or operating heavy equipment. Driving while on opioids may be considered driving under the influence (DUI).
- Babies born to mothers taking opioids will be dependent on opioids at birth. You should not take opioids if you are trying to get pregnant. If you do get pregnant while taking opioids, talk with your doctor to make a plan regarding your medicine.

Current side effects from opioids: {OPIOID SIDE EFFECTS:18778}
**OPIOID REFILL PROCESS**
- I, @Me@, am the doctor responsible for ordering refills for your medicine. Prescriptions for chronic pain medicine should be provided only by me.
- Your refills will be provided on a schedule with a specific number of pills to last until the next refill. You agree not to take extra doses.
- Please contact Pharmacy Services 7 days before your scheduled pickup date to refill through your pharmacy. You may, at times, be asked to bring your medicines to the pharmacy for a pill count.
- For occasional changes in your scheduled refill plan, please contact your care team.
- Keep your medicines in a secure, locked place. These medicines could cause serious illness or death to a child, pet or other people. **Lost or stolen medicine will not be replaced.**
- Many of these medicines contain acetaminophen (Tylenol). Use caution when using other medicines that contain acetaminophen (Tylenol). Do not take a total daily dose of more than 3,000mg of acetaminophen without first talking with a member of your care team.
- Safely dispose of unused medicines and left over medicine when transferring to a different medicine. Do not toss in garbage or flush down the toilet - take them to a medication disposal site. Several Kaiser Permanente Pharmacies have medicine disposal containers, or check the 'Take back your meds' website for a location near you: [http://www.takebackyourmeds.org/](http://www.takebackyourmeds.org/)

**REASONS FOR LOWERING DOSE OR STOPPING MEDICINE**
I may decide that it is no longer safe or appropriate to continue prescribing chronic opioid therapy, or that I need to taper down the dose of the medicine if:
- You are experiencing side effects from treatment
- You abuse alcohol
- You sell, give away, trade, or share your medicine
- You frequently request refills for lost prescriptions
- Your urine drug screen shows cocaine or methamphetamine, or other “street drugs”
- Your urine shows evidence of medicines that I did not prescribe, including marijuana
- You seek prescriptions for opioid pain medicine from other providers
- New knowledge about opioid therapy becomes available
- Medication is not helping you to achieve your functional goals

**Kaiser Permanente Washington clinicians use the Washington Prescription Monitoring Program.**

**LAB TEST PLAN**
- Kaiser Permanente asks patients to have drug screens on a regular basis.
- The results of your urine drug screen (UDS) improve our ability to safely manage your opioid treatment plan. Your results will also help us know if you’re taking other medicines that might interfere or cause problems with your opioid treatment.
- As with other tests and exams, the results of your UDS will be part of your medical record.

Depending on your medical coverage, there may be a cost associated with the UDS. For questions about your medical coverage, please call Member Services at 1-800-901-4636.

**FOLLOW-UP PLAN**
Because of the risks associated with taking opioids, Kaiser Permanente and I want you to receive regular follow-up while taking these medicines.

Your follow-up plan is:
{OPIOID MONITORING REQS:18786}
- Do not increase the amount of your opioids without first talking with me or another member of your care team.
- Do tell a member of the care team if you become or plan to become pregnant.
- During office hours, contact your care team if you have questions or concerns.
- For emergency situations after-hours and on weekends, call the Consulting Nurse Service at 1-800-297-6877 or go to Urgent Care.
- If you require treatment for a new or acute problem from a doctor or clinic other than me or another Kaiser Permanente doctor, I expect that you will tell the other doctor or clinic about the medicines I am already prescribing.
for you and that we have this established care plan. I also expect that you will let me know if another doctor gives you opioid pain medicine.

Learn more about treatments for chronic pain
I’d like you to watch a video about living with chronic pain. This aid includes treatment options with the risks and benefits of each option. To view the video, go to https://wa.kaiserpermanente.org/html/public/health-wellness/care/decision-videos.html
Click on Living Better with Chronic Pain to start the video. You will be prompted to log in. If you don't have access to our enhanced online services, follow the instructions to upgrade your account. We will refer back to the material in these videos during our future visits.

In case of an overdose:
Read the following information for using naloxone. Share these instructions with family and friends who might need to help you in case of an overdose.

Naloxone is used to temporarily reverse the life-threatening effects of an opioid overdose. If you fear an opioid overdose, it is safe to give naloxone. Naloxone helps the person wake up and keep breathing. The person will go into withdrawal, which is unpleasant but not life-threatening.

How can I prepare myself to help someone who is having an overdose?
• Know the signs of an opioid overdose:
  • No response when you yell person's name or rub the middle of the chest hard
  • Blue lips or fingertips
  • Slow breathing (less than 1 breath every 5 seconds) or no breathing
  • Clammy, cool skin
  • Choking sounds or a gurgling, snoring noise
• Read the patient information included in the prescription.

What should I do if I think someone is having an overdose?
1. Lay the person on his or her back to receive a dose of naloxone nasal spray.
2. Remove naloxone nasal spray from the box and open the package.
3. Hold the naloxone nasal spray with your thumb on the bottom of the plunger and your first and middle fingers on either side of the nozzle.
4. Tilt the person's head back, providing support under the neck with your hand.
5. Gently insert the tip of the nozzle into one nostril until your fingers on either side of the nozzle lie against the bottom of the person's nose.
6. Press the plunger firmly to give the dose of naloxone nasal spray.
7. Remove the naloxone nasal spray from the nostril after giving the dose.
8. Call 911. Give the address and say your family member or friend is not breathing.
9. If the person is not breathing, try rescue breathing:
  • Make sure nothing is in the person's mouth.
  • Tilt the person's head back, lift the chin, and pinch the nose shut.
  • Give 1 slow breath every 5 seconds until the person starts breathing.
10. If there is no or hardly any breathing, or the person is unresponsive after 2 to 3 minutes, give another dose of naloxone nasal spray in the other nostril.
11. If the person is breathing, put the person on his or her side to prevent choking.
12. Comfort the person until the ambulance arrives.
Managing Pain: Important Information About Opioids
Today, we talked about creating a care plan to improve your quality of life and ability to stay active. As part of this discussion, we talked about opioid medicines for managing your pain.

Opioids are unlikely to relieve all of your pain. While these medicines are known to be effective for a few days, it’s unusual for them to provide significant relief for people suffering from long-term painful health conditions. Research shows that patients taking opioids for long periods of time tend to report having worse pain, and worse mental, physical, and social function than patients with similar health problems not taking opioids.

For some people, these medicines are addictive and have serious side effects. Opioids can cause physical dependence that makes it difficult to stop using them if the dose is increased over time.

Before I prescribe opioid medicine, it’s important for you to know the risks and side effects in taking these drugs.

The following table lists serious side effects and how often they happen in 100 people taking opioids.

<table>
<thead>
<tr>
<th>Serious risks and side effects</th>
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<tr>
<td>Depression or anxiety is common among patients using opioids. Pain can worsen depression, just as depression can worsen pain. Opioids can cause loss of interest in usual activities, increasing depression.</td>
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<td>Constipation – can lead to a potentially serious intestinal blockage in less than 1% of patients</td>
<td>30-40</td>
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<tr>
<td>Hormonal effects, including:</td>
<td>25-75</td>
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<td>• Lower sex drive (decreased testosterone)</td>
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</tr>
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</tr>
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</tr>
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<td></td>
</tr>
<tr>
<td>Sedation (feeling sleepy or sluggishly) - can cause difficulty driving or thinking clearly</td>
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</tr>
<tr>
<td>Problems with sleep and breathing problems during sleep</td>
<td>unknown</td>
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Other common less serious side effects include:
- Being more sensitive to pain (known as hyperalgesia)
- Muscle twitching
- Itching (this is a side effect and not an allergic reaction)
- Nausea or vomiting
- Dry mouth (may cause tooth decay)

Additionally, babies born to mothers taking opioids will be dependent on opioids at birth. You should not take opioids if you are trying to get pregnant.
Treatments to help manage your pain with fewer risks
There are other things we talked about to help manage your pain. These treatments are less risky and can improve your pain for the long-term.

- Over-the-counter medicines, such as acetaminophen (Tylenol), ibuprofen (Advil), or naproxen (Aleve). Follow the package instructions and do not exceed the recommended dose.
- Physical activity and participating in meaningful life activities are the most effective ways to improving your sense of well-being and function.
- Physical therapy, massage therapy and other forms of non-drug treatments might help ease your pain.
- Sign up for a Living Well with Chronic Conditions workshop to learn effective ways to manage your pain. For more information, call the Kaiser Permanente Resource Line at toll-free 1-800-992-2279 or visit kp.org/wa (look under Classes and Events).

Additional options we discussed today: ***

Learning more about treatments for chronic pain
I’d like you to watch a video about living with chronic pain. This aid includes treatment options with the risks and benefits of each option. To view the video, go to https://kp.org/wa/decisions. Click on Living Better with Chronic Pain to start the video. You will be prompted to log in. If you don't have access to our enhanced online services, follow the instructions to upgrade your account.
Dear @FNAME@,

Your safety is our first priority.

The *** medicine is being tapered for the following reason: *** - this increases your risk of overdose and other complications from opioid therapy (listed below), and is unsafe.

As we discussed, your *** prescription will taper off as follows:

**TAPER SCHEDULE FOR *****
Take medicine exactly as prescribed. Do not take additional opioid medicines.

**Prescribed: *** tablets for ***-day taper**

**WEEK 1: ***
**WEEK 2: ***
**WEEK 3: ***
**WEEK 4: ***
STOP taking medicine.

While you taper your opioid medicine, you may also use Extra Strength Tylenol (acetaminophen 500 mg tabs). Take 2 tablets up to three times daily as needed. **Do not exceed 3000mg/day total of acetaminophen - this includes prescribed opioids and over-the-counter products.**

While opioids can help some people with bad short-term pain, such as after surgery, they are usually not helpful for managing long-term pain. For some people, these medicines are addictive and have serious side effects. Opioids also cause physical and psychological dependence that makes it difficult to stop using them. Opioid medicines are not indicated for the treatment of low back pain.

**Risks of opioids**
The following table lists serious side effects and how often they happen in 100 people taking opioids.

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Other common less serious side effects include:
- Being more sensitive to pain (known as hyperalgesia) - more likely if opioid is taken for many years or at high doses
- Muscle twitching
- Itching (this is a side effect and not an allergic reaction)
- Nausea or vomiting
- Dry mouth (may cause tooth decay)

It is possible you have developed opioid dependence as a complication of chronic opioid use and, if so, we can also work with you on treatment options through Kaiser Permanente's Mental Health. To make an appointment, call 206-901-6300 or toll-free 1-888-287-2680.

Here are some ways to help you manage chronic pain:

Exercise
Physical activity can help reduce pain and improve your physical and mental health. Start gradually with 5 minutes per day for the first week, and increase 1 minute per day each week. Use a stopwatch to measure the gradual increase and to keep from doing too much.

Moderate intensity aerobic training (activities that get your heart pumping) improves overall well-being and physical function. Strength training may help reduce pain and tender points. If it's hard to do activities on your own, physical therapy can help and will include guidance on getting started and staying motivated, pacing yourself, and setting realistic goals.

Cognitive Behavioral Therapy (CBT) – provided by Mental Health
CBT may include relaxation, stress management, and pain coping skills. If you're interested in trying this, please call 206-901-6300 or toll-free 1-888-287-2680 to make an appointment.

Meditation
Here are some CD tutorials on meditation for people with chronic pain:
Letting Go Of Stress by Miller and Halpern
Mindfulness Meditation for Pain Relief: Guided Practices for Reclaiming Your Body and Your Life by Jon Kabat-Zinn

Sleep hygiene
Getting plenty of restful sleep can reduce pain. Practicing good sleep hygiene can help you with sleep. This includes having a regular bedtime, wake-up time, and avoiding naps. Only use your bedroom for sleeping and sexual activity. Don't use your bedroom for working, having discussions, watching TV, or using your computer. Avoid exercise right before going to bed.

Books
A Day Without Pain by Mel Pohl
Managing Pain Before It Manages You by Margaret A. Caudill, MD, PhD
The Pain Chronicles by Melanie Thernstrom - a history of chronic pain and her own personal story of dealing with chronic pain.
The Pain Survival Guide: How to Reclaim Your Life by Dennis C. Turk, PhD
Feeling Good by David D. Burns, MD

Living Well Program
Living Well Programs have helped many people cope with the same challenges you're facing in managing a chronic pain condition. Go to Kp.org/wa/livingwell to find out more or to register for a workshop.

Other medicines
Other medicines such as Nortriptyline, Venlafaxine, or Gabapentin have also been used as part of a chronic pain management care plan. If you're able to tolerate one of these medicines and we decide to start it, you would take it along with doing other things in your care plan to manage fatigue and pain symptoms, and improve your mental health and well-being.

Learning more about treatments for chronic pain
I'd like you to watch a video about living with chronic pain. This aid includes treatment options with the risks and benefits of each option. To view the video, go to https://kp.org/wa/decisions. Click on Living Better with Chronic Pain to start the
video. You will be prompted to log in. If you don't have access to our enhanced online services, follow the instructions to upgrade your account.

We look forward to working with you on other ways to help you live better with chronic pain and decrease the effect of pain on your life.

Very kind regards,
@ME@