UNIVERSITY OF IOWA HEALTH CARE

# UIHC FAMILY MEDICINE SAFE OPIOID PRESCRIBING

## FAMILY MEDICINE & AMBULATORY PHARMACY COMANAGEMENT OF CHRONIC PAIN PROJECT AUGUST 2017 UPDATED


LEADER: KATE THOMA, MD, MME

MEMBERS: BRENDA CARMODY, BS PHARM
SHANE MADSEN, PHARM D
JASON WILBUR, MD
KEVIN SCHLEICH, PHARM D
CHAD TRIPLETT, PHARM D
MICHELLE BALTES-BREITWISCH, PHARM D
WENDY SHEN, MD, PHD
LISA MASCARDO, PHARM D
DEB STEINBAKER, RN

STUDY ID #:_____ DO NOT WRITE ABOVE THIS LINE HOSPITAL #:_____

## Brief Pain Inventory (Short Form)

Date:____/____/____ Time:_____

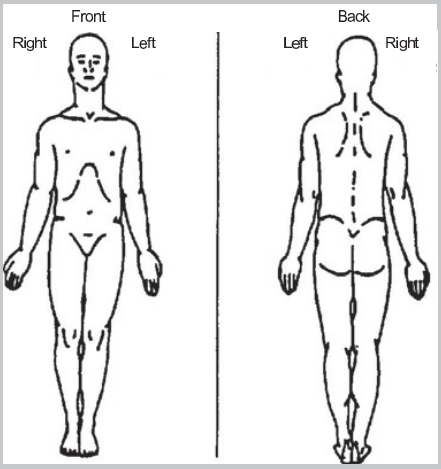
Name:_____ _____ _____

Last First Middle Initial

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these every-day kinds of pain today?

1. Yes ☐ ☐ 2. No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.




3. Please rate your pain by circling the one number that best describes your pain at its worst in the last 24 hours.

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
No Pain — Pain as bad as you can imagine

4. Please rate your pain by circling the one number that best describes your pain at its least in the last 24 hours.

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
No Pain — Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on the average.

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
No Pain — Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have right now.

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐
No Pain — Pain as bad as you can imagine

STUDY ID #:_____ DO NOT WRITE ABOVE THIS LINE HOSPITAL #:_____

Date:____/____/____ Time:_____

Name:_____ _____ _____

Last First Middle Initial

**7. What treatments or medications are you receiving for your pain?**

**8. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.**

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

No Relief — Complete Relief

**9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:**

**A. General Activity**

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere — Completely Interferes

**B. Mood**

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere — Completely Interferes

**C. Walking Ability**

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere — Completely Interferes

**D. Normal Work (includes both work outside the home and housework)**

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere — Completely Interferes

**E. Relations with other people**

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere — Completely Interferes

**F. Sleep**

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere — Completely Interferes

**G. Enjoyment of life**

0 1 2 3 4 5 6 7 8 9 10

Does not Interfere — Completely Interferes

**PEG Scale Assessing Pain Intensity and Interference (Pain, Enjoyment, General Activity)**

**1. What number best describes your pain on average in the past week?**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | | | | | | | | | | Pain as bad as you can imagine |

**2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Does not interfere | | | | | | | | | Completely interferes |

**3. What number best describes how, during the past week, pain has interfered with your general activity?**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| | Does not interfere | | | | | | | | | Completely interferes |

**Computing the PEG Score.**

Add the responses to the three questions, then divide by three to get a mean score (out of 10) on overall impact of points.

**Using the PEG Score.**

The score is best used to track an individual's changes over time. The initiation of therapy should result in the individual's score decreasing over time.

**Source.**

Krebs, E. E., Lorenz, K. A., Bair, M. J., Damush, T. M., Wu, J., Sutherland, J. M., Asch S, Kroenke, K. (2009). Development and Initial Validation of the PEG, a Three-item Scale Assessing Pain Intensity and Interference. Journal of General Internal Medicine, 24(6), 733–738. http://doi.org/10.1007/s11606-009-0981-1

## Per the CDC, a 30% improvement from baseline is clinically meaningful.

# Work Productivity and Activity Impairment Questionnaire

Chronic Pain Management Toolkit

The following questions ask about the effect of your health problems on your ability to work and perform regular activities. "Health problems" are defined as any physical or emotional problem or symptom. *Please fill in the blanks or check the appropriate box, as indicated.*

1. Are you currently employed (working for pay)?
   *If NO, check "NO" and skip to question 6.*
   ☐ Yes ☐ No

2. During the past seven days, not including today, how many hours did you miss from work because of **your health problems?**
   *Include hours you missed on sick days, times you went in late, left early, etc., because of your health problems. Do not include time you missed to participate in this study.*
   _____ HOURS

3. During the past seven days, not including today, how many hours did you miss from work because of any other reason, such as vacation, holidays, time off to participate in this study?
   _____ HOURS

4. During the past seven days, not including today, how many hours did you actually work?
   *(If "0", skip to question 6.)*
   _____ HOURS

5. During the past seven days, not including today, how much did your health problems affect your productivity while you were working?
   *Think about days you were limited in the amount or kind of work you could do, days you accomplished less than you would like, or days you could not do your work as carefully as usual. If health problems affected your work only a little, choose a low number. Choose a high number if health problems affected your work a great deal.*

   Consider only how much **health problems** affected productivity **while you were working.**

   Health problems had no effect on my daily activities — Health problems completely prevented me from doing my daily activities

   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

6. During the past seven days, not including today, how much did your health problems affect your ability to do your regular, daily, non-work activities?
   *"Regular activities" are defined as the usual activities you do, such as work around the house, shopping, childcare, exercising, studying, etc. Think about times you were limited in the amount or kind of activities you could do and times you accomplished less than you would like. If health problems affected your activities only a little, choose a low number. Choose a high number if health problems affected your activities a great deal.*

   Consider only how much **health problems** affected your ability to do your regular, daily, non-work activities.

   Health problems had no effect on my daily activities — Health problems completely prevented me from doing my daily activities

   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Reilly MC, Zbrozek AS, Dukes EM. The validity and reproducibility of a work productivity and activity impairment instrument. PharamcoEconomics 1993; 4(5):353-65

HOP 16050882

# Functional Goals

Chronic Pain Management Toolkit

**Which, if any, activities are limited due to pain? (Check all that apply)**

- ☐ walking
- ☐ exercise
- ☐ sleep
- ☐ sexual activity
- ☐ work
- ☐ housework
- ☐ relationships (family, friends)
- ☐ self-care (bathing, dressing, eating)
- ☐ Other:_____

Which activites are most important to you?

**Provider: Work with patient to determine realistic goals and on an action plan to achieve these goals.**

| Activity | Goal | Action |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Reassess improvement/decline in function at regular intervals.**

## The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

| Over the past 2 weeks, how often have you been bothered by any of the following problems? | Not At all | Several Days | More Than Half the Days | Nearly Every Day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed or hopeless | 0 | 1 | 2 | 3 |

# The Patient Health Questionnaire-2 (PHQ-2) - Overview

The PHQ-2 inquires about the frequency of depressed mood and anhedonia over the past two weeks. The PHQ-2 includes the first two items of the PHQ-9.

- The purpose of the PHQ-2 is not to establish final a diagnosis or to monitor depression severity, but rather to screen for depression in a "first step" approach.
- Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder.

## Clinical Utility

Reducing depression evaluation to two screening questions enhances routine inquiry about the most prevalent and treatable mental disorder in primary care.

## Scoring

A PHQ-2 score ranges from 0-6. The authors[1] identified a PHQ-2 cutoff score of 3 as the optimal cut point for screening purposes and stated that a cut point of 2 would enhance sensitivity, whereas a cut point of 4 would improve specificity.

## Psychometric Properties[1]

| Major Depressive Disorder (7% prevalence) | | | | Any Depressive Disorder (18% prevalence) | | | |
|---|---|---|---|---|---|---|---|
| PHQ-2 Score | Sensitivity | Specificity | Positive Predictive Value (PPV*) | PHQ-2 Score | Sensitivity | Specificity | Positive Predictive Value (PPV*) |
| 1 | 97.6 | 59.2 | 15.4 | 1 | 90.6 | 65.4 | 36.9 |
| 2 | 92.7 | 73.7 | 21.1 | 2 | 82.1 | 80.4 | 48.3 |
| **3** | **82.9** | **90.0** | **38.4** | **3** | **62.3** | **95.4** | **75.0** |
| 4 | 73.2 | 93.3 | 45.5 | 4 | 50.9 | 97.9 | 81.2 |
| 5 | 53.7 | 96.8 | 56.4 | 5 | 31.1 | 98.7 | 84.6 |
| 6 | 26.8 | 99.4 | 78.6 | 6 | 12.3 | 99.8 | 92.9 |

** Because the PPV varies with the prevalence of depression, the PPV will be higher in settings with a higher prevalence of depression and lower in settings with a lower prevalence.*

1. *Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: Validity of a Two-Item Depression Screener. Medical Care 2003, (41) 1284-1294.*

# PATIENT HEALTH QUESTIONNAIRE
## Family Medicine

File most recent on Bottom in Section One

University of Iowa Hospital and Clinics (UIHC) requests this information for the purpose of providing patient care. No persons outside UIHC are provided this information without your consent. If you fail to provide this information, patient care may be impaired. If you have questions, please ask for help.

DATE

HOSP.#

NAME

BIRTH DATE

ADDRESS

IF NOT IMPRINTED, PLEASE PRINT DATE, HOSP. #, NAME AND LOCATION

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip a question.

**Name** _____ **Age:** _____ **Sex:** ☐ **Female** ☐ **Male** **Today's Date** _____

**1. Over the last 2 weeks, how often have you been bothered by any of the following problems?**

| | Not At all | Several Days | More than half the days | Nearly every day |
|---|---|---|---|---|
| a. Little interest or pleasure in doing things | ☐ | ☐ | ☐ | ☐ |
| b. Feeling down, depressed, or hopeless | ☐ | ☐ | ☐ | ☐ |
| c. Trouble falling or staying asleep, or sleeping too much | ☐ | ☐ | ☐ | ☐ |
| d. Feeling tired or having little energy | ☐ | ☐ | ☐ | ☐ |
| e. Poor appetite or overeating | ☐ | ☐ | ☐ | ☐ |
| f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down | ☐ | ☐ | ☐ | ☐ |
| g. Trouble concentrating on things, such as reading the newspaper or watching television | ☐ | ☐ | ☐ | ☐ |
| h. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | ☐ | ☐ | ☐ | ☐ |
| i. Thoughts that you would be better off dead, or of hurting yourself in some way | ☐ | ☐ | ☐ | ☐ |

**2. Questions about anxiety**

| | No | Yes |
|---|---|---|
| a. In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic? **If you checked "NO", skip to question 3.** | ☐ | ☐ |
| b. Has this ever happened before? | ☐ | ☐ |
| c. Do some of these attacks come suddenly out of the blue — that is, in situations where you don't expect to be nervous or uncomfortable? | ☐ | ☐ |
| d. Do these attacks bother you a lot or are you worried about having another attack? | ☐ | ☐ |
| e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach? | ☐ | ☐ |

**3. If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

FOR OFFICE CODING: Maj Dep Syn if answer to #1a or b and five or more of #1a-i are at least "More than half the days" (count #1i if present at all). Other Dep Syn if #1a or b and two, three, or four of #1a-i are at least "More than half the days" (count #1i if present at all). Pan Syn if all of #2a-e are "YES."

Screening for Drug and Alcohol Use--Single screening questions will be used.

1. **"How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?"** *An answer of one or more is positive.*

**100% sensitive and 73.5% specific for determine of a drug use disorder compared to standardized diagnostic interview.* Arch Intern Med. 2010 Jul 12;170(13):1155-60. doi: 10.1001/archinternmed.2010.140.

2. **A pre-screening question, "Do you sometimes drink alcoholic beverages?", and then the single screening question, "How many times in the past year have you had X or more drinks in a day?"** *(where X is 5 for men and 4 for women, and a response of ≥1 is considered positive).* J Gen Intern Med. 2009 Jul; 24(7): 783–788.

** 81.8% sensitive and 79.3% specific for detection of unhealthy alcohol use.*

# Opioid Risk Tool

Chronic Pain Management Toolkit

| | | Mark each box that applies | Item Score if Female | Item Score if Male |
|---|---|---|---|---|
| **1. Family History of Substance Abuse** | Alcohol | ☐ | ☐ 1 | ☐ 3 |
| | Illegal Drugs | ☐ | ☐ 2 | ☐ 3 |
| | Prescription Drugs | ☐ | ☐ 4 | ☐ 4 |
| **2. Personal History of Substance Abuse** | Alcohol | ☐ | ☐ 3 | ☐ 3 |
| | Illegal Drugs | ☐ | ☐ 4 | ☐ 4 |
| | Prescription Drugs | ☐ | ☐ 5 | ☐ 5 |
| **3. Age** *(Mark box if 16-45)* | | ☐ | ☐ 1 | ☐ 1 |
| **4. History of Preadolescent Sexual Abuse** | Alcohol | ☐ | ☐ 3 | ☐ 0 |
| **5. Psychological Disease** | Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia | ☐ | ☐ 2 | ☐ 2 |
| | Depression | ☐ | ☐ 1 | ☐ 1 |
| | **TOTAL** | | _____ | _____ |

**Total Score Risk Category**
Low Risk 0-3
Moderate Risk 4-7
High Risk ≥ 8

Risk Category:
Low (score 0-3): 6% change of aberrant behavior
MODERATE (score 4-7): 28% change of aberrant behavior
HIGH (>8): 90% change of aberrant behavior

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Used with permission.
Webster LR. Predicting abberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. Pain Management. 2005;6(6):432-442.
HOP 16050882

# Urine Drug Testing



## Screening (see chart on next page)

Most guidelines recommend screening patients to determine risks of drug misuse and abuse and to mitigate those risks as much as possible. Unfortunately, there are no risk assessment tools that have been validated in multiple settings and populations. Screening is typically based on risk factors that can be identified through a thorough patient history, the use of prescription drug monitoring programs (PDMPs), the opioid risk tool (provided in this toolkit), and, on occasion, drug screening. However, it is important to standardize testing as cited risk factors (e.g. sociodemographic factors, psychological comorbidity, substance use disorders, etc.) might unfairly impact certain vulnerable populations. Involvement of the whole health care team and full disclosure and discussion of the screening protocol with patients is central to providing patient-centered and comprehensive pain management. Prior to drug testing, physicians should inform the patient of the reason(s) for testing, how often they will be tested, and what the results might mean. This gives patients an opportunity to disclose any additional drug or substance use which may help with identification of false positives and appropriate interpretation of test results.

Physicians must understand the limitations of the urine and confirmatory tests available, including what substances are detected by a particular test, and the reasons for false-positive and false-negative tests. Changes in prescribing for a particular patient should not be based on the result of one abnormal screening test, but should only occur after looking at all available monitoring tools as well as repeating the drug screen with the most specific test available.

## Interpretation of Results

Following initial testing, physicians should request confirmatory testing for the following results:

- Negative for the opioid(s) prescribed
- Positive for drugs not prescribed
- Positive for other substances such as alcohol, amphetamines, or cocaine (or metabolites)

## Additional Resources

**Washington State Medical Directors Guideline**
http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

**SAMHSA Guideline for Drug Testing**
https://store.samhsa.gov/shin/content/SMA12-4668/SMA12-4668.pdf

| Urine Drug Testing for Commonly Used and Misused Drugs | | | |
|---|---|---|---|
| **OPIATES** | | | |
| **Drug** | **Detection Time** | **Test Order** | **False Positive** |
| Codeine | 1-3 days | Opiates Immunoassay*<br>Confirmatory test: GC/MS or LC/MS/MS** | Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates |
| Morphine | 1-3 days | Opiates Immunoassay*<br>Confirmatory test: GC/MS or LC/MS/MS | Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates |
| Fentanyl | 1-3 days | GC/MS or LC/MS/MS Fentanyl | n/a |
| Meripidine | 1-3 days | GC/MS or LC/MS/MS Meperidine | n/a |
| Methadone | 3-7 days | Methadone Immunoassay<br>Confirmatory test: GC/MS or LC/MS/MS Methadone | Diphenhydramine, clomipramine |
| Hydrocodone | 1-3 days | Opiates immunoassay<br>Confirmatory test: GC/MS or LC/MS/MS | Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates |
| Hydromorphone | 1-3 days | Opiates immunoassay<br>Confirmatory test: GC/MS or LC/MS/MS | Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates |
| Oxycodone | 1-3 days | Opiates immunoassay<br>Confirmatory test: GC/MS or LC/MS/MS | Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates |
| Oxymorphone | 1-3 days | Opiates immunoassay<br>Confirmatory test: GC/MS or LC/MS/MS | Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates |
| **ADDITIONAL SUBSTANCES** | | | |
| **Drug** | **Detection Time** | **Test Order** | **False Positive** |
| Alcohol | Up to 8 hours | Alcohol | n/a |
| Amphetamines | 2-3 days | Amphetamines, methamphetamines, or MDMA immunoassay | Ephedrine, pseudoephedrine, selegiline |
| Barbiturates | 1-3 days short acting<br>Up to 30 days long-acting | Barbiturates Immunoassay | NSAIDs |
| Benzodiazeph-ines | 1-3 days short acting<br>Up to 30 days long-acting | Benzodiazepines Immunoassay***<br>Confirmatory test: GC/MS or LC/MS/MS Alprazolam, Diazepam, Clonazepam, Lorazepam, etc. | Sertraline, oxaprozin |
| Cocaine | 2-4 days | Cocaine metabolites immunoassay | Coca leaf tea |
| Marijuana | 2-4 days<br>Up to 30 days with chronic use | Cannabinoids (THC) Immunoassay | NSAIDs, proton pump inhibitors, food containing hemp, efavirenz |

**Opiates Immunoassay – Confirmatory test required to determine which opiate is present*

*** GC/MS/LC – Gas Chromatography/Mass Spectrometry/Liquid Chromatography*

****Benzodiazepine Immunoassay – High false-negative rate; consider confirmatory testing if high suspicion of use*

| Urine Drug Testing for Commonly Used and Misused Drugs | | | |
|---|---|---|---|
| **OPIATES** | | | |
| **Drug** | **Detection Time** | **Test Order** | **False Positive** |
| Codeine | 1-3 days | Opiates Immunoassay*<br>Confirmatory test: GC/MS or LC/MS/MS** | Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates |
| Morphine | 1-3 days | Opiates Immunoassay*<br>Confirmatory test: GC/MS or LC/MS/MS | Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates |
| Fentanyl | 1-3 days | GC/MS or LC/MS/MS Fentanyl | n/a |
| Meripidine | 1-3 days | GC/MS or LC/MS/MS Meperidine | n/a |
| Methadone | 3-7 days | Methadone Immunoassay<br>Confirmatory test: GC/MS or LC/MS/MS Methadone | Diphenhydramine, clomipramine |
| Hydrocodone | 1-3 days | Opiates immunoassay<br>Confirmatory test: GC/MS or LC/MS/MS | Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates |
| Hydromorphone | 1-3 days | Opiates immunoassay<br>Confirmatory test: GC/MS or LC/MS/MS | Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates |
| Oxycodone | 1-3 days | Opiates immunoassay<br>Confirmatory test: GC/MS or LC/MS/MS | Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates |
| Oxymorphone | 1-3 days | Opiates immunoassay<br>Confirmatory test: GC/MS or LC/MS/MS | Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates |
| **ADDITIONAL SUBSTANCES** | | | |
| **Drug** | **Detection Time** | **Test Order** | **False Positive** |
| Alcohol | Up to 8 hours | Alcohol | n/a |
| Amphetamines | 2-3 days | Amphetamines, methamphetamines, or MDMA immunoassay | Ephedrine, pseudoephedrine, selegiline |
| Barbiturates | 1-3 days short acting<br>Up to 30 days long-acting | Barbiturates Immunoassay | NSAIDs |
| Benzodiazeph-ines | 1-3 days short acting<br>Up to 30 days long-acting | Benzodiazepines Immunoassay***<br>Confirmatory test: GC/MS or LC/MS/MS Alprazolam, Diazepam, Clonazepam, Lorazepam, etc. | Sertraline, oxaprozin |
| Cocaine | 2-4 days | Cocaine metabolites immunoassay | Coca leaf tea |
| Marijuana | 2-4 days<br>Up to 30 days with chronic use | Cannabinoids (THC) Immunoassay | NSAIDs, proton pump inhibitors, food containing hemp, efavirenz |

**Opiates Immunoassay – Confirmatory test required to determine which opiate is present*

*** GC/MS/LC – Gas Chromatography/Mass Spectrometry/Liquid Chromatography*

****Benzodiazepine Immunoassay – High false-negative rate; consider confirmatory testing if high suspicion of use*

IOWA PMP

Welcome to Iowa's Prescription Monitoring Program (PMP). Please login to continue.

Username*

Password*

Forgot/Reset Password?

Login

Not a member? Register

**For registration questions, please contact PMP Administrator: Phone: 515-281-5944 Email: terry.witkowski@iowa.gov or jennifer.tiffany@iowa.gov.**

If you've lost or forgotten your password, please select Forgot/Reset Password above or contact PMP Administrative Support at: Phone: (515) 281-5944 or via Email: terry.witkowski@iowa.gov or jennifer.tiffany@iowa.gov.

**Please review your 'My Account' section to ensure that this information is accurate. After you login, go to 'My Account' to review and update all necessary information, especially your email address.**

**A PMP User's Guide, with detailed information about the Iowa PMP Web Center, is available on the Board's website at https://pharmacy.iowa.gov/documents/pmp-web-center-user-guide.**

| G-2e OPIOID MEDICATION AGREEMENT | DATE |
|---|---|
| (Reminder to person scanning to double check Epic flags)<br>*Provider must set Epic FYI flag upon completion of this consent* | HOSP.# |
| Monitored Telephone Consent recorded electronically via Epic<br>*Dotted lines to be completed by patient or representative as applicable.* | NAME |
| **Page 1 of 3** | BIRTH DATE |
| •This completed form must be scanned in Epic• | IF NOT IMPRINTED, PLEASE PRINT DATE, HOSP. #, AND NAME |

## Introduction to the Agreement Regarding Opioid (Narcotic) Medications

The healthcare providers* at University of Iowa Hospital and Clinics (UIHC) have decided to prescribe an opioid (narcotic) medication to manage chronic pain since other treatments have failed. Opioid medications are considered to be safe and effective when used properly, but may be harmful if used improperly. The goal of this treatment is to improve functional ability as well as social and work activities. Opioid medications require extra monitoring and follow-up, therefore we have developed a policy and agreement, which all patients and providers must follow if opioid medications are used for the treatment of chronic pain.

- It is required that you follow your provider's instructions when taking these medications.
- Examples of opioid medications include but are not limited to Oxycontin®, MS Contin®, Morphine, Vicodin®, Darvocet®, Methadone, and Codeine.
- Potential risks and side effects from this treatment may result in sedation, constipation, nausea and vomiting, confusion, difficulty with balance, decreased breathing, physical dependency, psychological dependence or addiction, tolerance, hypogonadotropism, decreased libido, osteoporosis, altered thyroid function, and risks regarding pregnancy.
- If a provider is found to be prescribing opioid medications to patients who are misusing them, that provider can lose the right to prescribe them.
- Iowa law on the use of opioids in nonmalignant pain is as follows:
  - Nonmalignant pain is defined as "It is pain that cannot be removed or otherwise treated in the generally accepted course of medical practice subsequent to an evaluation by the attending physician and at least one other physician specializing in the treatment of the area, system, or organ perceived to be the source of the pain for any of the following reasons: (1) no relief or cure for the cause of pain is possible; (2) no relief or cure for the cause of pain has been found; (3) relief or cure for the cause of pain through other medical procedures would adversely affect the well-being of the patient" [Iowa Statute 653 IAC 13.2(1)].
  - State law also mandates that the physicians shall review the course of treatment and the source of your pain [Iowa Statute 653 IAC 13.2(3)(d)].
- Only your provider will prescribe the opioid medication and refill it.
- You may see another provider for sick visits, however, it will not be acceptable for that provider to make changes or refills in your opioid medications.
- If refills are requested, the request must be made 7 days in advance and must occur Monday through Thursday 8am – 5pm excluding holidays.

We believe this agreement will help educate and protect our patients. Please read the attached agreement carefully and discuss it with your provider.

*Provider refers to MD, DO, Nurse Practitioner, and Physician Assistant

**References:**


- Iowa Statute 653 IAC 13.2(3)(d)
- Iowa Statute 653 IAC 13.2(1)
- *Virginia Board of Medicine Guidance Document*. 1999; 85(14):1-3.
- *N Engl J Med* 2003; 349: 1943-53
- *Journal of Pain & Palliative Care Pharmacotherapy*. 2002;16(3):5-26
- www.npecweb.org


*Continued on Page 2*

## Agreement for the Use of Opioid (Narcotic) Medications

Before UIHC providers will provide opioid (narcotic) medications, we require you to agree to the following conditions that are intended to reduce your risk of undesired side effects. Opioid medications can cause addiction, dependence, interfere with your ability to make judgments, or be responsible for others, and overdose can be life threatening. The conditions are:

I agree to obtain all prescriptions for opioid medications only from my provider at UIHC: _____

I agree to take the opioid medication only as prescribed by my provider.

I agree to follow the instructions of my provider regarding the dose and length of treatment with opioid medications.

I am responsible for the opioid medications prescribed to me. If my prescription or medication is lost, misplaced, stolen, or if I "run out early" I understand that the medications will NOT BE REFILLED EARLY.

My provider will reassess my use of opioid medications at every visit. If I fail to keep the appointment, my prescription will not be refilled.

I will provide a urine drug test at the request of the medical staff at UIHC. If the test is positive for illicit drugs the prescription will be terminated. If the test indicates I am not taking the prescribed medication, the prescription will be terminated.

Refills of the opioid medications:

- Early refills will not be allowed under any situation including transportation issues, vacations, or leaving town.
- Refills will not be made early or on an emergency basis for any reason or because I have suddenly "run out of medications" or taken a higher dose than prescribed by my doctor.
- Refill requests must be made 7 days in advance and must occur Monday through Thursday 8am to 5pm excluding holidays.

If I forge a prescription or sell the prescribed medication, my prescription will be terminated, and the police will be notified.

I will use the same pharmacy for all my opioid medications and will supply my provider with the name, address, and phone number of the pharmacy. If I change pharmacies, I will contact my provider's office and provide them with the name, address, and phone number of the new pharmacy.

If I plan to become pregnant or believe that I have become pregnant while taking this medication, I will immediately notify my provider. I am aware that the use of opioid medications is not generally associated with a risk of birth defects and that birth defects can occur whether or not the mother is on medicines. (Females only)

I understand that the main goals of treatment with chronic opioid medications are to reduce pain and improve my overall function. I agree to help myself reach these goals by following healthy lifestyles. This includes exercising, proper nutrition, eliminating alcohol and illicit drugs, and avoiding tobacco products. I must also follow the treatment plan as prescribed by my provider.

I will keep all appointments with provider, chemical dependency counselor, and/or psychiatrists.

*Continued on Page 3*

I understand that treatment with opioid medications will be stopped if any of the following occurs:

- I develop significant / serious side effects (allergic reaction or slowing of breathing rate).
- I develop rapid tolerance or loss of effect from this medication.
- I am unable to continue my work or daily routine because of medication side effects.
- I forge or alter prescriptions or unprescribed opioids / illicit drugs are detected in my urine.
- If I sell my opioid medications.
- If I fail to take the medication as prescribed by my provider.
- I fail to meet any of the conditions in this agreement.

I understand that if my provider chooses to discontinue opioid treatment, my dose will gradually be lowered over several days to avoid withdrawal symptoms. If my provider decides that I have a dependence problem, he or she may refer me somewhere else for management of that dependency.

It is my provider's responsibility to determine how and if these medications will be prescribed. These decisions will be based on ongoing evaluation of my medical conditions. These guidelines are designed to protect me from dangers associated with controlled medications. If I violate them, my physician may decide to discontinue or reduce the dose of my medication.

I have read this document, understand it, and have had all my questions answered satisfactorily. I consent to the use of opioids prescribed and understand that the treatment will be conducted in accordance with the conditions stated above. A copy of this agreement will be sent to the pharmacy I have chosen. If I change pharmacies, I will notify my provider so that a copy of this agreement can be sent to my new pharmacy.

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

**Signature** _____ **Date** _____
(Patient or person authorized to consent for patient)

_____ _____
(Printed name of person signing if not the patient) (Relationship to Patient)

**Staff Signature** _____ **Date** _____ **Time** _____

# Addiction Behaviors Checklist (ABC)

Designed to track behaviors characteristic of addiction related to prescription opioid medications in chronic pain patients. Items are focused on observable behaviors noted both during and between visits. ABC is focused on longitudinal assessment and tracking of problematic behaviors.

## Addiction Behaviors Checklist

***Instructions*: Code only for patients prescribed opioid or sedative analgesics on behaviors exhibited ''since last visit'' and ''within the current visit'' (NA = not assessed)**

**Addiction behaviors—since last visit**

| | | | |
|---|---|---|---|
| 1. Patient used illicit drugs or evidences problem drinking* | Y | N | NA |
| 2. Patient has hoarded meds | Y | N | NA |
| 3. Patient used more narcotic than prescribed | Y | N | NA |
| 4. Patient ran out of meds early | Y | N | NA |
| 5. Patient has increased use of narcotics | Y | N | NA |
| 6. Patient used analgesics PRN when prescription is for time contingent use | Y | N | NA |
| 7. Patient received narcotics from more than one provider | Y | N | NA |
| 8. Patient bought meds on the streets | Y | N | NA |

**Addiction behaviors—within current visit**

| | | | |
|---|---|---|---|
| 1. Patient appears sedated or confused (e.g., slurred speech, unresponsive) | Y | N | NA |
| 2. Patient expresses worries about addiction | Y | N | NA |
| 3. Patient expressed a strong preference for a specific type of analgesic or a specific route of administration | Y | N | NA |
| 4. Patient expresses concern about future availability of narcotic | Y | N | NA |
| 5. Patient reports worsened relationships with family | Y | N | NA |
| 6. Patient misrepresented analgesic prescription or use | Y | N | NA |
| 7. Patient indicated she or he ''needs'' or ''must have'' analgesic meds | Y | N | NA |
| 8. Discussion of analgesic meds was the predominant issue of visit | Y | N | NA |
| 9. Patient exhibited lack of interest in rehab or self-management | Y | N | NA |
| 10. Patient reports minimal/inadequate relief from narcotic analgesic | Y | N | NA |
| 11. Patient indicated difficulty with using medication agreement | Y | N | NA |

**Other**

| | | | |
|---|---|---|---|
| 1. Significant others express concern over patient's use of analgesics | Y | N | NA |

*Item 1 original phrasing: (''Patient used ETOH or illicit drugs''), had a low correlation with global clinical judgment. This is possibly associated with difficulty in content interpretation, in that if a patient endorsed highly infrequent alcohol use, he or she would receive a positive rating on this item, but not be considered as using the prescription opioid medications inappropriately. Therefore, we include in this version of the ABC a suggested wording change for this item that specifies problem drinking as the criterion for alcohol use.

## ABC Score: _____

Score of ≥3 indicates possible inappropriate opioid use and should flag for further examination of specific signs of misuse and more careful patient monitoring (i.e., urine screening, pill counts, removal of opioid).

Checklist developed by Bruce D. Naliboff, Ph.D. with support from VA Health Services Research and Development. Used with permission.

Published in: Wu SM, Compton P, Bolus R, et al. The addiction behaviors checklist: validation of a new clinician-based measure of inappropriate opioid use in chronic pain. *J Pain Symptom Manage*. 2006;32(4):342-351.

## UI Health Care

# Opioids: What you need to know

### Opioids: Strong medicines used to decrease pain

### Benefits of opioids:

- You may have less pain
- May improve short-term function

### Risks of opioids:

- Constipation
- Feeling sick, vomiting, dry mouth
- Sleepiness
- Dizziness
- Confusion
- Decreased sexual desire and function
- Decreased breathing
- Overdose
- Death
- Addiction
- Anxiety, depression

### Guidelines for Taking Opioids:

- Use only as directed
- Do not use with alcohol and other medicines such as muscle relaxants, nerve pills or sleeping aids
- Store in a safe place
- Do not share with other people or use another person's prescription
- Safely dispose of opioids by bringing them back to our pharmacy

### Naloxone— What it's used for:

- A medicine to treat accidental overdose

### Risk Factors for Opioid Overdose:

- Mental health conditions
- High doses of opioids
- Combining opioids with other certain types of medicines and alcohol

### For more information:

**https://www.cdc.gov/drugoverdose/prescribing/patients.html**

University of Iowa Hospitals & Clinics
University of Iowa Health Care
*Department of Pharmaceutical Care*

# Figure 1: Risk Assessment for Overdose or Serious Opioid-Induced Respiratory Depression

## Step 1: Determine Score for Risk Index for Overdose or Serious Opioid-induced Respiratory Depression (RIOSORD)

| Question[1] | Points for "Yes" Response |
|---|---|
| **In the past 6 months, has the patient had a healthcare visit (outpatient, inpatient or ED) involving any of the following health conditions?[2]** | |
| Substance use disorder (abuse or dependence)? **includes opioids, antidepressants, sedatives/anxiolytics, alcohol, amphetamines, cannabis, cocaine, hallucinogens* | 25 |
| Bipolar disorder or schizophrenia? | 10 |
| Stroke (cerebrovascular accident, CVA) or other cerebrovascular disease? | 9 |
| Chronic kidney disease with clinically significant renal impairment? | 8 |
| Heart failure? | 7 |
| Non-malignant pancreatic disease (e.g., acute or chronic pancreatitis)? | 7 |
| Chronic pulmonary disease (e.g., emphysema, chronic bronchitis, asthma, pneumoconiosis, asbestosis)? | 5 |
| Chronic headache (e.g., migraine)? | 5 |
| **Does the patient consume:** | |
| Fentanyl? (e.g., transdermal or transmucosal immediate-release products) | 13 |
| Morphine? | 11 |
| Methadone? | 10 |
| Hydromorphone? | 7 |
| An extended-release or long-acting (ER/LA) formulation of any prescription opioid, including the above?[3] | 5 |
| A prescription benzodiazepine? (e.g., diazepam, alprazolam) | 9 |
| A prescription antidepressant? (e.g., fluoxetine, citalopram, venlafaxine, amitriptyline) | 8 |
| Is the patient's current maximum prescribed opioid dose ≥ 100 mg morphine equivalents per day? (Include all prescription opioids consumed on a daily basis) | 7 |
| **Total point score** (maximum 146) | |

## Step 2: Identify Risk Class for OSORD

| Risk Class | RIOSORD Score (Points) | Average Probability of OSORD |
|---|---|---|
| 1 | 0-4 | 2% |
| 2 | 5-7 | 5% |
| 3 | 8-9 | 7% |
| 4 | 10-17 | 15% |
| 5 | 18-25 | 30% |
| 6 | 26-41 | 55% |
| 7 | ≥42 | 83% |

Patients in Risk Class 4-7 should have naloxone co-prescribed with opioids.
OSORD, overdose or serious opioid-induced respiratory depression

[1]This questionnaire is intended for completion and interpretation by a healthcare professional. It is not a replacement for clinical judgment and is intended to guide and inform clinical decision-making for patients who are prescribed opioids.

[2]The condition does not have to be the primary reason for the visit but should be entered in the chart or EHR as one of the reasons or diagnoses for the visit.

[3]A patient consuming 1 or more opioids with an ER/LA formulation receives 5 additional points for 'ER/LA formulation of any prescription opioid' regardless of the number of different ER/LA products consumed.

Zedler, et al. Validation of a Screening Risk Index for Serious Prescription Opioid-Induced Respiratory Depression or Overdose in a US Commercial Health Plan Claims Database. Pain Medicine 2017; 11: 1-11.