Pain Management Agreement

The purpose of this document is to inform you about our policies related to ***the use of medicines, including opioids, as part of a plan for extended pain management.*** This Agreement is to help you and your provider comply with the current recommendations regarding use of controlled pharmaceuticals. It is in addition to any verbal agreement that we have with you regarding use of these medications.

Recent social as well as healthcare trends have portrayed opioid medication as "high risk" choice. A discriminatory attitude toward this one class of medication, based on medical hysteria described as an "Opioid Epidemic," is beginning to interfere with our patients' ability to get the care they need. Based on our expertise and years of experience in Pain Management, we are confident in prescribing these medications as a sound, safe and effective treatment option for our patients. We want to assure you that we have many cases in which these medications allow a patient to experience maximum quality of life, despite a pain disability.

General Information about use of Controlled Medications for Pain Management

- **Medication tolerance** will develop over a period of use, making these medications less effective and/or requiring an increasing dose. If this occurs, please discuss it with your provider.
- **Rebound headaches** (medication-overuse headaches) can be caused by regular, long-term use of medication to treat headaches, such as migraine.
- **Physical Dependence and Addiction.** Dependence refers to a physical condition in which the body has adapted to the presence of a drug. Withdrawal symptoms occur if the drug is suddenly discontinued. Addiction is defined as a compulsive, overwhelming need to use a drug despite harmful consequences. Regular, prescribed use of a medication does not mean you are addicted to it.
- **Possibility of misuse, abuse or diversion.** Due to recent increased awareness that others may obtain and misuse your medications, we ask that extra caution be taken with storage.

Common Side Effects

- Sedation, Dizziness.
- Respiratory Depression. Never start a new medication at bedtime.
- Severe Constipation. There are many methods to address this issue. Please ask if you need help.
- Nausea, Vomiting

Pain Management Agreement

Guidelines for Managing your Prescription

- Use medicine only as prescribed. Any changes to dosage, frequency or type of medication should be pre-approved by your provider.
- We ask that all medication be brought to appointments for review.
- Plan ahead. Prescriptions cannot be filled outside of regular office hours. On-call providers ***will not*** fill your prescription.
- Acknowledge that your provider and pharmacy use a Prescription Monitoring Program to prevent use of multiple providers and/or pharmacies.
- Lost or stolen medications will be difficult to replace. Keep your medication in a safe, protected space.
- This medication is prescribed because other non-opioid therapies have not been effective. It is prescribed in the lowest possible dose to manage your pain.

Caution

- Avoid alcohol while taking most medication, as this combination can cause problems including increased sedation or liver challenges.
- Do not use illegal substances or other controlled substances while taking this prescription.
- Do not share your medication with anyone else.
- Do not attempt to obtain controlled substances from other providers. Do not use multiple pharmacies for filling prescriptions. There is a national data register of persons using these medications.
- All pharmacies are required to check this database before dispensing medication.
- Be aware that you may experience changes in your gross motor skills – affecting driving and other skilled activity.

Pain Management Agreement

Your Treatment Plan:

- I understand that medications have been chosen as a part of ***my overall treatment plan.*** They will be used in conjunction with other strategies that may include other medications, exercises, psychological counseling and life-style change recommendations or requirements.
- I will complete self-monitoring tools accurately and completely when requested. These will be given to you at your provider's discretion.
- I will comply with recommended additional /supportive therapies and referrals
- When necessary my provider will taper me off the medicine over a period of several days. I may be given other medication to assist with this process.
- I will safely store my medications to avoid loss and misuse.

These guidelines have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered.

I have received a copy of CDC Guidelines "Turn the Tide: Prescribing Opioids for Chronic Pain.

More information is available at www.drbradeli.com. Under the Patient Resources tab

I understand that if I am ***unable to follow these guidelines,*** my provider may discontinue prescribing this medication for me.

Patient Signature _____ Date _____

_Provider _____ Date _____

TURN THE TIDE

PRESCRIBING OPIOIDS FOR CHRONIC PAIN

ADAPTED FROM CDC GUIDELINE

Opioids can provide short-term benefits for moderate to severe pain. Scientific evidence is lacking for the benefits to treat chronic pain.

IN GENERAL, DO NOT PRESCRIBE OPIOIDS AS THE FIRST-LINE TREATMENT FOR CHRONIC PAIN (for adults 18+ with chronic pain > 3 months excluding active cancer, palliative, or end-of-life care).

BEFORE PRESCRIBING

1 ASSESS PAIN & FUNCTION

Use a validated pain scale. Example: PEG scale where the score = average 3 individual question scores (30% improvement from baseline is clinically meaningful).

Q1: What number from 0 – 10 best describes your PAIN in the past week? (0 = "no pain", 10 = "worst you can imagine")

Q2: What number from 0 – 10 describes how, during the past week, pain has interfered with your ENJOYMENT OF LIFE? (0 = "not at all", 10 = "complete interference")

Q3: What number from 0 – 10 describes how, during the past week, pain has interfered with your GENERAL ACTIVITY? (0 = "not at all", 10 = "complete interference")

2 CONSIDER IF NON-OPIOID THERAPIES ARE APPROPRIATE

Such as: NSAIDs, TCAs, SNRIs, anti-convulsants, exercise or physical therapy, cognitive behavioral therapy.

3 TALK TO PATIENTS ABOUT TREATMENT PLAN

- Set realistic goals for pain and function based on diagnosis.
- Discuss benefits, side effects, and risks (e.g., addiction, overdose).
- Set criteria for stopping or continuing opioid. Set criteria for regular progress assessment.
- Check patient understanding about treatment plan.

4 EVALUATE RISK OF HARM OR MISUSE. CHECK:

- Known risk factors: illegal drug use; prescription drug use for nonmedical reasons; history of substance use disorder or overdose; mental health conditions; sleep-disordered breathing.
- Prescription drug monitoring program data (if available) for opioids or benzodiazepines from other sources.
- Urine drug screen to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.
- Medication interactions. AVOID CONCURRENT OPIOID AND BENZODIAZEPINE USE WHENEVER POSSIBLE.

WHEN YOU PRESCRIBE

START LOW AND GO SLOW. IN GENERAL:

- Start with immediate-release (IR) opioids at the lowest dose for the shortest therapeutic duration. IR opioids are recommended over ER/LA products when starting opioids.
- Avoid ≥ 90 MME/day; consider specialist to support management of higher doses.
- If prescribing ≥ 50 MME/day, increase follow-up frequency; consider offering naloxone for overdose risk.
- For acute pain: prescribe < 3 day supply; more than 7 days will rarely be required.
- Counsel patients about safe storage and disposal of unused opioids.

See below for MME comparisons. For MME conversion factors and calculator, go to TurnTheTideRx.org/treatment.

50 MORPHINE MILLLIGRAM EQUIVALENTS (MME)/DAY:

- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15mg)

90 MORPHINE MILLLIGRAM EQUIVALENTS (MME)/DAY:

- 90 mg of hydrocodone (18 tablets of hydrocodone/acetaminophen 5/300)
- 60 mg of oxycodone (4 tablets of oxycodone sustained-release 15mg)

AFTER INITIATION OF OPIOID THERAPY

ASSESS, TAILOR & TAPER

- Reassess benefits/risks within 1-4 weeks after initial assessment.
- Assess pain and function and compare results to baseline. Schedule reassessment at regular intervals (≤ 3 months).
- Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.
- If over-sedation or overdose risk, then taper. Example taper plan: 10% decrease in original dose per week or month. Consider psychosocial support.
- Tailor taper rates individually to patients and monitor for withdrawal symptoms.

TREATING OVERDOSE & ADDICTION

- Screen for opioid use disorder (e.g., difficulty controlling use; see DSM-5 criteria). If yes, treat with medication-assisted treatment (MAT). MAT combines behavioral therapy with medications like methadone, buprenorphine, and naltrexone. Refer to findtreatment.samhsa.gov. Additional resources at TurnTheTideRx.org/treatment and www.hhs.gov/opioids.
- Learn about medication-assisted treatment (MAT) and apply to be a MAT provider at www.samhsa.gov/medication-assisted-treatment.
- Consider offering naloxone if high risk for overdose: history of overdose or substance use disorder, higher opioid dosage (≥ 50 MME/day), concurrent benzodiazepine use.

ADDITIONAL RESOURCES

CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN:
www.cdc.gov/drugoverdose/prescribing/guideline.html

SAMHSA POCKET GUIDE FOR MEDICATION-ASSISTED TREATMENT (MAT):
store.samhsa.gov/MATguide

NIDAMED: www.drugabuse.gov/nidamed-medical-health-professionals

ENROLL IN MEDICARE: go.cms.gov/pecos
Most prescribers will be required to enroll or validly opt out of Medicare for their prescriptions for Medicare patients to be covered. Delay may prevent patient access to medications.

JOIN THE MOVEMENT

and commit to ending the opioid crisis at TurnTheTideRx.org.

TURN THE TIDE

The Office of the Surgeon General

CDC
Centers for Disease Control and Prevention