

# OMA 2016



## Harm Reduction Strategies for Chronic Pain Patients

*Presented by  
Paul Coelho, MD  
PM&R, Pain Medicine*

# Disclosures

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**Dr. Coelho has nothing to disclose.  
I will not be discussing any off-label use.**

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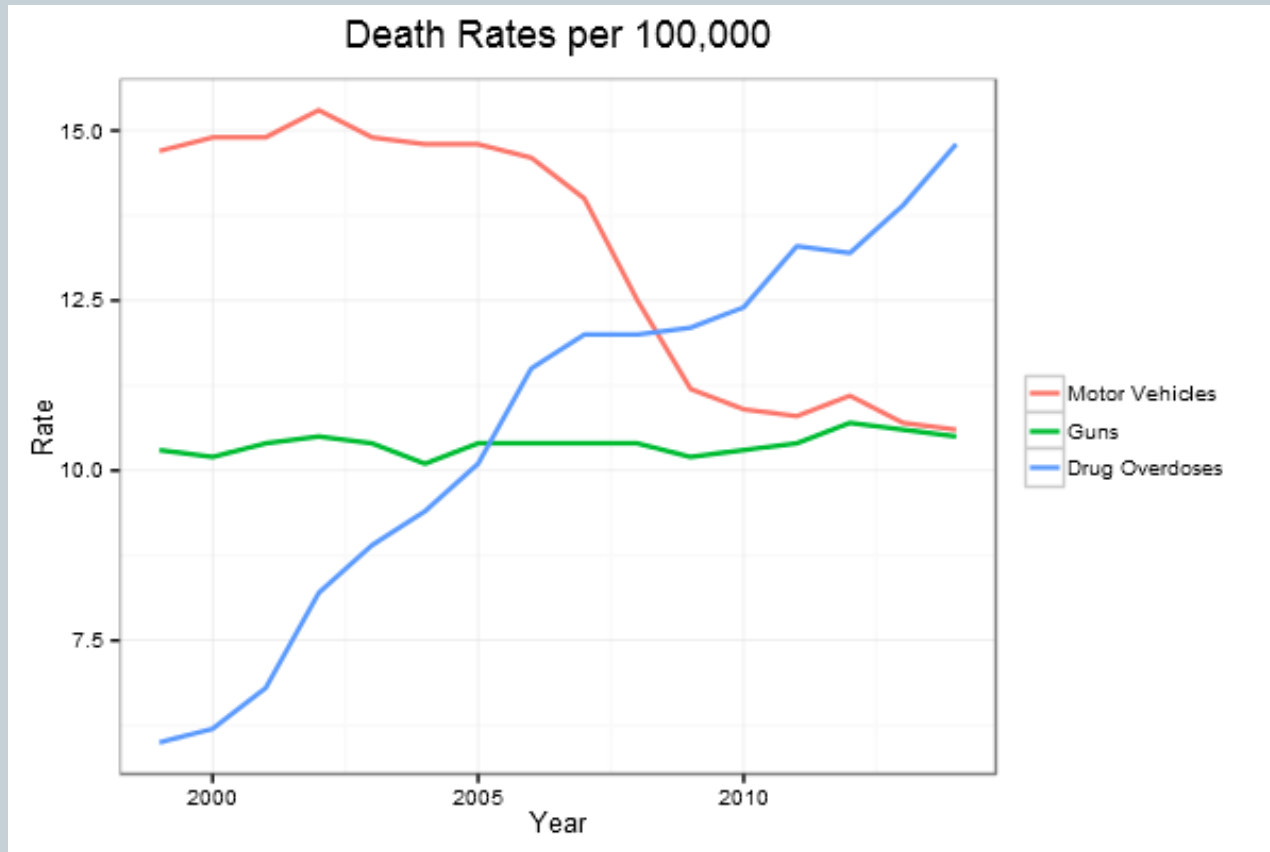
1. The Opioid Epidemic
2. Risk Factors for Overdose
3. Risk Factors for Opioid Use Disorder (Addiction)
4. Harm Reduction Strategies
5. Sample Cases



# Overdose Deaths 2000-2015

4

## US National Data

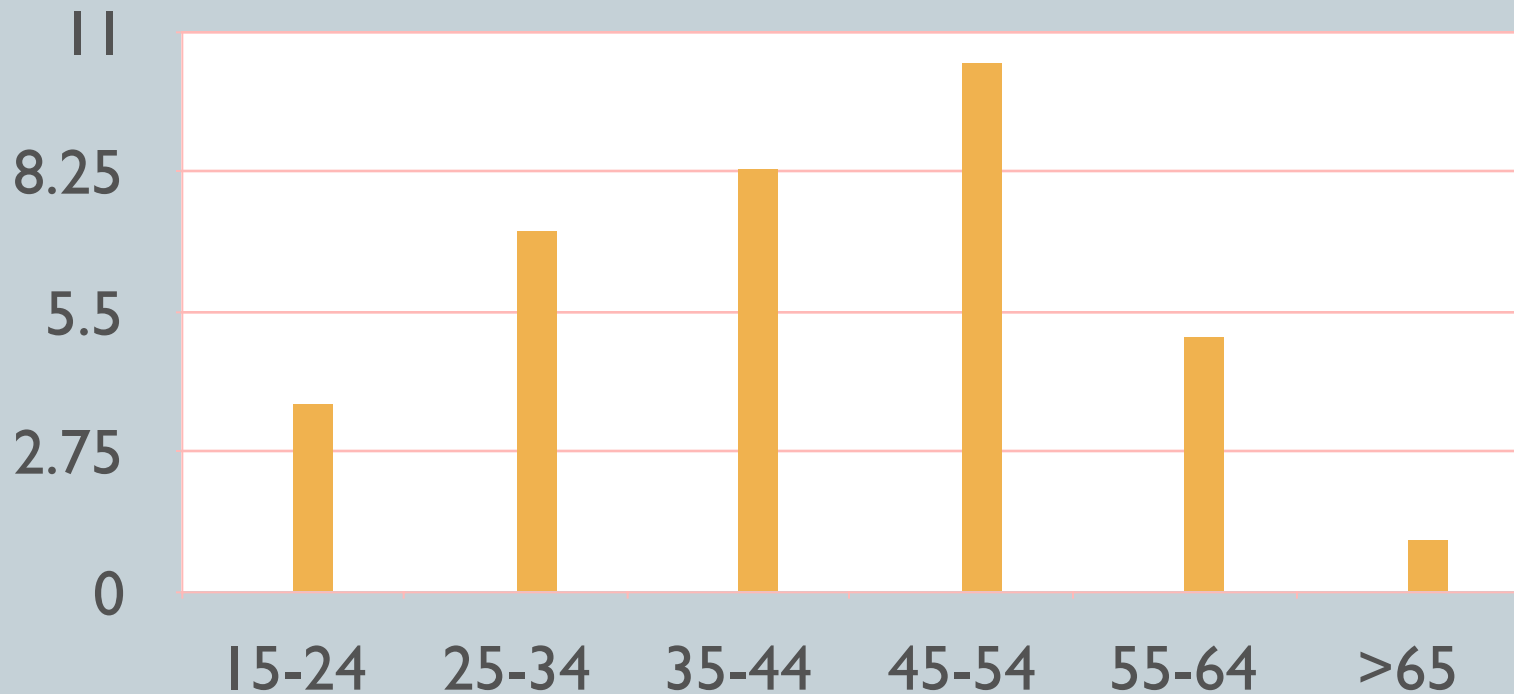


[http://www.realclearpolicy.com/blog/2015/12/21/guns\\_vs\\_cars\\_and\\_drugs\\_1500.html](http://www.realclearpolicy.com/blog/2015/12/21/guns_vs_cars_and_drugs_1500.html)

# Overdose Deaths By Age

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1999-2010

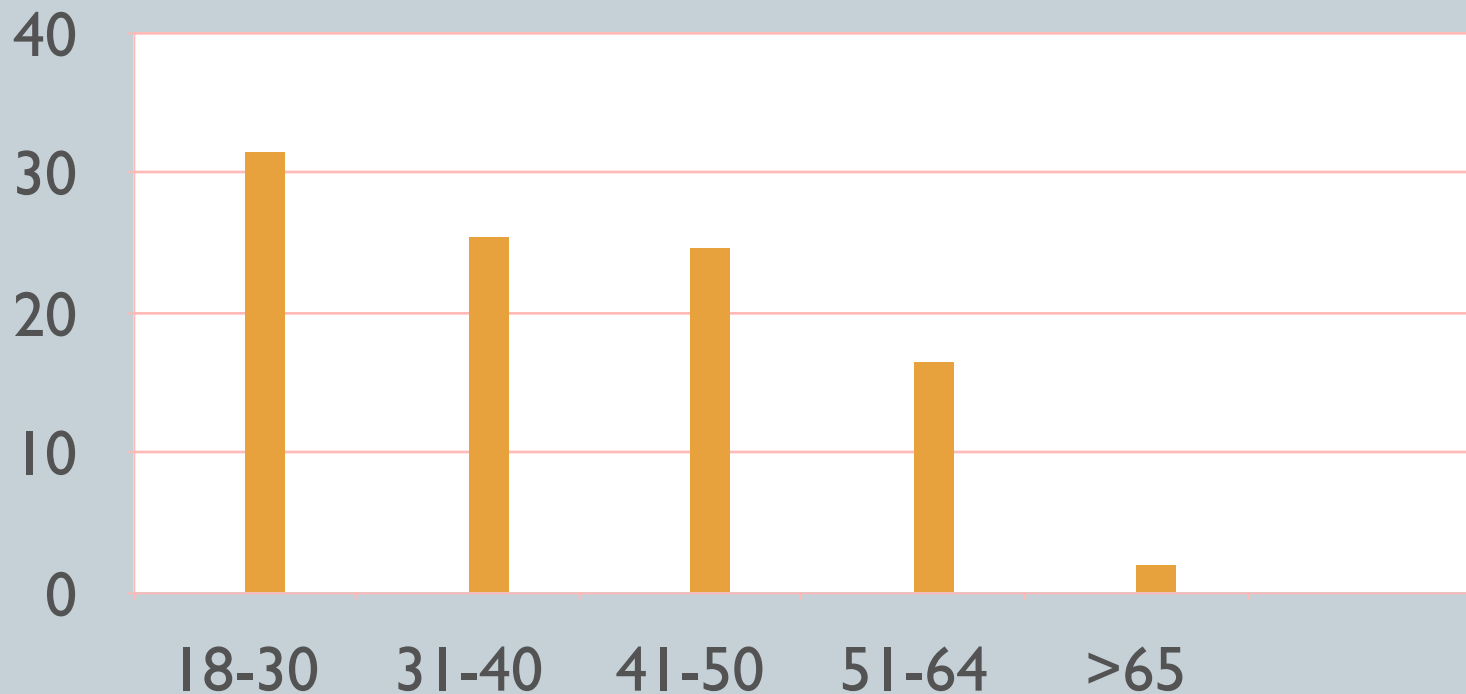


[www.cdc.gov/mmwr/preview/mmwrhtml/mm6126a5.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6126a5.htm)

# Addiction Diagnosis by Age

6

TROUP STUDY N = 570K

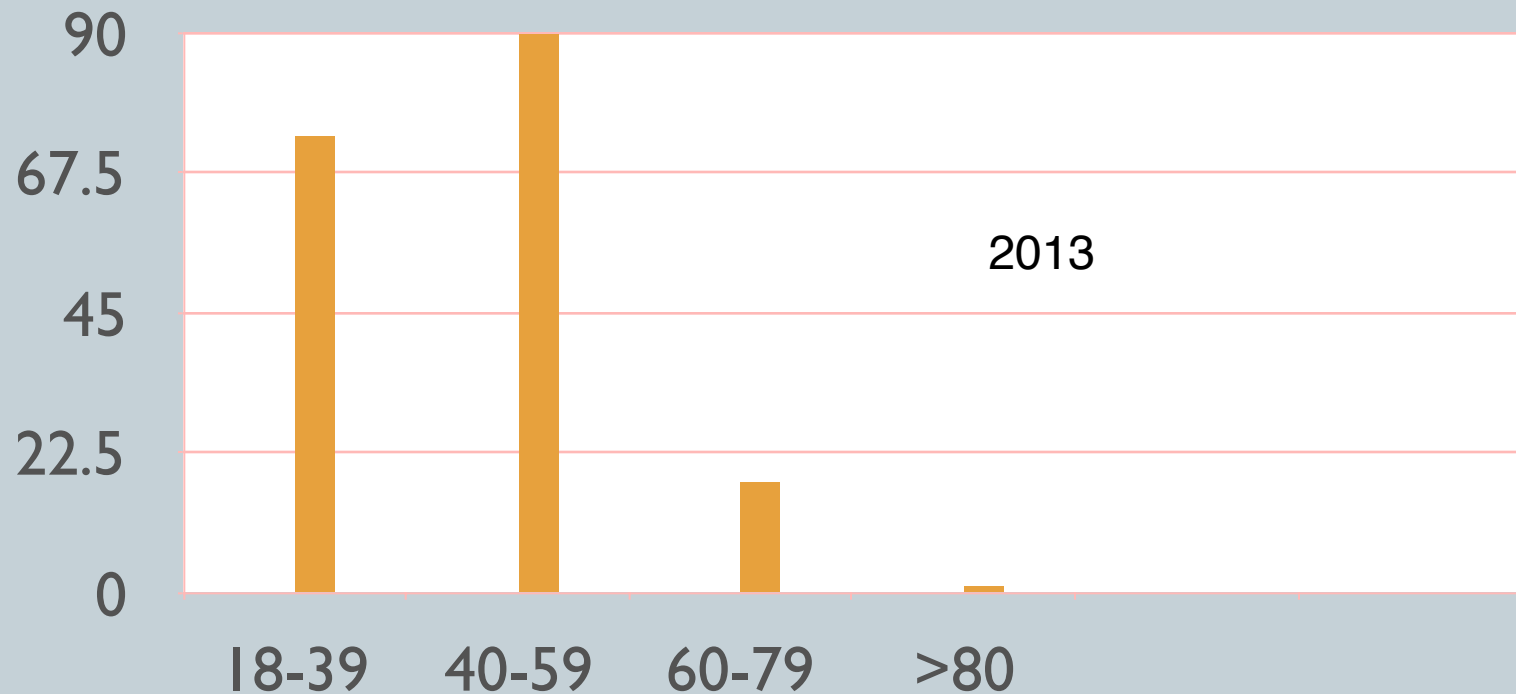


<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4032801/>

# OR Medicaid Opioid Rx's by Age

7

Top 10% Prescribers Rx'd 80% of All Opioids



<http://www.ncbi.nlm.nih.gov/pubmed/26766755>

# 14% Increase In ODD's Nationally 2013-2014

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Number and age-adjusted rates of drug-poisoning deaths involving opioid analgesics and heroin: United States, 2000-2014

Year	Drug poisoning					
	All		Opioid analgesics		Heroin	
	Number	Deaths per 100,000	Number	Deaths per 100,000	Number	Deaths per 100,000
1999	16,849	6.1	4,030	1.4	1,960	0.7
2000	17,415	6.2	4,400	1.5	1,842	0.7
2001	19,394	6.8	5,528	1.9	1,779	0.6
2002	23,518	8.2	7,456	2.6	2,089	0.7
2003	25,785	8.9	8,517	2.9	2,080	0.7
2004	27,424	9.4	9,857	3.4	1,878	0.6
2005	29,813	10.1	10,928	3.7	2,009	0.7
2006	34,425	11.5	13,723	4.6	2,088	0.7
2007	36,010	11.9	14,408	4.8	2,399	0.8
2008	36,450	11.9	14,800	4.8	3,041	1.0
2009	37,004	11.9	15,597	5.0	3,278	1.1
2010	38,329	12.3	16,651	5.4	3,036	1.0
2011	41,340	13.2	16,917	5.4	4,397	1.4
2012	41,502	13.1	16,007	5.1	5,925	1.9
2013	43,982	13.8	16,235	5.1	8,257	2.7
2014	47,055	14.7	18,893	5.9	10,574	3.4

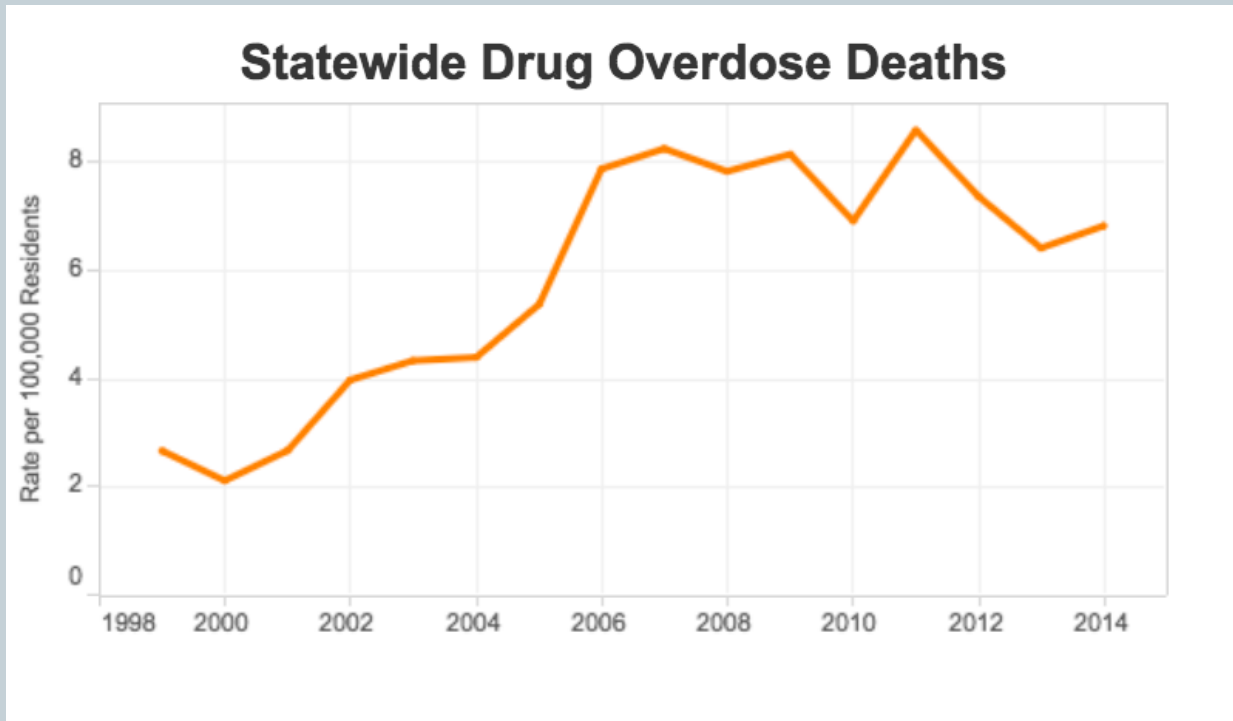
[http://www.cdc.gov/nchs/data/health\\_policy/AADR\\_drug\\_poisoning\\_involving\\_OA\\_Heroin\\_US\\_2000-2014.pdf](http://www.cdc.gov/nchs/data/health_policy/AADR_drug_poisoning_involving_OA_Heroin_US_2000-2014.pdf)



# OR Opioid Overdose Deaths

9

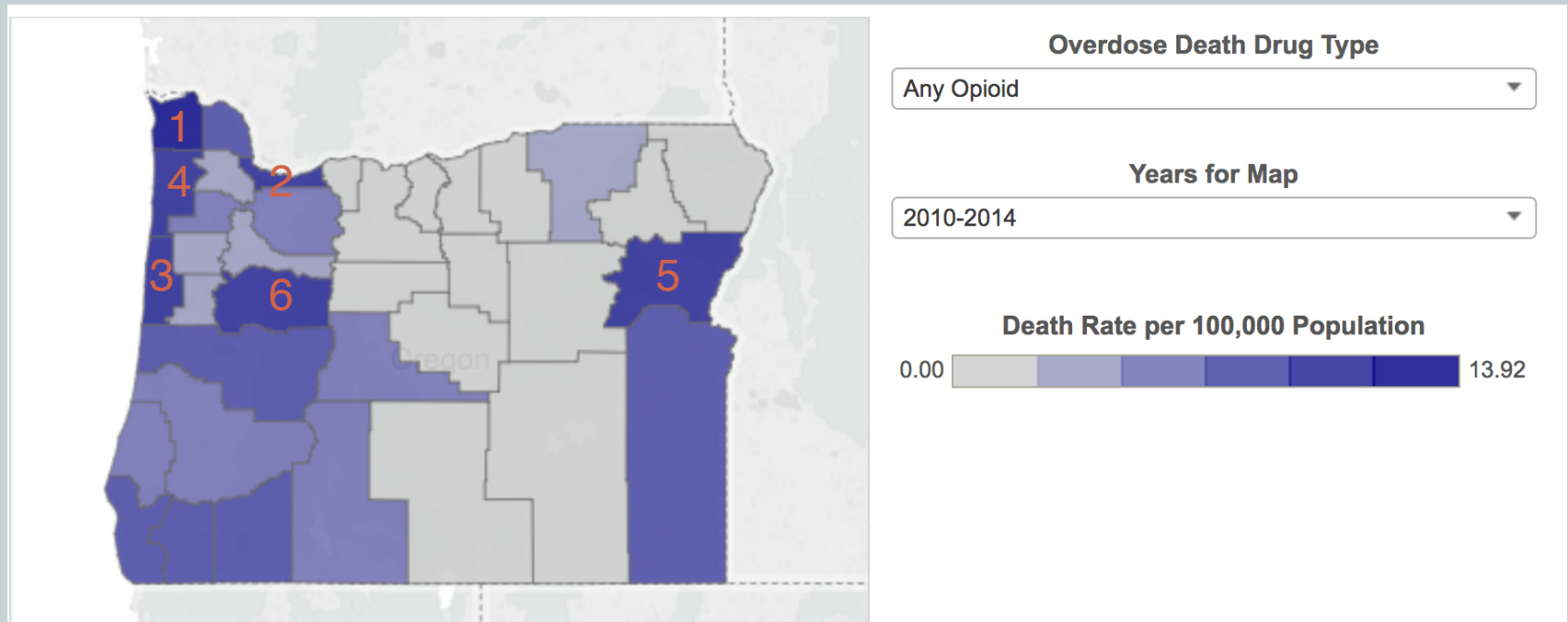
All Opioids



<http://public.health.oregon.gov/PreventionWellness/SubstanceUse/Opioids/Pages/data.aspx>

# Oregon Opioid Overdose Deaths

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<http://public.health.oregon.gov/PreventionWellness/SubstanceUse/Opioids/Pages/data.aspx>

# Oregon Opioid Overdose Deaths

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1. Clatsop
2. Multnomah
3. Lincoln
4. Tillamook
5. Baker
6. Linn

<http://public.health.oregon.gov/PreventionWellness/SubstanceUse/Opioids/Pages/data.aspx>

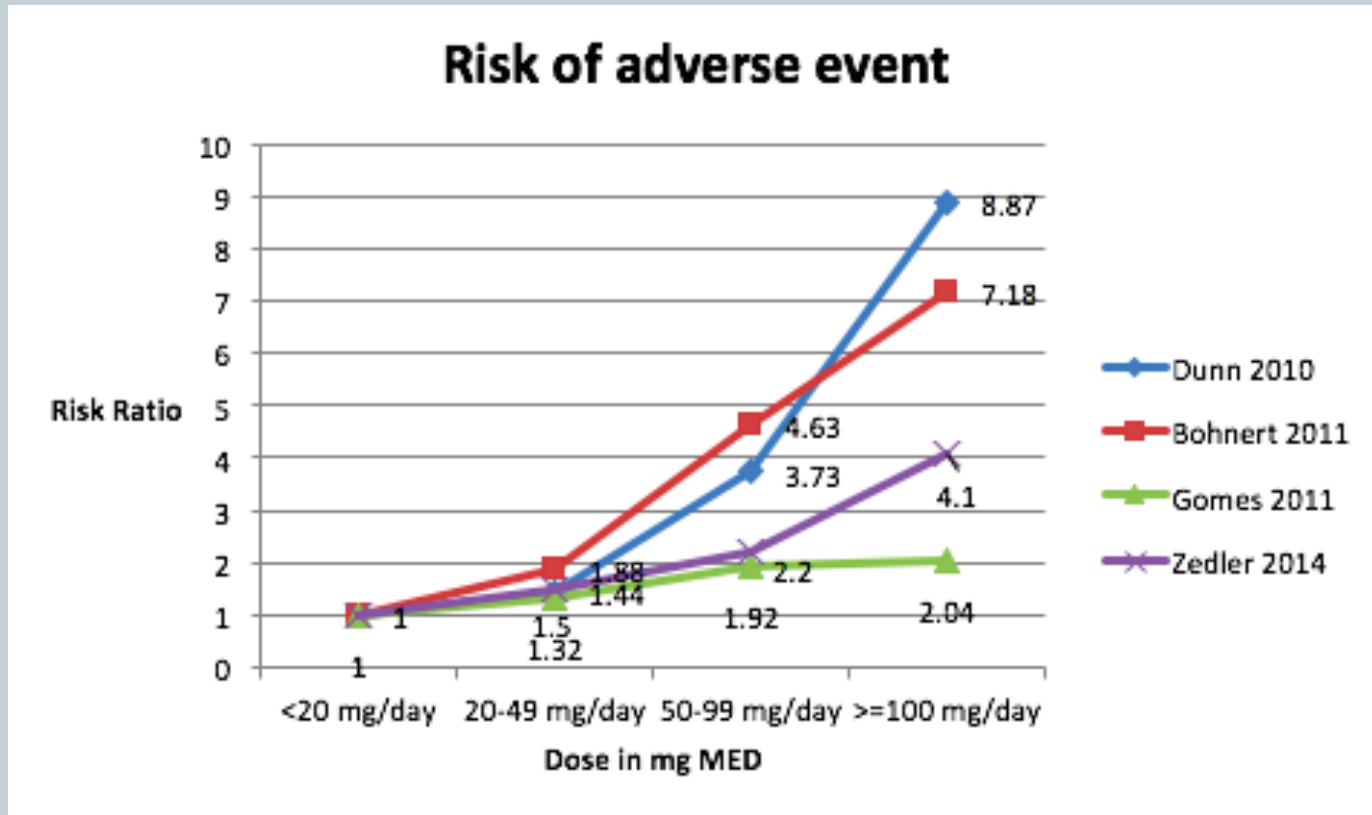
# Risk Factors for Overdose Death

12

1. Opioid Dose  $\geq$  120mg Morphine/day (MED)
2. Methadone  $\geq$  40mg/day
3. Opioids + Benzodiazepines/Sedatives
4.  $\geq$  4 Prescribers or Pharmacies in 1yr

# Dose as a Risk Factor for Overdose Death

13

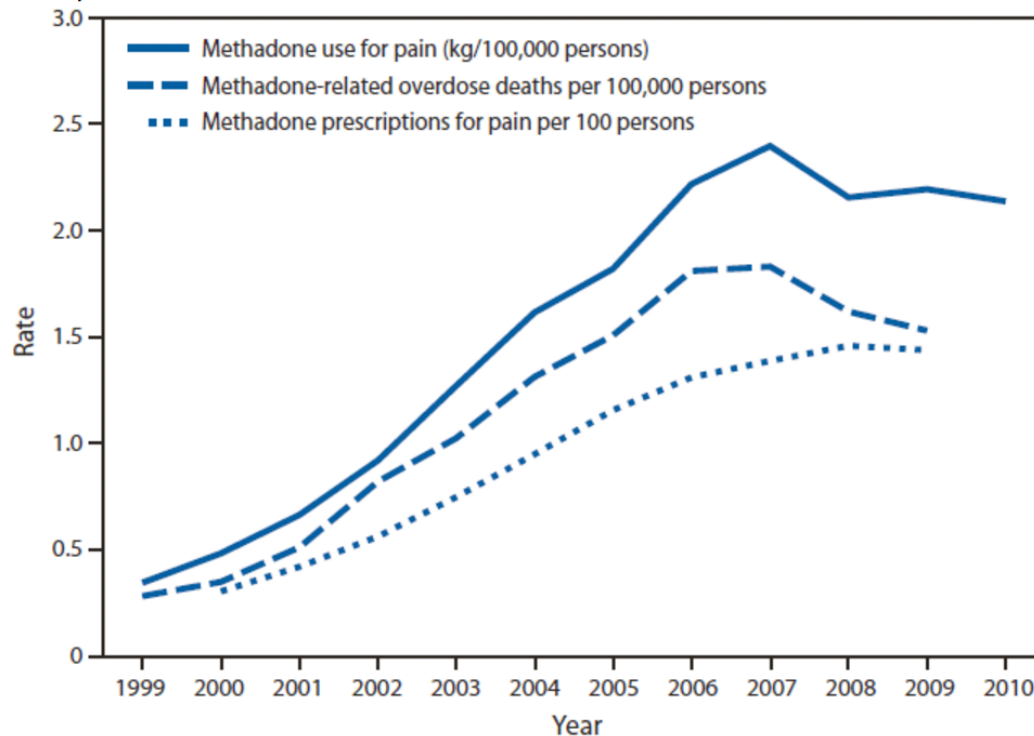


[https://www.aan.com/uploadedFiles/Website\\_Library\\_Assets/Documents/3.Practice\\_Management/2.Quality\\_Improvement/2.Patient\\_Safety/2.Patient\\_Safety\\_Education/C171 - Franklin.pdf](https://www.aan.com/uploadedFiles/Website_Library_Assets/Documents/3.Practice_Management/2.Quality_Improvement/2.Patient_Safety/2.Patient_Safety_Education/C171 - Franklin.pdf)

# Methadone as a Risk Factor for Overdose Death

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**FIGURE 1. Rates of methadone distribution for pain, methadone-related overdose deaths, and methadone prescriptions for pain — United States, 1999–2010**

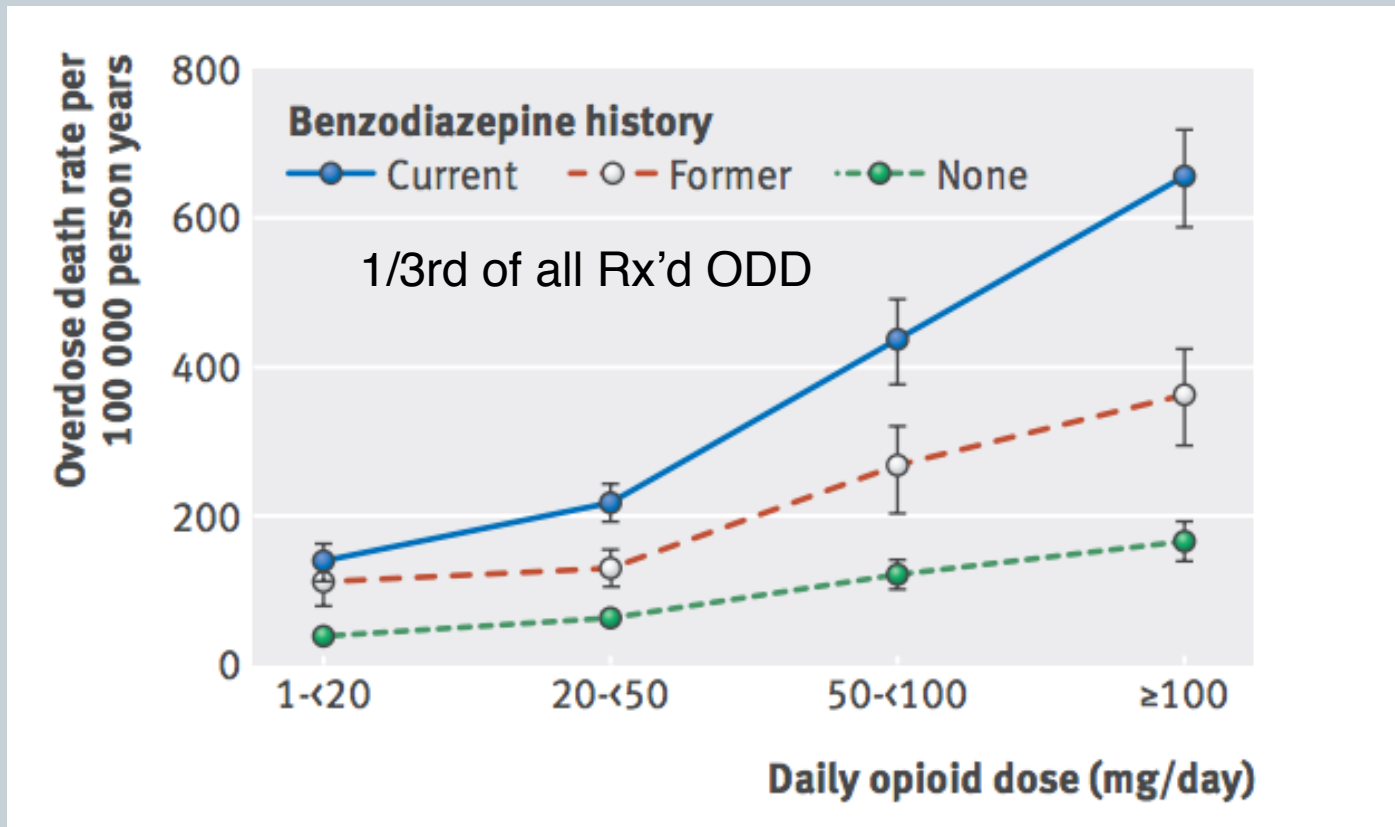


1/3rd of all Rx'd ODD

[www.cdc.gov/mmwr/preview/mmwrhtml/mm6126a5.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6126a5.htm)

# Co-prescribed Benzodiazepines as a Risk Factor for Overdose Death

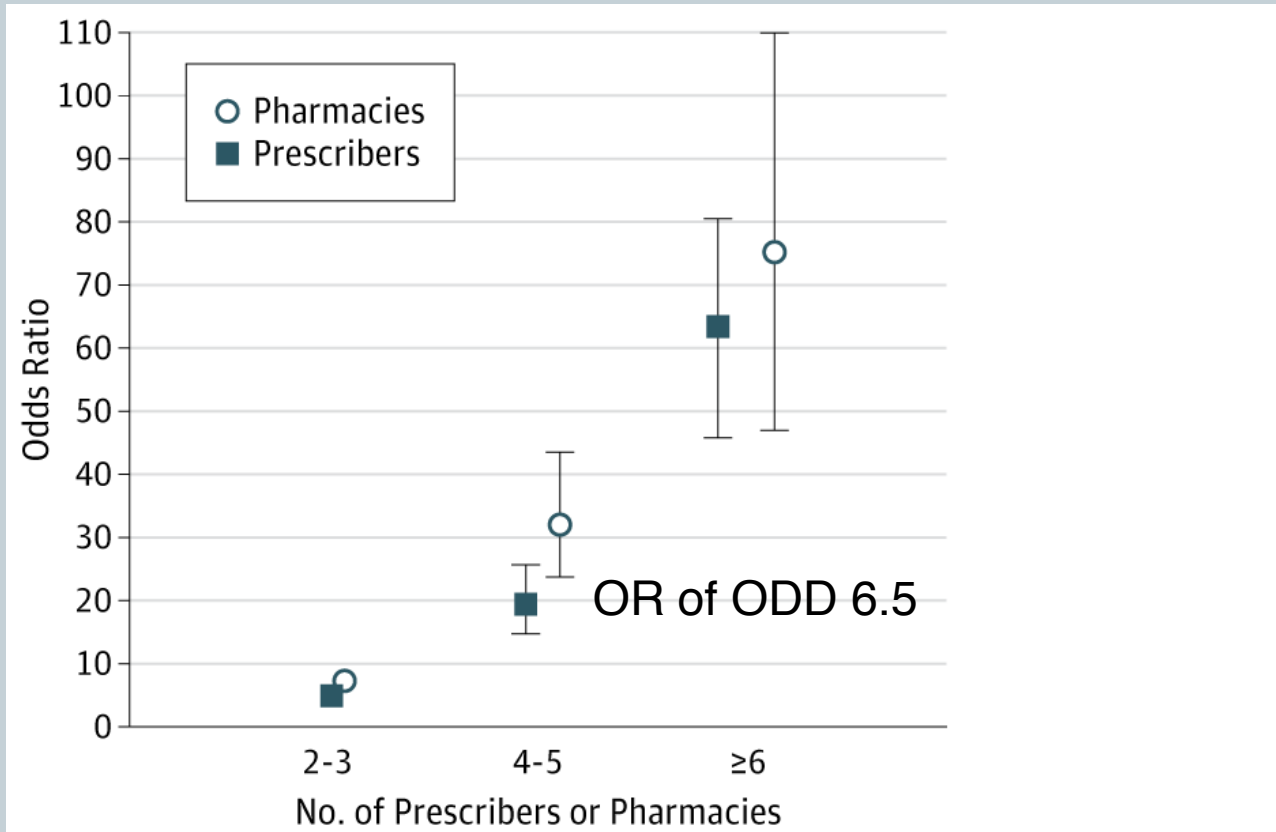
15



<http://www.ncbi.nlm.nih.gov/pubmed/26890165>

# ≥4 Pharmacies or Prescribers

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<http://archinte.jamanetwork.com/article.aspx?articleid=1840033>



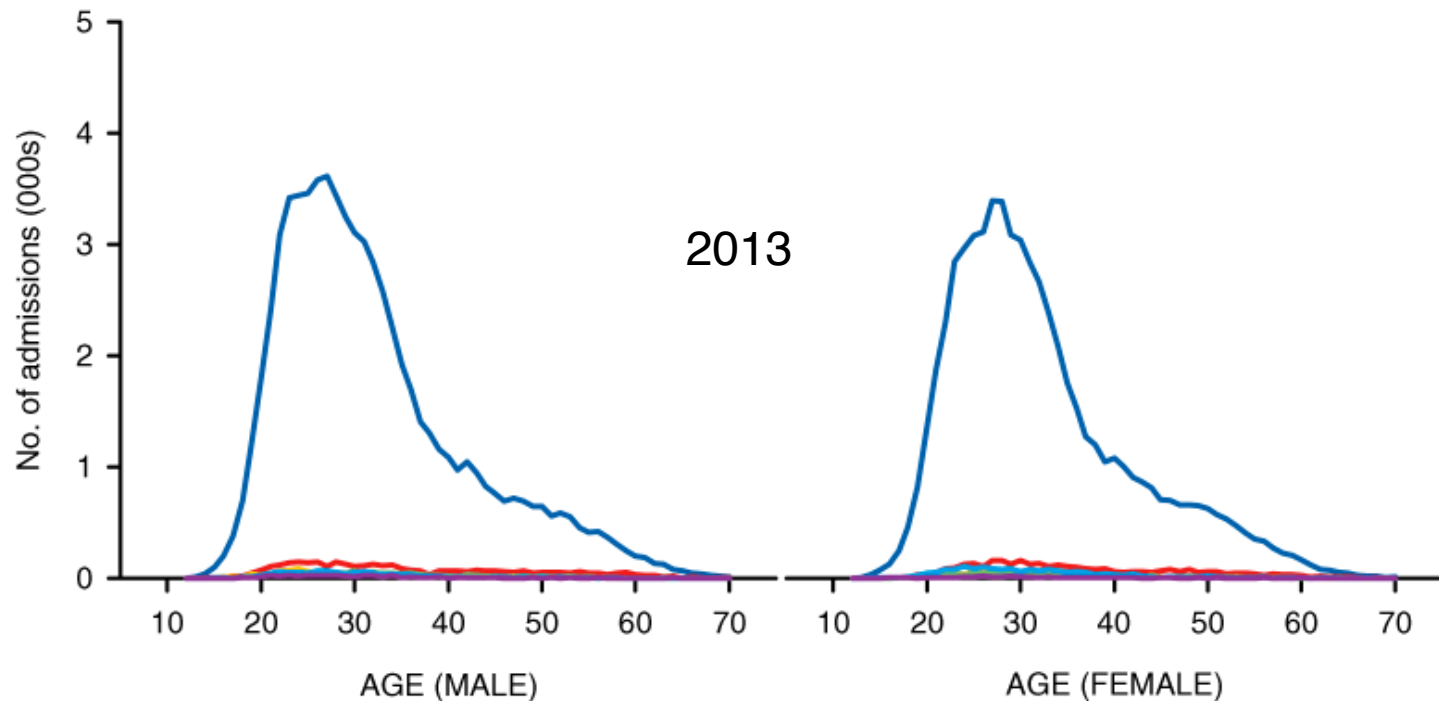
# Selected Risk Factors for Addiction DMS-V “Opioid Use Disorder”

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1. Age
2. Length of Exposure
3. Dose

# Inpatient Addiction Treatment By Age

Figure 9. Non-heroin opiate admissions, by gender, age, and race/ethnicity: 2013

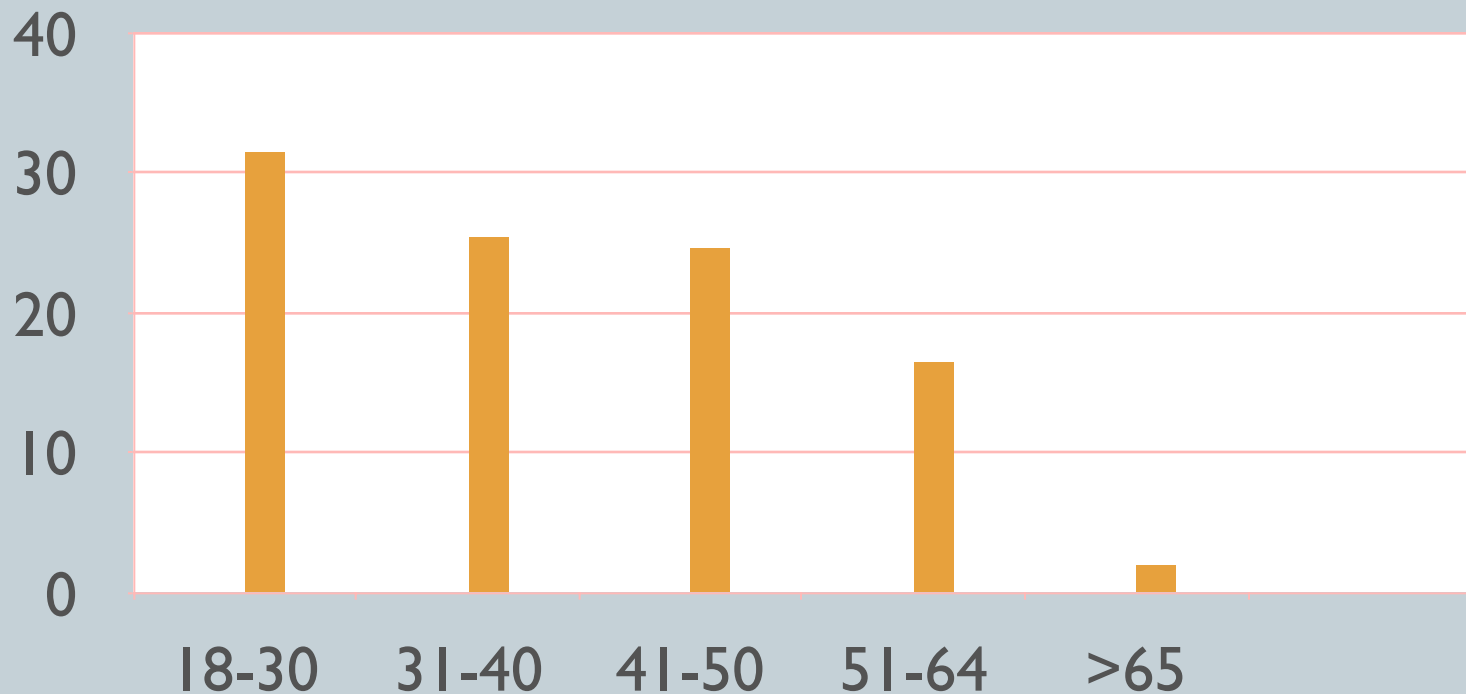


[http://www.samhsa.gov/data/sites/default/files/2013\\_Treatment\\_Episode\\_Data\\_Set\\_National/2003\\_2013\\_Treatment\\_Episode\\_Data\\_Set\\_National\\_Body.html](http://www.samhsa.gov/data/sites/default/files/2013_Treatment_Episode_Data_Set_National/2003_2013_Treatment_Episode_Data_Set_National_Body.html)

# Addiction Diagnosis by Age

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TROUP STUDY N = 570K

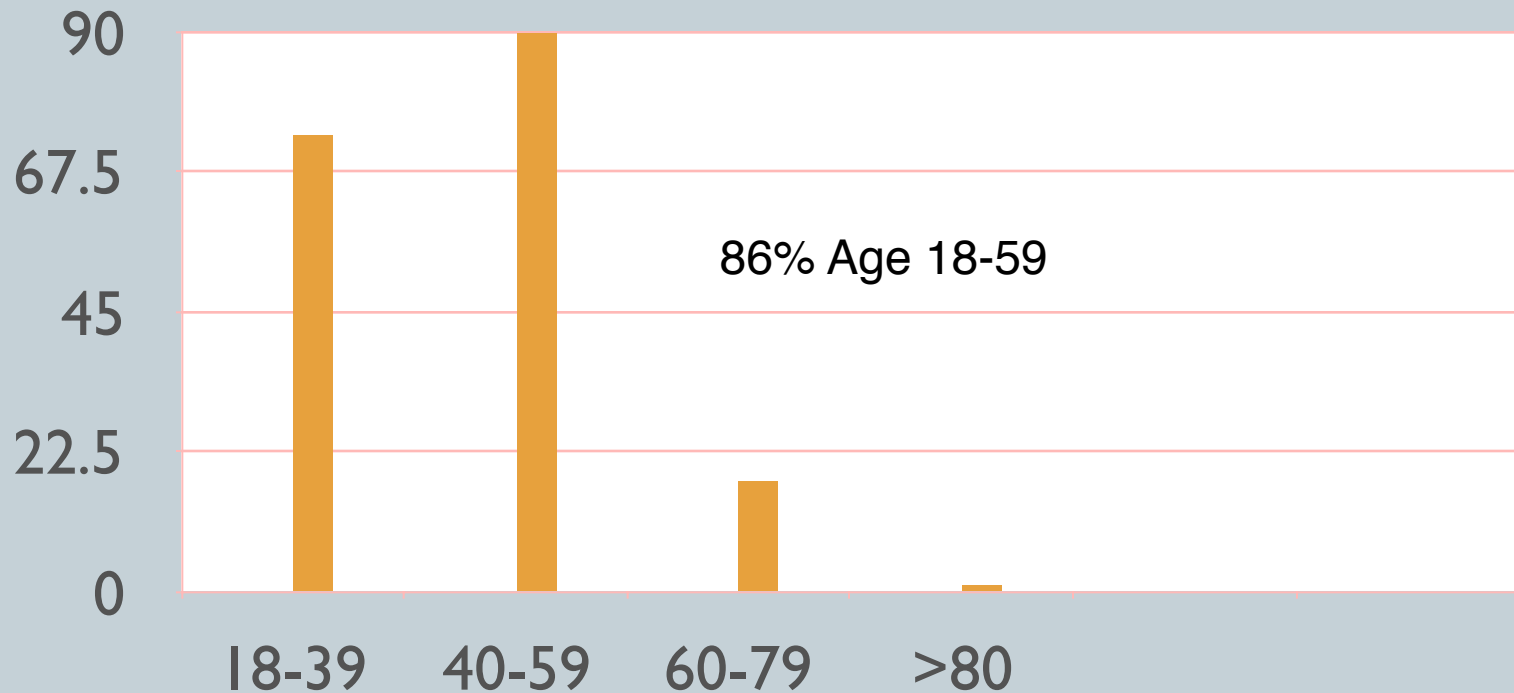


<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4032801/>

# OR Medicaid Opioid Rx's by Age

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Top 10% Prescribers Rx'd 80% of All Opioids



<http://www.ncbi.nlm.nih.gov/pubmed/26766755>

# Length of Exposure $\geq$ 3mo

21

TROUP STUDY N = 570K

J Gen Intern Med. 2011 Dec;26(12):1450-7. doi: 10.1007/s11606-011-1771-0. Epub 2011 Jul 13.

## Long-term chronic opioid therapy discontinuation rates from the TROUP study.

Martin BC<sup>1</sup>, Fan MY, Edlund MJ, Devries A, Braden JB, Sullivan MD.

 Author information

$\pm$ 70% Stay on Opioids 5yrs

### Abstract

**OBJECTIVE:** To report chronic opioid therapy discontinuation rates after five years and identify factors associated with discontinuation.

**METHODS:** Medical and pharmacy claims records from January 2000 through December 2005 from a national private health network (HealthCore), and Arkansas (AR) Medicaid were used to identify ambulatory adult enrollees who had 90 days of opioids supplied. Recipients were followed until they discontinued opioid prescription fills or disenrolled. Kaplan Meier survival models and Cox proportional hazards models were estimated to identify factors associated with time until opioid discontinuation.

**RESULTS:** There were 23,419 and 6,848 chronic opioid recipients followed for a mean of 1.9 and 2.3 years in the HealthCore and AR Medicaid samples. Over a maximum follow up of 4.8 years, 67.0% of HealthCore and 64.9% AR Medicaid recipients remained on opioids. Recipients on high daily opioid dose (greater than 120 milligrams morphine equivalent (MED)) were less likely to discontinue than recipients taking lower doses: HealthCore hazard ratio (HR) = 0.66 (95%CI: 0.57-0.76), AR Medicaid HR = 0.66 (95%CI: 0.50-0.82). Recipients with possible opioid misuse were also less likely to discontinue: HealthCore HR = 0.83 (95%CI: 0.78-0.89), AR Medicaid HR = 0.78 (95%CI: 0.67-0.90).

**CONCLUSIONS:** Over half of persons receiving 90 days of continuous opioid therapy remain on opioids years later. Factors most strongly associated with continuation were intermittent prior opioid exposure, daily opioid dose  $\geq$  120 mg MED, and possible opioid misuse. Since high dose and opioid misuse have been shown to increase the risk of adverse outcomes special caution is warranted when prescribing more than 90 days of opioid therapy in these patients.

<http://www.ncbi.nlm.nih.gov/pubmed/21751058>

# Risk of Dose & Length of Exposure

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## TROUP Study 570K Individuals 2000-2005

*Clin J Pain* • Volume 30, Number 7, July 2014

*Opioids and OUDs Among Individuals With CNCP*

**TABLE 3.** Variables Associated With Incident OUDs

Variables†		Unadjusted OR (95% CI)	Adjusted OR (95% CI)
Opioid dose and days			
No opioid use (reference)		1.00	1.00
Low dose, acute	0-36mg	3.31 (2.54-4.31)***	3.03 (2.32-3.95)***
Low dose, chronic		17.63 (12.33-25.20)***	14.92 (10.38-21.46)***
Med dose, acute	37-120mg	3.04 (2.30-4.01)***	2.80 (2.12-3.71)***
Med dose, chronic		35.19 (24.75-50.02)***	28.69 (20.02-41.13)***
High dose, acute	>120mg	2.68 (1.45-4.98)**	3.10 (1.67-5.77)***
High dose, chronic		171.95 (105.97-279.00)***	122.45 (72.79-205.99)***



<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4032801/>

# Harm Reduction Strategies

# Identify At Risk Patients

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1. Morphine Equivalent Dose  $\geq$  120mg/day
2. Methadone
3. Chronic opioid use [ $\geq$  90days]
4. Opioid and co-prescribed benzodiazepine
5.  $\geq$  4 or more Rx'ers or Pharmacies in 1yr



# Prescription Drug Monitoring Program

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OREGON.gov

## Oregon Prescription Drug Monitoring Program



Home

Access System

Help

Quick Links

### Oregon Healthcare Providers and Pharmacists Query Site

The Oregon Prescription Drug Monitoring Program (PDMP) is a tool to help healthcare providers and pharmacists provide patients better care in managing their prescriptions. Oregon Revised Statute 431.962 requires the Oregon Health Authority to establish and maintain a PDMP system for the reporting of all Schedules II, III and IV controlled substances dispensed by Oregon-licensed pharmacies to Oregon residents. The protected health information is collected and stored securely. The program was started to support the appropriate use of prescription drugs. The information is intended to help people work with their healthcare providers and pharmacists to determine what medications are best for them.

The Oregon Health Authority grants system access accounts to licensed healthcare providers and pharmacists and their staff. By law access to PDMP information by authorized system users is limited to patients under their care.



Copyright © 2013 Health Information Designs, LLC

If you need further assistance, please contact the [PDMP Help Desk](#)

Oregon Prescription Monitoring Program - IPE

800 NE Oregon St, Suite 772

Portland, OR 97232

Phone: (971) 673-0741 / Fax: (971) 673-0990 / TTY: (971) 673-0372

Email: [pdmp.health@state.or.us](mailto:pdmp.health@state.or.us)

<http://www.orpdmp.com/health-care-provider/>

# PDMP Prescriber Dashboard

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**OREGON.gov** Oregon Prescription Drug Monitoring Program

Home **Query** Report Queue User Management Help Quick Links Log Out

**Recipient Query**  
Prescriber History Query  
Prescriber DEA Query  
**Prescriber Dashboard**

**Oregon Healthcare Providers and Pharmacists Query Site**

**Query Creation Tip**

Make your query as general as possible and then drill down to more specific information once you have identified the person for whom you are looking. For example, you could enter the last name of the individual, the first letter of the first name, and a birth date, and then click Next. When the preliminary results are displayed on the screen, you can highlight the person that you want to query and then click Submit to submit the query for processing.

If you enter a specific birth date for an individual and the query results are blank, click the Within field just below the Date of Birth field and resubmit the query with a wider date range, for example, within two years of birth date, to create a query with broader search criteria.

Once you have submitted the query for processing, you will be redirected to the Report Queue. In the Report Queue, click the Job Sequence ID number to view the report you requested. If the Job Sequence ID is not a hyperlink, click your browser's refresh button. The Job Sequence ID will appear as a hyperlink when the report is ready for viewing.

**Oregon Health Services**  
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If you need further assistance, please contact the PDMP Help Desk

Oregon Prescription Monitoring Program - IPE  
800 NE Oregon St, Suite 772  
Portland, OR 97232  
Phone: (971) 673-0741 / Fax: (971) 673-0990 / TTY: (971) 673-0372  
Email: [pdmp.health@state.or.us](mailto:pdmp.health@state.or.us)

1.  $\geq 120\text{MED}$
2. Methadone  $\geq 40\text{mg}$
3. Opioid  $\geq 90\text{d}$
4. Opioid + Benzodiazepine
5. Rx from  $\geq 4$  Prescribers or Pharmacies

# Prescription Drug Monitoring Program

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County	MD/DO	PDMP Accounts	% Participation
Clatsop	146	77	53%
Multnomah	4,988	2151	43%
Lincoln	21	8	38%
*Tillamook	10	1	10%
*Baker	78	8	10%
*Linn	197	53	27%

[http://www.orpdmp.com/orpdmpfiles/12\\_2015\\_PDMP\\_YTD.pdf](http://www.orpdmp.com/orpdmpfiles/12_2015_PDMP_YTD.pdf)

# Opioid Dose Calculator

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## Opioid Dose Calculator

Patient's Name:

Today's Date: April 9, 2016

This calculator can be used as a web-based tool on mobile devices. Please refer to your device's instructions (or refer here: [Android](#) or [iPhone/iPad](#)) to learn how to add this calculator to your home screen for quick and easy access.

**Instructions:** Fill in the mg per day\* for whichever opioids your patient is taking. The web page will automatically calculate the total morphine equivalents per day.

Opioid (oral or transdermal):	mg per day: *	Morphine equivalents:
Codeine	<input type="text" value="0"/>	
Fentanyl transdermal (in mcg/hr)	<input type="text" value="0"/>	
Hydrocodone	<input type="text" value="0"/>	
Hydromorphone	<input type="text" value="0"/>	
Methadone	<input type="text" value="0"/>	
Morphine	<input type="text" value="0"/>	
Oxycodone	<input type="text" value="0"/>	
Oxymorphone	<input type="text" value="0"/>	
Tapentadol	<input type="text" value="0"/>	
Tramadol	<input type="text" value="0"/>	
<b>TOTAL daily morphine equivalent dose (MED) = 0</b>		

\*NOTE: All doses expressed in mg per day with exception of fentanyl transdermal, which is expressed in mcg per hour

Calculate

Print

Reset

**CAUTION:** This calculator should NOT be used to determine doses when converting a patient from one opioid to another. This is especially important for fentanyl and methadone conversions. Equianalgesic dose ratios are only approximations and do not account for genetic factors, incomplete cross-tolerance, and pharmacokinetics.

This opioid dose calculator was developed by the Washington State Agency Medical Directors' Group to be used in conjunction with the Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain. For more info, please refer to the guideline at: [AMDG - Opioid Dosing](#)

For technical questions or comments, please contact: [AMDG IT Support](#)

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<http://agencymeddirectors.wa.gov/mobile.html>

# Examples of 120MED

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Fentanyl 50ucgh/hr

Buprenorphine 4mg

\*Methadone 40mg

Hydromorphone 30mg

Oxycodone/Oxycontin 80mg

Oxymorphone 40mg

Morphine 120mg

Codeine 800mg

# MED > 90 Consider Rx'ing Nasal Naloxone

30

1. SB 384 legalized for lay administration in 2013.
2. Stock in your pharmacies.
3. Some patients must pay out of pocket (\$35.00 -\$75.00.)



<http://www.amphastar.com/assets/naloxone.pdf>

# Consider a Data-2000 Waiver to Prescribe Buprenorphine

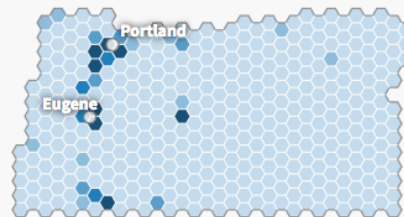
31

17K MD/DO in OR but only 400 with Wavier [2%]

## Oregon

For every 1,000 Oregon residents, **9.1 more people** were addicted to opiates in 2012 than could be treated.

2012	People / 1,000 residents
Patient Capacity	3.7
Estimated Opioid Abuse	12.8



0-1 2-3 4-7 8-10 11+  
certified doctors

<http://projects.huffingtonpost.com/dying-to-be-free-heroin-treatment/opioid-abuse-outpace-treatment-capacity>

# Buprenorphine

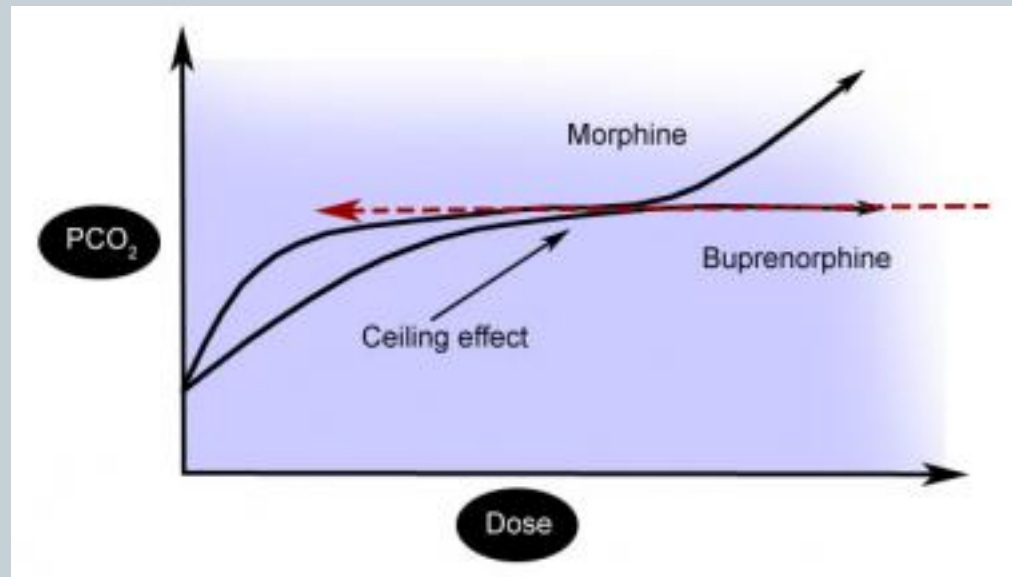
32

1. A schedule III drug, partial mu agonist
2. FDA approved for both pain - Butrans/Belbuca - and addiction - Suboxone/Subutex.
3. Ceiling effect for respiratory suppression.



# Buprenorphine's Ceiling Effect for Respiratory Suppression

33

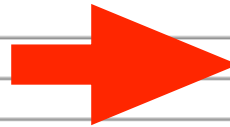


# Buprenorphine & Overdose Deaths

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**TABLE. Drug-related deaths involving opioids, by type of opioid — Drug Abuse Warning Network Medical Examiner System, 13 states, 2009**

Opioid	No.	Death rate per 100 kg MME	RR	(95% CI)
<b>All deaths</b>				
Buprenorphine	20	0.8	0.02	(0.01–0.04)
Fentanyl	364	7.7	0.28	(0.25–0.32)
Hydrocodone	550	14.3	0.42	(0.38–0.47)
Hydromorphone	74	9.1	0.27	(0.21–0.34)
Morphine	824	20.2	0.64	(0.58–0.70)
Oxycodone	1,097	8.7	0.26	(0.24–0.28)
Methadone	1,034	33.6	1.00	referent
<b>Total*</b>	<b>3,294</b>	<b>10.4</b>		
<b>Single-drug deaths</b>				
Buprenorphine	2	0.1	0.01	(0.00–0.03)
Fentanyl	99	2.1	0.26	(0.21–0.33)
Hydrocodone	42	1.1	0.11	(0.08–0.16)
Hydromorphone	4	0.5	0.05	(0.02–0.14)
Morphine	153	3.8	0.41	(0.34–0.50)
Oxycodone	150	1.2	0.12	(0.10–0.15)
Methadone	298	9.7	1.00	referent
<b>Total</b>	<b>748</b>	<b>2.4</b>		



**Abbreviations:** MME = morphine milligram equivalent; RR = rate ratio; CI = confidence interval.

\* Counts for each opioid might not sum to the total shown for all deaths because some deaths involved more than one opioid.

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6126a5.htm>

# Buprenorphine Substitution for High Dose Opioids

35

Pain Med. 2014 Dec;15(12):2087-94. doi: 10.1111/pme.12520. Epub 2014 Sep 12.

**Conversion from high-dose full-opioid agonists to sublingual buprenorphine reduces pain scores and improves quality of life for chronic pain patients.**

Daitch D<sup>1</sup>, Daitch J, Novinson D, Frey M, Mitnick C, Pergolizzi J Jr.

 **Author information**

**CONCLUSION:** Average pain scores decreased from 7.2 to 3.5, and quality of life scores increased from 6.1 to 7.1 for 35 patients converted from high-dose full-opioid agonists to SL buprenorphine therapy for more than 60 days. Clinicians should consider buprenorphine SL conversion for all patients on high-dose opioids, particularly patients with severe pain (7-10) unrelieved by their current opioid regimen or patients for whom the clinician does not feel comfortable prescribing high-dose opioids.

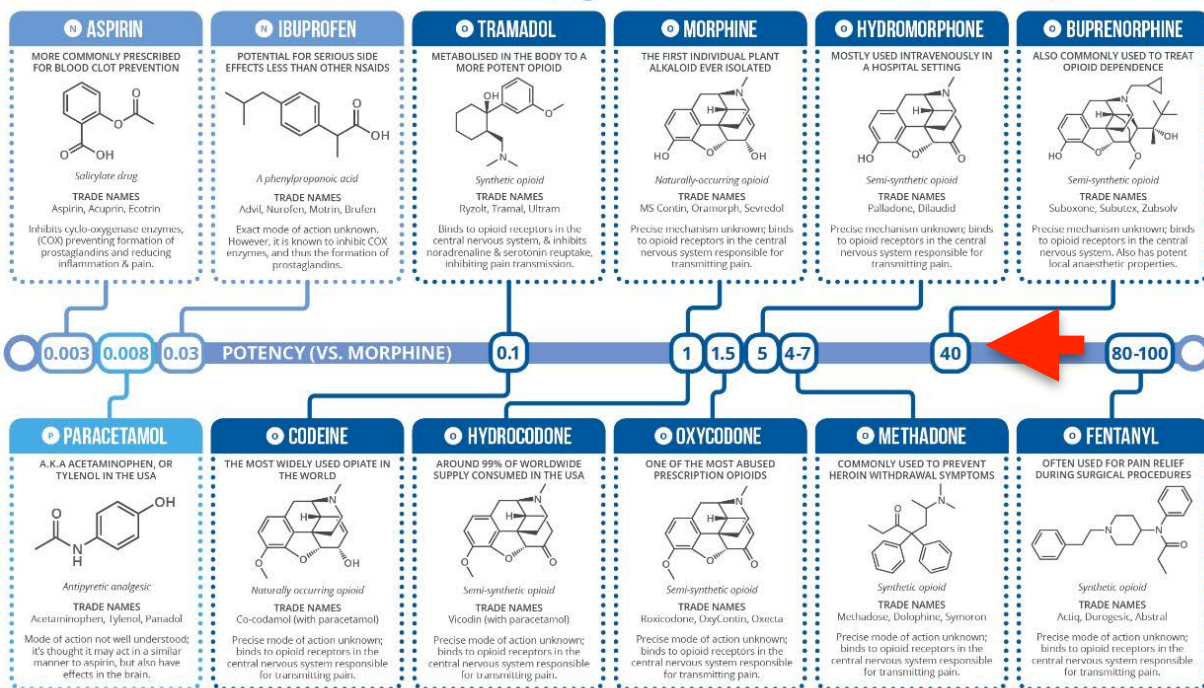
<http://www.ncbi.nlm.nih.gov/pubmed/25220043>

# Buprenorphine Is A Powerful Analgesic

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## A BRIEF GUIDE TO SELECTED COMMON PAINKILLERS

THERE ARE TWO MAIN CLASSES OF PAINKILLERS - PARACETAMOL IS AN EXCEPTION. **Key:** **N** NON-STEROIDAL ANTI-INFLAMMATORY DRUGS **P** PARACETAMOL **O** OPIOID ANALGESICS



**Note:** Potency values are for oral administration. Numeric measures of potency are variable; the figures given are merely general approximations, and can be affected by a number of factors.



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<http://www.compoundchem.com/2014/09/25/painkillers/>

# Sample Cases

# Case 1: Teresa

38

75y/o retiree with diffuse OA. Lives alone in Seaside. Uses Oxycodone-APAP 10/325, five per day (MED 70). No h/o aberrant behavior or addiction.



# Case 1: Teresa

39

Teresa reports that the medications give her comfort. She was started on her current dose years ago.

**Recommendations:**  
Continue as prescribed.



# Case 2: Cleatus

40



68y/o retired logger with failed back surgery syndrome. Lives with spouse Rx'd Methadone 10mg (MED~120). No h/o addiction or aberrant behaviors.



# Case 2: Cleatus

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## **Recommendations:**

Call Cleatus & his spouse in. Explain that his dose and medication are both unsafe and will need to change.

- a. Prescribe nasal naloxone & train spouse in assembly and use.
- b. Offer a conversion to Morphine Sulfate ER 75mg QD (30,15,30) at his next refill.

<http://www.slideshare.net/101N/opioid-withdrawal-attenuation-cocktail>

# Case 3: Jane

42

55y/o woman with FMS. Lives alone in Tillamook. Uses OxyContin 30mg PO BID (MED 80), and alprazolam 0.5mg po QID. No h/o aberrant behavior or addiction.



# Benzodiazepine Alternatives

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## MODIFIED FROM TIP 54 SAMHSA: BENZODIAZEPINE ALTERNATIVES

### Alternatives to Benzodiazepines for Sleep

1. Trazodone: 50mg – 100mg po QHS
2. Mirtazapine: 15mg po QHS
3. Amitriptyline: 10mg po QHS
4. Nortriptyline: 25mg po QHS
5. Trimipramine 25mg po QHS
6. Doxepin: 10mg – 25mg po QHS
7. Cyclobenzaprine: 10mg po QHS
8. Benadryl: 50mg po QHS
9. Melatonin: 5mg po QHS
10. Hydroxyzine: 25-50mg po QHS
11. Tizanidine: 4mg po QHS

### Alternatives to Benzodiazepines for Anxiety

1. Citalopram: 20mg po QD
2. Pregabalin: Escalating dose over 8wks to 450mg po QD.
3. Gabapentin: Escalating dose over 8wks to 2700mg po QD.
4. Lamotrigine: (PTSD) Escalating dose over 8wks to 500mg po QD
5. Buspirone: 7.5mg po BID increase by 5mg Q 3D, to 15mg po BID. Maximum daily dose 60mg.
6. Clonidine 0.1mg po can repeat x 1 (Caution with BP)
7. Hydroxyzine: 25-50mg po
8. Sertraline: 25mg QD escalating to 50po QD after 1wk

### Alternatives to Benzodiazepines for Panic Attacks

Acute: Clonidine 0.1mg po can repeat x 1 (Caution with BP)

Acute : Propranolol 10mg can repeat x 1 (Caution with BP)

Acute: Atenolol 25mg po x 1 (Caution with BP)

Valproic Acid: 500mg to 2000mg Escalating dose over 8wks.

### Prophylaxis for Panic Attacks

Propranolol 10mg po TID. (Caution with BP)

Atenolol 25mg po BID (Caution with BP)

<http://www.slideshare.net/101N/alternatives-to-benzodiazepines-60701295>

# Case 3: Jane

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## Recommendations:

Call Jane in to clinic.

Explain that the combination of alprazolam and Oxycodone is unsafe.

- a. Offer a conversion to clonazepam 2mg BID.
- b. Taper clonazepam by .5 -1mg/mo over 4-8mo.
- c. Offer non-benzodiazepine alternatives for anxiety/sleep/panic attacks.



[www.slideshare.net/101N/alternatives-to-benzodiazepines-60678319](http://www.slideshare.net/101N/alternatives-to-benzodiazepines-60678319)

# Case 4: Luc

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49y/o married restaurant owner with chronic migraine. Prescribed Oxycodone 5mg BID, 30/mo over many years. No h/o addiction or aberrant behavior. Recent review of the PDMP with at a f/u visit reveals visits to 6 other prescribers over the past 3mo for opioids. Patient acknowledges that he is overusing pain medication and wants your help in getting off opioids entirely.

# Case 4: Luc

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## Recommendations:

Use your data-2000 waiver to offer Luc treatment of opioid use disorder. Stop opioids.

- a. Offer conversion to buprenorphine (Suboxone/Subutex) with a planned 3mo taper off. (8mg QD, 4mgQD, 4mg QOD)
- b. Offer an addiction counseling referral.
- c. Continue to see frequently for followups with both urine or saliva drug screens and frequent checks of the PDMP to ensure adherence.

# Resources

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## **Alternatives to Benzodiazepines:**

<http://www.slideshare.net/101N/alternatives-to-benzodiazepines-60701295>

## **Oregon Prescription Drug Monitoring Signup:**

<http://www.orpdmp.com/health-care-provider/>

## **Free Buprenorphine X-Wavier Courses:**

Friday 4/29 Portland, OR & Thursday 5/19 Medford, OR,  
To register contact Marie Payment: [payment@ohsu.edu](mailto:payment@ohsu.edu)

## **Nasal Naloxone:**

<http://www.amphastar.com/assets/naloxone.pdf>

<http://www.narcannasalspray.com/nns-4-mg-dose/how-to-use-nns/>

# Resources

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## **Oregon Drug & Alcohol Services by County:**

<https://www.oregon.gov/oha/amh/publications/provider-directory.pdf>

## **Oregon Pain Guidance May Conference:**

<http://cmetracker.net/ASANTE/doSelectForm>

## **Withdrawal Attenuation Cocktail:**

<http://www.slideshare.net/101N/opioid-withdrawal-attenuation-cocktail>

## **DMS-V Opioid Use Disorder Criteria**

<http://www.slideshare.net/101N/dmsv-opioid-use-disorder-criteria>



# Special Thanks To



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