HOW TO SET UP A PAIN MANAGEMENT PRACTICE IN YOUR PRIMARY CARE CLINIC

WITHOUT THE PITFALLS

HISTORY OF PAIN MANAGEMENT

- PRACTICED BY PRIMARY CARE PHYSICIANS AND OTHER SUBSPECIALTIES, SURGICAL SPECIALTIES
- 1992-FIRST CREDENTIALING EXAM BY THE ACPM (NAME LATER CHANGED TO ABPM)

DEFINITION OF PAIN

pain
pān/
noun
physical suffering or discomfort caused by illness or injury.

DURATION OF PAIN

- **ACUTE PAIN:** pain of less than 3 to 6 months duration
- **CHRONIC PAIN**: pain lasting for more than 3-6 months, or persisting beyond the course of an acute disease, or after tissue healing is complete.
- **ACUTE-ON-CHRONIC PAIN**: acute pain flare superimposed on underlying chronic pain.

TYPES OF PAIN

- **Nociceptive**: represents the normal response to noxious insult or injury of tissues such as skin, muscles, visceral organs, joints, tendons, or bones.
  - Examples include:
    - Somatic: musculoskeletal (joint pain, myofascial pain), cutaneous; often well localized
    - Visceral: hollow organs and smooth muscle; usually referred
- **Neuropathic**: pain initiated or caused by a primary lesion or disease in the somatosensory nervous system.
  - Sensory abnormalities range from deficits perceived as numbness to hypersensitivity (hyperalgesia or allodynia), and to paresthesias such as tingling.
  - Examples include, but are not limited to, diabetic neuropathy, postherpetic neuralgia, spinal cord injury pain, phantom limb (post-amputation) pain, and post-stroke central pain.
- **Inflammatory**: a result of activation and sensitization of the nociceptive pain pathway by a variety of mediators released at a site of tissue inflammation.
  - The mediators that have been implicated as key players are proinflammatory cytokines such IL-1-alpha, IL-1-beta, IL-6 and TNF-alpha, chemokines, reactive oxygen species, vasoactive amines, lipids, ATP, acid, and other factors released by infiltrating leukocytes, vascular endothelial cells, or tissue resident mast cells
  - Examples include appendicitis, rheumatoid arthritis, inflammatory bowel disease, and herpes zoster.

TYPES OF PAIN MEDICINE

- OTC: APAP, NSAIDS
- TRANSDERMAL PATCHES (LIDOCAINE/ DICLOFENAC)
- NEUROPATHIC AGENTS
- TCAs
- TOPICAL ANESTHETICS/ ANTI-INFLAMMATORIES
- ANTICONVULSANTS
- OPIOIDS

NARCOTIC PAIN MEDICATIONS

- Buprenorphine.....BELBUCA/ BUTRANS
- Codeine.....TYLENOL III
- Fentanyl.....DURAGESIC
- Hydrocodone.....LORCET
- Hydromorphone.....DILAUDID/ EXALGO
- Meperidine.....DEMEROL
- Methadone.....DOLOPHINE/ METHADOSE
- Morphine.....MS CONTIN
- Oxycodone.....PERCOCET
- Oxymorphone.....OPANA
- Tapentadol.....NUCYNTA
- Tramadol.....ULTRAM/ULTRACET

COMMON CAUSES OF PAIN

- DEGENERATIVE DISEASE
- ARTHRITIC CONDITIONS
- NEUROPATHIES
- VITAMIN DEFICIENCIES
- HORMONE DEFICIENCIES
- INFLAMMATORY DISEASE
- COMPLEX REGIONAL PAIN SYNDROME / RSD
- FIBROMYALGIA
- PSYCHOSOMATIC

DOCUMENTATION OF HISTORY

- CC: Patient presents for evaluation/follow-up of acute/chronic pain in……..
- HPI: Must include the following:
- Area
- Severity
- Chronicity
- Exacerbating/ Alleviating factors
- ADLs (be specific)
- Mood
- Effect on relationships
- Is current medication regimen providing adequate relief?
- ED or Hospital Admissions for pain
- Adverse effects of meds (nausea, sedation, constipation)
- Documentation of failed meds
- **SIGN PAIN MANAGEMENT CONTRACT**

Pain Management Contract

- This agreement relates to my use of controlled substances for chronic pain prescribed by a physician. I have been informed and understand the policies regarding the use of controlled substances. I understand that I will be provided controlled substances while actively participating in this program only if I adhere to the following conditions:
- 1. I will use the substances only as directed by my physician.
- 2. I will not expect to receive replacement medications for any medications that I have lost or have been stolen. A police report must be produced for any consideration of replacement of any lost or stolen medication.
- 3. I will receive controlled substances only from one physician. Information that I have obtained controlled substances from another physician without prior knowledge will lead to discontinuation of treatment.
- 4. I will not expect to receive additional medication prior to the time of my next scheduled refill, even if my prescription runs out.
- 5. I will accept generic brands of my prescription medication, where determined appropriate by my physician.
- 6. If it appears to the physician that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I will gradually taper my medication as directed by my prescribing physician.
- 7. I agree to submit to urine and blood screens to detect the use of nonprescribed controlled medications (including “street” drugs) and verify the presence of my prescribed medications at any time.
- 8. I will bring all my bottles, even if empty, to ALL my appointments.

Pain Management Contract, cont'd

- 9. I recognize that my chronic pain represents a complex problem, which may benefit from physical therapy, psychotherapy, and behavioral medicine strategies. I also recognize that my active participation in the management of my pain is extremely important. I agree to actively participate in all aspects of my treatment to maximize functioning and improve coping with my condition.
- 10. I agree to schedule and keep scheduled follow-up appointments with my physician at recommended intervals. I understand that failure to keep appointments may lead to discontinuation of treatment.
- 11. I am responsible for keeping track of the amount of medication that I have left and to plan ahead for arranging the refill of my prescriptions in a timely manner so I will not run out of medications.
- 12. I agree to use one pharmacy for filling all my prescriptions except in case of emergency.
- 13. I will agree to count my pills that I receive from pharmacy and will ensure that the correct amount is received. I understand that I will not expect my physician to cover me for any shortage of medication. Any shortage found must be discussed immediately upon my receiving the prescription with the pharmacist.
- 14. I agree to subject to random pill counts and urine drug testing.
- 15. If I violate any of the above conditions, my obtaining prescriptions and/or treatment may be terminated.

Pain Contract, cont'd

- 16. If I violate any of the above conditions and the violation involves obtaining controlled substances, or any prescription, for my pain condition from another individual, or, if I engage in any illegal activity such as altering a prescription, I understand that the incident may be reported by my physician. As deemed appropriate for the violation, my physician may report my violations to other physicians caring for me, local medical facilities, pharmacies, local police departments, and/or Drug Enforcement Agencies.
- 17. I can designate up to two other people to pick up my prescriptions. I understand that I must notify my physician in advance each and every time a prescription is refilled if an alternate person will be picking up the prescription. Failure to do this could result in the prescription not being released. The names of these people must be entered at the bottom of this contract.
- 18. This Controlled Substances Contract will become part of my permanent medical record.
- This agreement will supersede all other agreements.
- By signing below, I indicate that I understand and agree to all the terms of the above agreement. I have received a copy of this for my own records.
- **Patient: _____ Physician:_____**
- **Date and Time: _____ Date and Time:_____**
- Names of the 2 people that I designated to pick up my prescriptions
- #1_____ **#2**_____

OTHER DOCUMENTATION OF HISTORY

- PMH/ PSH
- PSYCH HISTORY: includes history of previous/present mental illness, suicide attempts, current suicidal/ homicidal ideations
- DEPRESSION SCREEN (at each visit)
- OPIOID RISK SCREEN (at initial evaluation)
- ABERRANT BEHAVIOR
- URINE DRUG SCREEN RESULTS
- UPDATE MEDICATION LIST AND PHARMACY
- CHECK CONTROLLED SUBSTANCE REPORT
- ALLERGIES
- FAMILY HISTORY
- SMOKING HISTORY/OTHER DRUG AND ALCOHOL HISTORY

DIAGNOSTIC TESTS, IMAGING and PREVIOUS PROCEDURES

(document date of procedure and findings)

- LABORATORY TESTING
- XRAYS
- ULTRASOUNDS
- CT SCANS
- MRIs
- MRAs
- EPIDURALS
- TRIGGER POINT INJECTIONS
- FACET JOINT INJECTIONS
- RADIOFREQUENCY ABLATIONS
- NERVE BLOCKS
- BOTOX INJECTIONS

DEPRESSION SCREENING SCALE

- Hamilton Depression Rating Scale (HDRS)
- Beck Depression Inventory (BDI)
- Patient Health Questionnaire (PHQ)
- Major Depression Inventory (MDI)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Zung Self-Rating Depression Scale (SDS)
- Geriatric Depression Scale (GDS)
- Cornell Scale for Depression in Dementia (CSDD)
- **(MINIMAL, MILD, MODERATE, SEVERE, BASED ON SCORE)**

ABUSE
definition of terms

- ***Substance misuse*** is the use of any drug in a manner other than how it is indicated or prescribed.
- ***Substance abuse*** is defined as the use of any substance when such use is unlawful or when such use is detrimental to the user or others.
- ***Addiction*** is a behavioral pattern of substance abuse characterized by overwhelming involvement with the use of a drug. It is generally understood to be a chronic condition from which recovery is possible; however, the underlying neurobiologic dysfunction, once manifested, is believed to persist. Addiction focuses on compulsive use of the drug that results in physical, psychological, and social harm to the user.
- ***Pseudoaddiction*** is seen in patients who are undermedicated and may demonstrate drug-seeking behaviors or try and self-manage unauthorized dosage increases in an attempt to find relief. Among many of these patients, once adequate relief from the pain is obtained, the drug-seeking behaviors, otherwise known as pseudoaddiction, disappear.
- ***Physical dependence*** is a common phenomenon, characterized with physical withdrawal symptoms when an opioid is discontinued.

Definition of terms, cont'd

- ***Tolerance*** is also a commonly observed phenomenon when taking opioids over time in which the individual becomes used to the drug and has a need for increasing doses to maintain the same effect. Both physical dependence and tolerance are typically found in opioid users and are unrelated to true addiction.
- ***Aberrant drug-related behavior (or diversion)*** is behavior suggestive of a substance abuse and/or addiction disorder. Examples are selling prescription drugs, prescription forgery, stealing or "borrowing" drugs from others, injecting oral formulations, obtaining prescription drugs from nonmedical sources, multiple episodes of prescription "loss," repeatedly seeking prescriptions from other clinicians, evidence of deterioration in function (work, home, and family), and repeated resistance to change therapy despite evidence of physical and psychological problems.

ABUSE RISK
determined by

- AGE
- SEX
- URINE DRUG SCREEN ABERRANCY (1 in 12 mos, 1 in 6 mos, etc,)
- NC CSR (with multiple prescribers, other controlled substances, viz., benzos, ambien, amphetamines, barbiturates, etc,)
- MULTIPLE ER VISITS (for pain management)
- ABERRANT BEHAVIOR (missed appts, not bringing bottles, replacing opioids with similar looking meds, peeling off labels, etc,)
- PAIN CONTRACT violations
- SUBSTANCE ABUSE HISTORY
- MEDICAL AND PSYCHIATRIC CO-MORBIDITIES
- (mild, moderate, severe, based on scale)

OPIOID RISK TOOLS

- Screener and Opioid Assessment for Patients in Pain-Revised (SOAPP-R).
- Current Opioid Misuse Measure (COMM).
- Opioid Risk Tool (ORT).
- Diagnosis, Intractability, Risk, and Efficacy (DIRE).
- Screening Instrument for Substance Abuse Potential (SISAP).
- The Pain Assessment and Documentation Tool (PADT).

RISK FACTORS FOR OPIOID MISUSE

- Family history of substance abuse.
- Personal history of substance abuse.
- Young age.
- History of criminal activity and/or legal problems including DUIs.
- Regular contact with high-risk people or high-risk environments.
- Problems with past employers, family members, and friends (mental disorder).
- Risk taking or thrill seeking behavior.
- Heavy tobacco use.
- History of severe depression or anxiety.
- Psychosocial stressors.
- Prior drug and/or alcohol rehabilitation.

OPIOID COMPLIANCE CHECKLIST

- Print name: _____
- Date: _____
- Please answer the following questions as honestly as possible:
- Over the past month have you:
- Taken your opioid medication other than the way they were prescribed? Yes No
- Used more than one pharmacy to fill your opioid prescriptions? Yes No
- Received opioid prescriptions from more than one provider? Yes No
- Lost or misplaced your opioid medication? Yes No
- Run out of your pain medication early? Yes No

OPIOID COMPLIANCE CHECKLIST, cont'd

- Missed any scheduled medical appointments? Yes No
- Borrowed opioid medication from others? Yes No
- Used any illegal or unauthorized substances? Yes No
- Taken the highest possible degree of care of your prescription medication? Yes No
- Taken any unauthorized substance that might be found in your urine? Yes No
- Been involved in any activity that may be dangerous to you or someone else if you felt drowsy or were not clear thinking? Yes No
- Been completely honest about your personal drug use? Yes No
- Please explain anything further below. Thank you.
- Signed: _____
- Date: _____

LABS AND OTHER TESTS

- ESR
- hsCRP
- ANA
- ANTI CCP (**Anti**-cyclic citrullinated peptide)
- RA FACTOR
- TSH, TESTOSTERONE, ESTRADIOL
- URIC ACID
- VITAMIN D, VITAMIN B12
- 12 LEAD EKG, ECHO AND/OR CARDIOLYTE STRESS TEST
- SLEEP STUDY (if patient has the appropriate body habitus or is >50 lbs overweight)
- FULL PFTs with DLCO diffusing capacity or transfer factor of the lung for carbon monoxide (CO), otherwise known as single breath diffusion
- CXR

Explanation of previous slide

- BLOOD TESTS ARE NECESSARY FOR THOSE PATIENTS WHO PRESENT WITH ARTHRALGIAS, MYALGIAS, NEUROPATHIC PAIN, OR A PREVIOUS DIAGNOSIS OF FIBROMYALGIA
- A SLEEP STUDY IS REQUIRED FOR OVERWEIGHT/ OBESE PATIENTS WITH A HISTORY OF SNORING OR INTERRUPTED SLEEP, DAYTIME SOMNOLENCE, OR A PREVIOUS DIAGNOSIS OF OSA, IF TESTING WAS MORE THAN 5 YEARS AGO OR IF PT HAS HAD SIGNIFICANT WEIGHT GAIN SINCE THE INITIAL TESTING
- CXR AND PFTs WITH DLCO IS REQUIRED FOR PATIENTS WHO HAVE A TOBACCO HISTORY, SOB, OR HAVE A PREVIOUS DIAGNOSIS OF COPD, WITH PFTs MORE THAN 3 YEARS AGO, WHOSE SOB HAS WORSENED
- CXR, EKG, ECHO FOR PTS WITH SOB AT REST OR ON EXERTION, WITH A HISTORY OF CAD OR CHF
- CST FOR PTS WITH ESTABLISHED DIAGNOSIS OF CAD, WHO HAVE NOT HAD ONE FOR >3 YRS OR WHO HAVE UNDIAGNOSED CP OR WITH OTHER CARDIAC RISK FACTORS

URINE DRUG SCREENS

- **POC (POINT OF CARE):**tests include Methadone, Opiates, Buprenorphine THC and Amphetamines for screening and has available results in minutes. The utilization of a **POC** urinary **drug** screen **test** in pain management is very limited and the information it provides is often not sufficient to enable proper patient consultation. **Can be quite inaccurate.**
- **IMMUNOASSAY:** Immunoassay tests use antibodies to detect the presence of drugs. These tests can be processed rapidly, are inexpensive, and are the preferred initial test for screening. The most commonly ordered drug screens are for **cocaine metabolites, amphetamines, phencyclidine, marijuana metabolites, and opiate metabolites.** The accuracy of immunoassay testing varies, with a high predictive value for marijuana and cocaine, and a lower predictive value for opiates and amphetamines. A number of commonly prescribed medications can cause **false positive immunoassay tests.**
- **LCMS (LIQUID CHROMOTOGRAPHY, MASS SPECTROMETRY):** confirmatory test for the fast detection and identification of **301 forensically important drugs,** e.g. tranquilizers (benzodiazepines), hypnotics, drugs of abuse (opiates, cocaine, amphetamines, cannabinoids), antidepressants, neuroleptics. **Highly accurate.**

FALSE POSTIVE AND FALSE NEGATIVE UDS

- False positive tests can occur with less accurate testing methods and with certain medications. If POC or IA are positive, it is imperative to send out for further testing. Exceptions can be made for self-pay patients but caution should be exercised and repeat testing required, with Rxs written for no more than one week at a time. Random urine drug tests should also be done to ensure compliance.
- The concern for false-negative results is most acute when testing for adherence to a prescribed therapeutic regimen. Adherence can be masked by dilute urine, time since ingestion, quantity ingested, or the laboratory's established threshold limits. Discussing adherence with the patient is helpful, but testing for a particular medication may be necessary to resolve issues of diverting the prescribed medication. Negative results in a dilute urine specimen make interpretation problematic.

URINE DRUG TEST "TRICKS" and HOW TO SOLVE THE ISSUE

- Most commonly seen: bringing in someone else's urine in a condom or other container, hidden in the clothes. This is manifested by either "cold" or "hot" urines, (Temps<92'F or >99.9'F), abnormal pH, creatinine and/or oxidants (adding other substances to the urine or bringing in fake urine).
- Sprinkling medication into the urine at time of collection.
- SOLUTION: Observed urines, random urines, repeated urines on the same day. Confront the patient and ask why they felt the need to bring in a sample or sprinkle med. Remind them of their contract violation.

REVIEW OF SYSTEMS AND COMPLETE PHYSICAL EXAM

- Must be performed at every visit. “Canned” notes, where previous ROS and exams are merely carried down from the previous visits are inappropriate and new symptoms and signs should be documented carefully and addressed in the assessment and plan. Document pertinent negatives and positives.

ASSESSMENT AND PLAN

- Assessment is ALWAYS:
- 1.Chronic Pain Syndrome, (ICD-10 G89.4)
- 2. Long term drug use, (Z79.891)
- 3. POC urine drug test, (Z02.89)
- OTHER DIAGNOSES LISTED SEPARATELY

- Plan is as described in treatment choices on next slide and must include labs, imaging and other testing as deemed necessary

TREATMENT CHOICES

ALWAYS CONSIDER OTHER APPROPRIATE TREATMENTS FIRST (NON-OPIOID) BEFORE TREATMENT WITH OPIOIDS

- NSAIDS/ APAP
- NEUROPATHIC AGENTS
- STEROIDS (ORAL or INJECTIONS)
- CARTILAGE REPLACEMENT INJECTIONS (for knees)
- TRIGGER POINT INJECTIONS
- FACET JOINT INJECTIONS
- EPIDURAL INJECTIONS
- NERVE BLOCK
- BOTOX (for migraine)
- VITAMIN REPLENISHMENT
- HORMONE REPLACEMENT
- ACCUPUNCTURE
- DRY NEEDLING
- PHYSICAL THERAPY
- WEIGHT LOSS
- EXERCISE
- CBT

THE CDC GUIDELINES ADOPTED BY THE NCMB

- **1. OPIOIDS ARE NOT FIRST-LINE THERAPY:** Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy, as appropriate.
- **2. ESTABLISH GOALS FOR PAIN AND FUNCTION:** Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
- **3. DISCUSS RISKS AND BENEFITS:** Non-pharmacologic therapies and nonopioid medications include: • Non-opioid medications such as acetaminophen, ibuprofen, or certain medications that are also used for depression or seizures • Physical treatments (eg, exercise therapy, weight loss) • Behavioral treatment (eg, CBT) • Interventional treatments (eg, injections) Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CDC GUIDELINES, cont'd

- **USE IMMEDIATE-RELEASE OPIOIDS WHEN STARTING:** When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/ long-acting (ER/LA) opioids.
- **USE THE LOWEST EFFECTIVE DOSE:** When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.
- **PRESCRIBE SHORT DURATIONS FOR ACUTE PAIN:** 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 needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed. Immediate-release opioids: faster acting medication with a shorter duration of pain-relieving action Extended release opioids: slower acting medication with a longer duration of pain-relieving action Morphine milligram equivalents (MME)/day: the amount of morphine an opioid dose is equal to when prescribed, often used as a gauge of the abuse and overdose potential of the amount of opioid that is being given at a particular time

CDC GUIDELINES, cont'd

- **EVALUATE BENEFITS AND HARMS FREQUENTLY:** Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.
- **USE STRATEGIES TO MITIGATE RISK:** Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

CDC GUIDELINES, cont'd

- **REVIEW PDMP DATA:** Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
- **USE URINE DRUG TESTING:** When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
- **AVOID CONCURRENT OPIOID AND BENZODIAZEPINE PRESCRIBING:** Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
- **OFFER TREATMENT FOR OPIOID USE DISORDER:** Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

SHORT-ACTING OPIOIDS

- TRAMADOL +/- APAP (ULTRAM/ ULTRACET)
- TYLENOL III
- HYDROCODONE/ APAP (LORCET)
- OXYCODONE +/- APAP (PERCOCET)
- MORPHINE IR
- HYDROMORPHONE IR (DILAUDID)

LONG-ACTING OPIOIDS

- HYSINGLA (HYDROCODONE)
- EMBEDA (MORPHINE)
- LEVORPHANOL
- OXYCONTIN (OXYCODONE)
- OPANA ER (OXYMORPHONE)
- EXALGO (HYDROMORPHONE)
- MORPHINE ER (MS CONTIN)
- NUCYNTA ER (TAPENTADOL)
- FENTANYL TDS
- BUTRANS TDS (BUPRENORPHINE)
- BELBUCA (BUPRENORPHINE BUCCAL FILM)
- PROBUPHINE (BUPRENORPHINE IMPLANT)
- METHADONE

CONVERSION TO MORPHINE EQUIVALENTS

- Buprenorphine patch 12.6
- Buprenorphine tab or film 10
- Butorphanol 7
- Codeine 0.15
- Dihydrocodeine 0.25
- Fentanyl buccal or SL tablets, or lozenge/troche 0.13
- Fentanyl film or oral spray 0.18
  Fentanyl nasal spray 0.16
- Fentanyl patch 7.2
- Hydrocodone 1
- Hydromorphone 4
- Levorphanol tartrate 11
- Meperidine hydrochloride 0.1
- Methadone 3
- Morphine 1
- Nalbuphine 1
- Opium 1
- Oxycodone 1.5
- Oxymorphone 3
- Pentazocine 0.37
- Tapentadol 0.4
- Tramadol 0.1

OPIOID USE DISORDER

- Drug seeking behavior
- Multiple prescriptions from different providers
- Increased use over time
- Opioid cravings
- Multiple medical complications from drug use (HIV/AIDS, hospitalizations, abscesses)
- Legal or social ramifications secondary to drug use
- Tolerance
- Withdrawal symptoms
- Constipation

TREATMENT FOR OPIOID USE DISORDER

- METHADONE (INDEFINITE TREATMENT)
- SUBOXONE (2 YEAR OUTPATIENT TREATMENT)

- ADDICTION COUNSELING WITH BOTH OF THE ABOVE

THANK YOU!!!

QUESTIONS???