

Electronic Prescribing of Controlled Substances and PDMP integration

Carl Christensen MD, PhD

Clinical Associate Professor, Wayne State Univ School of Medicine, Detroit MI

Distinguished Fellow, American Society of Addiction Medicine

Medical Director, Michigan Health Professional Recovery Program

No financial relationships to disclose

ab7059@wayne.edu



Topics

- ▶ Electronic prescribing
 - ▶ Use of PDMPs in electronic prescribing
 - ▶ Michigan Opioid Laws, CDC Guidelines and Prescribing Practice
- 

Disclaimers



- No financial relationships to disclose
- Buprenorphine / Naltrexone provider, A2
- Medical Director Dawn Farm
- Consultant, DEA/DOJ



Electronic Prescribing Controlled Substances (EPCS)

- ▶ Started off as Computerized Physician Order Entry (CPOE)
 - ▶ Adopted during Meaningful Use
 - ▶ Allowed paper prescriptions
 - ▶ NO CS by CPOE initially; later adopted.
- ▶ ePrescribing
 - ▶ No authentication required after logon
 - ▶ No CS
- ▶ EPCS

Why EPCS?

ATTENTION DETECTIVE KEVIN MCGUIRE

CARL CHRISTENSEN M.D.
DEA # AC 3102629
4201 St. Antoine, Suite 4E & F
DETROIT, MI 48201
(313) 745-4380



NAME Rico Walker AGE _____
ADDRESS 10-17-70 DATE 02-11-13

R Promethazine w/codine
Sig: 7 tsp Q4-6° po prn
Disp: # 16oz.

Refill 1-2-3-4-PRN

CC Christensen M.D.
(Signature)

Another brand of generically equivalent product, identical in dosage, form and content of active ingredients, may be dispensed unless box is initialed D.A.W.



BFPS0084070

Allergic to "naloxone"?

THIS DOCUMENT CONTAINS VOID PANTOGRAPH, MICROPRINTED BIOMETRIC LINE,
BLUE PATTERN BACKGROUND, THERMOCHROMIC INK

MAMOON A. RASHEED, MD
DEA #BR4567092 LIC. #MD055855L NPI # 1760448468

MARK S. TOMICH, PA-C
DEA #MT4570203 LIC. #MA059541 NPI # 1841700762
600 NORTH PENN STREET 234 W. MAIN STREET
CONNELLSVILLE, PA 15425 UNIONTOWN, PA 15401
(724) 628-3010 TEL., (724) 628-3262 FAX (724) 550-4600 TEL.

NAME Daniel [REDACTED] AGE _____
ADDRESS _____ DATE 10/23/18

R
Patient is allergic to
Aspirin, Naloxin.

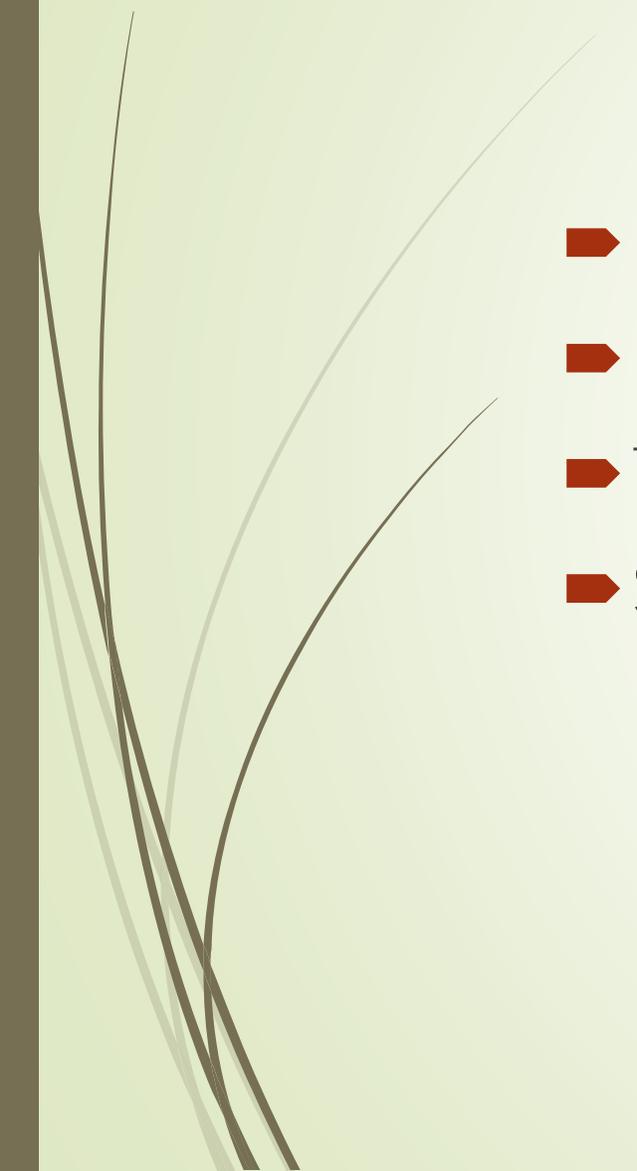
LABEL
REFILL - 0 - 1 - 2 - 3 - 4 - PRN
SUBSTITUTION PERMISSIBLE _____
IN ORDER FOR A BRAND NAME PRODUCT TO BE DISPENSED,
THE PRESCRIBER MUST HAND-WRITE "BRAND NECESSARY"
OR "BRAND MEDICALLY NECESSARY" IN THE SPACE BELOW.

PP96703-04-18

FOR USE WITH HEAT SENSITIVE INK: PULL THIS STRIP BETWEEN FINGERS



Getting started with EPCS: 4 steps

- Find out if your EHR has EPCS
 - Identify proofing
 - Two factor authentication
 - Software access
- 



Getting started with EPCS

- ▶ Find out if your EHR has EPCS
 - ▶ Inpatient vs outpatient
 - ▶ Software upgrade may be needed (\$\$\$)



Getting started with EPCS

- ▶ Identify proofing
 - ▶ Private practice: EHR will walk you through security questions when EHR was purchased.
 - ▶ May require interview with vendor
 - ▶ Hospital practice: produce MI license and DEA



Getting started with EPCS

- ▶ Two factor authentication
- 



Getting started with EPCS

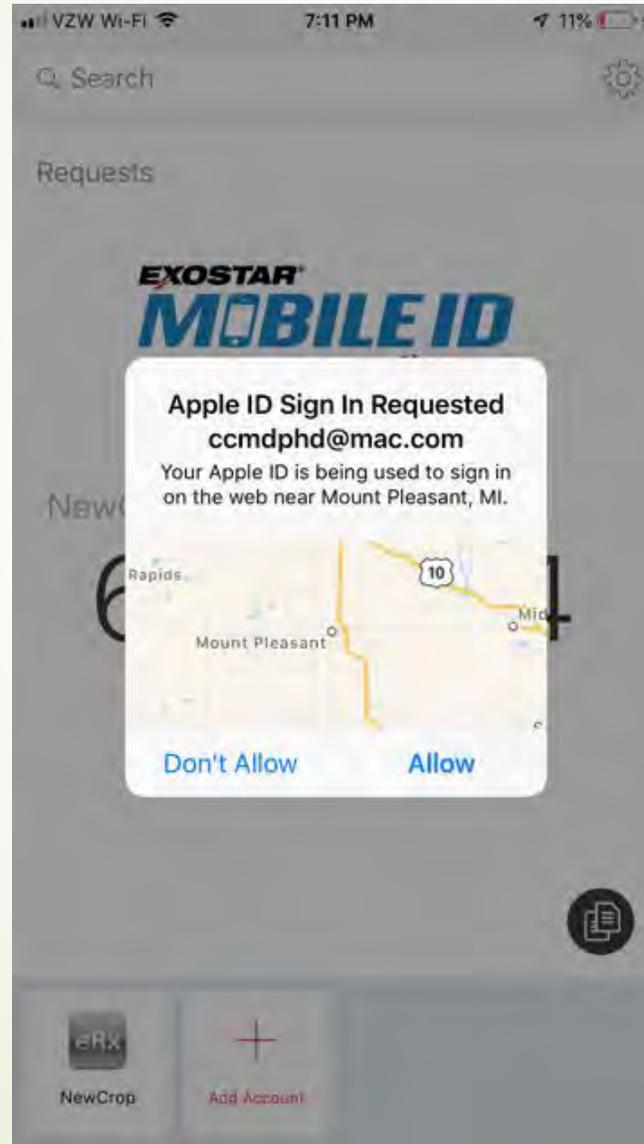
- ▶ Two factor authentication
 - ▶ Two Step vs. Two Factor
 - ▶ Two Step:
 - ▶ Need password to log on to VPN (virtual private network), then password to log on to hospital server.
 - ▶ Google sign on using SMS (texting)
 - ▶ Claims of security breaches with SMS

Getting started with EPCS

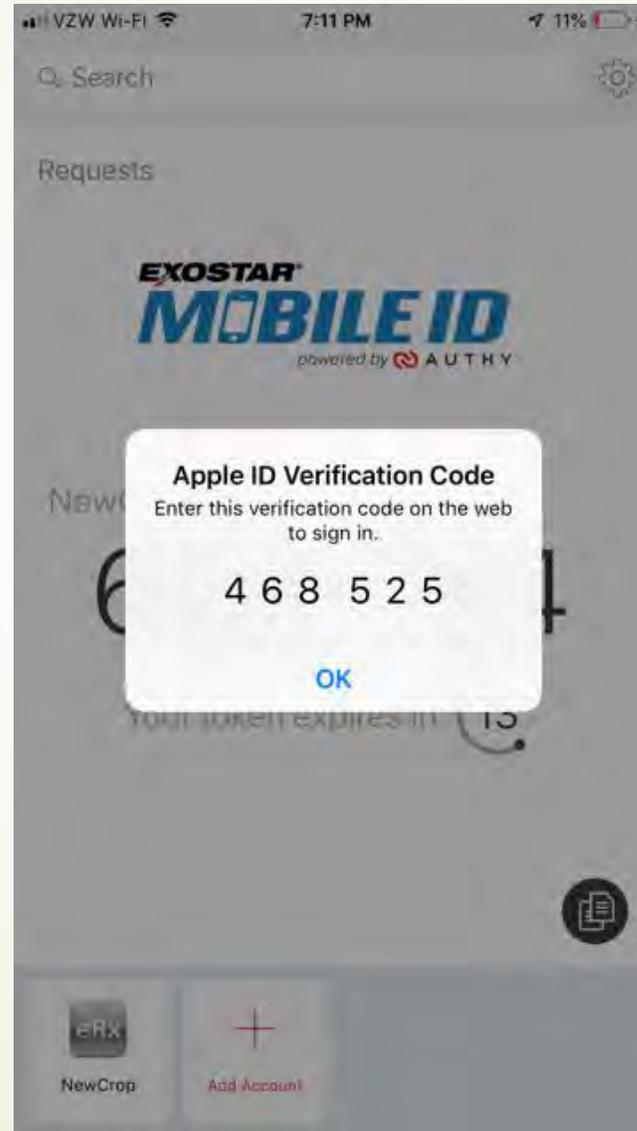
- ▶ Two factor authentication
 - ▶ Two Step vs. Two Factor
 - ▶ Two Factor: something you know + something you have



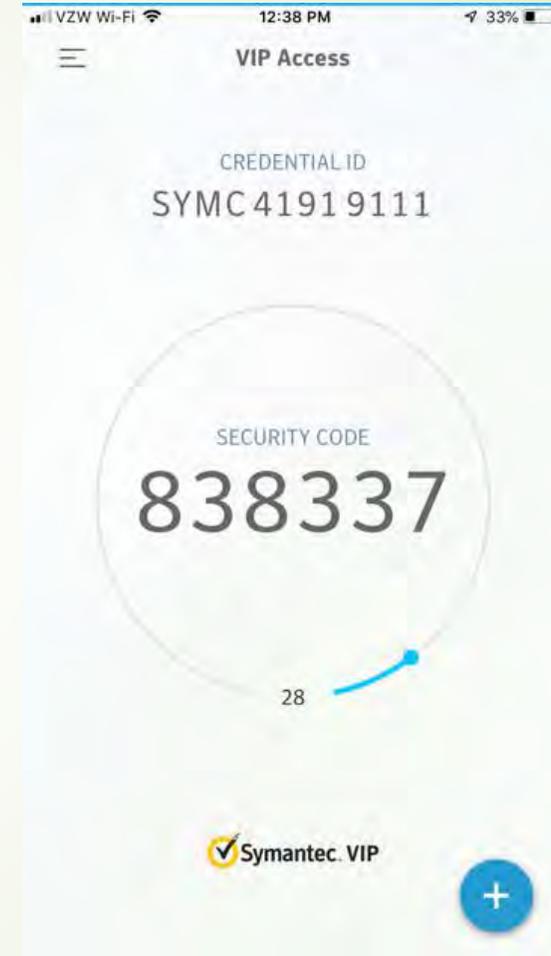
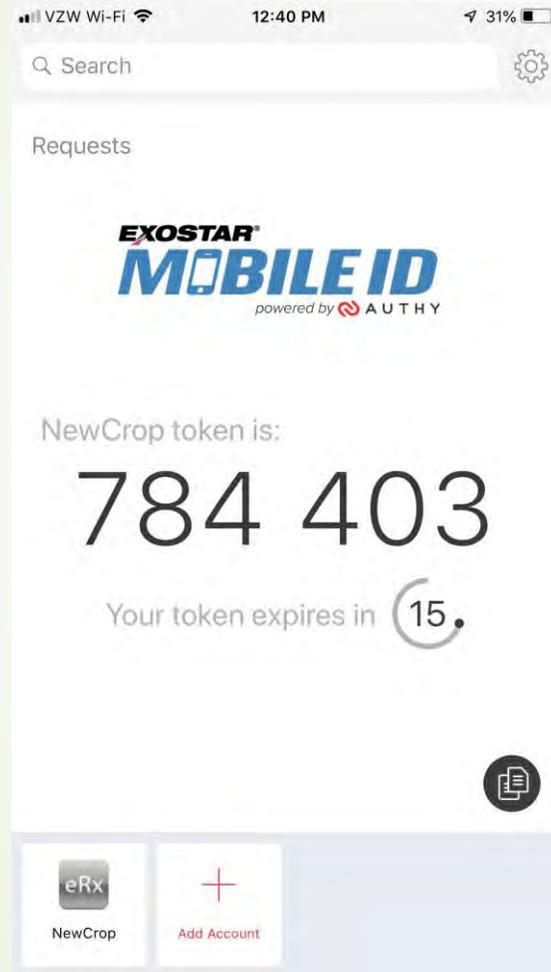
Two Factor Authentication



Two Factor Authentication

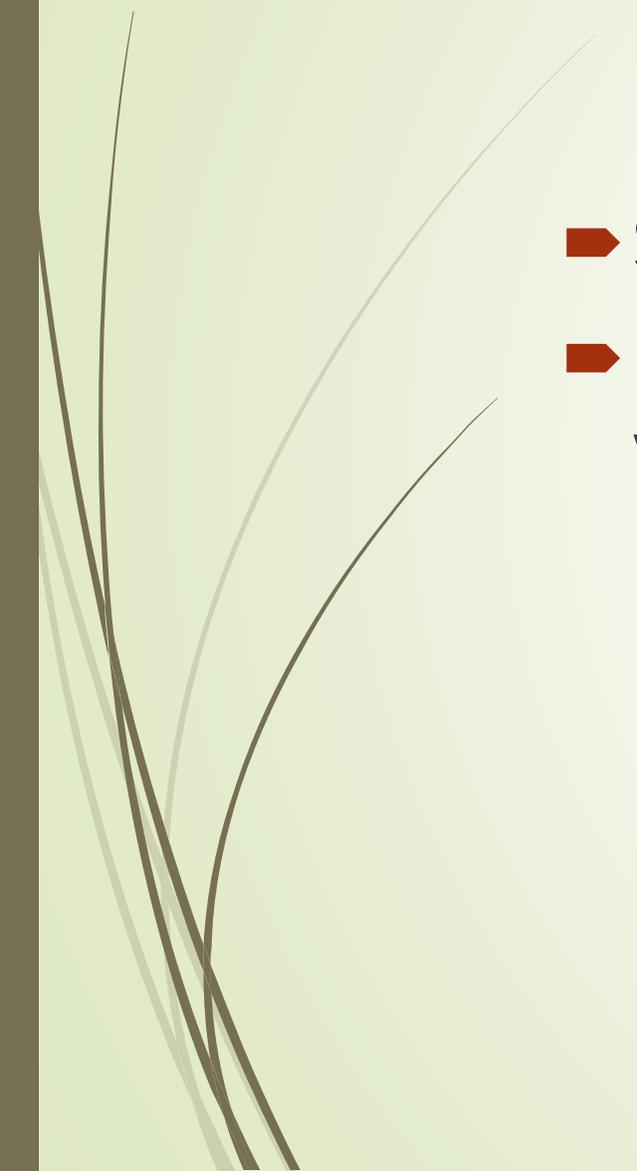


Two Factor Authentication





Getting started with EPCS

- ▶ Software access
 - ▶ Requires endorsement by another prescriber who already has EPCS access.
- 

To Send EPCS:

Christensen Recovery Services MacPractice

Pend-0 New-0

[Select Dr./Staff](#) [Compose Rx](#) [Med Entry](#) [Prior Auth/Orders/Resources](#) [Pt. Details](#) [Diagnoses](#) [Admin](#)

Christensen Recovery Services/Resources Carl Christensen MD Designated Dr/Prescriber: **C. Christensen**

[Prior Auth: Inc-0 Pend-0 New-0](#) [Progress Note](#) [Face Sheet](#) [Orders](#) [DME/CPAP/O2/Supplies](#)

Compose Rx

New: DME/CPAP/O2/Supplies

Patient: **Ann Icteric** DOB: **12/3/1952** Gender: **Female**

Surescripts Benefit/Drug History: not available for this patient. PBM: SURESCRIP

To display Ann Icteric's drug costs and pricing information from their drug benefit card (last updated: Never): Save

RxBIN: RxPCN: RxGroup: RxMember ID:

Pharmacy Selection Needed to display pricing information: [Select Patient Pharmacy](#)

Pending Rx [Review / Prescribe](#) [Transmit / Prescribe](#)

Date	Drug	Sig	#	Refill	Source
06/02/19	Norco 10 mg-325 mg tablet	1 every 4-6 hours	42	0	C. Christensen EDIT X

Real-Time Benefits: Patient- and Pharmacy-Specific [Add/Select Pharmacy](#)

Drug	#	Pt. Pay	Pharmacy	Total Savings	Message
Norco 10 mg-325 mg tablet	42				

Powered by RelayHealth - The Patient Pay Amount displayed is an estimate based on the selected pharmacy. Select preferred pharmacy to display Benefits Information.

PDMP Automated

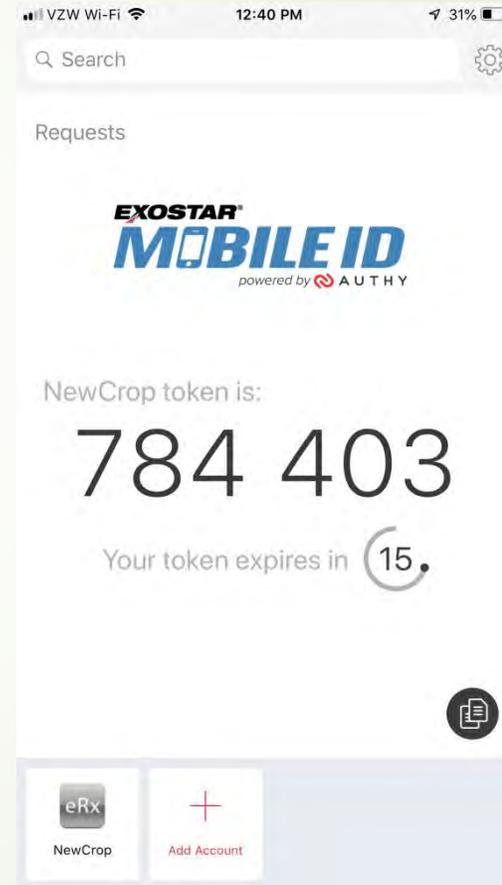
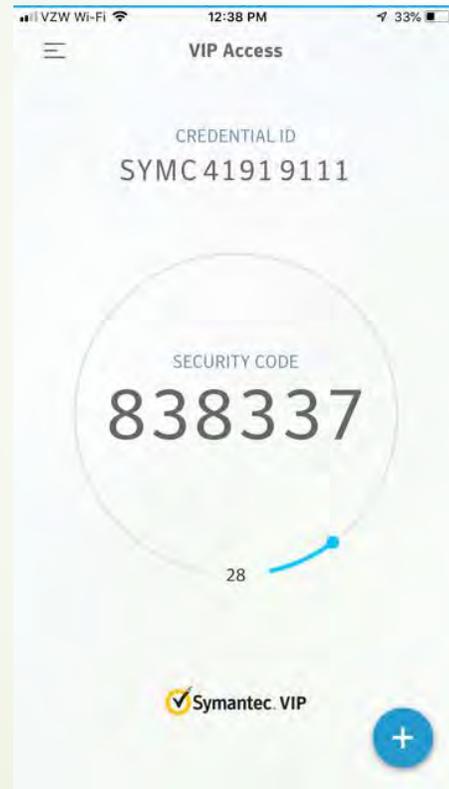
[Drug Search](#) [Drug Sets/Compounds](#) [Doctor's List](#)

Include 'obsolete' drugs Ophthalmic only Insulin+Supplies Pediatric Dosing

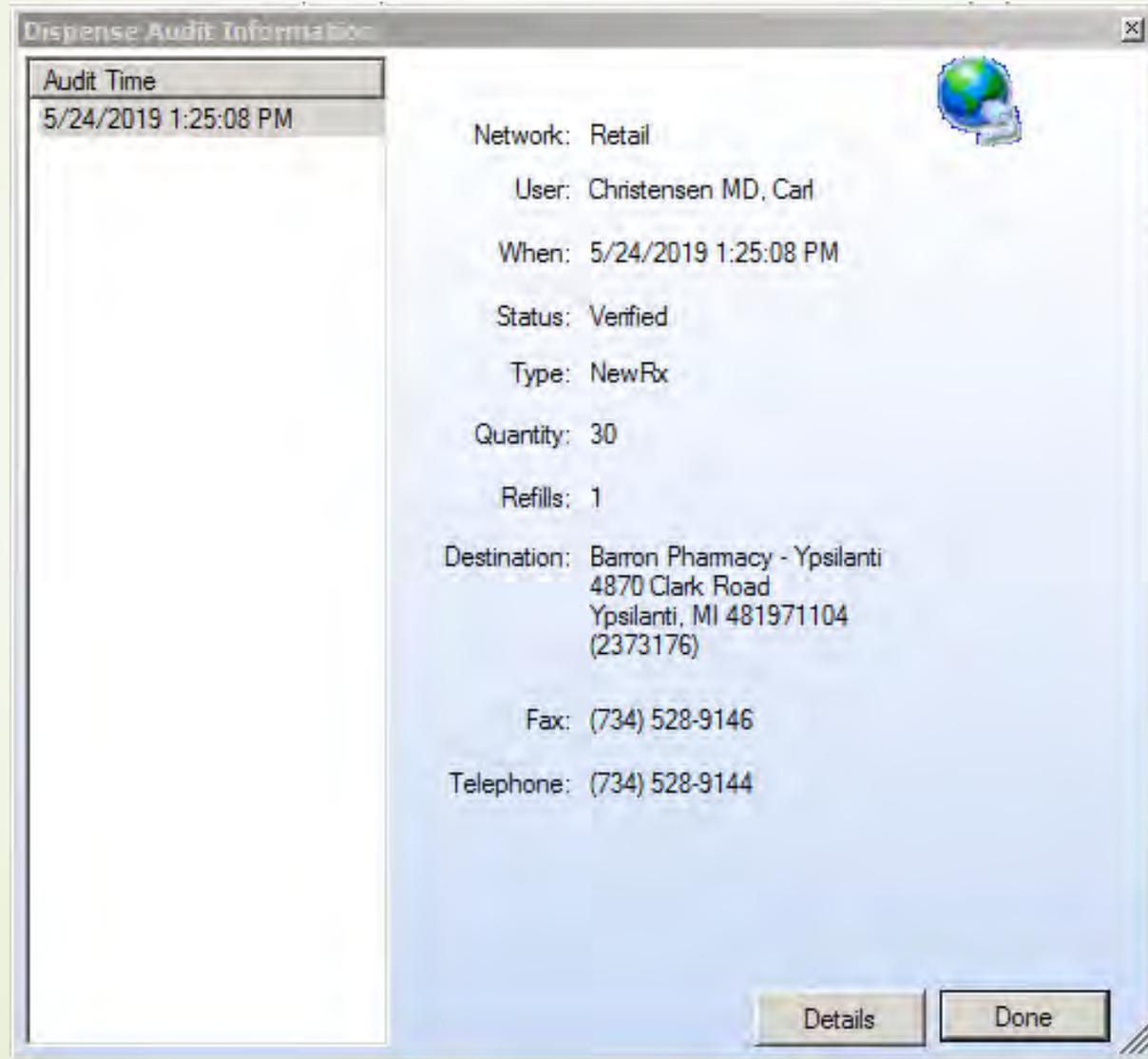
Allergy / Intolerance [View Log](#)

	Onset	Severity
Codeine		Mild
Norco		Severe

Authentication: requires password and token (two factor)



Dispensing History: confirms scrip sent



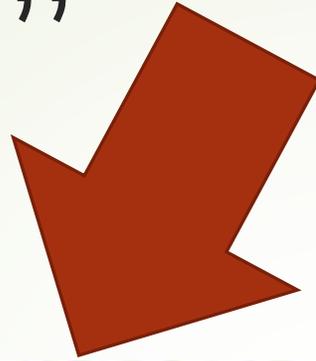
The screenshot shows a software window titled "Dispense Audit Information". On the left, there is a table with one row containing the audit time. On the right, there is a list of audit details. At the bottom right, there are two buttons: "Details" and "Done".

Audit Time
5/24/2019 1:25:08 PM

Network: Retail
User: Christensen MD, Carl
When: 5/24/2019 1:25:08 PM
Status: Verified
Type: NewRx
Quantity: 30
Refills: 1
Destination: Barron Pharmacy - Ypsilanti
4870 Clark Road
Ypsilanti, MI 481971104
(2373176)
Fax: (734) 528-9146
Telephone: (734) 528-9144

Details Done

“fails”



Christensen Recovery Services **Pharm: 8 Failed Rx: 0 Pend: 2 Prior Auth: Inc-5 Pend-11 New-12** MacPractice
eDME:Inc-0 Pend-0 New-0

Select Dr./Staff Compose Rx Med Entry Prior Auth/Orders/Resources PL Details Diagnoses **Admin**

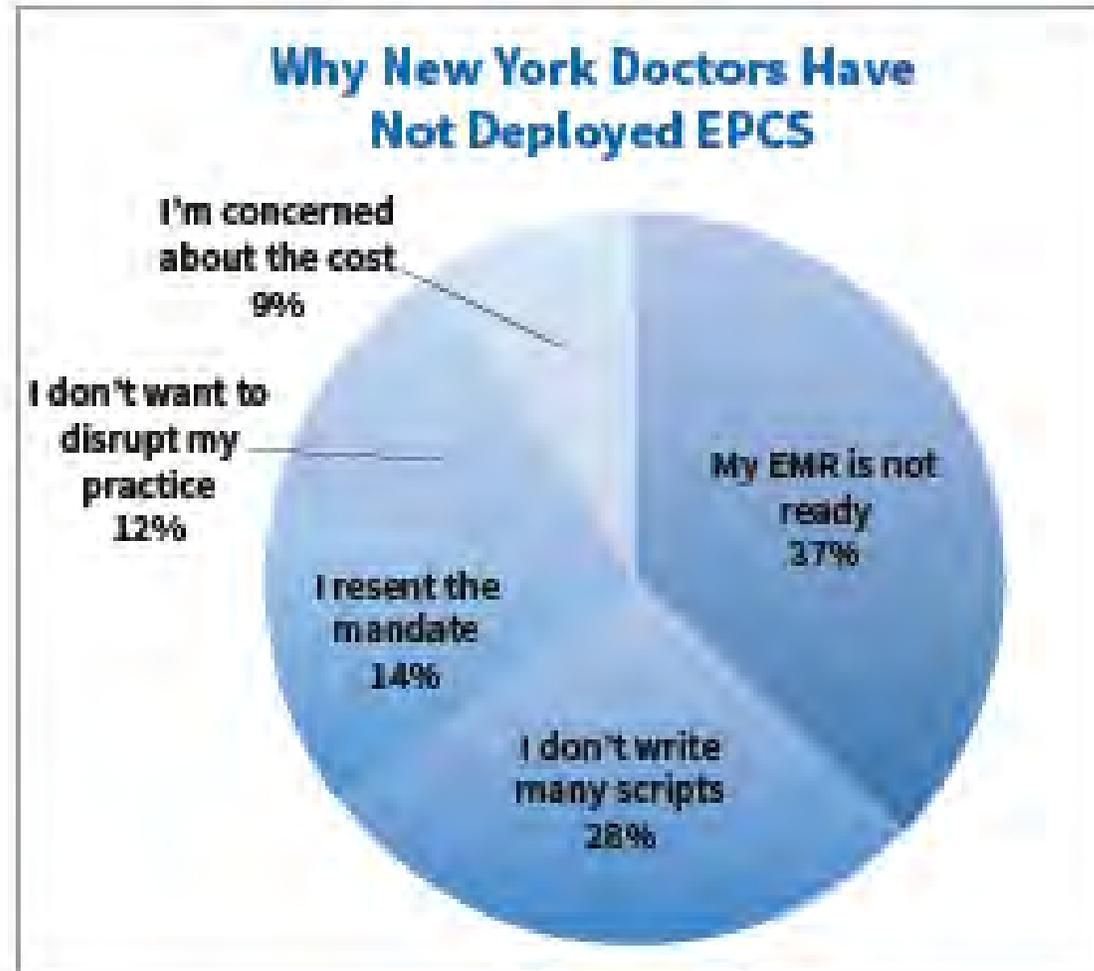
[Christensen Recovery Services/Resources](#) Carl
Christensen MD

Status Designated Dr/Prescriber: **C. Christensen**

New:
DME/CPAP/O2/Supplies
[details hide](#)

At day's end, all rx left on this page are unfinished work.

Resistance to EPCS: New York



Source: *MSSNY Member E-Prescribing Survey, December 2015*



Benefits of EPCS

- ▶ Literature on benefits in terms of O.D. etc is tied in to PDMPs. However:
- ▶ Improved patient safety
- ▶ Time savings (vs paper for CS and electronic for non-CS)
- ▶ Claims of savings: 15, 769 per FTE*
- ▶ Increased security
- ▶ Reduced doctor shopping via medication module and PDMP review
- ▶ “Enables Prescriber Pattern Analysis”
- ▶ Enhances Patient Satisfaction **

https://go.drfirst.com/hubfs/2016-03-24/2h8klr/8842/141586/EPCS_Whitepaper_DrFirst_3.2016.pdf

*Clinicians Guide to E prescribing, www.mgma.com, 2011 |

Benefits of EPCS: DEA

- ▶ Stealing/printing prescription pads, and writing non-legitimate paper scrips.
- ▶ Altering a legitimate prescription to obtain a higher dose or or more dosage units (change 10 to 40).
- ▶ Phoning in non-legitimate prescriptions late in the day when it is difficult for a pharmacy to complete confirmation call to the practitioner's office; and
- ▶ Altering a prescription record at the pharmacy to hide diversion from pharmacy stock.
- ▶ Savings due to reduced number of phone calls, and elimination of storage of paper records (***)

Economic Impact Analysis of the Interim Final Electronic Prescription Rule.

https://www.deadiversion.usdoj.gov/ecomm/erx/eia_dea_218.pdf

*168 Effect of New York State Electronic Prescribing
Mandate on Opioid Prescribing Patterns*

*D. Danovich, J. Chacko, J. Greenstein, B. Ardolic, N.
Berwald*

Annals of Emergency Medicine
Volume 70, Issue 4, Pages S67-S68 (October 2017)
DOI: 10.1016/j.annemergmed.2017.07.195



	Pre-NYM EPCS (N= 1366)		Post-NYM EPCS (N= 642)	
Arthralgia/Myalgia ($p<0.0001$)	272	19.9%	115	17.9%
Back Pain ($p<0.0001$)	178	13.0%	86	13.4%
Dental Pain ($p<0.0001$)	157	11.5%	64	10.0%
Fracture ($p=0.0015$)	138	10.1%	90	14.0%
Soft Tissue Injury ($p<0.0001$)	136	10.0%	55	8.6%
Urolithiasis ($p=0.0169$)	112	8.2%	79	12.3%
Abdominal Pain ($p<0.0001$)	109	8.0%	46	7.2%
Other ($p=0.0024$)	64	4.7%	34	5.3%
Neuropathic Pain ($p<0.0001$)	63	4.6%	21	3.3%
Genital Pain ($p<0.0001$)	49	3.6%	15	2.3%
Abscess ($p=0.0195$)	35	2.6%	18	2.8%
Headache ($p=0.0011$)	18	1.3%	3	0.5%
UTI ($p=0.1266$)	14	1.0%	7	1.1%
Post-operative Pain ($p=0.0455$)	12	0.9%	4	0.6%
Corneal Abrasion ($p=0.2850$)	9	0.7%	5	0.8%

Opioid Prescriptions by Diagnosis

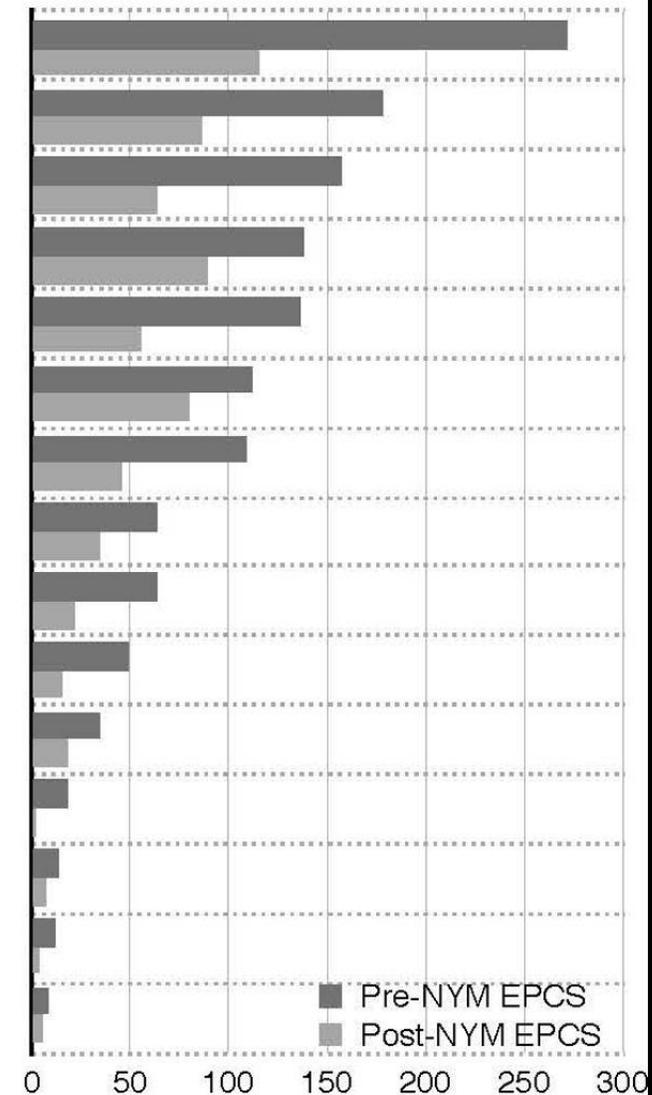


Figure 1. Prescriptions by diagnosis category Pre- and Post-NYM EPCS.





MAPS, the Michigan Opioid Laws, and the CDC Guidelines

What is this NARx Score???

NarxCare Report



Report Prepared: 09/28/2018

Date Range: 09/28/2016 – 09/28/2018

Risk Indicators

NARX SCORES

Narcotic	Sedative	Stimulant
541	481	000

OVERDOSE RISK SCORE

550
(Range 000-999)

ADDITIONAL RISK INDICATORS (2)

- i** >= 5 opioid or sedative providers in any year in the last 2 years
- i** > 100 MME total and 40 MME/day average

This NarxCare report is based on search criteria supplied and the data entered by the dispensing pharmacy. For more information about any prescription, please contact the dispensing pharmacy or the prescriber. NarxCare scores and reports are intended to aid, not replace, medical decision making. None of the information presented should be used as sole justification for providing or refusing to provide medications. The information on this report is not warranted as accurate or complete.

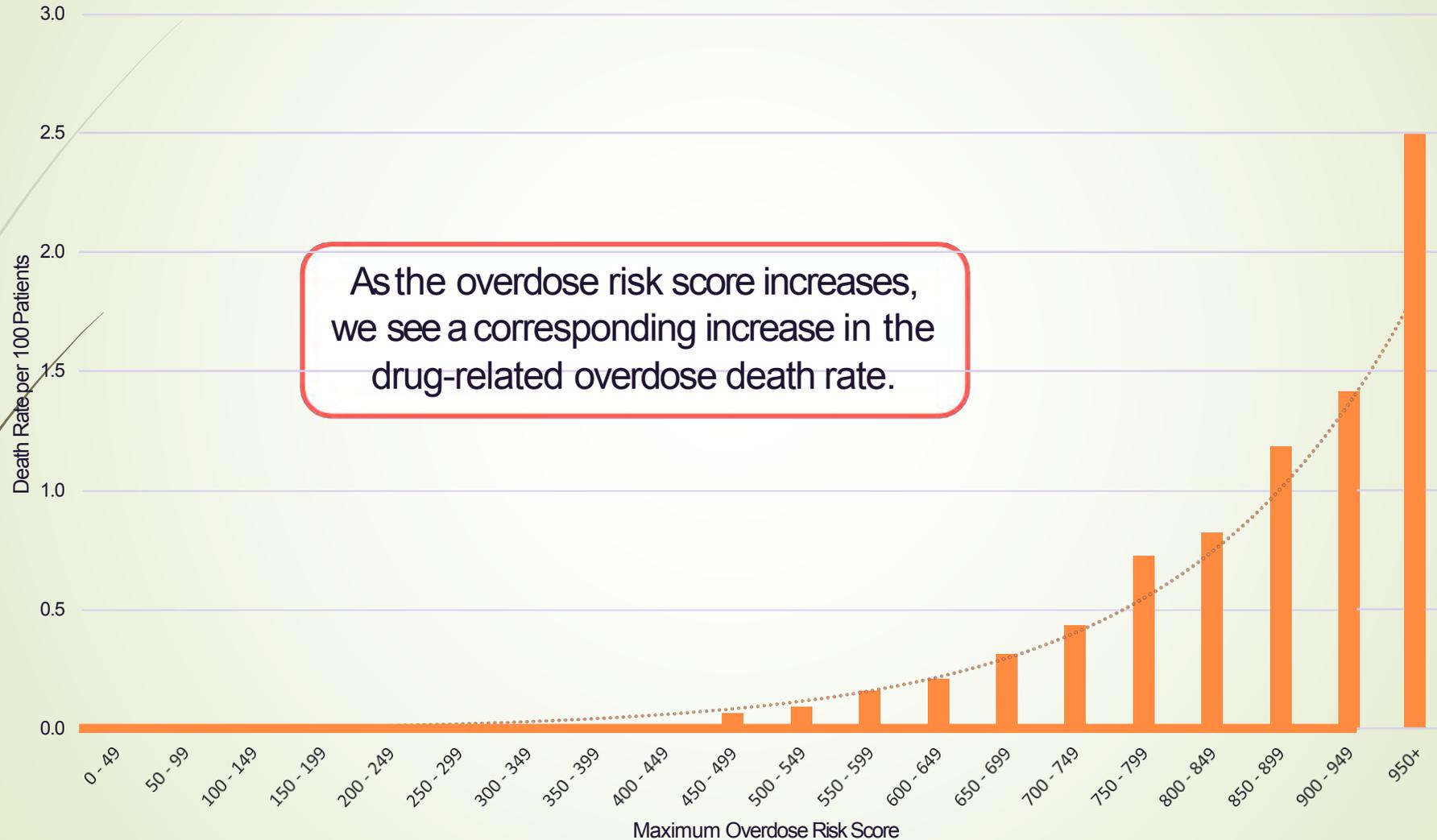
Relative Risk of Fatal Overdose by NARx score

Huizenga, Breneman, Appriss, Inc



➤ <100	1	➤ 500-599	32
➤ 100-199	8	➤ 600-700	56
➤ 200-299	10	➤ 700-800	76
➤ 300-399	10	➤ 800-900	101
➤ 400-499	16	➤ 900-999	168

Drug-Related Overdose Death Rate by Overdose Risk Scores



Source: Michigan PDMP 2013-2015 and Michigan 2015 drug-related deaths

Note: Excludes decedents whose death was prior to 2015, because 2 years of prescription history data not available. Overdose Risk Score is the maximum over the entire PDMP history for that patient



Where there's a will.....

PRESCRIPTIONS

Total Prescriptions: 24

Total Private Pay: 1

Fill Date	ID	Written	Drug	Qty	Days	Prescriber
01/10/2019	1	01/10/2019	Acetaminophen-Cod #3 Tablet	12	3	Sa Hur
01/09/2019	2	01/07/2019	Suboxone 8 Mg-2 MG SL Film	15	7	Ca Chr



What About Sedatives?

- Benzodiazepines: Xanax, Klonopin, Valium, Librium
- Sleepers: Ambien, Lunesta, Sonata
- Gabapentin, Pregabalin (Lyrica)
- Muscle Relaxers: Flexeril, Robaxin, Zanaflex
- SOMA

What are the RISKS of Sedatives?

- Benzodiazepines TRIPLE the risk of opioids if you currently uses them.*
- They DOUBLE the risk even if you have stopped (?)*
- Benzodiazepines are associated with dementia**
- SOMA: part of the Holy Trinity (Soma, Norco, and Xanax)
- Benzodiazepines may paradoxically increase pain!***
- Pregabalin (Lyrica) is the most common non-opioid found to be involved in OD deaths (MAPS data)

https://www.michigan.gov/documents/lara/BPL_ApprissStatewideOpioidAssesementMICHIGAN_03-29-2018_620258_7.pdf

*Park TW et al. BMJ 2015; 350:h2698

**Billioti de Gage S et al. BMJ 2012; 345 e 6231

***Ciccone DS et al. J Pain Symptom Manage 2000 Vol 20(3), p180.

Drug Type	Number of Dispensations (N=103,214,576)		Total Patients ¹ (N=7,575,033)		Deaths ² (N=4,444)		Deaths per 1,000 Patients with a prescription ³
	n	%	n	%	n	%	
Narcotic ⁴	51,117,258	49.53%	6,391,737	84.38%	3366	75.74%	0.52
Buprenorphine MAT	2,171,525	2.10%	72,780	0.96%	380	8.55%	5.82
Sedative	31,028,518	30.06%	2,849,423	37.62%	2924	65.80%	0.97
Stimulant	14,934,746	14.47%	934,717	12.34%	508	11.43%	0.53
Neuropain	1,953,315	1.89%	201,248	2.66%	346	7.79%	1.96
GINarcotic	373,205	0.36%	116,584	1.54%	64	1.44%	0.52
Steroid	949,011	0.92%	108,737	1.44%	61	1.37%	0.54
Cannabinoid	75,510	0.07%	22,669	0.30%	6	0.14%	0.36
Unassigned	44,431	0.04%	18,216	0.24%	0	0.00%	0.00
Anesthetic	2,006	0.00%	832	0.01%	0	0.00%	0.00
Other	565,074	0.55%	136,163	1.80%	19	0.43%	0.12

At least one prescription for that drug type in the year prior to death, 2014-2015 limited to F-Div. Only 2014-2015 deaths were included to ensure a full year of history in the PDMP. 4. Narcotic drug type excludes Buprenorphine MAT prescriptions.

While the largest proportion of deaths are associated with narcotic (75.7%) and sedative (65.8%) dispensations, the controlled substances with the highest death rates are those for buprenorphine MAT (5.82 deaths per 1,000 patients), neuropain (1.96 deaths per 1,000 patients), and sedatives (0.97 death per 1,000 patients).



Michigan Opioid Laws and the CDC Guidelines: where did “7 days” come from?

- ▶ Michigan Law: 7 days CS prescription for acute pain with MAPS report, 3 days without.
- ▶ No automatic refills for schedule 3 meds.
- ▶ No pre written prescriptions for schedule 2 meds.
- ▶ NOTE: if you have to refill a schedule 2 prescription offsite, you MUST have EPCS!



Michigan Opioid Laws and the CDC Guidelines: where did “7 days” come from?

- ▶ CDC Guidelines (#6):
 - ▶ Long term opioid use often begins with treatment of acute pain.
 - ▶ When opioid are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release (IR) opioid and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioid.
 - ▶ Three days or less will often be sufficient; more than seven days will rarely be needed.



Michigan Opioid Laws and the CDC Guidelines: where did “7 days” come from?

- ▶ Exclusions:
- ▶ CHRONIC pain (put it on the scrip!)
- ▶ End of life care
- ▶ Cancer pain

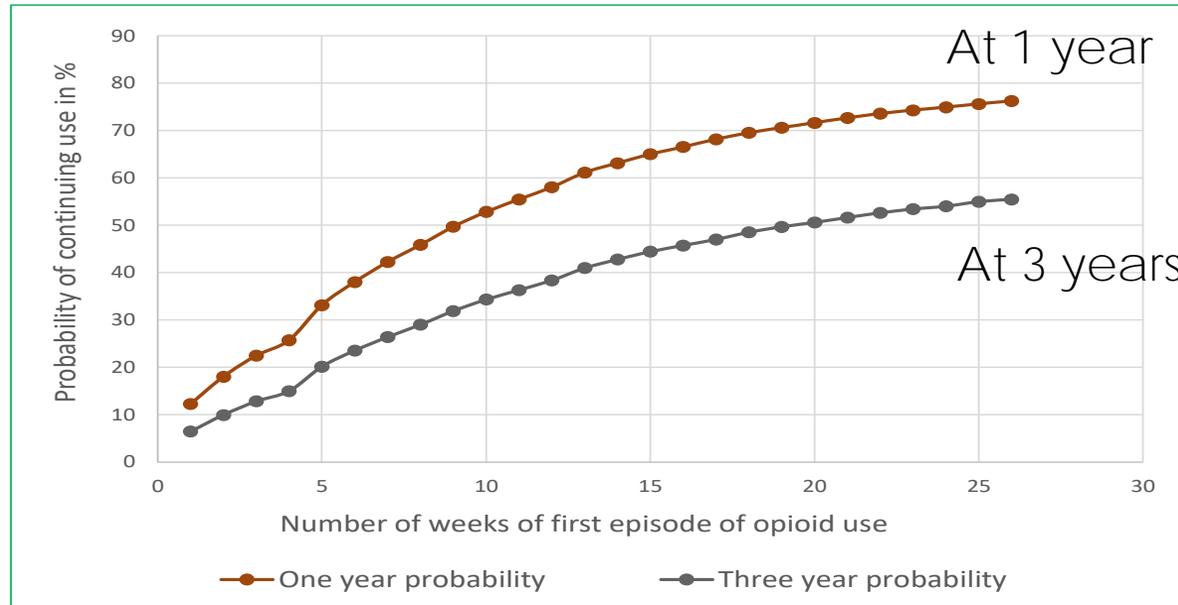
Opioid selection, dosage duration, follow up and discontinuation : Guideline 6

- ▶ Note: it will be impossible to prescribe additional opioids offsite unless you have EPCS available
 - ▶ Exception: schedule 3 meds: codeine, tramadol, buprenorphine.
- ▶ Do not prescribe ER/LA opioids for treatment of acute pain!
- ▶ https://www.michigan.gov/documents/lara/LARA_DHHS_Opioid_Laws_FAQ_05-02-2018_622175_7.pdf

Effect of duration of first use

FIGURE 1. One- and 3-year probabilities of continued opioid use, by duration of first episode in weeks (base case)

Y axis:
Percentage
chance of
being
“hooked”
(continued use)

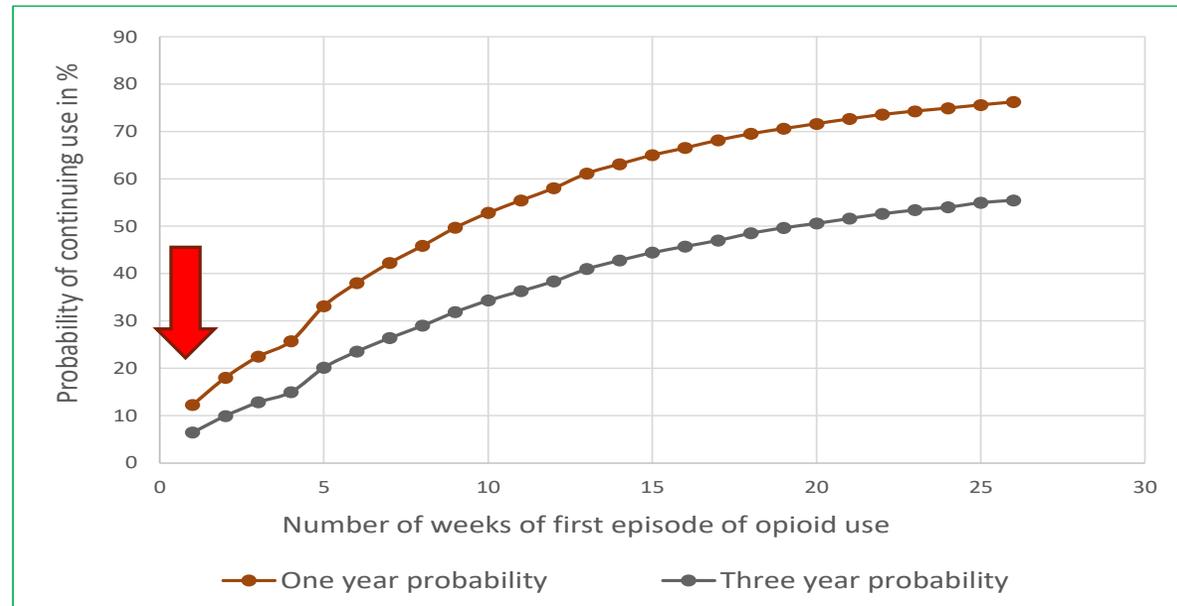


X axis: Number of weeks for
first opioid prescription

Duration is expressed in terms of weeks (1-26) with increments of 1 week. Discontinuation is defined as 180 opioid-free days and allowable gap to assess continuous opioid use in first episode was 30 days. One-week duration is defined as having an episode lasting 7 or more days.

Effect of duration of first use

FIGURE 1. One- and 3-year probabilities of continued opioid use, by duration of first episode in weeks (base case)

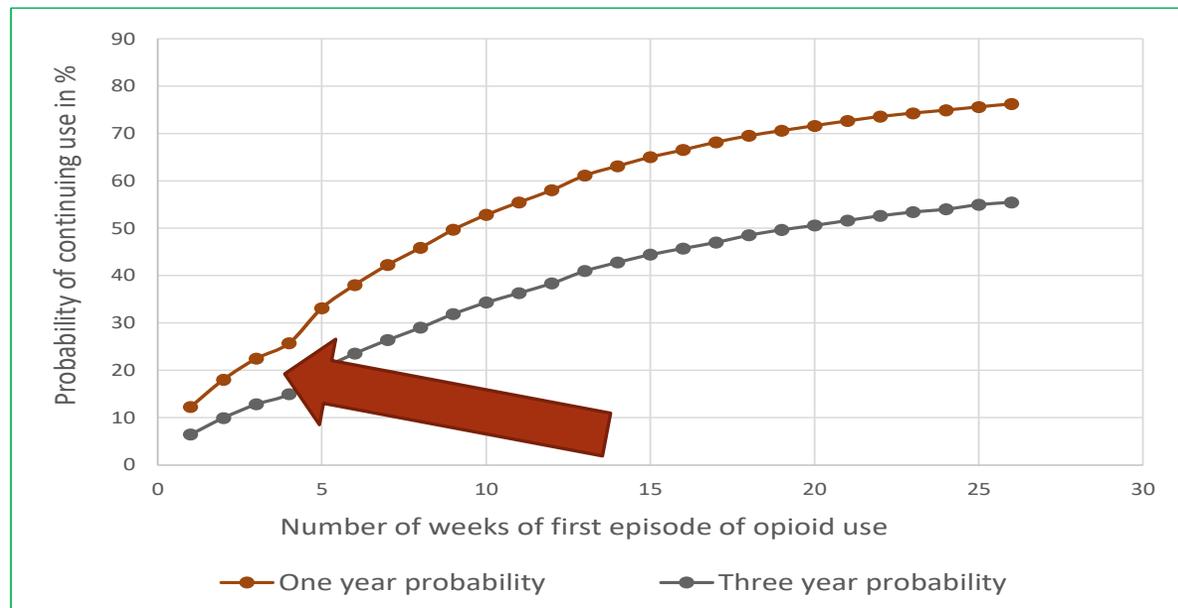


1 week initial scrip = 5 to 15 % of long term use!

Duration is expressed in terms of weeks (1-26) with increments of 1 week. Discontinuation is defined as 180 opioid-free days and allowable gap to assess continuous opioid use in first episode was 30 days. One-week duration is defined as having an episode lasting 7 or more days.

Effect of duration of first use

FIGURE 1. One- and 3-year probabilities of continued opioid use, by duration of first episode in weeks (base case)



4 week initial scrip =
15 to 25% of long term use!

Duration is expressed in terms of weeks (1-26) with increments of 1 week. Discontinuation is defined as 180 opioid-free days and allowable gap to assess continuous opioid use in first episode was 30 days. One-week duration is defined as having an episode lasting 7 or more days.

What's wrong with postop pain meds?

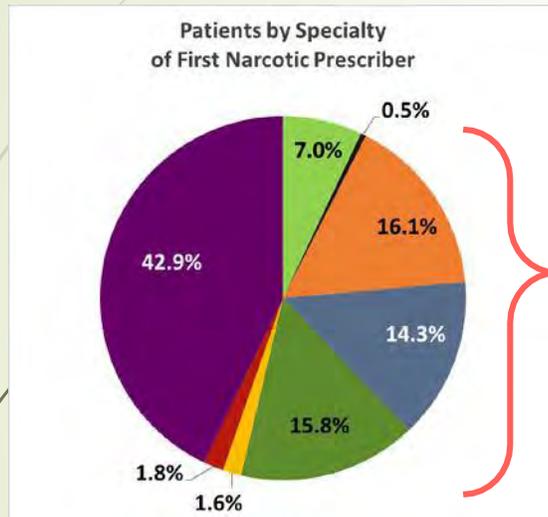
(Chad Brummet, MD) JAMA Surgery. 2017; 152 (6): e 170504

- Long term use of opioids after surgery did not depend on the TYPE of surgery (minor vs. major)!
- Overall, 6% of postop patients continued to use opioids.
- Risks for persistent opioid use:
 - Tobacco
 - Alcohol and Substance Use Disorders
 - Mood disorders
 - Anxiety
 - Dose (M.E.D.) did NOT matter*

- *Sekhri, Shaina, et al. "Probability of Opioid Prescription Refilling After Surgery: Does Initial Prescription Dose Matter?." *Annals of Surgery* (2017).

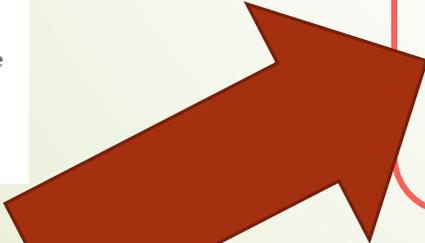
First Narcotic Prescription and Future Use

(no scrip x 1 year)

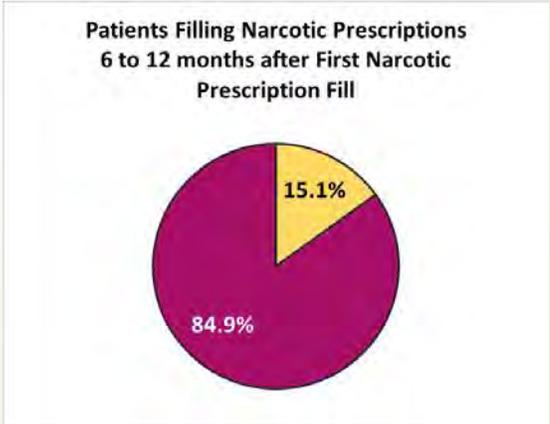


Large percentage of patients' first narcotic prescription are written in Surgery (15.8%), ED/Urgent Care (14.3%), and Dentistry (16.1%), though these specialties make up 10.2%, 3.6%, and 7.0% of prescribers, respectively

- Primary Care
- Pain Management
- Psychiatry
- Surgery
- ED/Urgent Care
- Dentistry
- Oncology
- Other



15.1% of patients are still filling narcotic prescriptions 6 months to 1 year after their first narcotic fill



Source: Michigan PDMP Oct. 23, 2016 - Oct. 23, 2017, supplemented by NPESNPI file
Excludes prescribers missing primary specialty classification, Other specialty includes specialties not classified elsewhere; Excludes patients whose first narcotics fill was in 2016, because 1 year of follow-up data not available. Incident narcotic prescriptions were written in 2014 or later; criteria used due to insufficient prescription data prior to 2013.



Decrease in oxycodone related mortality after PDMP-Florida

Drug and Alcohol Dependence

Volume 150, 1 May 2015, Pages 63-68

Abrupt decline in oxycodone-caused mortality after implementation of Florida's Prescription Drug Monitoring Program ☆

Chris Delcher ^a  , Alexander C. Wagenaar ^a, Bruce A. Goldberger ^b, Robert L. Cook ^c, Mildred M. Maldonado-Molina ^a

Highlights

- A 25% drop in oxycodone-caused deaths occurred after the start of the Prescription Drug Monitoring Program (PDMP) in Florida.
- Our findings suggest that health care provider use of the PDMP played a role.
- Results have implications for national prescription drug abuse policy.

Opioid Overdose Deaths and Florida's Crackdown on Pill Mills

Alexe Kennedy-Hendricks, PhD, Matthew Richey, PhD, Emma E. McCinty, PhD, MS, Elizabeth A. Stuart, PhD, Colleen L. Barry, PhD, MPP, and Daniel W. Webster, ScD, MPH

(Am J Public Health. 2016;106:291–297. doi:10.2105/AJPH.2015.302953)



“Modest Decrease” in opioid prescriptions

Research

Original Investigation

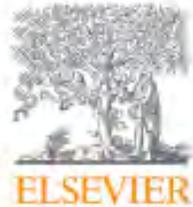
Effect of Florida's Prescription Drug Monitoring Program and Pill Mill Laws on Opioid Prescribing and Use

Lainie Rutkow, JD, PhD, MPH; Hsien-Yen Chang, PhD; Matthew Daubresse, MHS; Daniel W. Webster, ScD, MPH; Elizabeth A. Stuart, PhD; G. Caleb Alexander, MD, MS

JAMA Intern Med. 2015;175(10):1642-1649.

doi:10.1001/jamainternmed.2015.3931 Published online August 17, 2015.

Prescriptions decreased, mortality increased: I-STOP



Drug and Alcohol Dependence

Volume 178, 1 September 2017, Pages 348-354



Full length article

Impact of New York prescription drug monitoring program, I-STOP, on statewide overdose morbidity

Richard Brown ^a , Moira R. Riley ^b  , Lydia Ulrich ^c, Ellen Percy Kraly ^d , Paul Jenkins ^b , Nicole L. Krupa ^b ,
Anne Gadomski ^b  

PDMP: decrease in pills, no increase in mortality

Addictive Behaviors 69 (2017) 65–77

Contents lists available at ScienceDirect

 **Addictive Behaviors** 

journal homepage: www.elsevier.com/locate/addictbeh

Prescription drug monitoring programs, nonmedical use of prescription drugs, and heroin use: Evidence from the National Survey of Drug Use and Health 

Mir M. Ali ^{a,*}, William N. Dowd ^b, Timothy Classen ^c, Ryan Mutter ^a, Scott P. Novak ^d

^a Center for Behavioral Health Statistics & Quality, Substance Abuse & Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20852, United States
^b Behavioral Health Economics, RTI International, United States
^c Department of Economics, Loyola University Chicago, United States
^d Behavioral Health Epidemiology, RTI International, United States

HIGHLIGHTS

- First paper to examine the role of prescription drug monitoring program (PDMP) on individual level opioid related outcomes.
- Significant association between PDMP implementation and reduction in 'doctor shopping' behavior.
- No significant associations between PDMP implementation or its associated features on heroin initiation.
- No significant associations between PDMP implementation on nonmedical use/initiation/abuse of opioids.



PUBLIC HEALTH CODE (EXCERPT) Act 368 of 1978

- ▶ (4) A person that receives data or any report under subsection (2) containing any patient identifiers of the system from the department shall not provide it to any other person except by order of a court of competent jurisdiction.



Does HIPAA provide extra protections for mental health information compared with other health information?

- ▶ Generally, the Privacy Rule applies uniformly to all protected health information, without regard to the type of information. One exception to this general rule is for psychotherapy notes, which receive special protections.
- ▶ Psychotherapy notes are treated differently from other mental health information both because they contain particularly sensitive information and because they are the personal notes of the therapist that typically are not required or useful for treatment, payment, or health care operations purposes, other than by the mental health professional who created the notes.

<https://www.hhs.gov/sites/default/files/hipaa-privacy-rule-and-sharing-info-related-to-mental-health.pdf>



U.S. Food and Drug Administration
Protecting and Promoting Your Health

Drug Safety Communications

FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering

Safety Announcement

[4-9-2019] The U.S. Food and Drug Administration (FDA) has received reports of serious harm in patients who are physically dependent on opioid pain medicines suddenly having these medicines discontinued or the dose rapidly decreased. These include serious withdrawal symptoms, uncontrolled pain, psychological distress, and suicide.



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Drug Safety Communications

While we continue to track this safety concern as part of our ongoing monitoring of risks associated with opioid pain medicines, we are requiring changes to the prescribing information for these medicines that are intended for use in the outpatient setting. These changes will provide expanded guidance to health care professionals on how to safely decrease the dose in patients who are physically dependent on opioid pain medicines when the dose is to be decreased or the medicine is to be discontinued.



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Drug Safety Communications

Rapid discontinuation can result in uncontrolled pain or withdrawal symptoms. In turn, these symptoms can lead patients to seek other sources of opioid pain medicines, which may be confused with drug-seeking for abuse. Patients may attempt to treat their pain or withdrawal symptoms with illicit opioids, such as heroin, and other substances.

<https://www.hhs.gov/ash/advisory-committees/pain/reports/index.html>

PAIN MANAGEMENT

BEST PRACTICES



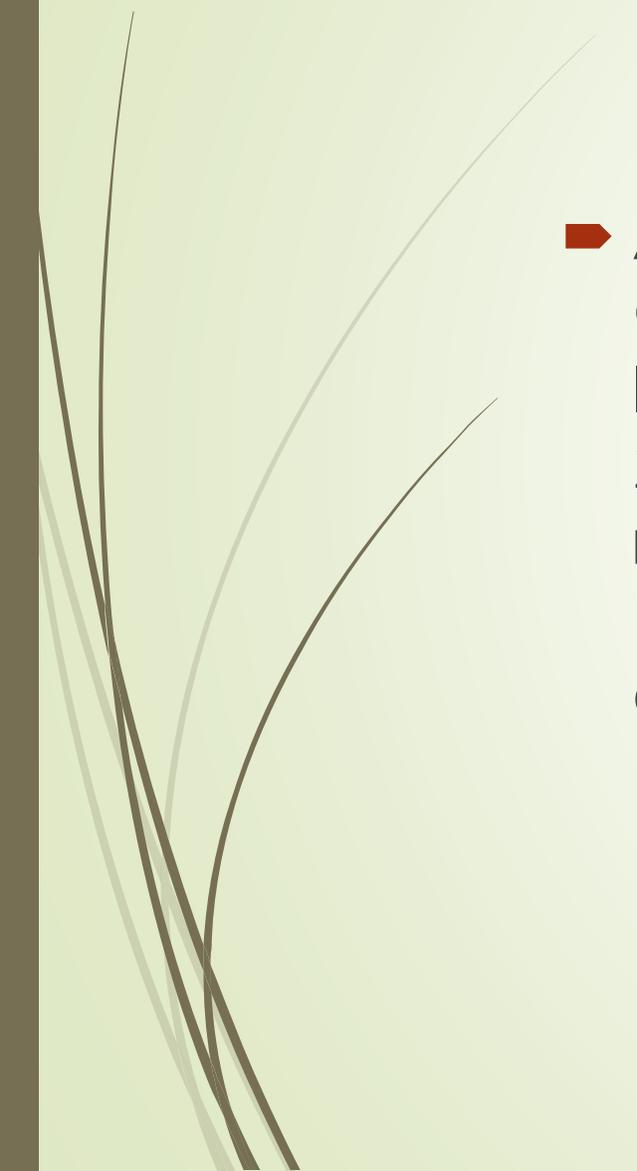
PAIN MANAGEMENT BEST PRACTICES INTER-AGENCY TASK FORCE REPORT

Updates, Gaps, Inconsistencies, and Recommendations

FINAL REPORT

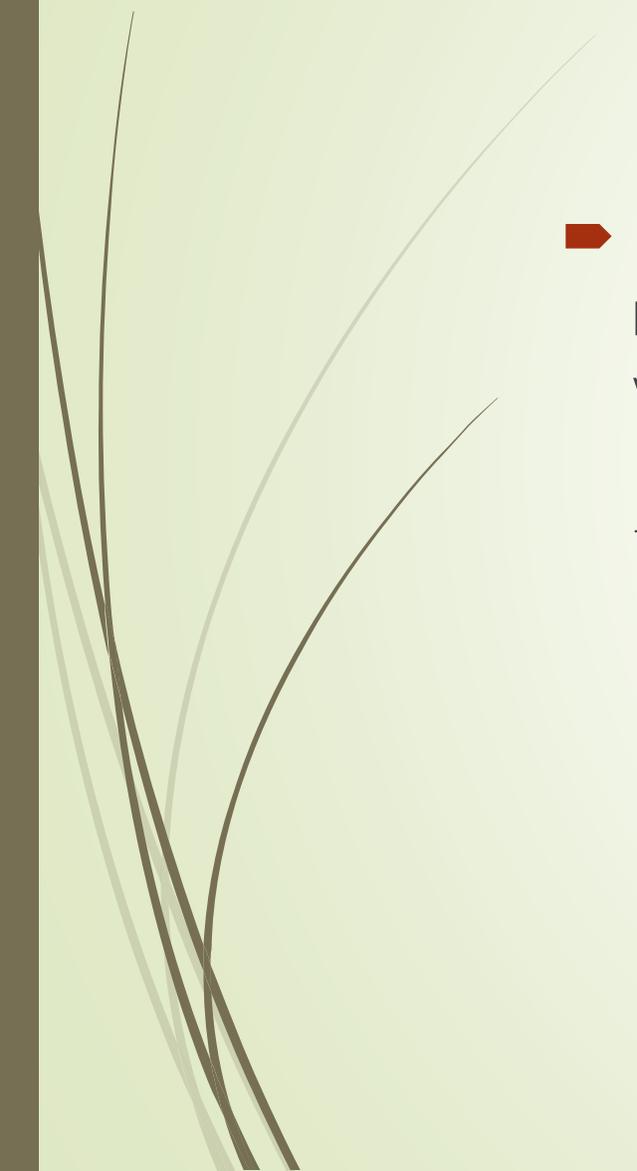


Pain Management Best Practices: Inter-agency Task Force Report

- ▶ A review of the CDC Guideline (as mandated by the Comprehensive Addiction and Recovery Act legislation): The Task Force recognizes the utility of the 2016 Guideline for Prescribing Opioids for Chronic Pain released by the CDC and its contribution to mitigating unnecessary opioid exposure and the adverse outcomes associated with opioids.
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Pain Management Best Practices: Inter-agency Task Force Report

- ▶ It also recognizes unintended consequences that have resulted following the release of the guidelines in 2016, which are due in part to misapplication or misinterpretation of the guideline, including forced tapers and patient abandonment.
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Pain Management Best Practices: Inter-agency Task Force Report

- ▶ The CDC recently published a pivotal article in the New England Journal of Medicine on April 24, 2019, specifically reiterating that the CDC Guideline has been, in some instances, misinterpreted or misapplied.¹ The authors highlight that the guideline does not address or suggest discontinuation of opioids prescribed at higher dosages.

Questions?

