Florida's Prescription Drug Monitoring Program

E-FORCSE
Electronic-Florida Online Reporting of Controlled Substances Evaluation

A Powerful Tool in the Fight Against the Opioid Epidemic

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To get more information or copies of this guide, PDMP flyer and Pocket Card please email requests to
preventoverdoseduval@flhealth.gov

The PDMP Guide was produced by the OD2A team which is part of a program within the Florida Department of Health in Duval County.

This PDMP guide was produced in February 2021.

Florida Health: the first accredited health system in the U.S.

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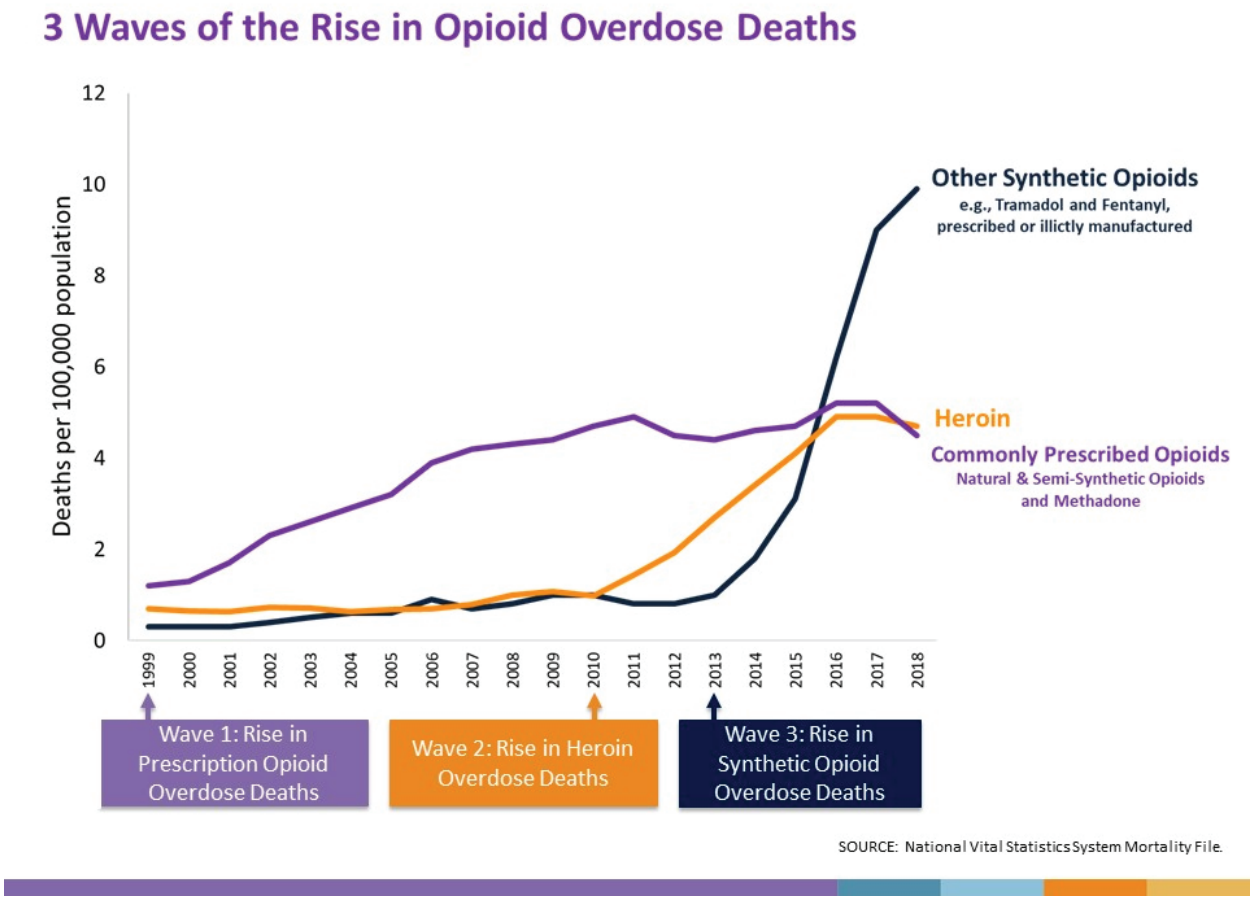
The Opioid Epidemic

From 1999-2018, almost 450,000 people died from an overdose involving any opioid, including prescription and illicit opioids.[1]

The rise in opioid overdose deaths can be outlined in 3 distinct waves:

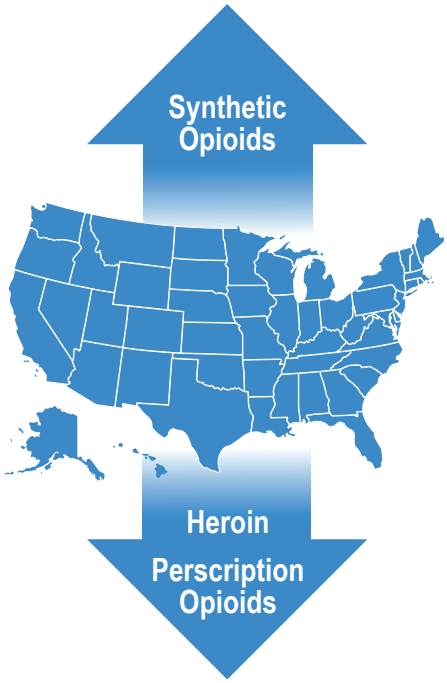
1. Increased prescribing of opioids in the 1990s, with overdose deaths involving prescription opioids (natural and semi-synthetic opioids and methadone) increasing since at least 1999.[2]
2. 2010 with rapid increases in overdose deaths involving heroin.[3]
3. 2013 with significant increases in overdose deaths involving synthetic opioids, particularly fentanyl.[4-6]



References:

1. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2020.
2. Centers for Disease Control and Prevention (CDC). Vital signs: overdoses of prescription opioid pain relievers—United States, 1999–2008. MMWR MorbMortal Wkly Rep. 2011 Nov 4; 60(43):1487-1492.
3. Rudd RA, Paulozzi LJ, Bauer MJ, Burleson RW, Carlson RE, Dao D, Davis JW, Dudek J, Eichler BA, Fernandes JC, Fondario A. Increases in heroin overdose deaths—28 states, 2010 to 2012. MMWR MorbMortal Wkly Rep. 2014 Oct 3; 63(39):849.
4. Gladden RM, Martinez P, Seth P. Fentanyl law enforcement submissions and increases in synthetic opioid-involved overdose deaths—27 states, 2013–2014. MMWR MorbMortal Wkly Rep. 2016; 65:837–43.
5. O'Donnell JK, Gladden RM, Seth P. Trends in deaths involving heroin and synthetic opioids excluding methadone, and law enforcement drug product reports, by census region—United States, 2006–2015. MMWR MorbMortal Wkly Rep. 2017; 66:897–903.
6. O'Donnell JK, Halpin J, Mattson CL, Goldberger BA, Gladden RM. Deaths involving fentanyl, fentanyl analogs, and U-47700—10 states, July–December 2016. MMWR Morb Mortal Wkly Rep. 2017; 66:1197–202.

United States Overdose Statistics



In 2018, 67,367 people died of a drug overdose.[1]

Opioids were involved in 46,802 of these deaths (nearly 70%).

- More than 28,000 involved synthetic opioids (60%).
- 14,996 involved heroin (32%).
- 14,975 involved prescription opioids (32%).

Overall overdose death rates decreased by 4.1% from 2017 to 2018 in the United States.[2]

Death rates involving heroin decreased by 4%.[3]

Death rates involving prescription opioids decreased by 13%.[3]

While progress has been made to combat overdose deaths, death rates involving synthetic opioids (excluding methadone) increased by 10% from 2017 to 2018 in the United States.[3]

References:

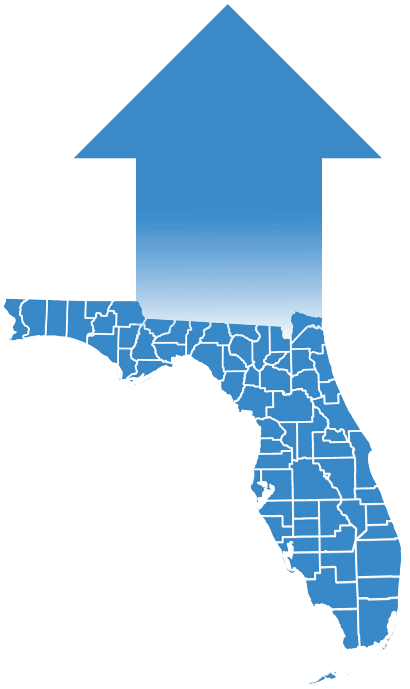
1. NCHS, National Vital Statistics System, Mortality.
2. Hedegaard H, Miniño AM, Warner M. Drug overdose deaths in the United States, 1999–2018. NCHS data brief, no 356. Hyattsville, MD: US Department of Health and Human Services, CDC, National Center for Health Statistics; 2020.
3. Wilson N, Kariisa M, Seth P, et al. Drug and Opioid-Involved Overdose Deaths—United States, 2017-2018. MMWR Morb Mortal Wkly Rep 2020;69:290-297.

In 2018, 128 people died every day from an opioid overdose.

Another way to view this…everyone aboard a Boeing 737 dying in a plane crash daily.

Florida Overdose Statistics

In 2018, 4,698 people died of a drug overdose.[1]



Opioids were involved in 3,189 of these deaths (nearly 68%).

- 2,091 involved synthetic opioids (66%).
- 689 involved heroin (22%).
- 1,282 involved prescription opioids (40%).

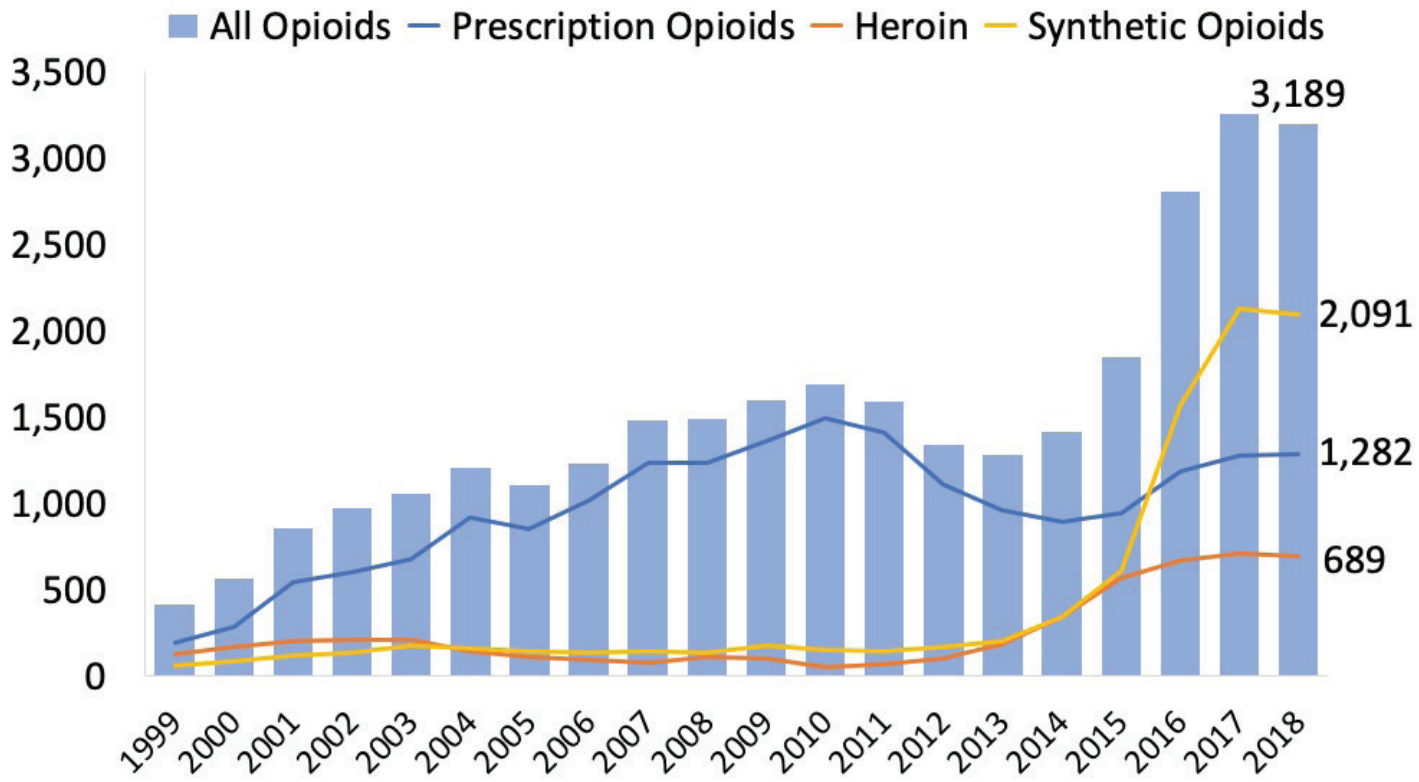


Figure: Number of drug and opioid-involved overdose deaths in Florida. Deaths may have involved more than one substance. **Source: CDC WONDER, 2020.**

Reference:

1. Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2018 on CDC WONDER Online Database released in 2020. Data are from the Multiple Cause of Death Files, 1999-2018, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. (2020 February 14).

E-FORCSE®: Florida's Prescription Drug Monitoring Program

Florida's Prescription Drug Monitoring Program, known as E-FORCSE® (Electronic-Florida Online Reporting of Controlled Substances Evaluation) is a database that collects and stores schedule II-V controlled substance dispensing information. Authorized users are able to access patient histories to provide medical treatment to a current patient.

The purpose of using E-FORCSE® is to encourage safer prescribing of controlled substances and reduce drug abuse and diversion within the state.

Florida's prescription drug monitoring program (PDMP) has been in use since 2011 and it shares information with 29 states and the Military Health System.

When it comes to opioids, E-FORCSE® improves patient safety by:

- Identifying patients who are obtaining opioids from multiple providers.
- Calculating the total amount of opioids prescribed per day (in MME/day).
- Identifying patients who are being prescribed other substances that may increase risk of opioids—such as benzodiazepines.

After Florida implemented its PDMP in 2011, it saw a 50% decrease in oxycodone overdose deaths in 2012.

Florida Legal Requirements Related to Consulting The PDMP

Florida House Bill 21: Controlled Substances

Effective: July 2018

Mandated the following changes (among others) to opioid prescribing:

- A limit of a 3-day to 7-day supply of opioids for acute pain.
- A prohibition of refills ordered with the initial opioid prescription for acute pain.
- A requirement that the prescribing physician or his or her designee check Florida's PDMP prior to prescribing opioids.

Requirements for Prescribing a Controlled Substance:

The legal requirements for prescribing a controlled substance fall under Florida Statutes sections 456.44 (Controlled substance prescribing) and 893.055 (Prescription drug monitoring program).

Below are the PDMP legal requirements related to prescribers and dispensers:

Fla Stat 893.055 (8): A prescriber or dispenser or a designee of a prescriber or dispenser **must consult the system to review a patient's controlled substance dispensing history before prescribing or dispensing a controlled substance for a patient age 16 or older**. This requirement does not apply when prescribing or dispensing to a patient who has been admitted to hospice.

Fla Stat 893.055 (8) (b): A prescriber or dispenser or designee of a prescriber or dispenser who does not consult the system shall **document the reason he or she did not consult the system in the patient's medical record** or prescription record and **shall not prescribe or dispense greater than a 3-day supply of a controlled substance** to the patient.

Fla Stat 893.055 (11): A prescriber or dispenser, or his or her designee, may have access to the information which relates to a patient of that prescriber or dispenser as needed for the purpose of reviewing the patient's controlled substance prescription history.

Statutory Exemptions Include:

- If the patient is less than 16 years of age.
- Drug being prescribed is a non-opioid schedule V.
- System is not operational (see requirement above).
- Requestor has technological or electrical failure (see requirement above).

Disciplinary Actions Under PDMP Law:

- The PDMP program manager, upon determining a pattern consistent with the rules and having cause to believe a violation has occurred, may provide relevant information to the applicable law enforcement agency.
- The department shall issue a non-disciplinary citation to any prescriber or dispenser who fails to consult the system as required by this subsection for any initial offense. Each subsequent offence is subject to disciplinary action pursuant to s. 456.073.
- A person who willfully and knowingly fails to report the dispensing of a controlled substance as required by this section commits a misdemeanor of the first degree.
- A person who willfully and knowingly inappropriately accesses the PDMP information commits a felony of the third degree, punishable as provided in s. 775.082, s. 77.083, or s. 775.084.

E-FORCSE® Patient Requests and Patient Advisory Reports

Clinicians may request patient-specific information and reports to guide their prescribing decisions.

RxSearch

The RxSearch section of the E-FORCSE® portal menu contains the query functions available. These functions include:

- Creating a patient request.
- Performing a bulk patient search.
- Viewing historical requests.
- Viewing prescriber reports.

Creating A Patient Request

The patient request allows providers to create a report that displays the prescription drug activity for a specific patient for a specified time-frame. This report is called a NarxCare report and includes the following:

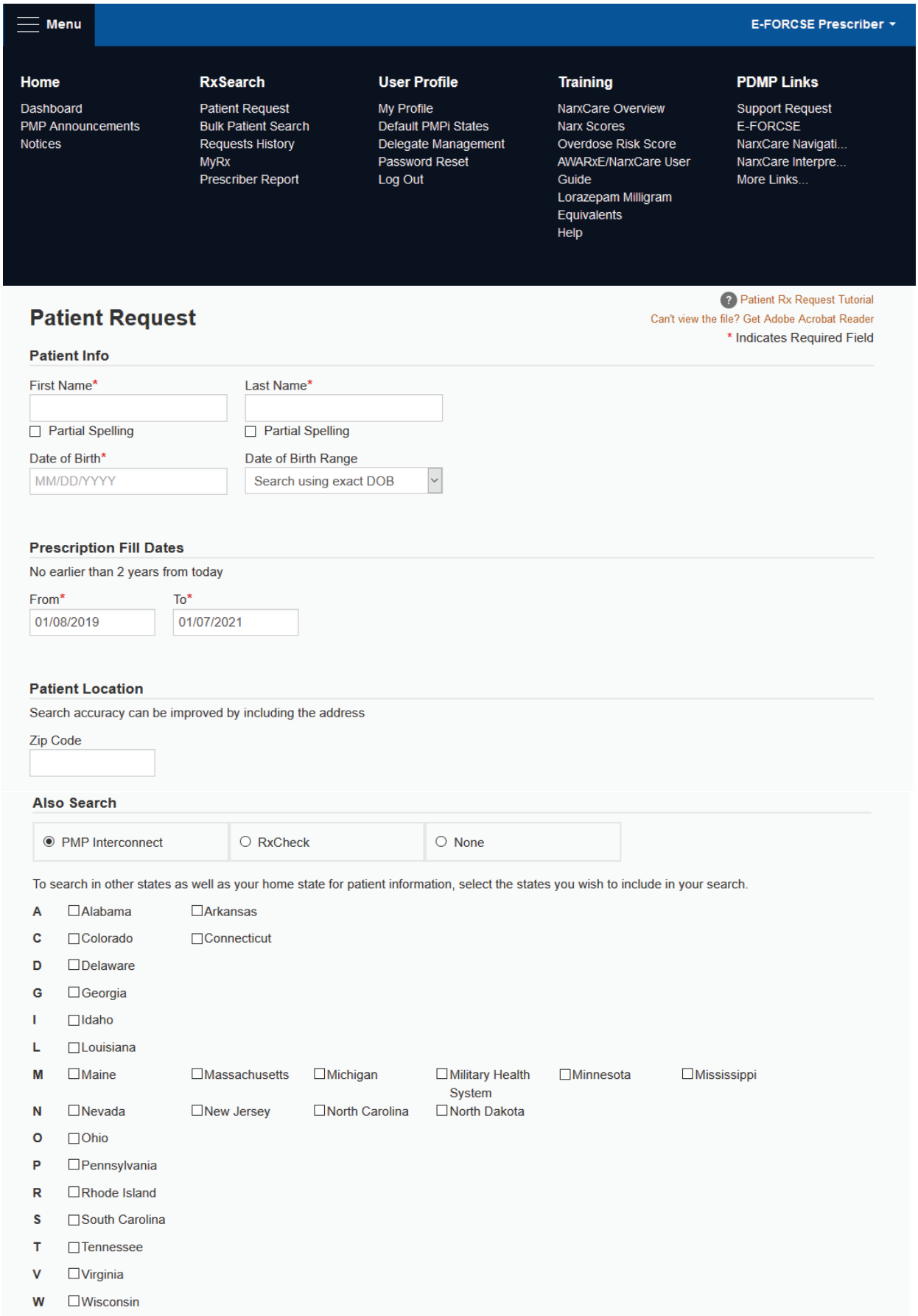
- Patient information
- Patient Overdose Risk Score
- Prescriptions
- Prescribers
- Dispensers
- Summary

Under "**RxSearch**", choose "**Patient Request**". Fill out required information and then click "**Search**". At a minimum, the following must be provided:

- First Name
- Last Name
- Date of Birth (MM/DD/YYYY)
- Prescription fill dates (MM/DD/YYYY)

From your search results, select one or more of the patients displayed, and then click "**Run Report**".

Patient Request Web Page Example



Patient Advisory Report (NarxCare Report)
NarxCare is a care management platform within E-FORCSE® that allows prescribers and pharmacists to analyze real-time controlled substance data. It helps clinicians make decisions with objective insight into a patient's controlled substance use history, ultimately leading to improved patient safety.

NarxCare improves best practices by:

- Preventing duplicate prescribing of controlled substances.
- Identifying potential interactions and helps prevent adverse drug events.
- Detecting if a patient received multiple prescriptions for the same drug from multiple clinicians.
- Verifies therapeutic adherence.

Clinicians can download a PDF or CSV report file of the PDMP data and show and discuss the information found on this report with patients to assist in treatment decisions.

> **NOTE:** Clinicians cannot give copies to the patient. Patients should be directed to the E-FORCSE® website to request copies of their reports.

The report provides:

- Narcotic, sedative and stimulant scores (Narx scores).
- Overdose risk score (ORS).
- Additional risk indicators.

Explanations and guidance for each report parameter are provided within the report.

The NarxCare report and Narx scores are intended to aid, not replace, medical decision making. The information presented should not be used as sole justification for providing or refusing to provide medications.

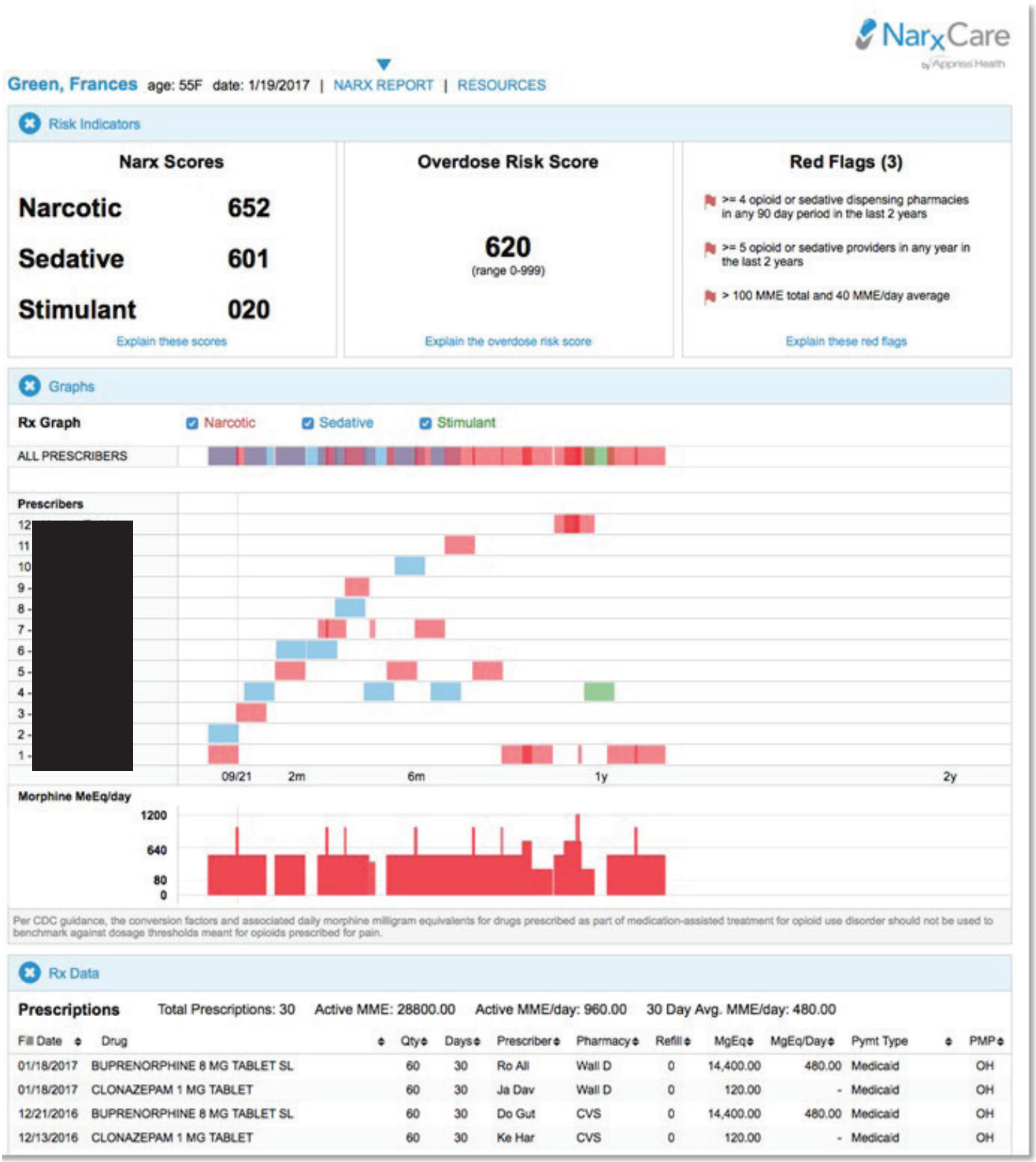
How Does NarxCare work?
NarxCare automatically accesses PDMP data, analyzes it, scores it, and generates an interactive visually enhanced report that enables the prescriber or dispenser to quickly understand the nature of a patient's controlled substance use history.

The report contains functional areas aimed to rapidly raise awareness of risk and prescription use patterns and when required individual prescription detail.

How Do I Navigate NarxCare?
The report interface is designed such that data becomes more detailed as you move down the report. Data visualization is enhanced with color-coded graphical displays where appropriate.

Clicking on the **menu icon** at the top of the page allows for navigation to all functional areas. The NarxCare report is the default screen. The **resources tab** enables providers to link patients with treatment and easily obtain useful reference materials and patient handouts.

NarxCare Report Example



NarxCare Risk Indicators

Narx Scores for Narcotics, Sedatives and Stimulants

Narx Score Range: 000-999

Every NarxCare report includes type specific use scores for narcotics, sedatives and stimulants. Narx scores are delivered into workflow automatically as discreet data, easily viewable within a patient's record. Scores are best viewed at the beginning of a patient encounter and should be obtained at or near the time a patient is registered.

These scores are intended to raise awareness to the amount and complexity of the PDMP data available. In general, the scores correspond to the number of risk factors for the patient that exist within their history in the PDMP data. These risk factors include:

- Number of prescribers
- Number of pharmacies
- Amount of medication (in milligram equivalents)
- Overlapping prescriptions

Increasing numbers of prescribers, pharmacies, milligram equivalencies, and overlapping prescriptions result in higher scores. More recent activity is weighted more heavily than distant activity as are overlapping prescriptions.

A patient who uses a high dose of medication for a long period of time will not necessarily have a high score.

The last digit of a Narx score equals the number of active prescriptions of that drug type.

- **Example**: A narcotics score of 504 indicates a patient should have 4 active narcotic prescriptions according to the dispensing information in the PDMP.

Narx scores are distributed within the PDMP population as follows:

- 75% of patients score below 200
- 5% of patients score above 500
- 1% of patient score above 650

- Patients who use small amounts of medication with limited provider and pharmacy usage will have **low scores**.
- Patients who use large amounts of medications in accordance with recommended guidelines (single provider, single pharmacy, etc.) will have **mid-range scores**.
- Patients who use large amounts of medications while using many providers and pharmacies, and with frequently overlapping prescriptions, will have **high scores**.

How is a Narx Score Calculated?
Narx scores represent a relative scoring system. The risk factors representing use within a PDMP report are counted and then converted to a percentile-based reference value that ranges from 0-99. Add the number of active prescriptions for a narcotic, sedative or stimulant and you get a Narx score.

To Note:

- A Narx score must be applied to the clinical scenario before evaluating appropriateness.
- Scores that raise concern should trigger a discussion, not a decision!
- Narx scores are not abuse scores.

Narx Score-based Guidance

Score/Range	Notes	Recommendations
000	This may be the first prescription of this type for the patient.	Discuss risks/benefits of using a controlled substance. Consider informed consent.
010-200	Approximately 75% of scores fall in this range. Occasionally, patients in this score range have a remote history of high usage (>1 year ago).	Review use patterns for unsafe conditions. Discuss any concerns with patient. See guidance below. If previously high usage exists with recent abstinence, consider risk/benefits of new prescriptions.
201-650	Approximately 24% of scores fall in this range.	Review use patterns for unsafe conditions. Discuss any concerns with patient. See guidance below.
>650	Approximately 1% of scores fall in this range. Some patient records may have a score in this range and *still be within prescriber expectations*. Many patient records include some level of multiple provider episodes, overlapping prescriptions, or elevated milligram equivalency.	Review use patterns for unsafe conditions. If multiple providers involved in unsafe prescribing, discuss concern with patient and consider contacting other providers directly. If multiple pharmacies involved in unsafe prescribing, discuss concern with patient and consider pharmacy lock-in program. If overlapping medications of same or different type, discuss concern with patient and consider taper to lower dose and/or discontinuation of potentiating medications. If patient has evidence of a substance use disorder, consider inpatient admit or referral for outpatient evaluation and treatment.

Overdose Risk Score (ORS)

ORS Score Range: 000-999

Represents the risk of unintentional overdose death. Higher scores indicate an increased risk of unintentional overdose.

Based on an Ohio study evaluating 1,687 unintentional overdose deaths from the year 2014.

Utilizes 10 variables based on their independent predictive ability.

The risk of unintentional overdose death approximately doubles for every 100-point increase in the ORS.

Patient's with a history of previous overdose automatically get a score of 991 unless they have had multiple overdose events, in which case the last digit equals the number of previous overdoses (i.e. 3 prior overdoses=993).

The ORS can be applied to clinical practice in a manner similar to daily morphine milligram equivalent (MME):

- ORS of **450** can be used as a threshold of risk approximately equivalent to a patient receiving opioid doses of **50 MME/day**.
- ORS of **650** can be used as a threshold of risk approximately equivalent a patient receiving opioid doses of **90 MME/day** (the CDC's recommended maximum daily MME).

The ORS captures equivalent or greater risk at the above thresholds, and patients may be appropriate for:

- Naloxone* prescriptions
- Substance use disorder evaluation and treatment (if appropriate)
- Discontinuation of potentiating drugs (if present)
- Dose reduction
- Provider lock-in
- Pharmacy lock-in
- Consideration of non-opioid therapy

*The CDC Guideline for Prescribing Opioids for Chronic Pain recommend naloxone be considered in patients receiving opioid doses at a level of 50 MME/day, and that most patients should be provided naloxone if receiving doses at a level of ≥90 MME/day.

To Note:

ORS often correlates with the Narx scores, but not always. When differences exist, it is often because of different weighting associated with those elements that contribute to overdose risk. For instance, pharmacy usage is more predictive of overdose death than daily MME therefore carries more weight in the ORS as compared with its weight in calculating a Narx score. Also, certain decreases in use may increase risk of death. For example, a person who obtains opioid medications sporadically may have a lower MME but is subject to opioid naïve periods and have a high ORS.

Overdose Risk Score (ORS) Score-based Guidance

Score	Approximate CDC MME Equivalent	Guidance
<010-440	<50 MME	Consider other sources of risk beyond PDMP data. See below.
450-650	50 MME (or more)	Consider Naloxone prescription. See below.
>650	90 MME (or more)	Consider naloxone prescription, especially if previous overdose is documented. Review use patterns for unsafe conditions. If multiple providers involved in unsafe prescribing discuss concern with patient and consider contacting other providers directly. If multiple pharmacies involved in unsafe prescribing discuss concern with patient and consider pharmacy lock-in program. If overlapping medications of same or different type, discuss concern with patient and consider taper to lower dose and/or discontinuation of potentiating medications. If patient has evidence of a substance use disorder, consider inpatient admit or referral for outpatient evaluation and treatment.

Additional Risk Indicators

3 additional risk indicators (ARIs) are included as part of the NarxCare report:

- More than 5 providers in any year (365 days).
- More than 4 pharmacies in any 90-day period.
- More than 40 MME/day average and more than 100 MME total at any time in the previous 2 years.

Additional Risk Indicator-based Guidance

Indicator	Guidance
More than 5 providers in any year (365 days)	Review use patterns for unsafe conditions. If multiple providers involved in unsafe prescribing, discuss concern with patient and consider contacting other providers directly.
More than 4 pharmacies in any 90-day period	Review use patterns for unsafe conditions. If multiple pharmacies involved in unsafe prescribing, discuss concern with patient and consider pharmacy lock-in program.
More than 40 MME/day average and more than 100 MME total at any given time in the past 2 years	Review use patterns for unsafe conditions. Consider taper to lower dose and/or discontinuation of potentiating medications.
If all 3 indicators present	Review use patterns for unsafe conditions. If multiple providers involved in unsafe prescribing, discuss concern with patient and consider contacting other providers directly. If multiple pharmacies involved in unsafe prescribing, discuss concern with patient and consider pharmacy lock-in program. If overlapping medications of same or different type, discuss concern with patient and consider taper to lower dose and/or discontinuation of potentiating medications. If patient has evidence of a substance use disorder, consider inpatient admit or referral for outpatient evaluation and treatment.

NarxCare RX Graph

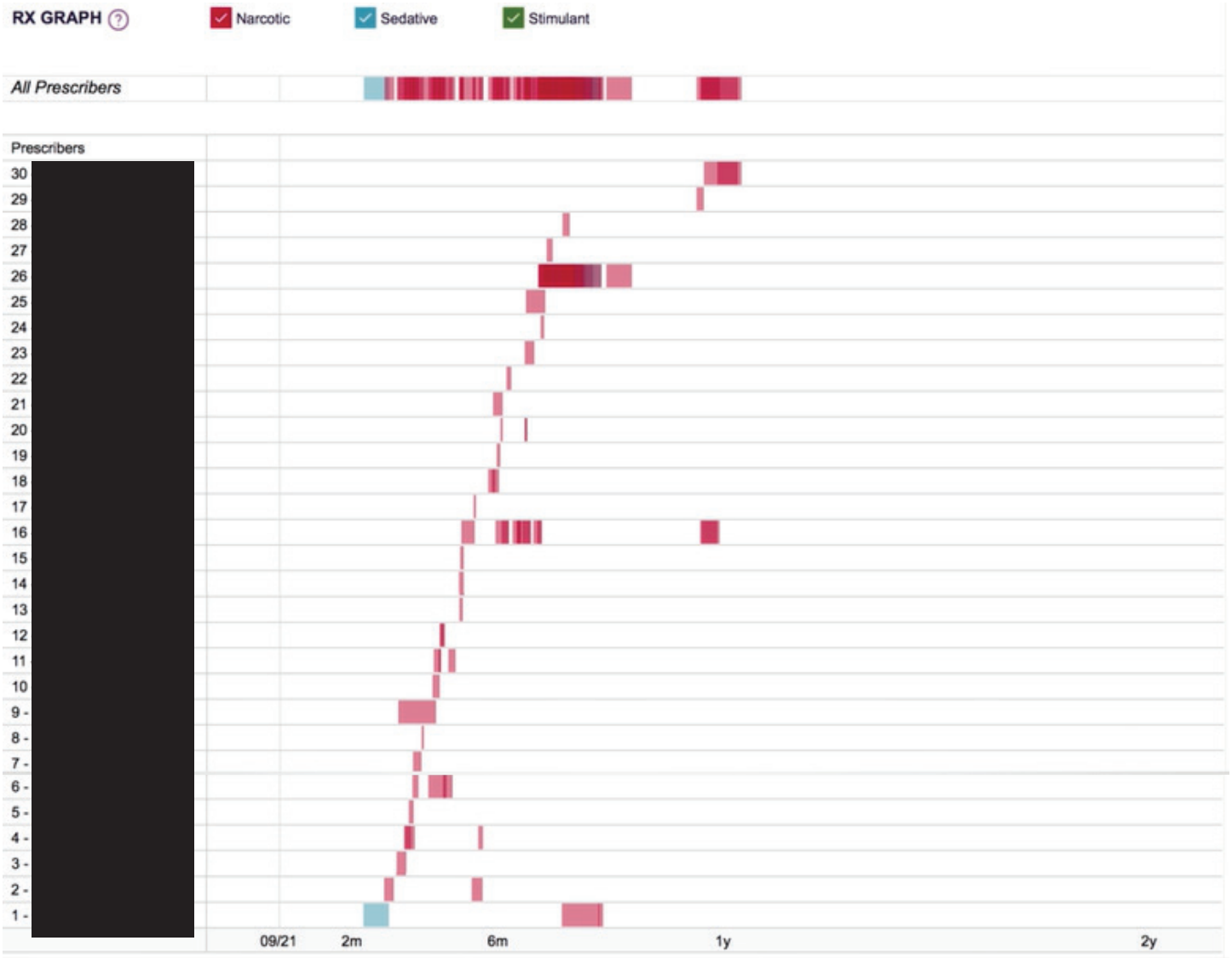
The RX graph portion of the NarxCare report is a key instrument that allows clinicians to rapidly see patterns and levels of use. Prescriptions are color coded as follows and may be selected at the top of the graph:

- Narcotics are **red**.
- Sedatives are **blue**.
- Stimulants are **green**.
- Buprenorphine is treated separately from other opioids and is **purple**.

The RX graph is reverse time ordered. The most recent prescriptions are on the left side of the graph and the oldest are on the right. Each pixel in the graph represents one day. A 1-3 day prescription appears as a narrow vertical bar. A 30-day prescription appears as a longer bar.

The RX graph is interactive. Prescriptions can be clicked on or dragged over to see greater detail. Providers can also be clicked on for additional information.

NarxCare RX Graph Example



Milligram equivalent dosing graphs are found beneath the RX graph. There are separate graphs for opioid and sedative medications.

Buprenorphine is treated separately from other opioids and has its own associated graph. Importantly, buprenorphine is not included in MME calculations.

NarxCare Summary

The summary section provides useful metrics that include current quantity which corresponds to an expected pill count for all active medications.

NarxCare RX Data

Each prescription dispensed to a patient is presented in a table format with selectable column headers. Hover the cursor over the prescriber and pharmacy fields for additional data. All prescriber and pharmacy identities are presented in a table as well.

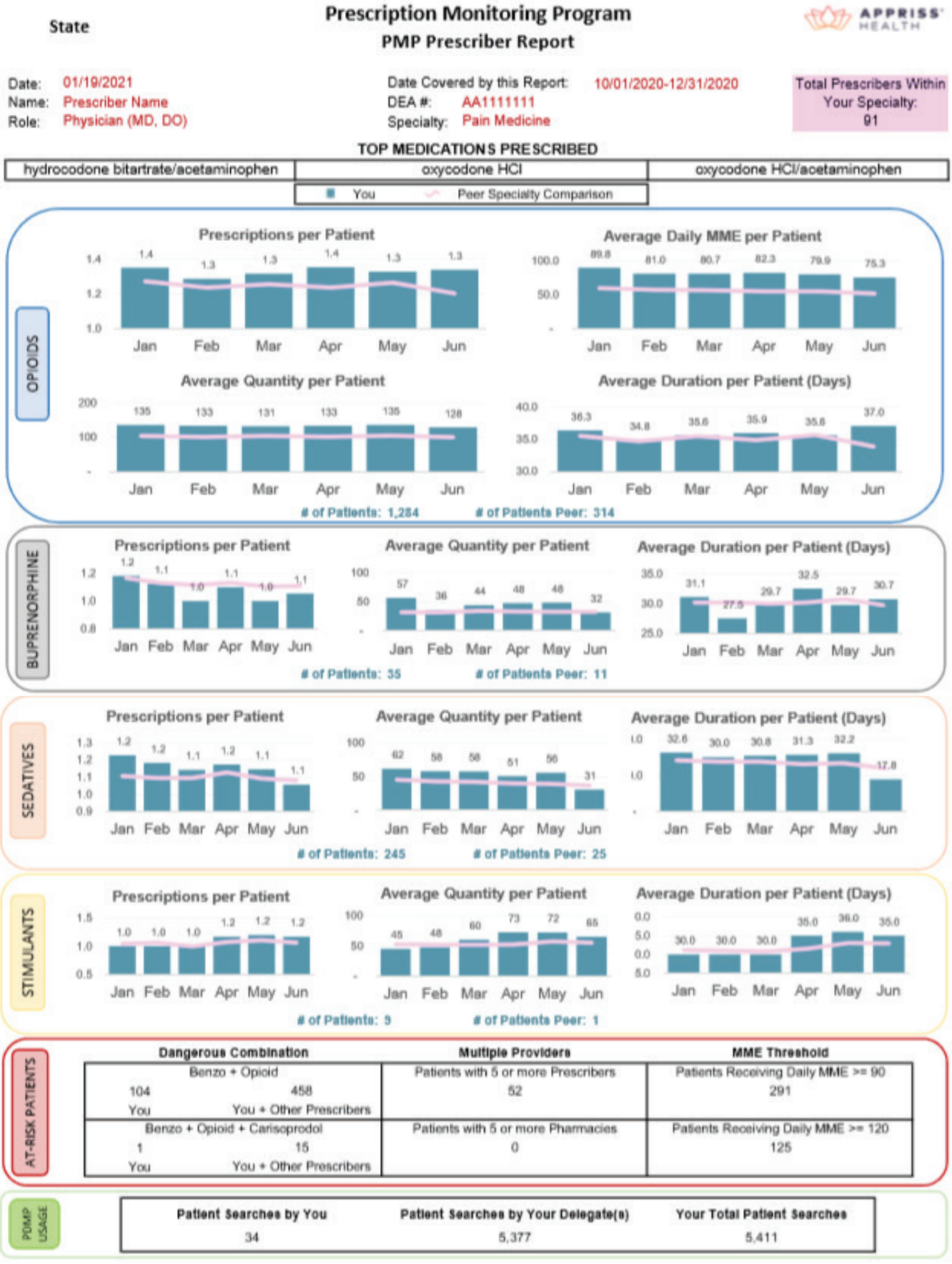
Prescriber Summary Quarterly Report

This report is delivered on a quarterly basis and providers a summary a prescribers' own prescribing history, including a comparison of their prescribing habits compared with the average prescriber of the same specialty, and a summary or graphical representation of their prescribing history.

Summary Includes:

- Top medications prescribed.
- Peer specialty comparison of:
  - Prescriptions per patient.
  - Average quantity per patient.
  - Average daily MME per patient.
  - Average duration per patient (days).
- Number patients at elevated risk:
  - Dangerous combinations.
  - Multiple providers and pharmacies.
  - MME threshold.
- PDMP usage:
  - Number of patient searches by clinician.
  - Number of patient searches by delegates.
  - Total patient searches.

Prescriber Summary Example



Create an E-FORCSE Account
To create an E-FORCSE account visit www.e-forcse.com. This website provides quick access to the PDMP platform.

For technical assistance, call 1-877-719-3120.

E-FORCSE Designee Registration
Prescribers may allow designees to access the system on their behalf to make patient requests.

Registering as a designee follows the same process as registering as any other healthcare professional role.

Supervisor (prescriber or pharmacist) must already have a registered account with E-FORCSE.

Designee cannot perform patient requests until supervisor has approved them.

E-FORCSE User Resources
The Department of Health/E-FORCSE provides the following resources to assist clinicians with use of the database:

- User Support Manual
- Quick Reference Guides
- Designee Access Information and Certification

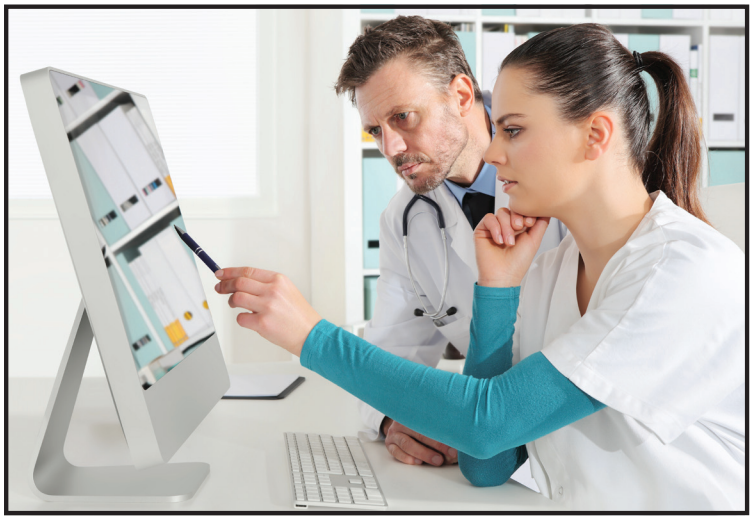
To obtain Information about all facets of the PDMP visit www.e-forcse.com.

E-FORCSE Training Resources
The following training resources are available upon logging into E-FORCSE:

- NarxCare Overview
- Narx Scores
- Overdose Risk Score
- AWARxE/NarxCare User Guide
- Lorazepam Milligram Equivalents

E-FORCSE
Electronic-Florida Online Reporting of Controlled Substances Evaluation

E-FORCSE Contact Information
Website: www.e-forcse.com
E-mail: e-forcse@flhealth.gov
Office: 850-245-4797
Technical Support: 877-719-3120



CDC Guideline for Prescribing Opioids for Chronic Pain

The CDC Guideline for Prescribing Opioids for Chronic Pain provides recommendations for the prescribing of opioid pain medication.

The guideline covers 3 main focus area and contains 12 recommendations:

1. **Determining when to initiate or continue opioids for chronic pain.**
   - Opioids Are Not First-Line Therapy.
   - Establish Goals for Pain and Function.
   - Discuss Risk and Benefits.

2. **Opioid selection, dosage, duration, follow-up and discontinuation.**
   - Use Immediate-Release Opioids When Starting.
   - Use the Lowest Effective Dose.
   - Prescribe Short Durations for Acute Pain.

3. **Assessing risk and addressing harms of opioid use.**
   - Evaluate Benefits and Harms Frequently.
   - Use Strategies to Mitigate Risk.
   - Review PDMP Data.
   - Use Urine Drug Testing.
   - Avoid Concurrent Opioid and Benzodiazepine Prescribing.
   - Offer Treatment for Opioid Use Disorder.

CDC Opioid Guideline Mobile App

- Milligram Morphine Equivalent (MME) calculator.
- Summaries of key recommendations.
- Link to full guideline.
- Motivational interviewing feature for practice.

Download for Free on Google Play or in the Apple Store!

All recommendations in the guideline were made based on a systematic review of the available evidence.

Reference:

1. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain--United States, 2016. JAMA. 2016 Apr 19;315(15):1624-45.

Highlighted within this guide are key points surrounding 5* of the 12 recommendations. To quickly access the full guideline, download the CDC mobile app.

Recommendation #1:	Opioids Are Not First-Line Therapy*
Recommendation #5:	Use the Lowest Effective Dose*
Recommendation #9:	Review PDMP Data*
Recommendation #11:	Avoid Concurrent Opioid and Benzodiazepine Prescribing*
Recommendation #12:	Offer Treatment for Opioid Use Disorder*

Opioids Are Not First-Line Therapy*: Nonpharmacologic 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 nonpharmacologic therapy and non-opioid pharmacologic therapy, as appropriate.

In a systematic review, opioids did not differ from non-opioid medication in pain reduction, and non-opioid medications were better tolerated, with greater improvements in physical function.[1]

While benefits for pain relief, function, and quality of life with long-term opioid use for chronic pain are uncertain, risks associated with long-term opioid use are clear and significant:

- Increased risk for opioid use disorder (OUD)
- Overdose
- Fractures
- Myocardial infarction
- Motor vehicle injury

Although opioids are commonly prescribed for many chronic pain conditions (e.g., low back pain, headache, fibromyalgia), the evidence is limited or insufficient for improved pain or function with long-term opioid therapy.

For many chronic pain conditions, there are disease-specific treatments available. For example, NSAIDS and acetaminophen for nociceptive pain, and tricyclic antidepressants, selected anticonvulsants, or transdermal lidocaine for neuropathic pain.

Non-opioid pharmacologic therapies are not generally associated with substance use disorder, and the numbers of fatal overdoses associated with non-opioid medications are a fraction of those associated with opioid medications.

Several non-opioid pharmacologic therapies are effective for chronic pain, examples include:

- **Acetaminophen (Tylenol)**
- **Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)**
  - Aspirin, Ibuprofen (Advil, Motrin), Naproxen (Aleve/Naprosyn)
- **Selected Antidepressants**
  - Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs):
    - Duloxetine (Cymbalta), Venlafaxine (Effexor XR), Milnacipran (Savella)
  - Tricyclic Antidepressants
- **Selected Anticonvulsants**
  - Gabapentin (Neuraptine), Pregabalin (Lyrica)
- **Medicated Creams, Foams, Gels, Lotions, Ointments, Sprays and Patches**
  - Anesthetics (Lidocaine), NSAIDS, Muscle Relaxers, Capsaicin, Compound Topicals

Recommended Treatments for Common Chronic Pain Conditions

CONDITION	MEDICATIONS	NONPHARMACOLOGIC THERAPIES	OTHER
LOW BACK PAIN	**First-Line:** NSAIDs, acetaminophen **Second-Line:** SNRIs, tricyclic antidepressants **Alternative First-Line:** Topical capsaicin	• Exercise • Cognitive behavioral therapy • Interdisciplinary rehabilitation	Self-care and education: Advise patient to remain active and limit bedrest
OSTEOARTHRITIS	**First-Line:** Oral NSAIDS, topical NSAIDs, acetaminophen **Second-Line:** Intra-articular hyaluronic acid, topical capsaicin, limited number of intra-articular glucocorticoid injections if acetaminophen and NSAIDs insufficient	• Exercise • Weight loss	Education
NEUROPATHIC PAIN **(DIABETIC NEUROPATHY AND POST-HEPATIC NEURALGIA)**	**First-Line:** Pregabalin, gabapentin, tricyclic antidepressants, SNRIs **Alternative First-Line:** Topical Lidocaine		
FIBROMYALGIA	**FDA-Approved:** Pregabalin, duloxetine, and milnacipran • Tricyclic antidepressants • Gabapentin	• Low-impact aerobic exercise (e.g., brisk walking, swimming, water aerobics, or bicycling) • CBT • Biofeedback • interdisciplinary rehabilitation	Education: Address diagnosis, treatment and the patient's role in treatment
MIGRAINES	**Preventive Treatments:** Beta-blockers, tricyclic antidepressants, antiseizure medications, calcium channel blockers **Acute Treatments:** Aspirin, acetaminophen, NSAIDs (may be combined with caffeine), Antinausea medication, triptans (migraine specific)	• CBT • Relaxation • Biofeedback • Exercise therapy	Avoid migraine triggers

Many nonpharmacologic therapies can ameliorate pain, examples include:

- Physical or occupational therapy to address posture, muscle weakness or repetitive occupational motions that contribute to musculoskeletal pain.
- Weight loss for knee osteoarthritis.
- Psychological therapies such as CBT and biofeedback.
- Heat and cold therapy.
- Massage therapy.
- Relaxation techniques: Guided Imagery, music, etc.
- Interventional procedures:
  - Arthrocentesis and intraarticular glucocorticoid injection for pain associated with rheumatoid arthritis or osteoarthritis.
  - Subacromial corticosteroid injection for rotator cuff disease.
- Exercise therapy for hip or knee osteoarthritis, low back pain, and fibromyalgia:
  - Aerobic, aquatic, and/or resistance
- Multimodal therapies and multidisciplinary biopsychosocial rehabilitation-combining approaches (e.g. psychological therapies with exercise).

Florida House Bill 743: Non-opioid Alternatives

Effective: July 1, 2020

Requires certain healthcare providers to inform patient about possible non-opioid alternatives and discuss advantages and disadvantages of non-opioid alternatives.

Before administering anesthesia involving the use of a Schedule II opioid, or prescribing or ordering a Schedule II opioid for the treatment of pain, a healthcare provider must:

- Inform patient of available non-opioid alternatives for the treatment of pain, which may include non-opioid medicinal drugs or drug products, interventional procedures or treatments, acupuncture, chiropractic treatments, massage therapy, physical therapy, occupational therapy, or any other appropriate therapy as determined by the healthcare practitioner. If there are NO appropriate alternatives to opioids, then the provider does not have to discuss alternatives.
- Discuss with patient the advantages and disadvantages of the use of non-opioid alternatives, including whether the patient is at a high risk of, or has a history of, controlled substance abuse or misuse and the patient's personal preferences.
- Provide the patient with a printed copy of an educational handout developed by the Department of Health. Handout available at: **http://www.floridahealth.gov/programs-and-services/non-opioid-pain-management/_documents/alternatives-facts-8.5x11-eng.pdf.**
- Document the non-opioid alternatives considered in the patient's record.

Exception: Providers do not have to provide this information when a patient is receiving care in a hospital critical care unit, the emergency department, or hospice.

Important to note that the above requirements <u>do not apply</u> if:

- Providing anesthesia that does not involve the use of a Schedule II opioid.
- Prescribing or ordering a Schedule II opioid for reasons other than the treatment of pain.
- Prescribing or ordering a Schedule III-V opioid, even for the treatment of pain.
- Prescribing or ordering a non-opioid controlled substance, regardless of the schedule.

Reference:

1. Welsch P, Sommer C, Schiltenwolf M, Häuser W. *Opioids in chronic non-cancer pain: are opioids superior to non-opioid analgesics?* a systematic review and meta-analysis of efficacy, tolerability and safety in randomized head-to-head comparisons of opioids versus non-opioid analgesics of at least four week's duration [in German]. Schmerz. 2015;29(1):85–95.

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.

Studies show that high dosages (≥100 MME/day) are associated with 2 to 9 times the risk of overdose compared to <20 MME/day.[1-2]

Always start at a low dose, go slow, and use an immediate-release opioid (recommendation #4).

Morphine Milligram Equivalent
An opioid dose should be examined in terms of its morphine milligram equivalent (MME) – its equivalency to morphine. Calculating MME accounts for differences in opioid drug type and strength.

Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk.

Higher doses of opioids are associated with higher risk of overdoses and death – even relatively low doses (20-50 MME per day) increase risk.[3] Dosages at or above 50 MME/day increase risk for overdose by at least 2x the risk at <20 MME/day.[3] Additionally, higher doses have not been shown to reduce pain over the long term.[4]

How much is 50 MME/Day for Commonly Prescribed Opioids:

- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (∽2 tablets oxycodone sustained-release 15 mg)
- 12 mg of methadone (<3 tablets of methadone 5 mg)

How Much is 90 MME/Day for Commonly Prescribed Opioids?

- 90 mg of hydrocodone (9 tablets of hydrocodone/acetaminophen 10/325)
- 60 mg of oxycodone (∽2 tablets of oxycodone sustained-release 30 mg)
- ∽20 mg of methadone (4 tablets of methadone 5 mg)

How Should the Total Daily Dose of Opioids be Calculated?

1) **DETERMINE** the total daily amount of each opioid the patient takes.
2) **CONVERT** each to MMEs – multiplying the dose for each opioid by its conversation factor (see table on page 25).
3) **ADD** them together.

Conversion Factors for Commonly Prescribed Opioids

OPIOID (doses in mg/day except where noted)	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	4
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

References:

1. Gomes T, Mamdani MM, Dhalla IA, Paterson JM, Juurlink DN. Opioid dose and drug-related mortality in patients with nonmalignant pain. Arch Intern Med. 2011 Apr 11;171(7):686-91.
2. Dunn KM, Saunders KW, Rutter CM, Banta-Green CJ, Merrill JO, Sullivan MD, Weisner CM, Silverberg MJ, Campbell CI, Psaty BM, Von Korff M. Opioid prescriptions for chronic pain and overdose: a cohort study. Ann Intern Med. 2010 Jan 19;152(2):85-92.
3. Zedler B, Xie L, Wang L, et al. Risk factors for serious prescription opioid-related toxicity or overdose among Veterans Health Administration patients. Pain Med. 2014;15(11):1911–1929.
4. Chou R, Deyo R, Devine B, Hansen R, Sullivan S, Jarvik JG, Blazina I, Dana T, Bougatsos C, Turner J. The Effectiveness and Risks of Long-Term Opioid Treatment of Chronic Pain. Evidence Report/Technology Assessment No. 218. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. 290-2012-00014-I.) AHRQ Publication No. 14-E005-EF. Rockville, MD: Agency for Healthcare Research and Quality; September 2014.

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.

A study showed patients with one or more risk factors (4 or more prescribers, 4 or more pharmacies, or dosage >100 MME/day) accounted for 55% of all overdose deaths.[1]

Use of PDMP Leads to Positive Outcomes[2-5]:

- Decline in per capita MME.
- Fewer prescription opioid-related overdose deaths.
- Reduction in the amount of opioids and benzodiazepines dispensed.
- Drop in patients seeing multiple provider for the same medication.

Most fatal overdoses are associated with patients receiving opioids from multiple prescribers and/or with patients receiving high total daily opioid dosages. These risk factors can be easily reviewed within the PDMP!

If PDMP Data Reveals a Concern

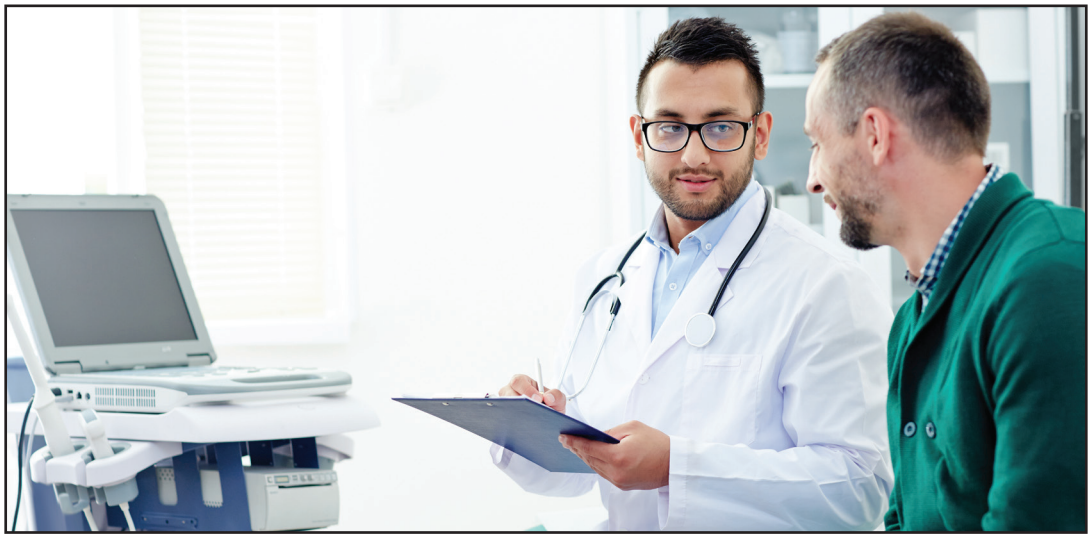
If a patient is found to have high opioid dosages, dangerous combinations of medications, or multiple controlled substance prescriptions written by different clinicians, several actions can be taken to augment your ability to improve patient safety:

- Discuss information from the PDMP with the patient and confirm that the patient is aware of the additional prescriptions. Occasionally, PDMP information can be incorrect (e.g., if the wrong name or birth date has been entered, the patient uses a nickname or maiden name, or another person has used the patient's identity to obtain prescriptions).
- Discuss safety concerns, including increased risk for respiratory depression and overdose, and consider offering naloxone.
- Discuss safety concerns with other clinicians prescribing controlled substances for your patient. Let your patient know that you plan to coordinate care with their other prescribers.
- Consider the possibility of a substance use disorder and discuss these concerns with your patient.
- If you suspect your patient might be sharing or selling opioids and not taking them, consider urine drug testing to assist in determine if opioids can be discontinued without causing withdrawal.

Whatever you do, do not dismiss patients from your practice on the basis of PDMP information. Doing so can adversely affect patient safety and result in missed opportunities to provide potentially life-saving information.

References:

1. Gwira Baumblatt JA, Wiedeman C, Dunn JR, Schaffner W, Paulozzi LJ, Jones TF. High-risk use by patients prescribed opioids for pain and its role in overdose deaths. JAMA Intern Med. 2014 May;174(5):796-801.
2. Dowell D, Zhang K, Noonan RK, Hockenberry JM. Mandatory Provider Review And Pain Clinic Laws Reduce The Amounts Of Opioids Prescribed And Overdose Death Rates. Health Aff (Millwood). 2016; 35(10):1876-1883.
3. Winstanley EL, Zhang Y, Mashni R, et al. Mandatory review of a prescription drug monitoring program and impact on opioid and benzodiazepine dispensing. Drug Alcohol Depend. 2018; 188:169-174.
4. Pardo B. Do more robust prescription drug monitoring programs reduce prescription opioid overdose? Addiction. 2017; 112(10):1773-1783.
5. State Successes. Centers for Disease Control and Prevention website. https://www.cdc.gov/drugoverdose/policy/successes.html.



Avoid Concurrent Opioid and Benzodiazepine Prescribing*: Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

One study found concurrent prescribing to be associated with a near quadrupling of risk for overdose death compared with opioid prescription alone.[1]

Benzodiazepines and opioids both cause central nervous system depression and can decrease respiratory drive, so concurrent use puts patients at greater risk for a potentially fatal overdose.

Muscle relaxants and hypnotics also cause central nervous system depression. Before prescribing any other medication that potentiates CNS depression, clinicians should consider whether benefits outweigh risk of concurrent use with opioids.

Reference:

1. Park TW, Saitz R, Ganoczy D, Ilgen MA, Bohnert AS. Benzodiazepine prescribing patterns and deaths from drug overdose among US veterans receiving opioid analgesics: case-cohort study. BMJ. 2015; 350:h2698.

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 (OUD).

A study showed patients prescribed high dosages of opioids long-term (>90 days) had 122 times the risk of opioid use disorder compared with patients not taking opioids.[1]

OUD is brain disorder characterized by loss of control of opioid use, risky opioid use, impaired social functioning, tolerance, and withdrawals.

OUD is common and treatable.

2 million people had an opioid use disorder in 2018.[2]

Medication-assisted treatment (MAT) is the gold standard for treating OUD. MAT is the use of medication in combination with counseling and behavioral therapies to provide a “whole-patient” approach. MAT medications are U.S. Food and Drug Administration (FDA)-approved and relieve withdrawal symptoms and psychological cravings.

Definition of OUD from the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)
A problematic pattern of opioid use leading to clinically significant impairment or distress, manifested by at least 2 defined criteria occurring within a year.

Diagnostic Criteria:

- Opioids are often taken in larger amounts or over a longer period of time than intended.
- There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- Craving, or a strong desire to use opioids.
- Recurrent opioid use resulting a failure to fulfill major role obligations at work, school or home.
- Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- Important social, occupational or recreational activities are given up or reduced because of opioid use.
- Recurrent opioid use in situations in which it is physically hazardous.
- Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
- Tolerance, as defined by either of the following:
    - A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
    - Markedly diminished effect with continued use of the same amount of an opioid.
- Withdrawal, as manifested by either of the following:
    - The characteristic opioid withdrawal syndrome.
    - The same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms.

If you suspect OUD based on screening, patient concerns or behaviors or on findings in PDMP data or from urine drug testing, discuss these concerns with your patient. Alternatively, you can arrange for a substance use disorder treatment specialist to assess for the presence of OUD.

Medication-Assisted Treatment Services Locators
The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. They provide services and links to useful resources for clinicians and patients.

SAMHSA's Buprenorphine Practitioner Locator
Find practitioners authorized to treat opioid dependency with buprenorphine by state.
https://www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator

SAMHSA's Opioid Treatment Program Directory
Find opioid treatment programs in a state.
https://dpt2.samhsa.gov/treatment/

SAMHSA's Behavioral Health Treatment Service Locator
A confidential and anonymous source of information for persons seeking treatment facilities in the United States for substance use/addiction and/or mental health problems.
https://findtreatment.samhsa.gov/

Medications for OUD

Opioid agonists and antagonists are used in MAT:

Methadone:

- Full opioid agonist.
- **Relieves withdrawal and prevents cravings.**
- Highly effective.
- Can be used in pregnancy.
- Prescribed and administered through **Opioid Treatment Programs (OTP):**
  - Regulated SAMHSA and must meet both federal and state regulations.
  - Unable to be prescribed in an office-based clinic setting for OUD.

When used to treat OUD, methadone given as part of an OTP has:

- Lower abuse potential.
- Lower overdose potential.
- Less diversion risks.
- Prevents withdrawal, can be initiated before withdrawal symptoms start.

Buprenorphine:

- Partial opioid agonist.
- **Relieves withdrawal and decreases cravings.**
- Highly effective.
- Can be used in pregnancy (buprenorphine).
- Prescribed by providers through **Office Based Opioid Programs** (outpatient).
- Providers must have Data Waiver and be registered with the Drug Enforcement Administration (DEA) as a buprenorphine prescriber:
  - Administered in clinic or prescribed for take-home.
  - Lower abuse, diversion and overdose potential when administered in the clinic.
  - Initiated once withdrawal symptoms have started or abstinence has occurred.
- Available as buccal film, sub-lingual tablet, sub-lingual film, implant, or injection.

Become a Buprenorphine Waivered Practitioner
Qualified practitioners can undergo training to receive a waiver from SAMHSA to be able to provide buprenorphine in an office-based setting to treat OUD.

Steps to Obtain Your MAT Waiver:

1) Check that you meet eligibility requirements
2) Take the MAT Waiver Course
3) Submit your Notification of Intent (NOI) form and Certificates of Completion to SAMHSA

For more information visit: https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner.

Naltrexone:

- Opioid antagonist (blocker).
- **Prevents relapse, may reduce cravings.**
- Effective in highly motivated individuals, less severe OUDs, and those legally mandated.
- Not recommended in pregnancy.
- No prescribing restrictions, can be prescribed through OTPs, opioid agonist treatment, or outpatient.
- No abuse or diversion potential.
- Overdose risk is high in those who relapse.
- Precipitated withdrawal possible if given when opioids still present or recently use:
  - Must be opioid/heroin free prior to initiating.
- Available as oral tablet or as a monthly injection.

Naloxone

Naloxone is an opioid antagonist indicated for the emergency treatment of an opioid overdose.

It has a higher affinity to the opioid receptors than opioids like heroin or oxycodone, so it knocks other opioids off the receptors for 30-90 minutes.

Prescribing information for opioids and medications used to treat OUD are required to include information about Naloxone, and healthcare providers should discuss the availability of naloxone and consider prescribing it to patients who:

- Have a history of overdose
- Have history of substance use disorder or opioid use disorder
- Are taking higher opioid dosages (≥50 MME/day)
- Are taking benzodiazepines concurrently with opioids.

There are 3 FDA-approved formulations of Naloxone:

- **Nasal Spray (Narcan):** Designed for use in the community. **Needle free and ready to use**. Sprayed into one nostril while patient lies on their back.
- **Auto-injectable (Evzio):** A pre-filled auto-injection device. Easy for families/friends or emergency personal to inject quickly into the outer thigh.
- **Injectable (Narcan)**: Professional training required. Commonly used by paramedics, emergency room doctors, and other specially trained first responders.

3 ways to provide Naloxone to your patients:

1. **Prescribe.**
2. **Direct** to a large chain pharmacy. Florida law allows pharmacists to dispense without a prescription. Medicaid recipients can obtain Narcan free of charge (limit 2 kits per 365 days).
3. **Refer** patients, family members, etc. to Narcan training programs* in the community that provide training on how to use Narcan and distribute it free of charge.

*Distribution of Narcan without training results in it not being used as frequently (confidence) or used incorrectly (test spray before use). Train patients and request that they train their friends and family members on how to use it!

Communicating with Patients About Naloxone

Patients may not realize that their opioid medication may be putting them at risk. Discussing naloxone provides the opportunity to highlight the risks associated with opioid use and offers a harm-reduction strategy.

Here are some conversation starters that can lead to an open and informative dialogue with patients:

- **Treating your chronic pain requires opioids.** Let's discuss the benefits and risks of opioids. While they can provide effective pain relief, there are risks, such as the possibility of an accidental overdose.
- **I see you may be taking sedating drugs called benzodiazepines in addition to your opioid medication, which may have an effect on your body's response to these medications.** The combination of these medications may increase your risk for a serious, life-threatening reaction.
- **Too much opioid medicine in your system can affect your breathing, which can be a sign of an accidental overdose.** It is important that we work together to manage your pain with opioids. So, as a "just-in-case" safe practice, I would like you to have an emergency treatment used to help reverse the effects of opioids while waiting for emergency medical care to arrive. Let me explain how this is used.
- **Is there a family member, caregiver, or close friend who could help in case of an opioid emergency?** Do they know the signs of an opioid-related emergency? Do you have a plan in place, in your home, in case an opioid-related emergency occurs?

References:

1. Edlund MJ, Martin BC, Russo JE, DeVries A, Braden JB, Sullivan MD. The role of opioid prescription in incident opioid abuse and dependence among individuals with chronic noncancer pain: the role of opioid prescription. Clin J. Pain. 2014; 30(7):557-64.
2. Substance Abuse and Mental Health Services Administration. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/.

Overdose Data to Action

Duval County

Addiction & Overdose Prevention

Duval.FloridaHealth.gov