PARTNERSHIP HEALTHPLAN RECOMMENDATIONS
For Safe Use of Opioid Medications

Dental Guidelines

Introduction

Partnership HealthPlan is the County Organized Health System covering Medical and Mental Health Benefits for Medi-Cal beneficiaries in 14 counties in Northern California. Our mission is to help our members, and the communities we serve, be healthy. In this spirit, we have launched a community-wide initiative to promote safer use of opioid medications.

Why is this important? In the last decade, the death rate from opioid overdose has quadrupled, making opioid overdose as common a cause of death as motor vehicle accidents. For every overdose death, there are 130 people who have a long-term dependence on opioids and 825 non-medical users of opioids (see figure at end of this policy). These numbers originate in prescriptions for opioid pain medications written by health professionals, so health professionals must work together to reverse this trend.

Dentists play a key role in community-wide efforts to ensure safe prescribing of opioid medications and prevention of chronic opioid abuse/misuse and diversion. PHC has reviewed the literature on this topic, and has the following recommendations for our dental colleagues:

Recommendations

PHC recommends dentists prescribe high dose NSAIDs for acute dental pain (studies show opioids are inferior for dental pain, and no more effective than placebo).

Dentists should not prescribe opioids for patients already on pain meds prescribed by a physician.

Dentists should also adhere to the Primary Care Clinician Prescribing Guidelines below.

1. If narcotic pain medication is prescribed, limit use to short periods and for conditions which typically expect to be associated with more severe pain.

2. Discuss the risk of opioid dependence, tolerance and hyperalgesia with patients initiated on opioid treatment.

3. Assess for risk of opioid abuse diversion, using a standardized tool if needed (see appendix for example). If patient is at high risk, consider baseline urine toxicology screen, use of non-opioids modalities to treat pain.

4. Patients between 18 to 25 years of age are at increased risk of abusing prescription drugs, so patients in this age range should be screened carefully.

5. Initiation and continuation of use of opioid pain medications for chronic, non-cancer and non-terminal pain should be weighed carefully by any prescriber. It is not appropriate for a dentist to prescribe chronic opioids. This should be done by the primary care provider. NOTE: There are standards required by PHC to PCPs and Specialists covering patients with chronic pain or chronic opioid use.

6. Chronic use of opioid medication (particularly when combined with other sedating medications such as benzodiazepines and muscle relaxants) or alcohol use is associated with an increased risk of accidental overdose and motor vehicle accidents. In addition, chronic use of opioids in high doses can cause opioid induced hyperalgesia, which ultimately causes the patient increased pain and debility. Unlike acute pain or pain associated with metastatic cancer or end-of-life care, the goal of opioid therapy for chronic non-cancer, non-terminal pain is improved functioning, not necessarily elimination of pain.

Other Guidelines for Safe Opioid Prescribing

Emergency Room Guidelines
Community Pharmacy Guidelines
Primary Care & Specialist Prescribing Guidelines

Key Points

1. Most experts world-wide advocate a maximum dose of 120 mg oral morphine equivalents daily (MED), to decrease the risk of overdose and opioid induced hyperalgesia. This does mean doses should be escalated to this point in all patients. Many are well-controlled at lower doses. PHC recommends this 120 mg MED limit be used as a community standard.

2. Have a random toxicology screen performed at least once a year to detect prescribed and non-prescribed opioids and other controlled or illicit drugs.

3. Have a signed medication use agreement with the prescriber or prescribing office, renewed yearly.

4. Run a CURES report on first prescription for a particular patient, and at least yearly thereafter. If a finding on the CURES report is not consistent with patient history, PHC recommends contacting the relevant pharmacies to confirm the accuracy of the CURES report, as reporting errors do occur.

5. Have at a minimum of three office visits yearly for chronic pain patients using opioids.

6. Limit each opioid prescription to 28 days, writing this on the prescription (e.g. "must last 28 days"). The 28-day refill, scheduled for a Tuesday, Wednesday or Thursday every 4 weeks is a best practice, to avoid weekends, holidays, and Friday refills.

References

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Silverman S, Opioid Induced Hyperalgesia: Clinical Implications for the Pain Practitioner. Pain Physician 2009: 12:679-684. Available at: http://www.painphysicianjournal.com/2009/may/2009;12;679-684.pdf

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Appendix A

Date ______________________

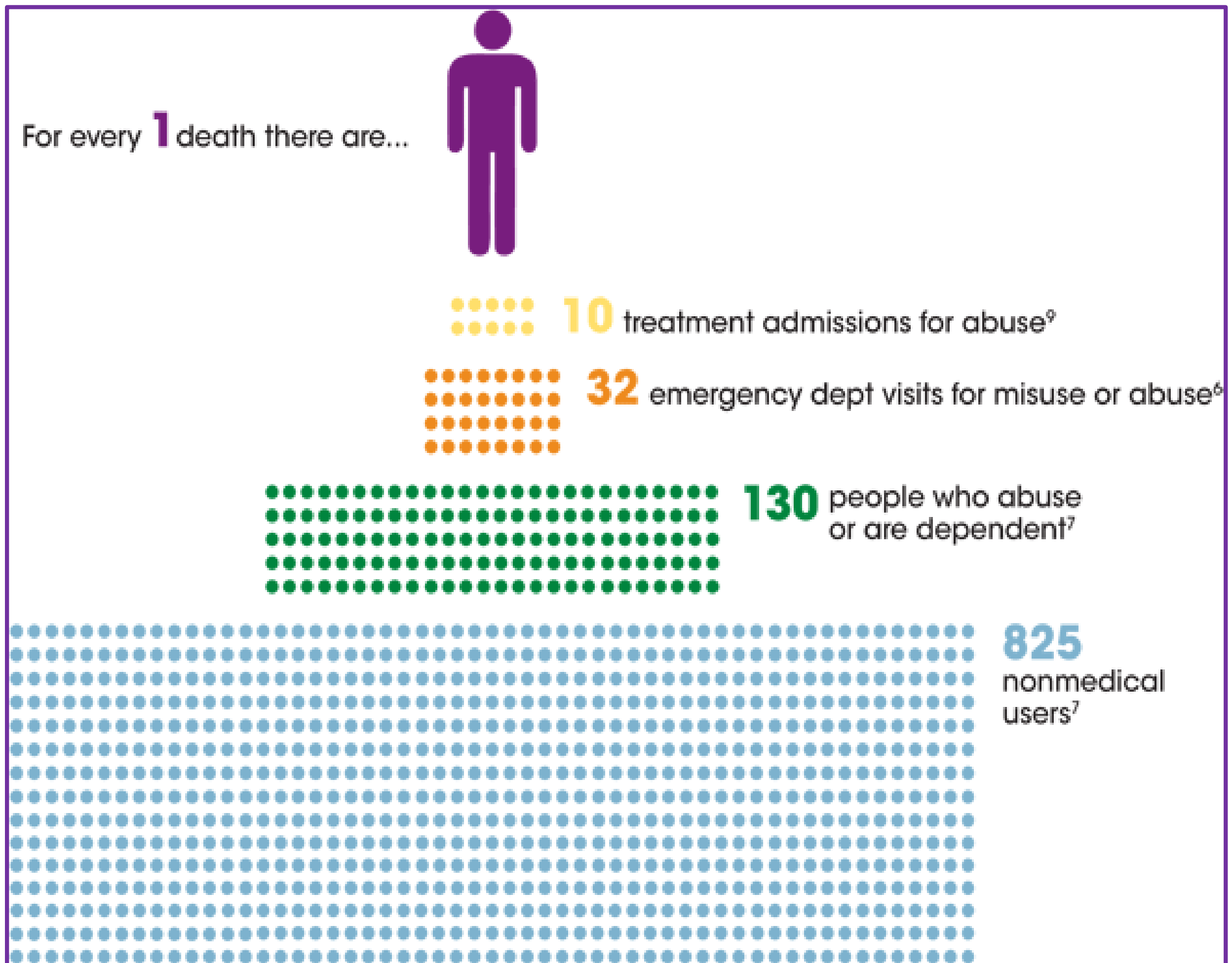
Patient Name ______________________

OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
		TOTAL	____	____

Total Score Risk Category
Low Risk 0 – 3
Moderate Risk 4 – 7
High Risk ≥ 8

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine.* 2005;6(6):432-442. Used with permission.



CDC statistics (2008)

Why we have shared responsibility to ensure safe opioid prescribing!