Suggested Opioid Prescribing FLOWCHART

The following flowchart offers a suggested process for evaluating each patient to determine if prescription opioids are appropriate for their pain management

ASSESSMENT

BEGIN

- Review medical history, including records from previous providers and existing comorbidities or treatments that increase patient risk (e.g. sleep apnea, obesity, benzodiazepine prescriptions etc.).
- Administer a physical exam to determine baseline function and pain.
- Check the Prescription Monitoring Program (PMP) to determine if there have been prior attempts to treat the pain with prescription opioid treatments.
- Do a Risk Assessment (medication abuse, psychosocial, psychiatric co-morbidity, substance use disorder, PTSD, suicide). If the patient is at risk for misuse or substance use disorder, make a plan to address and/or mitigate risks. Be sure benefits of opioid therapy outweigh potential risks.

NON-OPIOID OPTIONS

GREEN

Pharmacologic

- Use MultiModal Analgesia (MMA) as first-line therapy (i.e., Acetaminophen and/or NSAIDS scheduled
- Medical interventions: (i.e. Local Anesthetics, Nerve-blocks)

Non-Pharmacologic

- Create a plan of treatment with the patient that incorporates non-opioid interventions.
- Behavioral therapies: CBT, peer-to-peer or other peer support, case management, psychotherapy, and case management.
- Patient lifestyle improvement: exercise, weight loss.
- Primary Disease Management
- Physiotherapy modalities: OT, PT, Passive Modalities
- Discuss the use of a non-opiate directive for all future care.

ESTABLISHED PATIENTS

EACH VISIT

- Use these guidelines with new and established patients.
- Reassess and screen patients for new and existing risks and work your way through the flowchart.
- Consider non-opioid options and the ability to taper opioids at every visit
- Educate patients on available treatment and resources if suspected misuse occurs.

OPIOID PRESCRIBING CONSIDERATIONS

CAUTION

PROCEED WITH CAUTION!

- Limit first time prescriptions to 7 day supply or less (5 days or less in ED) unless an exception applies. Any exception must be documented in the patient's medical record.
- Prescribers should use the lowest effective dose, and as clinically appropriate, try to avoid concurrent opioid and benzodiazepine prescribing
- Extended release long acting opioids should not be prescribed on the first visit. When prescribed for long term opioid therapy, providers must enter into patient treatment agreement plans and should consider co-prescribing Naloxone for patients.
- Educate patients (and caregivers if necessary) on benefits, side effects, risks and important safety measures (See patient fact sheets)
- Discuss the amount prescribed, the option to fill lesser amount, and proper storage & disposal.
- Document in the Medical Record: Exceptions and reasons, patient education and treatment plan including follow up treatment & appointments.

STOP! REASSESS

STOP

- If you have concerns from your visit assessment, seek help from colleagues, community partners, or other specialists (e.g., addiction specialists).
- Re-evaluate your treatment plan/seek help from specialists if the following:
  - If your patient is not showing progress towards treatment goals
  - Therapeutic goals no longer outweigh the risks
  - If your patient shows signs of significant misuse or illicit drug use.
- Educate and refer patients to available treatment, and resources for overdose prevention and harm reduction as appropriate.

**This content was adapted from the Oregon Pain Guidance guidelines.www.oregonpainguidance.org*