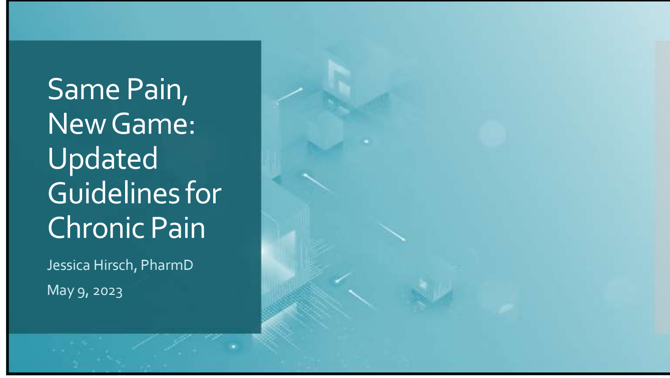

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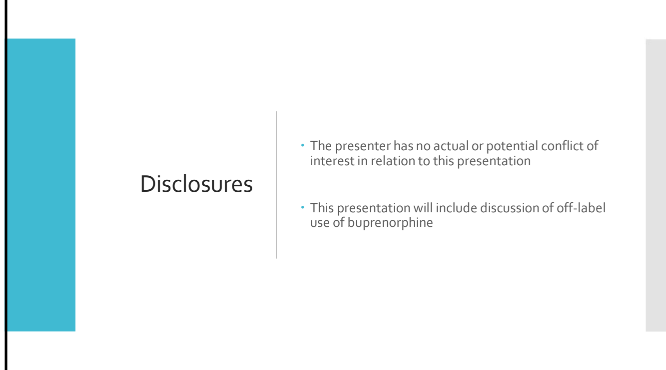

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Objectives

Pharmacist:

- Identify recommendations from the CDC/VA guidelines for pain management
- Interpret recommendations in order to relate to patient care
- Compare buprenorphine to other opioids to provide informed care for patients

Technician:

- Recognize recommendations from the CDC/VA guidelines for pain management
- Define strategies for safe opioid use
- Recognize different opioid pain management strategies

3

Guideline Updates

- Initiation and continuation of opioids
- Dose, duration, and taper of opioids
- Screening, assessment, and evaluation
- Risk mitigation

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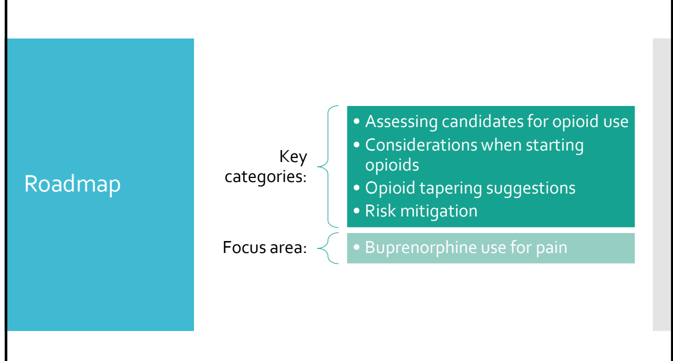

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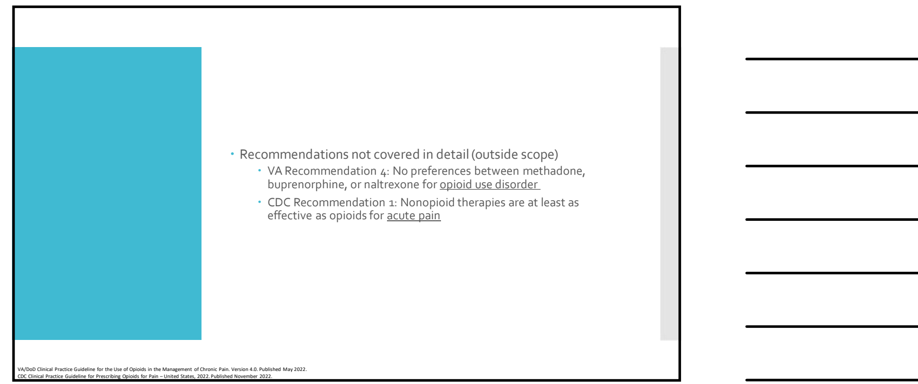

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Definitions

- Acute pain – sudden onset, time limited, known causes
- Subacute pain – pain present for 1-3 months
- Chronic pain – pain present for >3 months

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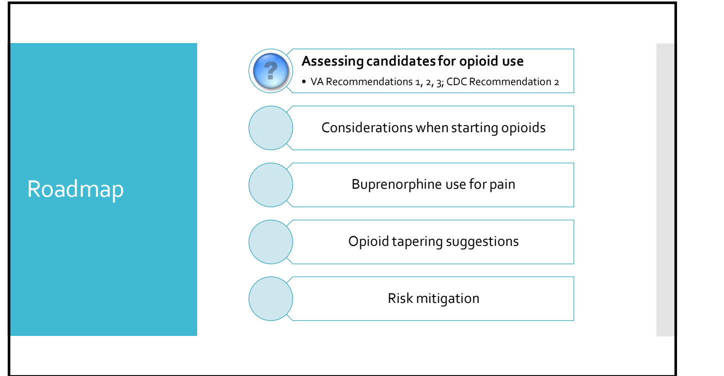

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Assessing patients prior to starting opioids:

For whom should I avoid opioids?

- Patients at higher risk for opioid use disorder (OUD) and overdose (OD):
  - Younger patients
  - Previous substance use disorder (SUD)
- Chronic non-cancer pain (VA guideline)
  - If considering daily opioids for chronic pain, consider buprenorphine instead of full agonist opioids

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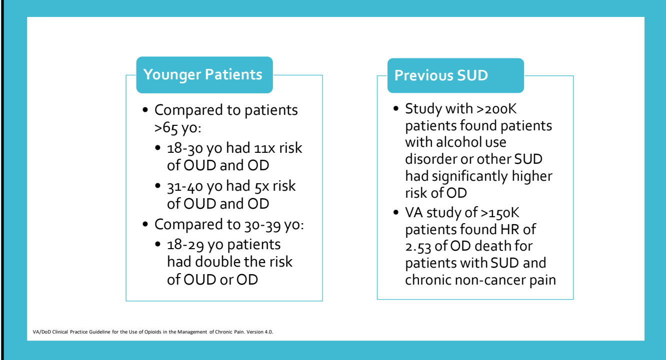

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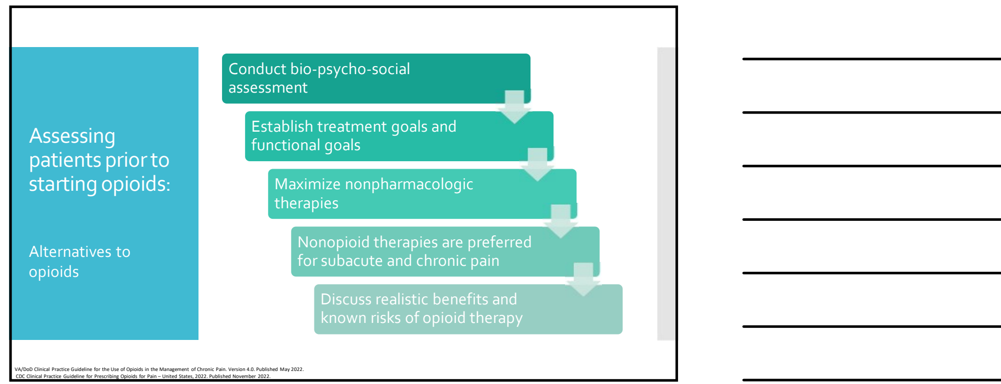
Assessing patients prior to starting opioids:

Alternatives to opioids



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Bio-psycho-social assessment

- Complete pain assessment (PQRST)
- Previous treatments for pain and results
- Impact of pain on daily functioning and quality of life
- Evaluate psychological/behavioral factors (suicide risk, pain avoidance, pain catastrophizing)
- Evaluate social situation
- Assess co-occurring conditions and confirm diagnosis
- Physical exam
- Assess patient beliefs and understanding of cause of pain, treatment preferences, perceived efficacy of treatment options

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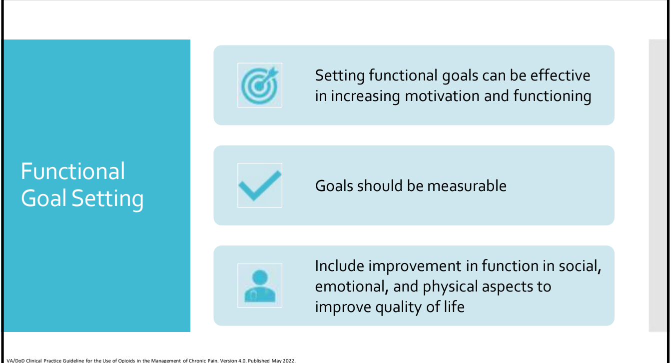

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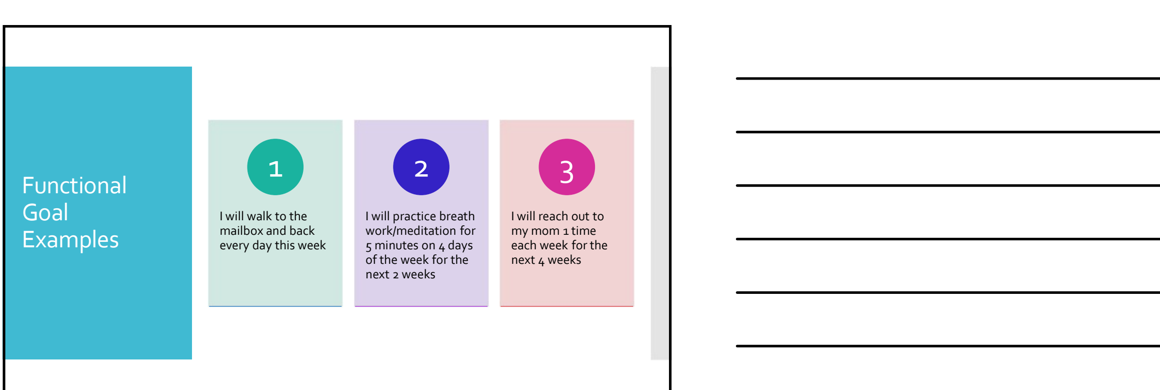

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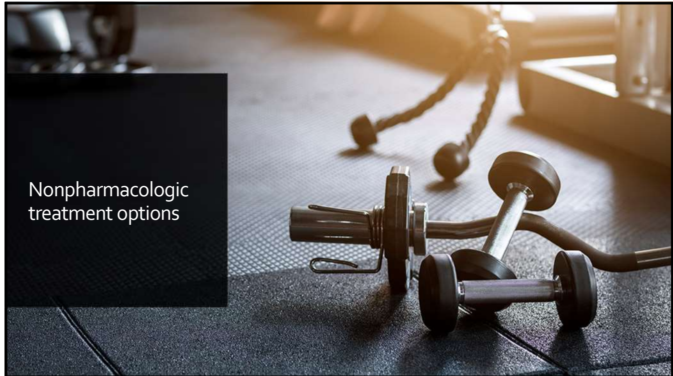

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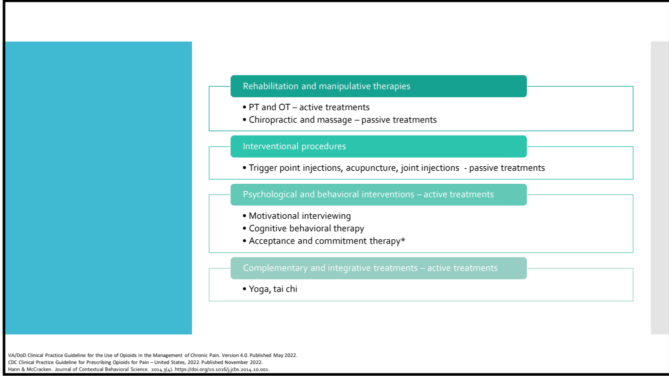

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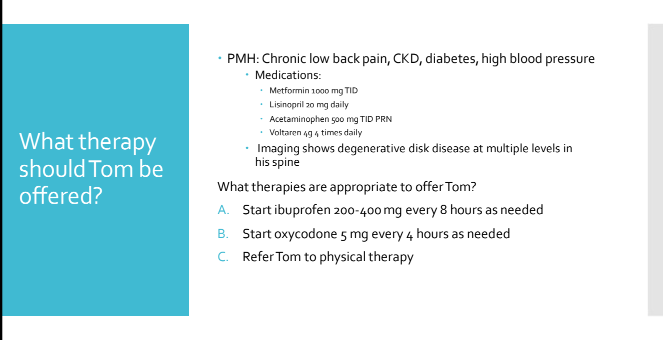

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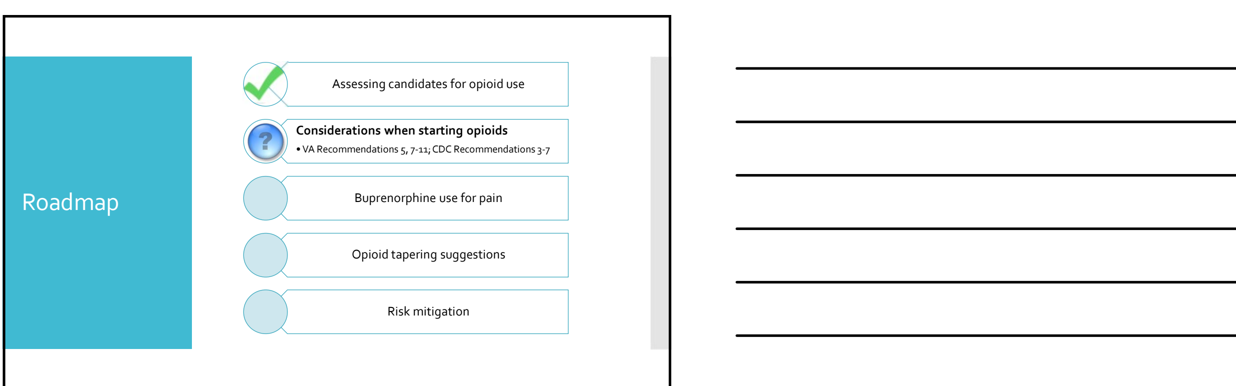

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Recommendations for Starting Opioids

- Discuss risk vs benefits of opioid therapy with patients
- Use the lowest effective dose
- Use the shortest duration as indicated for expected duration of severe pain
- Recommend evaluation within 1-4 weeks (CDC) or within 30 days (VA) and re-evaluate benefits and risks of opioids
  - Including opioid use disorder and risk of overdose
- Avoid increasing doses above levels that would yield diminishing returns

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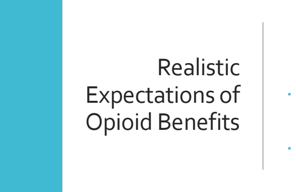

Realistic Expectations of Opioid Benefits

- A 2018 study encompassed over 26,000 patients from 96 RCTs and found that, in patients with chronic non-cancer pain, opioids provided small and **not clinically significant improvements** in pain and physical functioning compared to non-opioid controls
- A different review study found benefit but did not include information on improvements in quality of life
- Lack of robust evidence that opioids improve pain or function with long term use and **complete elimination of pain is unlikely**
  - Function can improve without pain elimination

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Risks of long-term opioid therapy

Higher doses have been shown to lead to a higher risk of OD and OUD	• Patients with > 100 oral morphine equivalents have anywhere from 4-12x increased risk for OD
Longer use has been shown to lead to higher risk of OD	• Use between 31-89 days have 4x risk of opioid related death • 90-179 days had 7x risk of opioid related death, increased risk of OUD
Increased risk of all-cause death	• Fractures, falls, myocardial infarction
Physiologic effects	• Hormone dysfunction, immune system effects, risk for hypoxemia, neurotoxicity

Baldini A et al. Prim Care Companion CNS Disord. 2012;14(3):PCC.11m01326

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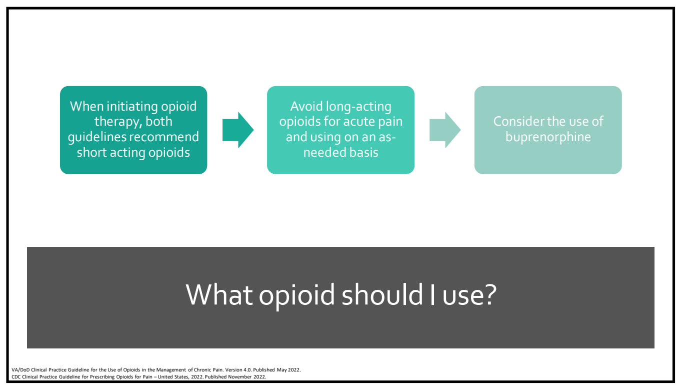

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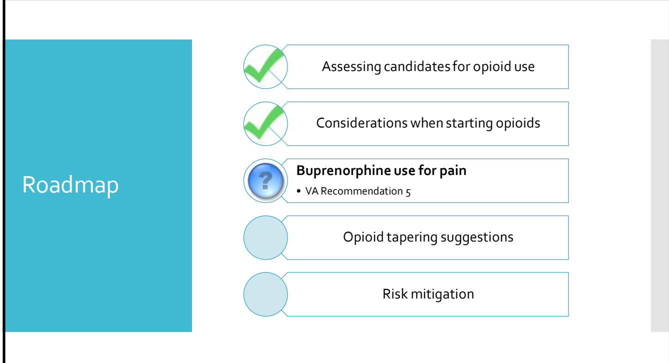

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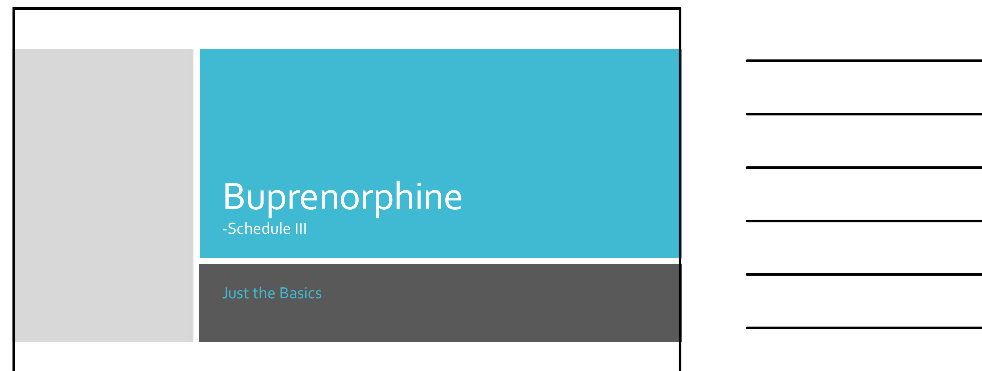

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How comfortable would you be caring for someone with pain on…

- Buccal buprenorphine films?
- Transdermal buprenorphine?
- Sublingual buprenorphine tablet?
- Sublingual buprenorphine film with naloxone?

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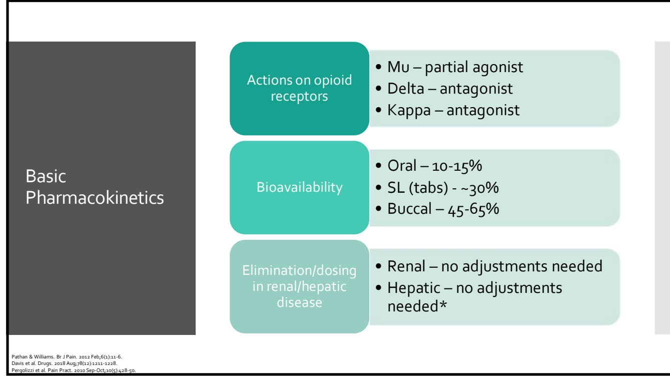

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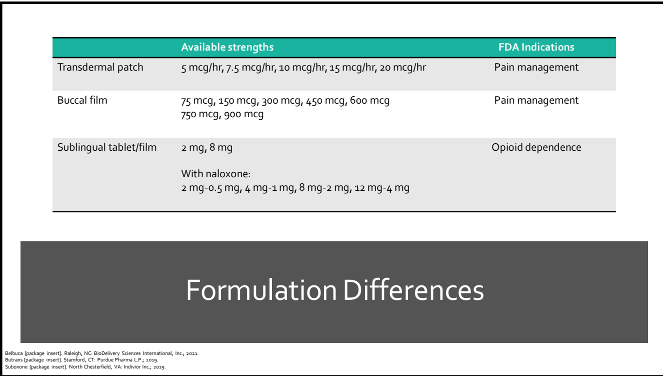

	Available strengths	FDA Indications
Transdermal patch	5 mcg/hr, 7.5 mcg/hr, 10 mcg/hr, 15 mcg/hr, 20 mcg/hr	Pain management
Buccal film	75 mcg, 150 mcg, 300 mcg, 450 mcg, 600 mcg 750 mcg, 900 mcg	Pain management
Sublingual tablet/film	2 mg, 8 mg With naloxone: 2 mg-0.5 mg, 4 mg-1 mg, 8 mg-2 mg, 12 mg-4 mg	Opioid dependence

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Will the buprenorphine block other opioids?

Buprenorphine Daily Dose	Mu Opioid Receptor Occupancy
1 mg	15-29%
2 mg	28-47%
4 mg	45-64%
8 mg	78-89%
16 mg	81-91%
24 mg	85-96%
32 mg	88-98%

Buprenorphine 20 mcg/hour patch delivers 0.48 mg per day

Quaye & Zhang. Pain Med. 2019 Jul 1;20(7):1395-1408.

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Buprenorphine Evidence for Pain

- Safety compared to traditional opioids:
  - 254 participants in a study of buprenorphine, there were no accidental overdoses
  - Ceiling effect on respiratory depression
- Efficacy compared to traditional opioids:
  - 2021 study compared pain reduction with buprenorphine to pain reduction with other opioids (hydrocodone, hydromorphone, morphine, oxycodone, oxymorphone, tramadol, and tapentadol), in most cases showing no difference

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Summary of Buprenorphine

Benefits:

- Maintained efficacy
- Decreased side effect profile
- Decreased development of tolerance, antihyperalgesic effects, decreased dysphoria and decreased cravings
- Decreased risk of overdose
- Flexible dosing for opioid naïve and tolerant patients

Drawbacks:

- Formulation availability
- FDA approval based upon formulation
- Lack of understanding
- Potential stigma

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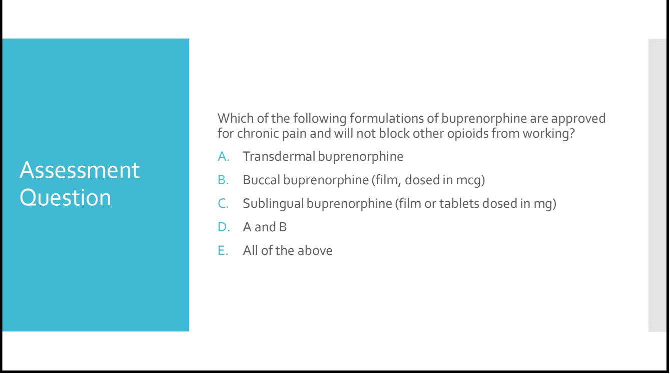

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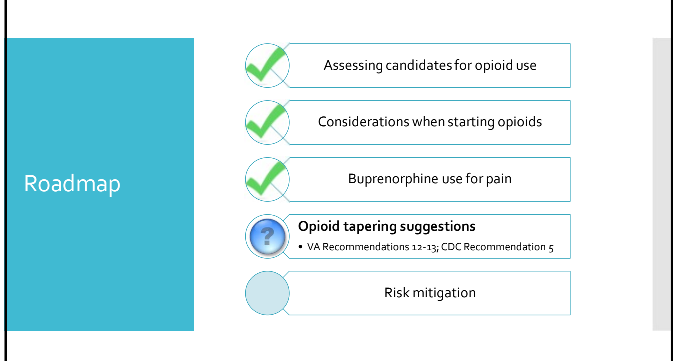

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Taper of Opioids

- Suggest a collaborative, patient-centered approach to opioid tapering
- Opioid therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages from higher dosages
- There is insufficient evidence to recommend for or against any specific tapering strategies

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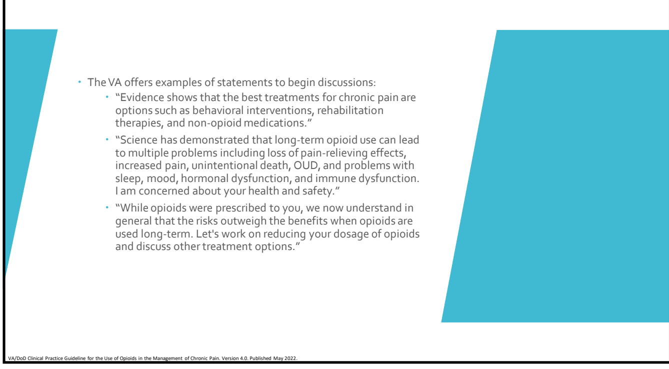

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Resources for Tapering

- VA Guide to Tapering Opioids: https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf
- Gives general information on appropriate dose reductions, how to treat withdrawal symptoms

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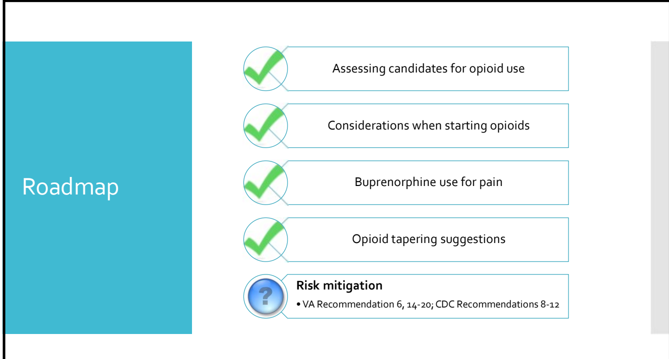

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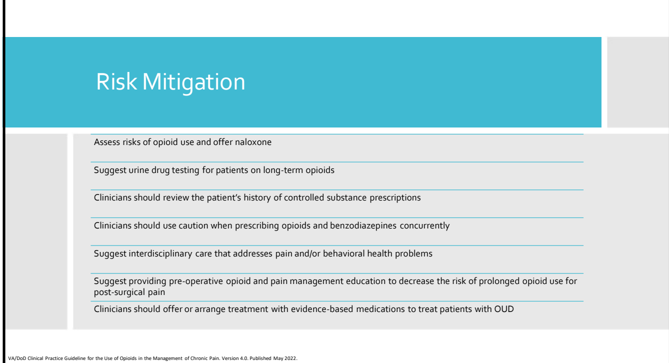

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Risk Assessments

Risk assessment to avoid harm:

- Contraindications to opioids:
  - SUD not in remission
  - Elevated suicide risk
  - Concomitant use of benzodiazepines
- If on opioids:
  - Self-escalation in doses
  - Early refills
  - Cravings
  - Interpersonal/social problems related to opioids

Checklist prior to prescribing opioids:

- Risks to not outweigh potential functional benefits
- Condition causing severe chronic pain, interfering with function, not responding to other treatments
- Clear and measurable goals established
- Patient is willing and able to follow up
- PDMP and urine screen appropriate
- Patient is informed and consents to treatment

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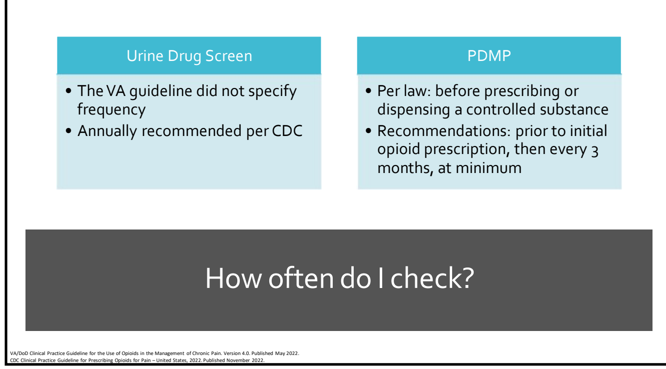

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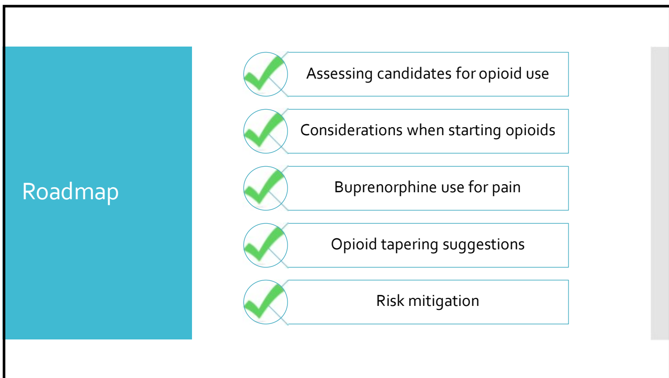

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How does this look in practice?

- Ohio State's Chronic Pain Team
  - MD, NP, pain psychologist, physical therapists, social workers, pharmacist, occupational therapist
- Initial appointment
  - 3-hour block to meet with each discipline for evaluation
  - Obtain baseline assessment
- Follow up appointments
  - Nearly always with social work/pain psychologist and PT
  - As needed with pharmacist and others
- Did not take over prescribing anything, recommendations made to PCPs and counseling and PT tailored to patients
- Grant funded

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- Assess patients and share risk vs benefits of opioid therapy
- If possible, explore nonpharmacologic options and nonopioid medications prior to starting opioids
- For patients on opioids, maximize other pain management modalities, assess risk vs benefit
- For tapering, take a patient centered approach and avoid discontinuing opioids suddenly
- Utilizing a team, close monitoring, and patient education can reduce risk surrounding opioid use
- Embrace buprenorphine as a viable option for chronic pain if opioids cannot be avoided

Key Take Home Points

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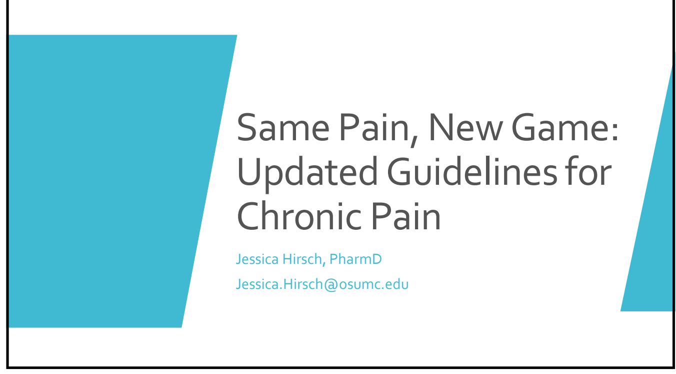

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