MOMENTUM
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LeadingAge Ohio

# Talk a Walk through the Opioid Analgesic Table

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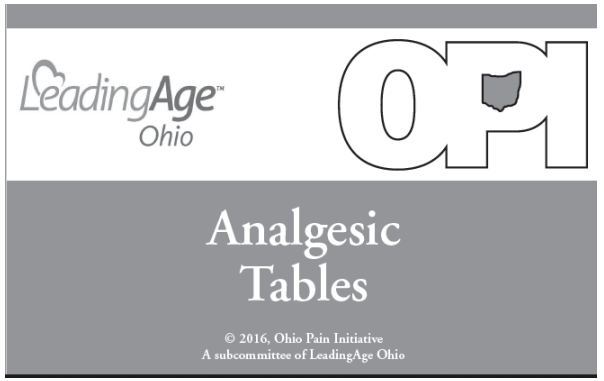
# Download the PDF from the conference app!

- Today's session is the first public release of the 2022 Opioid Analgesic Table and Pain Management Guidance
- PDF will be posted to the LeadingAge Ohio website following the conference

# History

- Originally created by the Ohio Pain Initiative (OPI)
  - Revised about every 5 years
  - OPI non-profit to promote pain management education for patients and providers
  - Absorbed into LeadingAge Ohio Professional Development committee

# Changes for 2022

- Expanded information for all sections
- Hyperlinked content to external drug information & calculators
- Bookmarked links to sections within tables
- References and resources listing
- Ohio regulatory updates for naloxone, opioid disposal, prescribing

# Content overview

- Opioid comparison table
- OME to methadone
- ❖ Buprenorphine info
- ❖ Transmucosal fentanyl info
- Practical opioid pharmacokinetics
- Opioid selection in liver/renal disease
- ❖ Opioid-induced neurotoxicity
- Managing opioid adverse effects
- Using opioids safely
- Opioid-sparing adjuvants
- Non-pharm for pain
- Naloxone info
- ❖ Safe opioid disposal
- ❖ Reference list & resources

❖ = New in 2022 edition

# Revised content for 2022

Updated opioid-specific drug information

- Simplified some equianalgesic conversions
- Added DEA schedule and ADF availability to comparison chart
- Expanded OME to methadone comments
- Added rectal admin pharmacokinetics

ADF: abuse deterrent formulation

# Revised content for 2022

More information on safe use, opioid-sparing, risk assessment

- Additional meds and comments for managing opioid adverse effects
- Expanded opioid risk assessment for using opioids safely
- Additional meds and comments for opioid-sparing adjuvants
- Additional non-pharm interventions

# 5 New Sections!

- Buprenorphine Products for Pain Management
- Transmucosal Immediate Release Fentanyl (TIRF) Products
- Opioid-Induced Neurotoxicity
- Safe Opioid Disposal
- Reference List & Additional Resources

| Buprenorphine Products for Pain Management | | |
|---|---|---|
| **Initial Dosing for Pain** | | *For experienced prescribers only. Consult a palliative care or pain specialist for assistance.* |
| **OME: BUP ER Buccal Film** | | • BUP is a partial opioid agonist. BUP may have a ceiling effect for both analgesia and respiratory depression. Patients on BUP may not be tolerant to the respiratory depressant effect of full-agonist opioids.<br>• For opioid-naïve patients with chronic pain severe enough to require around-the-clock, long-term opioid treatment, may initiate BUP transdermal 5mcg/HR x 7days, or BUP buccal 75mcg BID<br>• If converting from BUP ER buccal film or BUP transdermal patch, start conservatively. Consider using IR opioid only. Examples: BUP-TD 5mcg/HR remove patch in evening and initiate hydromorphone 2mg Q4H PRN on following morning. If BUP-TD 10mcg/HD, remove patch in evening and initiate MSER 15mg PO Q12H on following morning with morphine 5mg Q4H PRN. Evaluate pain control at day 3 and day 5; titrate if needed.<br>• For patients on BUP ER products for pain, if a short-acting opioid is needed for breakthrough pain, consider starting at 10% of the daily OME and titrate short-acting opioid PRN cautiously. Higher than anticipated PRN dose may be needed due to the BUP antagonizing effect on other opioids.<br>• BUP products with FDA-approval for pain management include transdermal system (Butrans), buccal ER film (Belbuca), and IR injection. X-waiver IS NOT required to prescribe BUP for pain management.<br>• Risk of QT prolongation especially w/concomitant use of other QT prolonging drugs<br>• X-waiver IS required to prescribe BUP for opioid use disorder (OUD). Additional training and information on medication-assisted treatment (MAT) available at SAMHSA.<br>• BUP for pain management is included Opioid Analgesics REMS along with other opioid analgesics.<br>• Link to prescribing information: BELBUCA (ER buccal film) or BUTRANS (transdermal patch) |
| < 30 mg | 75mcg BID | |
| 30 – 89 mg | 150mcg BID | |
| 90-160 mg | 300mcg BID | |
| OME > 160 mg – do not use | | |
| MAX BUP dose: 900 mcg BID | | |
| **OME: BUP Transdermal** | | |
| < 30 mg | 5 mcg/HR | |
| 30 – 80 mg | 10 mcg/HR | |
| MAX BUP dose: 20 mcg/HR | | |

## Transmucosal Immediate Release Fentanyl (TIRF) Products

*For experienced prescribers only. Consult a palliative care or pain specialist for assistance.*

| TIRF | Dosages (mcg) | BA |
|---|---|---|
| Buccal (Fentora) | 100, 200, 400, 600, 800 | 65% |
| Lozenge (Actiq) | 200, 400, 600, 800, 1200, 1600 | 50% |
| Nasal (Lazanda) | 100, 300, 400 | 75% |
| SL spray (Subsys) | 100, 200, 400, 600, 800, 1200, 1600 | 75% |

- **TIRF products are NOT equivalent on a mcg per mcg basis due to significant differences in TIRF bioavailability (BA)**. For example, buccal tablets 100mcg are approximately equivalent to lozenges 200mcg. Nasal and SL sprays have highest BA and fastest onset of action.
- *Opioid-tolerant patients only.* Transition from TIRF products to other IR opioids conservatively; titrate cautiously to adequate pain relief. Evaluate daily OME requirements for pain control and use about 10% of total daily dose as-needed for breakthrough pain.
- If converting to TIRF products from other IR opioids, always use the initial dose recommendations in the TIRF product chart or individual TIRF product prescribing information. Generally, initiate all patients at the lowest available dosage of selected TIRF (e.g., 100mcg or 200mcg), regardless of prior opioid use.
- TIRF access is restricted and enrollment in the TIRF REMS program is required for outpatients, inpatient & outpatient pharmacies, prescribers for outpatient use. TIRF REMS site includes links to patient Med Guides and complete prescribing information for each TIRF product.

## Opioid-Induced Neurotoxicity

### Risk Factors

Neurotoxicity can occur with ALL opioids but is most common with morphine and hydromorphone

- morphine > hydromorphone > oxycodone > fentanyl ≈ methadone
- renal insufficiency > normal renal function
- higher dose opioids > lower dose opioids
- dose and duration of opioid use

Precipitating factors: dehydration, renal insufficiency, advanced age, underlying delirium, other psychoactive medications (benzodiazepines)

### Signs & Symptoms

- Hyperalgesia – increased sensitivity to painful stimuli
- Allodynia – pain from stimuli that are not normally painful
- New onset myoclonus, seizures, delirium, hallucinations
- Unrelieved or worsening pain and discomfort despite reasonable increases in opioid doses
- Rapidly escalating opioid dose required to control pain with pain relief short-lived or no pain relief
- Pain “doesn’t make sense” – not consistent with recent pattern or known disease

### Managing Opioid-Induced Neurotoxicity

Rotate opioid to a structurally dissimilar opioid with differing receptor affinity profiles and a lower risk for neurotoxicity. Methadone is frequently selected for opioid rotation. Cautious use advised for patients with cardiac arrhythmias due to risk of QTc interval prolongation with methadone.

- Manage symptoms of neurotoxicity - treat delirium (e.g., haloperidol or an alternate antipsychotic). Behavioral excitation will resolve over hours to days depending on the patient’s ability to clear the causative opioid metabolites.
- Treat neuromuscular excitation and myoclonus with a benzodiazepine, baclofen, or barbiturate.
- If possible, hydrate patient to facilitate elimination of opioid metabolites.
- Consider opioid-sparing adjuvants to reduce reliance on opioids for pain control

## Safe Opioid Disposal

### Opioid Disposal Resources

- Avoid storing or saving controlled substances in the home for extended periods for any reason, including waiting for future Drug Take Back Day. As long as the unused or expired medication is in the home, the risk of diversion, misuse, or accidental ingestion and poisoning is present. Advise patients to disposal of medications as soon as they are no longer needed.
- Ask your pharmacist about medication disposal. Most pharmacies now supply drug disposal kits that allow the patient to mail-back unused medications for commercial incineration or inactivate the medications for safe disposal in household trash.
- When other disposal options are not available (e.g. Take Back Days, pharmacy drug disposal boxes, commercial drug disposal kits) follow instructions on the FDA's Flush List. Due to significant environmental impact, if the drug is not listed, avoid flushing of any medications.
- If none of these options are available, follow FDA instructions for disposal in cat litter or used coffee grounds and seal in a plastic container.
- DEA sanctioned National Drug Take Back Days occur twice each year, in April and October. Any unwanted or unused medications can be dropped off during these events at no cost and with no questions asked.

### Hospice

- Hospices licensed in Ohio are required by ORC 3712.062 to have a written policy in place establishing procedures to prevent diversion of controlled substances in a hospice patient's home, including procedures for disposal of opioids at the time of patient death or when no longer needed by the patient. Refer to the ORC section for complete information.

### Reduce Opioid Quantity Dispensed

- Ohio law allows partial fills for all schedule II controlled substances under 21 CFR 1306.13 and OAC 4729:5-5-12
- For patients who are terminally ill or residents of long-term care facilities, follow 21 CFR 1306.13. Prescription must indicate "terminally ill" or "LTCF patient"; total quantity dispensed cannot exceed total quantity prescribed; remaining portions of a partially dispensed schedule II controlled substance must be filled within **60 days** of the prescription date.
- For patients who are NOT terminally ill or residents of long-term care facilities, follow OAC 4729:5-5-12. Partial dispensing can be requested by the patient or the prescriber issuing the prescription; total quantity dispensed cannot exceed total quantity prescribed; remaining portions of a partially dispensed schedule II controlled substance must be filled within **30 days** of the prescription date.

# Reference List & Additional Resources

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## Buprenorphine Products for Pain Management


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# How we use the opioid analgesic tables

- Teaching learners in medical, nursing, pharmacy
- Quick reference
- Quick access to resources

# Time for questions and comments!

Or send to: bridget.protus@optum.com

# Acknowledgements


- LeadingAge Ohio & Professional Development Committee
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