Collaboration with Pharmacists on Pain Management

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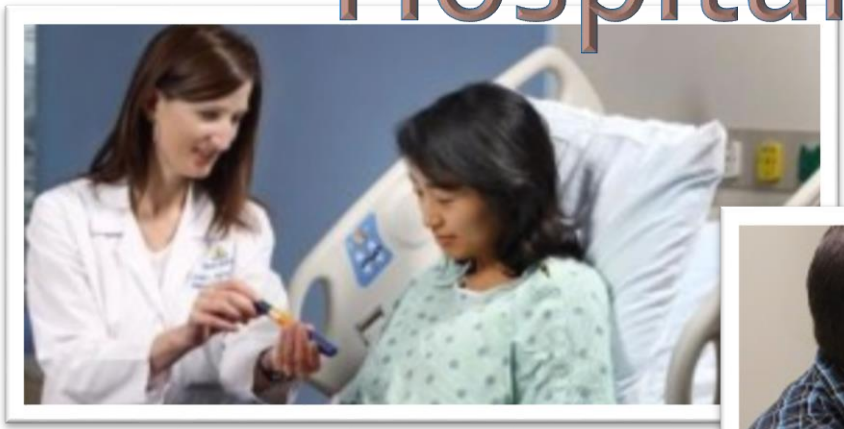
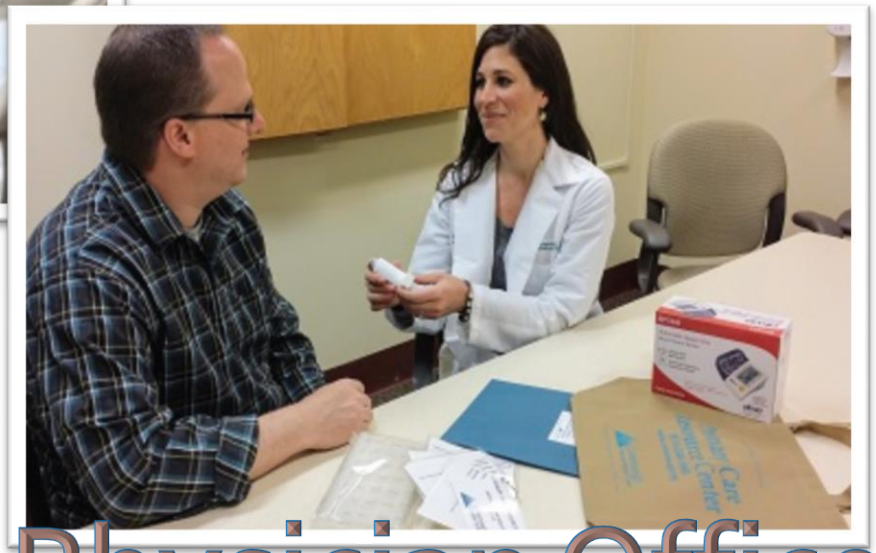
Objectives

- Provide ways to collaborate with pharmacists to appropriately manage patients with acute and chronic pain.
- Explain the options available for alternative medications to opioid therapy.
- Discuss how to taper a patient off opioid and benzodiazepine therapy.
- Explain ways to collaborate with pharmacists to appropriately screen and/or manage substance use disorder.

Pharmacists and Patient Care

Hospital





Physician Offices

Community Pharmacy

Who ya gonna call….

Medication Specialist

CPESN Pharmacies

- There are pharmacies who practice differently
- **Community Pharmacy Enhanced Service Network**
  - Offer a different type of pharmacy practice for patients that need a higher level of pharmacy care
  - Clinically integrated network of community pharmacies
- www.cpesn.com
  - Pharmacy Finder: https://collaboration.cpesn.com/finder

CPESN FLORIDA

"Mr. S"

Mr. S is a 26YO male prescribed an opioid prescription for a broken leg due to recent car accident. Medication was originally prescribed by ER physician and continued by a 2nd physician during physical therapy. The patient now brings in a prescription to the pharmacy from their primary care doctor (3rd physician) 8 months from when he was first prescribed the opioids.

- Is the patient still experiencing pain? Where is the pain located?
- What is the chronic pain diagnosis?
- What other options or alternatives has the patient tried for pain relief?
- What is the patient's goal for pain management?

CDC Recommendations

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

1 OPIOIDS ARE NOT FIRST-LINE THERAPY

Nonpharmacologic therapy and **nonopioid 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 nonopioid pharmacologic therapy, as appropriate.

Nonpharmacologic therapies and nonopioid medications include:

- Nonopioid medications such as acetaminophen, ibuprofen, or certain medications that are also used for depression or seizures
- Physical treatments (eg, exercise therapy, weight loss)
- Behavioral treatment (eg, CBT)
- Interventional treatments (eg, injections)

2 ESTABLISH GOALS FOR PAIN AND FUNCTION

Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3 DISCUSS RISKS AND BENEFITS

Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CDC Guidelines for Prescribing Opioids for Chronic Pain. Accessed at: https://www.cdc.gov/drugoverdose/pdf/prescribing/Guidelines_Factsheet-a.pdf

CDC Recommendations

Acute Pain

4 **USE IMMEDIATE-RELEASE OPIOIDS WHEN STARTING**

When starting opioid therapy for chronic pain, clinicians should prescribe **immediate-release opioids** instead of extended-release/long-acting (ER/LA) opioids.

5 **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.

6 **PRESCRIBE SHORT DURATIONS FOR ACUTE PAIN**

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

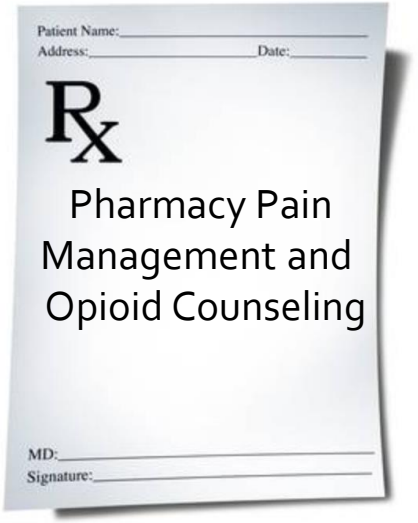
Immediate-release opioids: faster acting medication with a shorter duration of pain-relieving action

Extended release opioids: slower acting medication with a longer duration of pain-relieving action

Morphine milligram equivalents (MME)/day: the amount of morphine an opioid dose is equal to when prescribed, often used as a gauge of the abuse and overdose potential of the amount of opioid that is being given at a particular time

Ways to Collaborate with a Pharmacist

- In the **hospital** – establish a team approach where the pharmacist counsels all patients receiving opioids on the risks and benefits before discharge
- Manage patient's chronic pain as **outpatient** - work with the local pharmacists for opioid dispensing
  - Discuss the patient's chronic pain condition and consider adding pharmacist to opioid agreement
  - Refer patient for opioid counseling / pain management
- Need to modify patient's therapy
  - Discuss with the pharmacist on non-opioid options



Pharmacotherapy Options as Alternatives to Opioid Treatment

- **Acetaminophen** (Tylenol)
- **NSAID**
  - Oral: ibuprofen (Advil), naproxen (Aleve, Naprosyn), diclofenac (Voltaren), etodolac (Lodine), meloxicam (Mobic), celecoxib (Celebrex)
  - Topical: diclofenac (Voltaren), compounded pain creams
- **Tricyclic antidepressants**
  - amitriptyline (Elavil), doxepin (Sinequan), nortripyline (Pamelor)
- **SNRI**
  - duloxetine (Cymbalta), venlafaxine (Effexor), milnacipran (Savella)
- **Gabapentin** (Neurontin), **Pregabalin** (Lyrica)
- **Topical lidocaine** (Lidoderm, Icy Hot)
- **SSRI**
  - Citalopram (Celexa), paroxetine (Paxil)
- **Anticonvulsants**
  - Carbamazepine (Tegretol), lamotrigine (Lamictal), oxcarbazepine (Trileptal) , levetiracetam (Keppra)
- **Capsaicin** (Zostrix-HP)
- **Skeletal muscle relaxants**
  - tizantidine, baclofen, cyclobenzaprine, carisprodol, methocarbamol

Mr. "S"

Mr. S is has now been on opioids for 2 ½ years. He has switched between both short and long acting formulations. He currently is being treated with high doses of both short and long acting products. His PCP decides it is time to stop the opioid regimen.

How can pharmacists collaborate with the physicians?

- Discuss the patient's tapering schedule with the pharmacist
- Refer patient for pharmacy opioid counseling/pain management
  - Create a team approach to manage withdrawal symptoms and dosing schedule with frequent follow-ups

Taper off opioid therapy

- Tailor tapering schedule to each individual patient
- Minimize withdrawal symptoms while maximizing pain relief with other modalities
- **Go Slow** – decrease of 10% per month is reasonable for patients on opioids >1 year
  - Decrease of 10% per week for those on opioids for a shorter time
  - Monitor for withdrawal symptoms
- **Support** – make sure the patient receives appropriate psychosocial support
  - Arrange for mental health providers, opioid use disorder treatment and offer naloxone for overdose prevention
- **Team Approach** – reach out to pharmacists for additional assistance with follow-up and monitoring

Mr. "S"

Mr. S attempted to taper off opioids but is unable to and still remains on 2 types of opioids. His symptoms drive him to seek assistance with a new physician who prescribes Xanax.

- Common situation
- Safety concern as combined use causes CNS depression
  - Risk of overdose death increases 10-fold for those prescribed both opioid and benzos versus opioids alone
- Other concerns: tolerance, physical dependence, withdrawal symptoms

How can pharmacists collaborate with the physicians?

- Discuss the patient's tapering schedule with the pharmacist
- Create a team approach to manage withdrawal symptoms and dosing schedule with frequent follow-ups

Tapering Approaches for Benzodiazepines

Half-life of commonly prescribed benzodiazepines

Medication	Half-life (hours)
Alprazolam	6 to 12
Chlordiazepoxide	5 to 30
Clonazepam	18 to 50
Diazepam	20 to 100
Lorazepam	10 to 20
Oxazepam	4 to 15
Temazepam	8 to 22
Triazolam	2

Source: Reference 3

- **Basic Approach:**
  - Use same medication for tapering
  - Switch to longer-acting equivalent
  - Use adjunctive medications to mitigate withdrawal symptoms
- **Dosage reduction** depends on current dose
  - Higher doses can typically tolerate larger reductions than lower doses
- **Initial** Reduction: 5-25% of current dose
  - 25-35% with supratherapeutic doses
- **Reduce 5-10%** of dose every 1-4 weeks based on how patient tolerates withdrawal symptoms
- Initiate an **adjunctive medication** to mitigate withdrawal discomfort
  - carbamazepine, imipramine, divalproex, trazodone

Image Source: https://www.mdedge.com/psychiatry/article/157350/anxiety-disorders/benzodiazepines-sensible-prescribing-light-risks

Mr. "S"

Mr. S has had many attempts to taper off pain medications. Due to increased withdrawal symptoms Mr. S has resorted to use of heroin and fentanyl at times when he is unable to access prescription medications.

How can pharmacists collaborate with the physicians?

- Common situation
- Create a **team approach** to care
  - Reach out to pharmacists if drug seeking behavior is suspected with a patient
    - Pharmacists can see the situation from a different angle
  - Create a collaborative program with pharmacists to screen patients for substance use disorder with development of continuation of care for those at high risk

Key Points

- Management of opioid therapy for pain management takes a team approach to care
- Pharmacists can be the medication specialist on the team to assist with patients on chronic therapy, those tapering off regimens, or screening of patients for substance use disorders