

Schedule N – Prescribing Opioids

Attached to and forming part of By-Law No. 11 of the College

Preamble

This Standard establishes the standard of practice and ethical requirements of all physicians in Manitoba in relation to prescribing opioids. **This Standard excludes the treatment of active cancer pain, palliative care, end-of-life care, opioid replacement therapy, and opioid use disorder.** The purpose of this Standard is to assist members in prescribing opioids for maximum safety. Knowledge of the risk to benefit ratio of prescribing opioids has altered over time, so prescribing opioids must address pain, function, and the addiction. It recognizes that:

- Every member is professionally responsible for each opioid prescription the member provides to the patient.
- In prescribing opioids each member provides their clinical judgment, which is to be that of a physician acting reasonably in the circumstances and is documented.
- Patients living with chronic pain can reasonably expect to experience at best a modest improvement in their pain when treated with opioids. Indiscriminate opioid prescribing is associated with significant patient and societal harms. There is no evidence that long term opioid treatment is indicated or effective for certain medical conditions including chronic headache disorders, fibromyalgia, and axial low back pain.
- There is valuable information available on prescribing opioids and members should educate themselves through available resources. Three valuable resources affirmed by the College as a national consensus, which may change over time as new evidence emerges, are:
 - *The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain* http://nationalpaincentre.mcmaster.ca/documents/Opioid%20GL%20for%20CMAJ_01may2017.pdf and
 - *The Opioid Manager*, a tool designed to support healthcare providers in prescribing and managing opioids for patients with chronic non-cancer pain, <http://nationalpaincentre.mcmaster.ca/opioidmanager/>, both published by the National Pain Centre at McMaster University.
 - *Guidelines for Prescribing Opioids for Chronic Pain*, US Centers for Disease Control and Prevention, 2017, <https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>
- A helpful visualization of the risk of prescribing opioids is <https://www.cpd.utoronto.ca/opioidprescribing/wp-content/plugins/safe-opioids-infographic//files/navigating-opioids-web.pdf>. CMPA materials on opioid prescribing are also helpful.

- In prescribing opioids, federal and provincial controlled substances laws, regulations, and rules are to be complied with.

This Standard recognizes the following patients require different approaches to prescribing opioids based upon their needs and risk categorization:

- Part I - Acute pain or post-operative analgesia patient,
- Part II - Initial trial for non-acute non-cancer pain in opioid naïve patients prescribed up to 50 mg.
- Part III - Patients currently prescribed between 50 and 90 mg, (mid-level risk)
- Part IV - Patients currently prescribed in excess of 90 mg, (high level risk)
- Part V - Patients new to a member's practice and already taking opioids for a significant period of time,
- Part VI - Adolescents patients, and
- Part VII - Continued prescribing of opioids for patients with non-cancer pain.

The College's and CMA's Codes of Ethics and other College standards prohibit discrimination based on medical condition and complexity. Physicians must not exclude or dismiss patients from their practice based on their current use of, or request for, opioids, or a suspicion of misuse of prescription medications.

STANDARD OF PRACTICE

Part I – ACUTE PAIN OR POST-OPERATIVE ANALGESIA PATIENT

For patients with acute pain or who require post-operative analgesia, the member **shall**:

- (a) Prescribe the lowest effective dose of immediate release preparations limited to what the patient will need before community follow-up will be resumed (three days or less will often be sufficient; more than seven days will rarely be needed; but in exceptional circumstances, then up to one month).
- (b) When discharging patients from acute-care settings, or post-operatively, prescribe only the quantities of opioids that the patient will need before community follow-up will be resumed, or in accordance with the expected course of the illness where follow-up is not anticipated.
- (c) Obtain a second opinion (by teleconference is permitted) from a member or authorized prescriber prior to prescribing opioids after thirty days from the time of the onset of the acute pain or surgery.

- (d) Have regard to the patient's risk of opioid misuse and substance abuse history, optimizing non-opioid treatment options if appropriate. Much acute and post-operative pain can be managed with non-steroidal anti-inflammatories and acetaminophen alone or in combination.
- (e) Discuss the risks of opioids with the patient (side effects, physical dependence, crime; risks of addiction, and overdose resulting in death; risks of failure to store opioids safely, including diversion and death; risks of consuming alcohol or other sedating substances with opioids simultaneously; risks of operating a motor vehicle or heavy machinery, safety-sensitive occupational risks, and child and elder care responsibilities).

Part II – INITIAL TRIAL FOR NON-ACUTE NON-CANCER PAIN IN OPIOID NAÏVE PATIENTS PRESCRIBED AMOUNT UP TO 50 MILLIGRAMS MORPHINE EQUIVALENTS PER DAY

To determine if a trial of opioids is clinically appropriate for treatment of non-cancer pain for an opioid naïve patient, and prior to prescribing opioids, the member **shall**:

- (a) Conduct and document a comprehensive history and physical examination, including,
 - i. pain condition, general medical condition, current medication, opioid use history, psychiatric status, substance abuse history, trauma, and psychosocial history, and previous non-pharmacological treatments and therapies;
 - ii. assessing the patient's risk for opioid misuse, abuse, or diversion and consider appropriate screening tools such as those listed in the Opioids Manager (referenced above) to determine the patient's risk for addiction to opioids;
 - iii. obtaining applicable medical records; and
 - iv. obtaining (photo)identification from patient, unless well known to the member or the patient's social circumstances appear to be such that (photo)identification is unavailable.
- (b) Optimize available non-opioid treatment options, including non-opioid pharmacotherapy and non-pharmacological treatment modalities, including considering psychology, psychiatry, sports medicine, physiotherapy, occupational therapy, kinesiology, chiropractic, and dietary.
- (c) Review the patient's current and past medications utilizing DPIN or eChart. If DPIN or eChart access is unavailable, consult with a pharmacist to obtain DPIN. If no access to DPIN, eChart, or pharmacist, then a maximum three-day prescription can be written to permit such access.

- (d) Always start with a trial of opioids as a therapeutic trial of less than three months and if therapeutic goals are not met or the harms outweigh the benefits, then discontinue as a slow taper.
- (e) Always use caution and prescribe the lowest effective dosage of opioid medication. Titrate the dosage gradually, with frequent tolerability checks and clinical reassessments. Monitor opioid effectiveness until optimal dosage is attained, subject to, and documenting, the following:
 - i. Prescriptions may be written for a maximum of up to three months, but never authorize the dispensing of more than a one-month supply of any opioid. (For patients in remote communities or travelling, the dispensing may be for up to three months).
 - ii. All dosages must be recorded clearly in the medical record.
- (f) Re-assess the patient, including for pain and function - and benefits and risks, at least twice in the first month, monthly for the next two months; thereafter at least every three months. (For patients in remote communities reassess as frequently as possible if not able to achieve the above.)
- (g) Taper benzodiazepine(s) slowly to the lowest functional dose, or if possible zero, if a patient on existing long-term prescribed benzodiazepine(s) requires an opioid trial (either prior to or concurrently). Excluding acute and time-limited indications, do not initiate treatment with benzodiazepines in combination with long-term opioid therapy, except in limited and exceptional circumstances which are documented.
- (h) Document in the patient's record the discussion with the patient of the following:
 - i. Treatment goals including specific and realistic goals of reduced pain severity (not elimination of pain), and improved physical, psychological, social and functional states.
 - ii. Non-pharmacological therapy and non-opioid analgesics are preferred for chronic non-cancer pain;
 - iii. Potential benefit of long term opioid treatment is modest;
 - iv. Risks of side effects, physical dependence, crime (being targeted for their medication); risks of addiction, and overdose resulting in death; risks of failure to store opioids safely, including diversion and death; risks of consuming alcohol or other sedating substances with opioids simultaneously; risks of operating a motor vehicle or heavy machinery, safety-sensitive occupational risks, and child and elder care responsibilities;
 - v. Circumstances under which to seek help and where to obtain help if required;
 - vi. The end of treatment, including decreasing dosages and returning unused opioids to a pharmacy for safe disposal; and

- vii. which health care provider(s) will be providing refill prescription for the patient and which health care provider(s) will be following up and prescribing refill prescriptions if the usual health care provider(s) is not available.
- (i) Require baseline urine drug testing prior to initiating an opioid trial and require random and/or periodic urine drug testing on an annual basis, or more frequently if there are concerns.
- (j) Not prescribe opioids for patients with an active substance use disorder (excluding nicotine) without considering first obtaining guidance (by telephone is permitted) from a physician specializing in addiction.

Part III – PATIENTS CURRENTLY PRESCRIBED BETWEEN 50 AND 90 MILLIGRAMS MORPHINE EQUIVALENTS PER DAY (mid-level risk)

For the member's patients that the member is considering prescribing, or are currently prescribed, between 50 and 90 milligrams morphine equivalents per day, the member shall:

- (a) Maintain vigilance for potential diversion and other substances of concern by:
 - i. Verifying the patient's current and past medications utilizing DPIN or eChart at least every three months. If DPIN or eChart access is unavailable, consult with a pharmacist to obtain DPIN (or contact the prescribing doctor if opioids are prescribed by another doctor). If no access to DPIN, eChart, or pharmacist, then a maximum three-day prescription can be written to permit such access.
 - ii. Ordering an initial urine drug screen if not done in the past year, and at least yearly thereafter.
- (b) If not already done, document a comprehensive history and physical examination, including,
 - i. pain condition, general medical condition, current medication, opioid use history, psychiatric status, substance abuse history, and psychosocial history, and previous non-pharmacological treatments and therapies.
 - ii. assessing the patient's risk for opioid misuse, abuse, or diversion and consider appropriate screening tools to determine the patient's risk for addiction to opioids.
 - iii. Comprehensive reassessment of i and ii must occur at least yearly.
- (c) Always use caution and prescribe the lowest effective dosage of opioid medication. Titrate the dosage gradually, with frequent tolerance checks and clinical reassessment. Monitor opioid effectiveness until optimal dosage is attained, subject to, and documenting, the following:

- i. A careful reassessment of the dose is required including discussion and documentation of specific and realistic goals of reduced pain severity (not elimination of pain), and improved physical, psychological, and social functioning.
 - ii. Carefully reassessing evidence of individual benefits and risks when considering increasing dosage to more than **50 milligrams** morphine equivalents per day.
 - iii. Prescriptions may be written for a maximum of up to three months, but never authorize the dispensing of more than a one-month supply of any opioid. For patients in remote communities, the dispensing may be for up to three months. For patients travelling, the dispensing may be for up to three months, if the patient has been on a stable long-term prescription.
 - iv. All dosages must be recorded clearly in the medical record.
- (d) Taper benzodiazepine(s) slowly to the lowest functional dose, or zero if possible, if a patient on existing long-term prescribed benzodiazepine(s) is concurrently taking long-term opioids. Excluding acute and time-limited indications, do not initiate treatment with benzodiazepines in combination with long-term opioid therapy, except in limited and exceptional circumstances which are documented.
- (e) Once again, consider optimizing available non-opioid treatment options, including non-opioid pharmacotherapy and non-pharmacological treatment modalities, including considering psychology, psychiatry, sports medicine, physiotherapy, occupational therapy, kinesiology, chiropractic, and dietary.

Part IV – PATIENTS PRESCRIBED MORE THAN 90 MILLIGRAMS MORPHINE EQUIVALENTS PER DAY (high-level risk)

For the member's patients that the member is considering prescribing, or are currently prescribed, more than **90 milligrams** morphine equivalents per day, the member **shall**:

- (a) Perform each element in Part III.
- (b) Medications must not be abruptly discontinued – “bridging” prescriptions during assessment of the patient is entirely acceptable to avoid dangers of withdrawal.
- (c) Determine the lowest effective dose of opioid needed to achieve and/or maintain the goals of reduced pain severity (not elimination of pain), and improved physical, psychological, and social functioning, and **consider a trial of slow tapering of the opioids**. When tapering, if the patient has a substantial increase in pain and decrease in function that persists more than one month after a dose reduction, tapering may be undertaken more slowly, paused or potentially abandoned in such patients.
- (d) Consult with an appropriate specialist and/or multidisciplinary program (including

these possibilities: practice colleague, pain clinic, psychiatry, psychology, addiction specialist, sports medicine, pharmacist, physiotherapist, kinesiologist, chiropractor, occupational therapist, dietitian, if available) when the patient receives a **90 milligrams** morphine equivalents dose daily for longer than 90 days or the patient experiences serious challenges in tapering off opioids, or if opioid use disorder is suspected.

- (e) If the patient is on **90 milligrams** morphine equivalents per day or less, and there is documented benefit to the patient, then continue the treatment. See Part VII
- (f) Except in circumstances of exceptional need and clearly documented benefit, restrict prescription to no more than **90 milligrams** morphine equivalents per day. A second opinion of another member must be sought if considering escalating doses in excess of 90 milligrams morphine equivalents per day.

Part V - PATIENTS NEW TO A MEMBER'S PRACTICE AND ALREADY TAKING OPIOIDS FOR A SIGNIFICANT PERIOD OF TIME

For patients who are new to a member's practice and who have been taking opioids for a significant period of time (approximately six weeks) already the member **shall**:

- (a) Maintain vigilance for potential diversion and other substances of concern by verifying the current opioid prescription by:
 - i. Obtaining collateral information from both the previous prescriber(s) and dispensing pharmacy(ies) confirming the clinical indication and current opioid dosage;
 - ii. Reviewing the patient's current and past medications utilizing DPIN or eChart. If DPIN or eChart access is unavailable, consult with a pharmacist to obtain DPIN, (or contact the prescribing doctor). If no access to DPIN, eChart, or a pharmacist, then a maximum three-day prescription may be written to permit such access; and
 - iii. Ordering an initial urine drug screen.
- (b) Conduct and document a comprehensive history and physical examination including,
 - i. pain condition, general medical condition, current medication, opioid use history, psychiatric status, substance abuse history, trauma, and psychosocial history, and previous non-pharmacological treatment and therapies;
 - ii. assessing the patient's risk for opioid misuse, abuse, or diversion and consider appropriate screening tools to determine the patient's risk for addiction to opioids;
 - iii. obtaining applicable medical records; and

- iv. obtaining (photo)identification from patient, unless well known to the member or the patient's social circumstances appear to be such that (photo)identification is unavailable.
- (c) Always use caution and prescribe the lowest effective dosage of opioid medication. Titrate the dosage gradually, with frequent tolerance checks and clinical reassessment. Monitor opioid effectiveness until optimal dosage is attained, subject to, and documenting the following:
- i. Carefully reassess evidence of individual benefits and risks when considering increasing dosage to more than **50 milligrams** morphine equivalents per day.
 - ii. If the patient is on more than **90 milligrams** morphine equivalents per day, careful reassessment of the dose is required including discussion and documentation of specific and realistic goals of reduced pain severity (not elimination of pain), and improved physical, psychological, and social functioning. To determine the lowest effective dose of opioid needed to achieve and/or maintain these goals, **consider a trial of slow tapering of the opioids**. When tapering, if the patient has a substantial increase in pain and decrease in function that persists more than one month after a dose reduction, then tapering may be undertaken more slowly, paused, or potentially abandoned in such patients.
 - iii. In those rare circumstances where tapering is not appropriate, if the patient is on **90 milligrams** morphine equivalents per day or more, and there is documented benefit to the patient, then continue the treatment. See Part VII
 - iv. Medications must not be abruptly discontinued – “bridging” prescriptions during assessment of the patient is entirely acceptable to avoid dangers of withdrawal.
 - v. Prescriptions may be written for a maximum of up to three months, but never authorize the dispensing of more than a one-month supply of any opioid. For patients in remote communities, the dispensing may be for up to three months. For patients travelling, the dispensing may be up to three months, if the patient has been on a stable long-term prescription.
 - vi. All dosages must be recorded clearly in the medical record.
- (d) Taper benzodiazepine(s) slowly to the lowest functional dose, or zero if possible, if a patient on existing long-term prescribed benzodiazepine(s) is concurrently taking long-term opiates. Excluding acute and time-limited indications, do not initiate a new benzodiazepine(s) prescription in combination with long-term opioids except in limited and exceptional circumstances which are documented.
- (e) Consult with an appropriate specialist and/or multidisciplinary program (including these possibilities: practice colleague, pain clinic, psychiatry, psychology, addiction specialist, sports medicine, pharmacist, physiotherapist, kinesiologist, chiropractor,

occupational therapist, dietitian, practice colleague, if available) when the patient receives a **90 milligrams** morphine equivalents dose daily for longer than 90 days or the patient experiences serious challenges in tapering off opioids or if opioid use disorder is suspected.

Part VI – ADOLESCENT PATIENTS

The concern of opioid use in adolescents parallels the cautious approach in Parts I – V. There are additional vulnerabilities (including concern that dependency develops more quickly in adolescents) which add to the need for considering alternate treatments to opioids.

For the member's adolescent patients with acute pain or post-operative analgesia, the member **shall**:

- (a) Attempt, with caution, to adapt Part I to prescribing for adolescents.
- (b) Prescribe dosages of opioid that are reduced in proportion to the body mass and development stage of the adolescent.

For the member's adolescent patients for whom opioids are being prescribed (excluding cancer, palliative, and end-of-life care, and excluding with acute pain or post-operative analgesia) the member **shall**:

- (a) Attempt, with caution, to adapt Parts II - V to prescribing for adolescents (other than dosages which must be in proportion to the body mass and development stage of the adolescent).
- (b) Utilize non-steroidal anti-inflammatory medication and acetaminophen, or other alternate medication, unless otherwise contraindicated, prior to prescribing opioids.
- (c) Prior to prescribing opioids, document the consent of the adolescent if developmentally mature enough to provide consent. If the adolescent is not developmentally mature enough to provide consent, document consent of the parent(s) or legal guardian(s) prior to prescribing opioids.
- (d) Prescribe dosages of opioids that are reduced in proportion to the body mass and development stage of the adolescent.

Part VII - CONTINUED PRESCRIBING OF OPIOIDS FOR PATIENTS WITH NON-CANCER PAIN

Continued prescribing of opioids for patients with non-cancer pain under Parts II-VI must only occur if there is documentation of:

- i. measurable clinical improvement in pain, function, and quality of life evaluations and
- ii. maintenance of a satisfactory level of improvements in these parameters which outweighs the risks of continued opioid treatment.

Continuing to prescribe opioids, or even the same dose of opioids, solely on the basis that they have been prescribed previously is not acceptable.