

SOUTH DAKOTA STATE MEDICAL ASSOCIATION
POLICY

Subject: Opiate Prescribing and the Utilization of the South Dakota Prescription Drug Monitoring Program

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POLICY STATEMENT

When used appropriately, opiate analgesics can be important tools for relieving moderate to severe pain arising from a wide range of conditions, disease states, and medical procedures. These drugs, however, may also be misused and abused, and overprescribing of opiate pain relievers can result in multiple adverse health outcomes, including fatal overdoses.

Physicians must exercise their own best medical judgment when providing treatment, taking all relevant circumstances into account, including the potential for abuse, diversion and risk for addiction. There are many pharmacologic and non-pharmacologic options available to primary care physicians for the treatment of pain. Regardless of the course of action, options should be employed by using the following general principles:

1. Nonopioid therapies are at least as effective as opioids for many common types of acute pain. Physicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient. Before prescribing opioid therapy for acute pain, physicians should discuss with patients the realistic benefits and known risks of opioid therapy;
2. Nonopioid therapies are preferred for subacute and chronic pain. Physicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient. Before starting opioid therapy for subacute or chronic pain, physicians should discuss with patients the realistic benefits and known risks of opioid therapy, should work with patients to establish treatment goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks;
3. When starting opioid therapy for acute, subacute, or chronic pain, physicians should prescribe immediate-release opioids instead of extended-release and long-acting opioids;
4. When opioids are initiated for opioid-naïve patients with acute, subacute, or chronic pain, physicians should prescribe the lowest effective dosage. If opioids are continued for subacute or chronic pain, physicians should use caution when prescribing opioids at any dosage, should carefully evaluate individual benefits and risks when considering increasing dosage, and should avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients;
5. For patients already receiving opioid therapy, physicians should carefully weigh benefits and risks and exercise care when changing opioid dosage. If benefits outweigh risks of continued opioid therapy, physicians should work closely with patients to optimize nonopioid therapies

while continuing opioid therapy. If benefits do not outweigh risks of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper to lower dosages or, if warranted based on the individual circumstances of the patient, appropriately taper and discontinue opioids. Unless there are indications of a life-threatening issue such as warning signs of impending overdose, opioid therapy should not be discontinued abruptly, and physicians should not rapidly reduce opioid dosages from higher dosages;

6. When opioids are needed for acute pain, physicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids;
7. Physicians should evaluate benefits and risks with patients within 1–4 weeks of starting opioid therapy for subacute or chronic pain or of dosage escalation. Physicians should regularly reevaluate benefits and risks of continued opioid therapy with patients;
8. Before starting and periodically during continuation of opioid therapy, physicians should evaluate risk for opioid-related harms and discuss risk with patients. Physicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone;
9. When prescribing initial opioid therapy for acute, subacute, or chronic pain, and periodically during opioid therapy for chronic pain, physicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose;
10. When prescribing opioids for subacute or chronic pain, physicians should consider the benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances;
11. Physicians should use particular caution when prescribing opioid pain medication and benzodiazepines concurrently and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants;
12. Physicians should offer or arrange treatment with evidence-based medications to treat patients with opioid use disorder. Detoxification on its own, without medications for opioid use disorder, is not recommended for opioid use disorder because of increased risks for resuming drug use, overdose, and overdose death.

For patients presenting to the emergency department (ED) with an acute exacerbation or non-cancer chronic pain, the SDSMA recommends the following:

1. Physicians avoid routine prescribing of outpatient opiates for a patient with an acute exacerbation of chronic non-cancer pain seen in the ED;
2. If opiates are prescribed on discharge, limit the prescription to the amount needed until a follow-up visit can be scheduled – not to exceed seven (7) days;
3. Emergency physicians should not prescribe additional narcotics for a condition previously treated in the ED or by another physician unless there are extenuating circumstances;
4. Patients with chronic non-cancer pain not receive injections of opiates in the ED;
5. Emergency physicians not prescribe long acting narcotic agents such as Oxycontin, extended release morphine or methadone. Oxycodone (ex. Percocet), hydrocodone (ex. Vicodin) and hydromorphone (Dilaudid) have high abuse potential and the physician should consider using alternative agents;
6. Emergency physicians not replace lost or stolen prescriptions for controlled substances;
7. Emergency physicians not fill prescriptions for patients who have run out of pain medications – refills are to be arranged with the primary or specialty prescribing physician;
8. Avoid narcotic pain medication for certain conditions to include:
 - a. Back pain – whether acute or chronic
 - b. Routine dental pain
 - c. Migraines
 - d. Chronic abdominal or pelvic pain and gastroparesis;

9. Patients with suspected substance abuse behavior be referred to appropriate resources; and
10. Patients identified with multiple ED visits for pain, problematic or dishonest behavior (abusive, altering prescriptions, false reports) or use of multiple hospitals for pain be reviewed by the ED physician leadership team. The following should be considered:
 - a. Sending a certified letter stating the patient will no longer be provided opiates in the ED;
 - b. Adding an internal code (ex. 555) identifying probable drug seeking behavior into their medical record.

The potential benefit of using the SD PDMP includes the ability to identify patients who might be at higher risk for opiate overdose or opiate use disorder. The SD PDMP may also help determine which patients may benefit from great caution and increased monitoring or interventions when risk factors are present.

When prescribing opiates, the SDSMA recommends:

1. Emergency department physicians check a patient against the SD PDMP prior to prescribing opiate-based pain medication;
2. Physicians, regardless of setting, check a patient against the SD PDMP for all initial visits; and
3. Physicians, regardless of setting, check (established) patients against the SD PDMP every six months when prescribing opiates for chronic, non-cancer pain.

AUTHORITY

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