

Initiation of Opioids in Adults for Acute Pain

Tennessee regulations stipulate that a first-time opioid prescription of up to a 3-day supply has no requirements before prescribing; however, it is recommended that the clinician query the Controlled Substance Monitoring Database (CSMD) before issuing the prescription.

When opioids are determined appropriate to address severe acute pain for a period of time greater than 3 days but for no more than 7 days, the following steps should be taken before choosing and prescribing an opioid:

1. Document the specific condition that requires treatment with an opioid medication.
2. Document a thorough pain complaint assessment (See the Initial Pain Assessment Algorithm) that includes the relevant history and physical examination regarding the condition requiring treatment with the opioid medication and any contraindications of opioid therapy based on the patient's history.
3. Assess risk factors for misuse, abuse, or diversion using the Opioid Risk Tool
4. Document details of other pharmacologic and non-pharmacologic treatments tried, including use of any opioids previously.
5. Maximize non-opioid therapies, including the use of non-pharmacologic therapies.
6. Check the CSMD and document in the electronic medical record (EMR).
7. Only short-acting opioid medication should be prescribed.
8. **OPIOID Naïve:** If the patient is opioid naïve, the total daily dose of opioids should rarely exceed 20 Morphine Milligram Equivalents (MME). The lowest effective dose should be prescribed.
9. Should greater than 20 MME be required, no more than 50 MME should be prescribed with documentation of why the larger dosing is required within the EMR. A shorter length of therapy should be prescribed along with a planned follow-up appointment to assess efficacy and tolerance.
10. See table 1 for *calculation of MME*. Higher dosages of opioids are associated with a higher risk of overdose and death. Calculating the total daily dose of opioids helps to identify patients that may benefit from closer monitoring and other measures to reduce the risk of misuse and overdose.
11. **POSITIVE RISK SCREEN:** If the patient screens moderate to high risk on the opioid risk screener and is determined to still require an opioid prescription, the following additional steps will be followed:
 - a. No prescription should be written for more than 7 days.
 - b. The total number of opioid tablets prescribed should not exceed 12-15 tablets.
12. Discuss the adverse side effects and risks of opioid therapy including, but not limited to, nausea/vomiting, sedation, respiratory depression, physical and psychological dependence, harm to an unborn child, overdose, and death.

Table 1

<u>OPIOID</u> (Doses in mg/day except as noted)	<u>CONVERSION FACTOR</u>
Codeine	0.15
Fentanyl transdermal (in mcg/hr)*	2.4
Hydrocodone	1
Hydromorphone	4
Methadone**	
1-20mg/day	4
21-40mg/day	8
41-60mg/day	10
≥61-80mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

*Fentanyl is dosed in mcg/hr instead of mg/day and absorption is affected by any factors that influence the skin such as heat and other factors

**Methadone conversion factor increases at higher doses

Example:

A 56 yo female is taking Morphine ER 15 mg BID and oxycodone 10 mg TID. What is her MME? Total the daily dose of Morphine and multiply by the conversion factor of 1. Total the total daily dose of oxycodone multiplied by the conversion factor of 1.5. Add these two numbers together to get the Morphine Milligram Equivalents (MME).

Calculation:

$$[(15 + 15) \times 1] + [(10 + 10 + 10) \times 1.5] = 30 + 45 = 75 \text{ MME.}$$