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# Revolutionizing Pain Care: Applying the Latest Updates in Opioid REMS Education to Your Practice

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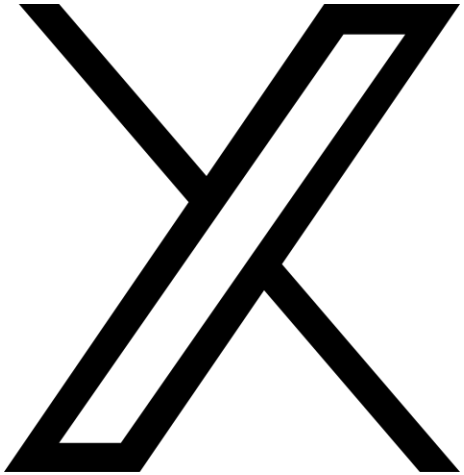

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# Learning Objective 1

Incorporate knowledge of physiologic mechanisms and biopsychosocial factors influencing pain development, persistence, and management into clinical assessment and appropriate management of pain

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# Learning Objective 2

Incorporate strategies from the 2022 CDC Guideline for Prescribing Opioids into the development of safe and effective pain management plans for patients with acute, subacute, and chronic pain

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# Learning Objective 3

Incorporate the DSM-5 criteria in the identification and diagnosis of OUD in patients prescribed opioids for acute and chronic pain

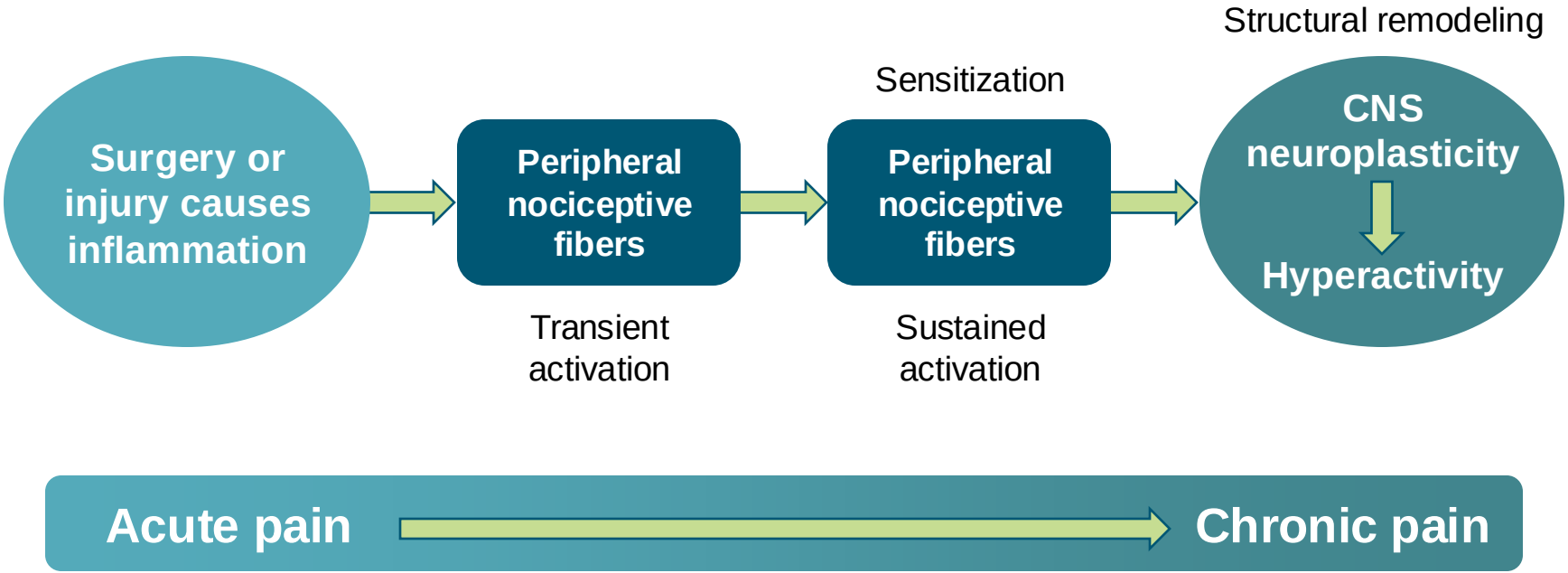
# Survey Question:

What are the most challenging aspects of treating patients with pain in your practice? (select your top 3)

a. Knowledge of drugs
b. Prior authorizations
c. Drug positioning
d. Patient comorbidities
e. Loss of response to treatments
f. Lack of time with patients
g. Staffing challenges

# Pain Basics & Assessment

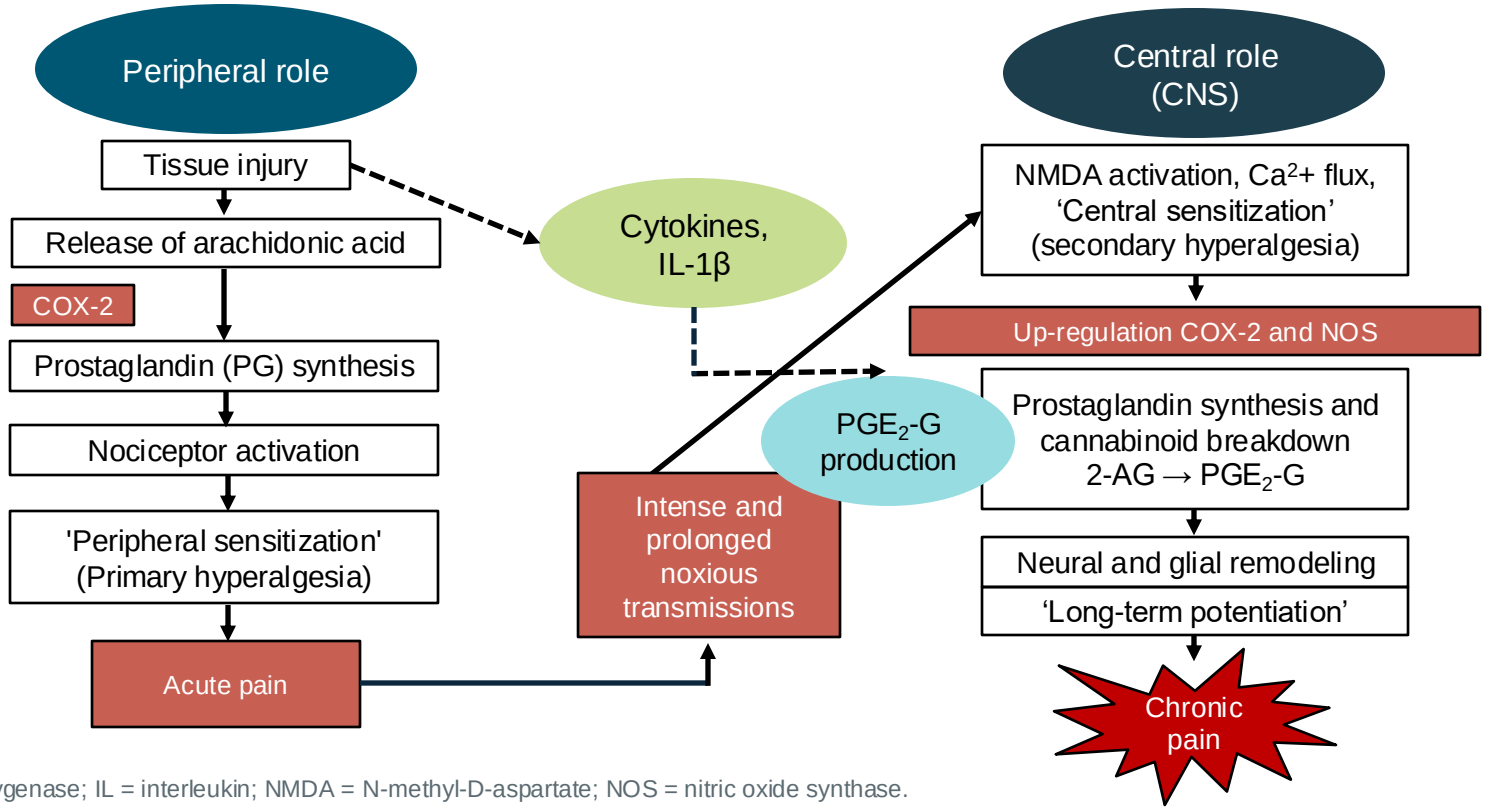
# Acute and Chronic Pain Pathways




CNS = central nervous system.

Pozek JP, et al. *Med Clin North Am.* 2016;100(1):17-30.

# Pathophysiology of Transition From Acute to Chronic Pain




COX = cyclooxygenase; IL = interleukin; NMDA = N-methyl-D-aspartate; NOS = nitric oxide synthase.

Voscopoulos C, Lema M. *BJA*. 2010;105(suppl 1):i1-i116.

# Pain Classification by Duration

## Acute

- Duration: < 4 weeks
- Due to acute injury, disease, or abnormal function
- Adaptive response eliciting motivation to minimize harm and allow healing

## Subacute

- Duration: 4-12 weeks
- May be due to attempting to resume normal activities following healing or scar tissue development

## Chronic

- Duration: > 12 weeks
- Maladaptive disorder of the somatosensory pain signaling pathways
- Due to chronic pathology or may occur after original insult has resolved

Dowell D, et al. 2022. *MMWR Recomm Rep*. 2022;71(No. RR-3):1-95. King W. *Encyclopedia of Pain*. 2013;60-63. Chanda ML. *J Pain*. 2011;12(7):792-800.

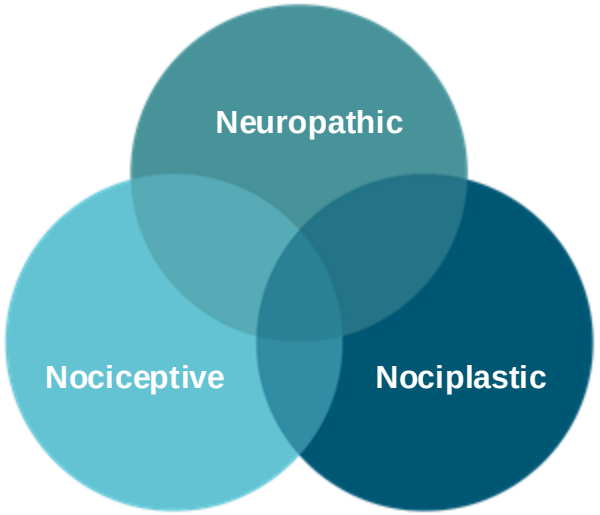
# Pain Classification by Origin

## Neuropathic

- Arises from lesion or disease of the somatosensory nervous system
- Examples: neuropathy, carpal tunnel, sciatica

## Nociceptive

- Arises from actual or threatened damage to non-neural tissue and activation of nociceptors
- Occurs in the setting of normal somatosensory nerve functioning
- Examples: trauma, surgery, osteoarthritis




**Mixed pain pathologies** associated with development of chronic pain

## Nociplastic (inflammatory)

- Arises from altered nociception despite no clear evidence of actual or threatened tissue damage
- Influenced by biopsychosocial factors
- Examples: fibromyalgia, complex pain syndromes

Stanos S, et al. *Postgrad Med.* 2016;128(5):502-515. International Association for the Study of Pain (IASP). 2021. https://www.iasp-pain.org/resources/terminology/. Fitzcharles MA, et al. *Lancet*. 2021;397(10289):2098-2110.

# What Increases the Risk of Developing Chronic Pain?

- Mental and physical comorbidities
- Tobacco or alcohol use
- Physical activity
- Sleep hygiene
- Nutrition
- Employment status and occupational factors
- Age
- Sex
- History of trauma, interpersonal violence or ACEs
- Cultural background
- Socioeconomic background
- Genetic factors
- Attitudes & beliefs about pain

ACE = adverse childhood experiences.

van Hecke O, et al. *Br J Pain.* 2013;7(4):209-217. Mills SEE, et al. *Br J Anaesth*. 2019;123(2):e273-e283. Tidmarsh LV et al. *Front Pain Res* (Lausanne). 2022;3:923866.

# Faculty Discussion:

What are some persistent misconceptions about chronic pain and opioid misuse seen in practice?

# The Biopsychosocial Model of Pain

- Pain pathology
- Inflammation
- Nociception
- Chronic disease

- Stress and coping
- Catastrophizing
- Depression/anxiety
- Cognition


- Sleep
- Nutrition/diet
- Exercise/mobility
- Substance use

- Social exclusion
- Discrimination
- Stigmatization
- Employment/income

Adams LM, et al. *J Appl Behav Res*. 2018; 23:e12125. Darnall BD, et al. *Pain Med*. 2017;18(8):1413-1415. Robinson-Lane SG, et al. *J Gerontol Nurs*. 2017;1-8. McClendon J, et al. *Arthritis Care Res (Hoboken)*. 2021;73(1):11-17.

# Patient Case

# Angelo: 38-Year-Old Man

## History of present illness

- Fell off a ladder 2 years ago; chronic neck and lower back pain
- On opioids long-term (18 months), primary care physician will no longer prescribe opioids after this next month

## Medical history

- Generally healthy; no significant comorbidities prior to incident
- Chronic neck and lower back pain impacting daily activities and ability to return to work full-time

## Procedure/surgical history

- Epidural steroid injections in cervical and lumbar levels
- Radiofrequency ablation
- Anterior cervical discectomy and fusion – gave partial relief of arm symptoms, neck pain not improved
- Hesitant to have lumbar surgery

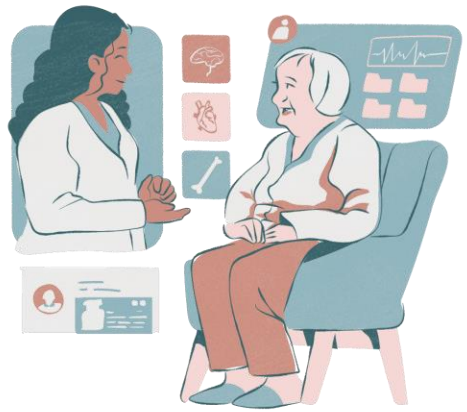
## Medications

- Morphine ER 15 mg twice daily
- Oxycodone 5 mg IR twice daily as needed for breakthrough pain
- Gabapentin 300 mg 3x daily
- Ibuprofen 200 mg 3x daily as needed

# Comprehensive Pain Assessment

**Shared Decision Making**

- Patient History
- Physical Examination
- Diagnostic Studies



- Functional Pain Assessment
- Psychosocial Evaluation
- Risk Screening

<u>Populations At Risk For Inaccurate Pain Assessment</u>

People of color - Women - LGBTQ+ - Elderly - End-of-life

Patients with: SUD, cognitive impairment, mental illness, cancer, sickle cell disease (SCD)

SUD = substance use disorder.

U.S. Department of Health and Human Services (HHS). *Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations.* 2019. https://www.hhs.gov/sites/default/files/pain-mgmt-best-practices-draft-final-report-05062019.pdf. Dowell D, et al. *MMWR Recomm Rep.* 2022;71(No. RR-3):1-95.

# Tools for Assessing Pain-Related Functionality

- Functional assessment more critical than numeric pain score (NPS)
  - Assess for impact of pain on function, daily activities, quality of life, mental health
  - Identify comorbidities and patient circumstances contributing to pain sensitivity
- Functional scoring tools
  - Patient Reported Outcome Measures Information System (PROMIS)
  - Short Form Health Survey (SF-36)
  - Pain intensity, Enjoyment of life, and General Activity (PEG)
- Assessing for depression or anxiety
  - PHQ-9 and GAD-7

**Remember**: all standardized scoring systems have gaps and limitations

PROMIS ITEM BANK V1.0 – PAIN INTERFERENCE – SHORT FORM 8A
Please respond to each question or statement by marking one box per row.

In the past 7 days…

| | | Not at all | A little bit | Somewhat | Quite a bit | Very much |
|---|---|---|---|---|---|---|
| 1. | How much did pain interfere with your day to day activities? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 |
| 2. | How much did pain interfere with work around the home? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 |
| 3. | How much did pain interfere with your ability to participate in social activities? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 |
| 4. | How much did pain interfere with your household chores? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 |
| 5. | How much did pain interfere with the things you usually do for fun? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 |
| 6. | How much did pain interfere with your enjoyment of social activities? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 |
| 7. | How much did pain interfere with your enjoyment of life? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 |
| 8. | How much did pain interfere with your family life? | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 | ☐ 5 |

GAD-7 = General Anxiety Disorder-7; PHQ-9 = Patient Health Questionnaire-9

Amtmann D, et al. *Pain*. 2010;150(1):173-182. Practical Pain Management. 2019. https://www.practicalpainmanagementesource-centers/opioid-prescribing-monitoring/list-clinically-tested-validated-pain-scales.

# Faculty Discussion:

How do you use screening and assessment tools in practice?

# Case cont.: Angelo's Exam and Assessment

## Updated physical examination:

- **Neck:** Continued tenderness over C5-C7, with limited neck mobility. Ongoing positive Spurling's test.
- **Back**: Tenderness over L4-S1, mild paraspinal muscle spasms. Straight-leg raise test still positive on the left side.
- **Neurological exam**: Persistent mild weakness (4+/5) in left biceps and wrist extensors, decreased sensation in left lateral arm and foot.

**Withdrawal symptoms**

- Mild symptoms present due to rapid taper over 3 weeks

**PROMIS**

- Indicates significant limitations, fatigue, elevated anxiety, moderate to high pain intensity

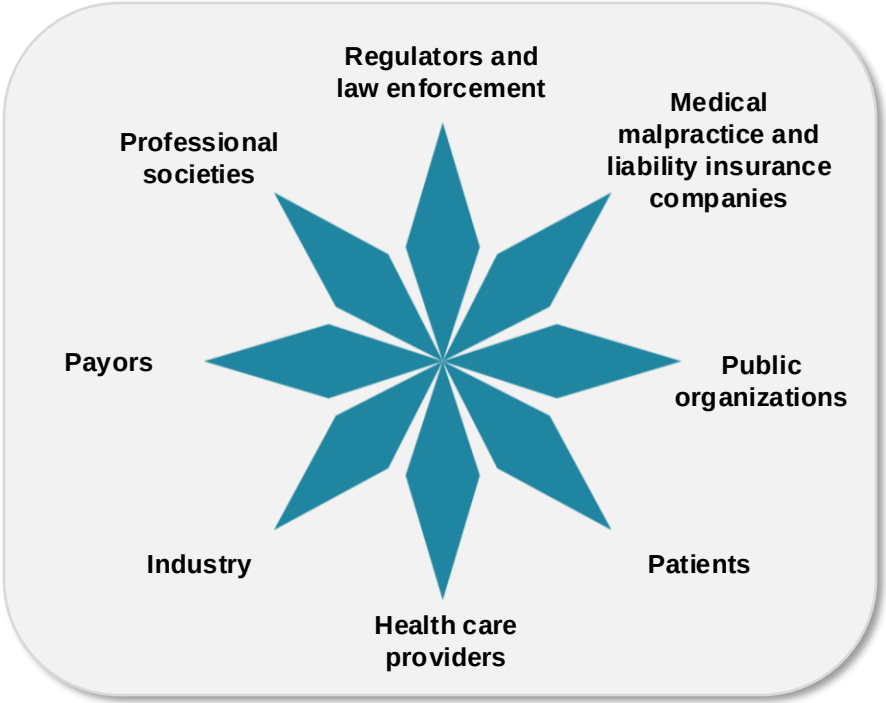
**PHQ-9**

- 10-14 (moderate depression)

**What is your next step in caring for this patient?**

# Misapplication of 2016 CDC Guideline

- HCPs policed themselves to avoid unwanted scrutiny and liability
- Interprofessional tension surfaced out of pressure to apply guidelines and avoid liability
- Subjective application of PDMPs neglected SDoH and cultivated discrimination against patients of color

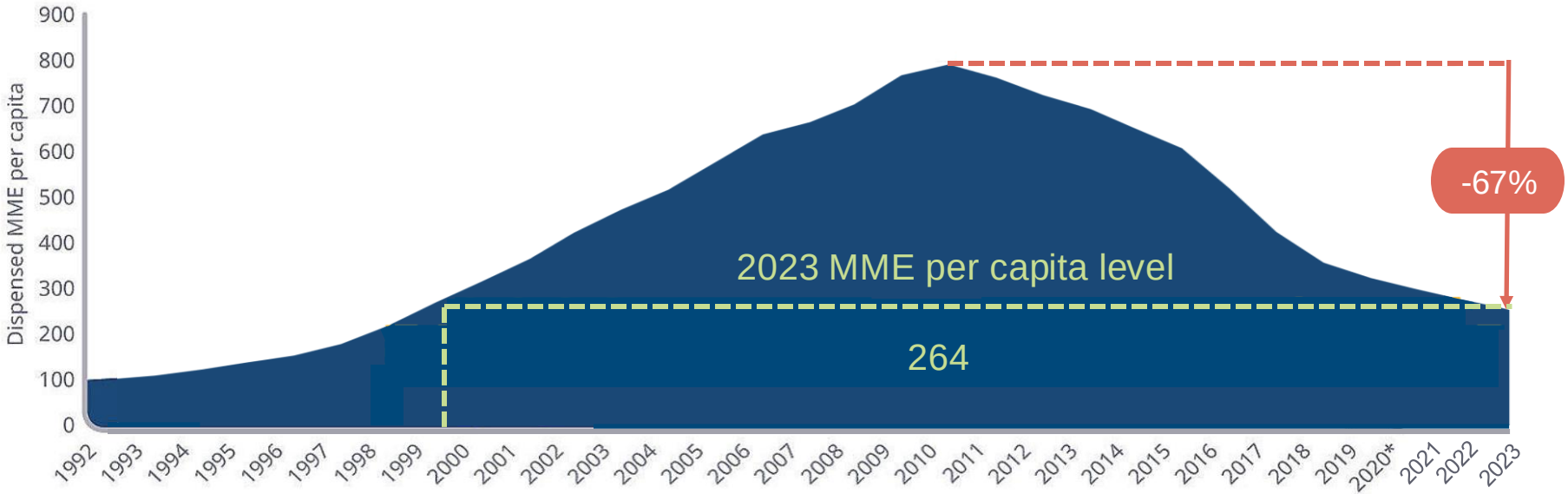



HCP = health care professional; PDMP = prescription drug monitoring program; SDoH = social drivers of health.

Dowell D, et al. *N Engl J Med.* 2019;380(24):2285-2287. Ranapurwala SI, et al. *Am J Prev Med.* 2021;60(3):343-351. Human Rights Watch (HRW). 2018. https://www.hrw.org/report/2018/12/18/not-allowed-be-compassionate/chronic-pain-overdose-crisis-and-unintended-harms-us.

# Opioid Prescribing Has Steadily Decreased Since 2011

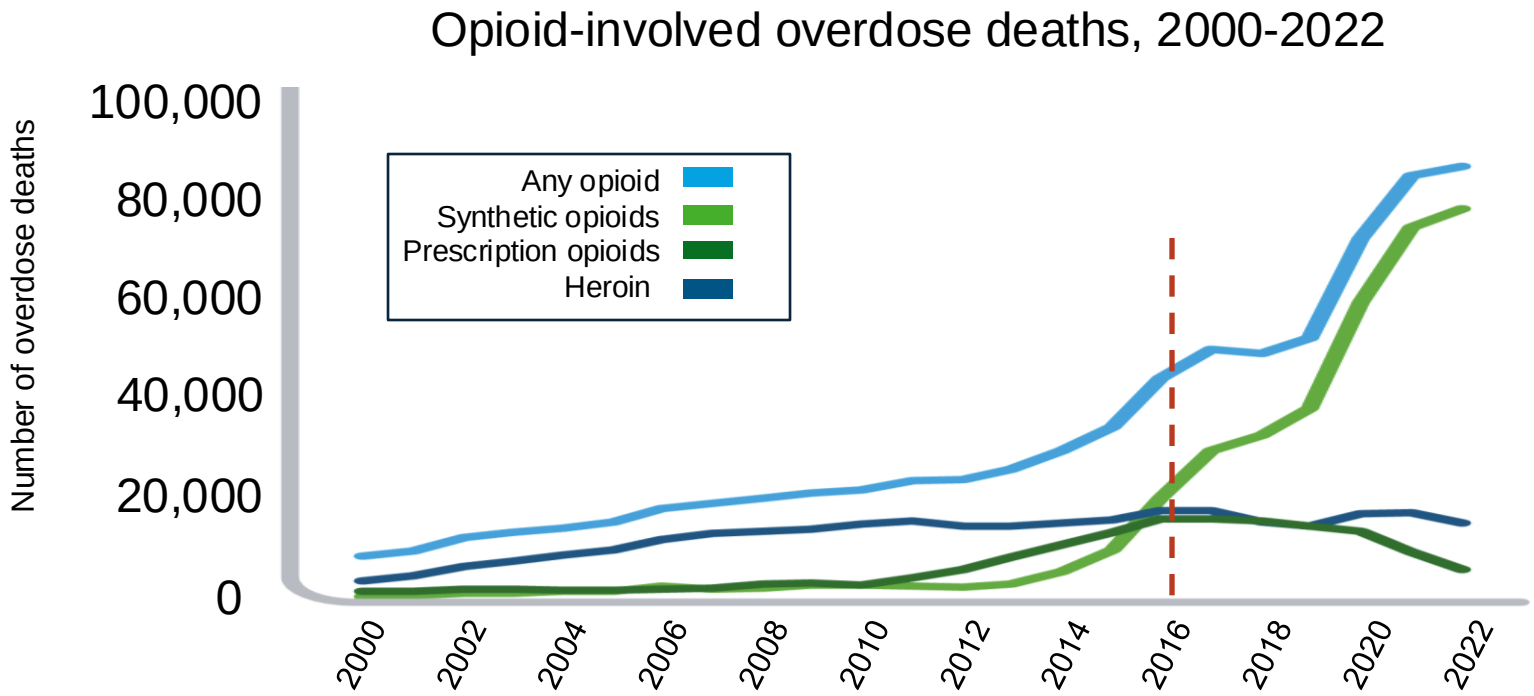
Morphine Milligram Equivalents (MME) per capita, 1992-2023




MME = morphine milligram equivalent

IQVIA. *Prescription Opioid Trends in the United States.* 2020. https://www.iqvia.com/insights/the-iqvia-institute/reports/prescription-opioid-trends-in-the-united-states.; IQVIA. *The Use of Medicines in the U.S. 2024.* 2024. https://www.iqvia.com/-/media/iqvia/pdfs/institute-reports/the-use-of-medicines-in-the-us-2024/the-use-of-medicines-in-the-us-2024-usage-and-spending-trends-and-outlook-to-2028.pdf.

# Opioid Overdose Death Increase Driven by Illicit Synthetic Opioids




IQVIA. *The Use of Medicines in the U.S. 2024.* 2024. https://www.iqvia.com/-/media/iqvia/pdfs/institute-reports/the-use-of-medicines-in-the-us-2024/the-use-of-medicines-in-the-us-2024-usage-and-spending-trends-and-outlook-to-2028.pdf.

# Faculty Discussion:

Impact of changing opioid policies have you seen in current practice?

# Key Principles of the 2022 CDC Guidelines

Acute, subacute, and chronic pain needs to be appropriately assessed and treated, whether or not opioids are part of a treatment regimen

Individualized, person-centered care is most important

Use a multimodal, multidisciplinary approach that includes physical & behavioral health, long-term services & support

Guidelines are meant to help not hurt patient care; avoid recommendations if they may lead to unintended harm

Clinicians, health systems, and payers should address health inequities by using culturally appropriate communication and ensuring access to care

Dowell D, et al. *MMWR Recomm Rep*. 2022;71(No. RR-3):1-95.

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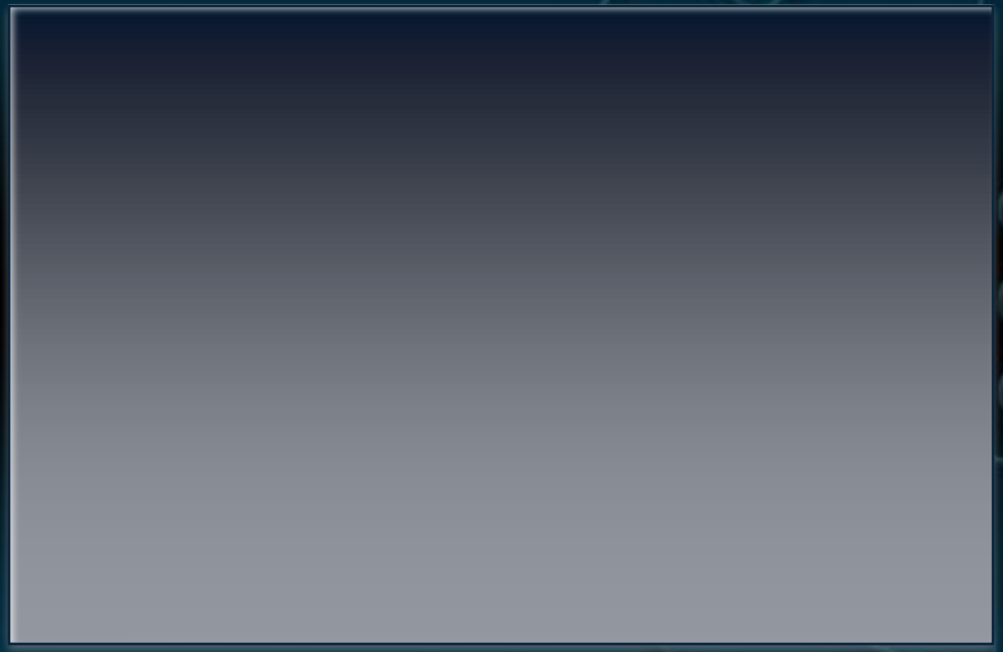
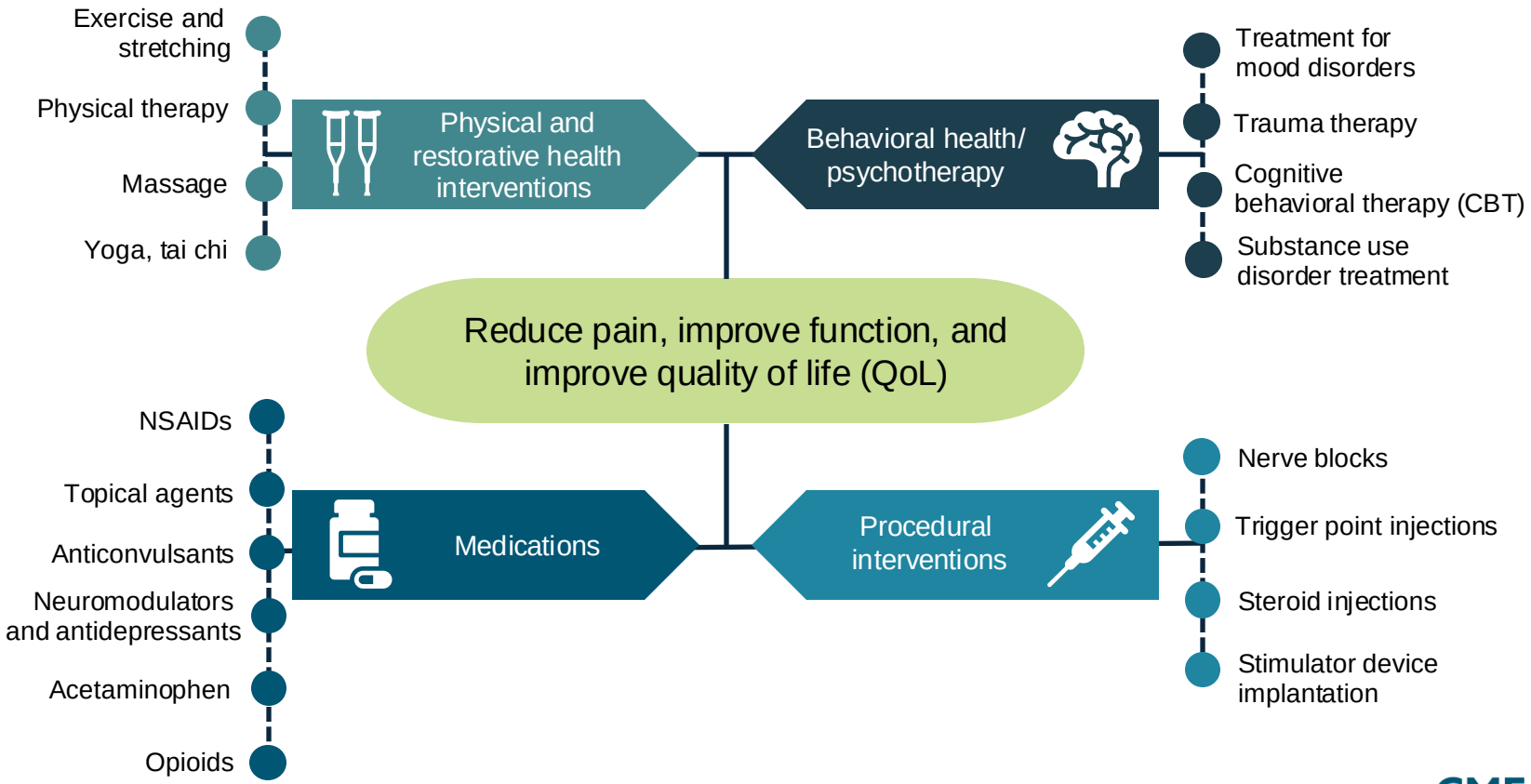
# Pain Treatment

# Patient experience with post operative pain care

Kirstin C.



# Multimodal Approach to Pain Care




NSAID = non-steroidal anti-inflammatory drug

Dale R, et al. *Med Clin North Am*. 2016;100(1):55-64. Dowell D, et al. *MMWR Recomm Rep*. 2022;71(No. RR-3):1-95.

# Options for Nonpharmacologic Therapies for Pain

| Treatment Category | Treatment Options |
|---|---|
| Lifestyle | Exercise, weight loss, nutrition/diet, sleep hygiene |
| Physical rehabilitation | Thermal therapies, physical and occupational therapy, massage, postural support |
| Mind–body | CBT, yoga, tai chi, muscle relaxation, hypnosis, meditation, mindfulness, music/art therapy, pain reprocessing therapy (PRT) |
| Complementary and alternative medicine | Acupuncture/acupressure |
| Device- and procedure-based | Surgery, transcutaneous electrical nerve stimulation, radiofrequency ablation, light therapy, electromyography, ultrasound, biofeedback, noninvasive brain stimulation |

Ashar YK, et al. *JAMA Psychiatry*. 2022;79(1):13-23. Shi Y, Wu W. *BMC Medicine*. 2023;21:372. HHS. *Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations.* 2019. https://www.hhs.gov/sites/default/files/pain-mgmt-best-practices-draft-final-report-05062019.pdf.

# Limitations & Challenges of Nonpharmacologic Therapies for Pain

| Potential Limitations | Challenges |
|---|---|
| Standardization | Lack of standardized treatment protocols and dosing guidelines for noninvasive prenatal testing (NINPT) make it difficult to compare efficacy across modalities and trials |
| Accessibility | Affordability, insurance coverage, access to specialized equipment or facilities (often determined by geography), lack to awareness of options |
| Adherence | Poor patient adherence may result if expectations not well-managed |
| Research methodology | Small sample sizes, lack of long-term follow up, difficulties with randomization and blinding |
| Patient selection | Appropriately matching modality to patient |

Ashar YK, et al. *JAMA Psychiatry*. 2022;79(1):13-23. Shi Y, Wu W. *BMC Medicine*. 2023;21:372. HHS. *Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations.* 2019. https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf.

# Non-Opioid Pharmacotherapy for Pain

| Medication or Drug Class | Condition for Use |
|---|---|
| Acetaminophen | Osteoarthritis (PO or topical NSAIDs recommended first-line) |
| NSAIDs | Chronic low back pain, osteoarthritis |
| Serotonin and norepinephrine reuptake inhibitor (SNRI) | Chronic low, back pain, neuropathic pain, osteoarthritis, fibromyalgia |
| Tricyclic antidepressants (TCAs) | Neuropathic pain |
| Gabapentinoids | Post-herpetic neuralgia, neuropathic pain, fibromyalgia |
| Anticonvulsants | Neuropathic pain |
| Topical lidocaine or capsaicin | Neuropathic pain |
| Antispasmodics / muscle relaxers | Spasticity |

**Ensure dose optimization for all medication treatments**

PO = by mouth

Cheng J, et al . *Pain Med*. 2020;21(1):1-3.; Dowell D, et al. *MMWR Recomm Rep*. 2022;71(No. RR-3):1-95.

# Faculty Discussion:

How do you incorporate non-pharmacologic therapies into your practice?

# Assessments for Risk of Opioid Misuse Have Limitations

2022 CDC Practice Guidelines:

"*Available risk stratification tools demonstrate limited and variable accuracy for classification of patients as at low or high risk for opioid use disorder or misuse*."

Examples listed

- Opioid Risk Tool
- Screener and Opioid Assessment for Patients with Pain [SOAPP] v.1
- SOAPP-R
- Brief Risk Interview

Dowell D, et al. *MMWR Recomm Rep*. 2022;71(No. RR-3):1-95.

# Acute Pain Management with Opioids

## Opioids may be indicated for:

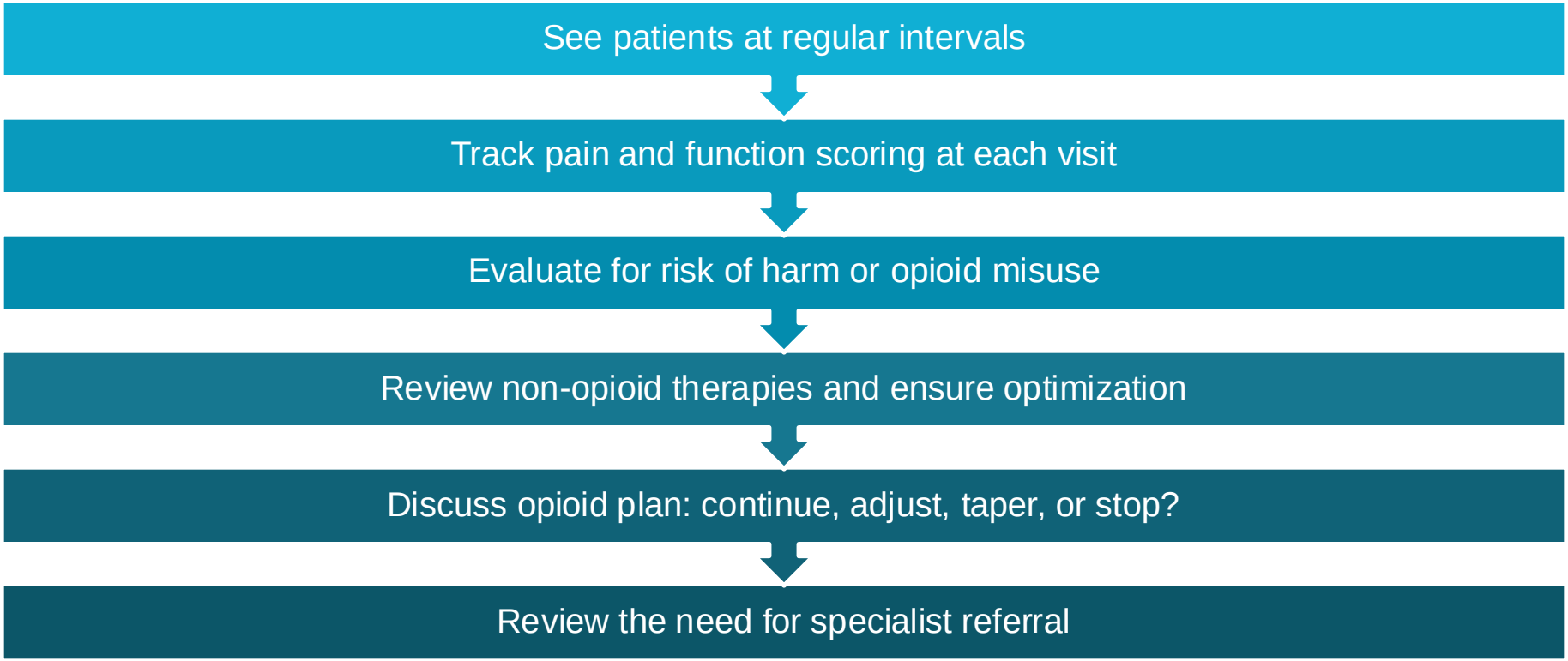
- Severe traumatic injuries (including crush injuries and burns)
- Invasive surgeries associated with moderate to severe postoperative pain
- Severe, acute pain when NSAIDs and other therapies are contraindicated or likely to be ineffective

## If using opioids for acute pain:

- Use as needed vs. scheduled dosing
- Utilize immediate-release opioids at the lowest effective dose for the shortest duration
- Maximize non-opioid pharmacologic and nonpharmacologic treatments
- Utilize a taper if opioids are used around-the-clock for more than a few days
- Opioids should not be automatically continued if pain becomes subacute or chronic

Dowell D, et al. *MMWR Recomm Rep*. 2022;71(No. RR-3):1-95.

# Opioids for Chronic Pain: Individualizing care




Dowell D, et al. *MMWR Recomm Rep*. 2022;71(No. RR-3):1-95.

# Faculty Discussion:

How does “opioid moderatism” come into play when you are developing pain treatment plans?

# Patient Case Review: Angelo Treatment Planning

**Using a shared decision-making (SDM) approach, you both discuss:**

- Could he consider spinal cord stimulation or peripheral nerve stimulation
- Referral to other specialty (e.g., neurosurgery)
- If he is in withdrawal, reintroduce opioids at lower dose
- Gradual taper with supportive meds
- Develop functional and mental health treatment goals

**What is the next step you would recommend for Angelo at the end his visit?**

# Faculty Discussion:

How do you handle the situation of someone using (legal) cannabis who is still in pain?

# Monitoring Plan Helps Patients Reach Their Treatment Goals Safely

- Advise patients of PDMP monitoring that occurs at physician and pharmacy visits
  - Check PDMP when starting opioids and with every new prescriptions or every 3 months
- Advise patients of any plans for UDS monitoring
  - Screening will be used to confirm adherence and identify use of illicit drugs or other medications that could interfere with treatment goals
  - No mandated frequency for UDS monitoring in 2022 practice guidelines
- Reinforce that monitoring strategies are designed to improve patient safety
  - Patient should understand and agree to treatment and monitoring plans

Patients should not be dismissed from a practice based on PDMP or UDS results

UDS = urine drug screening.

Dowell D, et al. *MMWR Recomm Rep*. 2022;71(No. RR-3):1-95.

# Review State Specific Rules for Telemedicine Rules for Controlled Substance Prescribing

- Full set of telemedicine flexibilities regarding the prescribing of controlled medications as were in place during the COVID-19 public health emergency (PHE), was extended through December 31, 2024.
- Different regulations for Schedule II vs Schedule III-V prescribing
- Review hardship exceptions that may impact the need for in-person visit
- State specific rules exist for telemedicine prescribing and in-person visit requirements

Drug Enforcement Administration. Second Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications. 88 FR 69879. https://www.federalregister.gov/d/2023-22406

# Patient Education: Optimize Safety for All

## Store & dispose of opioids safely

- Store opioids in a secure and preferably locked location, out of reach of children and pets
- To dispose of leftover opioids, drop them off at a drug take back site or flush down the toilet

## Prevent accidental exposure or diversion to family & friends

- Keep prescription opioids out of sight & out of reach from others
- Keep medications in original container; remove/black out the name and prescription number to protect identity before disposing

## Understand how to use naloxone for overdose

- Clinicians should educate patients about overdose prevention and teach members of the household about naloxone use

Dowell D, et al. *MMWR Recomm Rep*. 2022;71(No. RR-3):1-95. U.S. Food & Drug Administration (FDA). https://www.fda.gov/drugs/safe-disposal-medicines/disposal-unused-medicines-what-you-should-know. Montana State University Extension. 2021. https://www.montana.edu/extension/health/documents/2021_STA_Home_Safety_ROTA.pdf. Prescribe to Prevent. 2022. https://prescribetoprevent.org/clinician-resource/general/.

# Shared Decision-Making in Pain Management

| | |
|---|---|
| **Recommendation** | • Utilize a stepwise, multimodal approach approach<br>• Use shared decision making for starting or stopping any part of treatment plans |
| **Tapering** | • SDM approach is particularly important where the benefits & risks of continuing or tapering opioids are being discussed |
| **Pregnancy** | • In someone with childbearing potential, clinicians and patients should discuss contraception and potential effects of long-term opioid use on any future pregnancy |
| **Stigma** | • Prior experiences and existing stigma hinder SDM in pain management especially in patients with OUD |
| **Trust** | • Patients must be comfortable sharing their history<br>• Clinicians should not underestimate a patient's level of pain |

SDM= shared decision-making; Dowell D, et al. *MMWR Recomm Rep*. 2022;71(No. RR-3):1-95. Vu PD, et al. *J Clin Med*. 2023;12(10):3555.

# Is It Time to Taper Opioid Therapy?

## Consider tapering when benefits do not outweigh risks of continued therapy

- Considerations: patient request for dose reduction or discontinuation, pain improvement, opioid therapy no longer meaningfully reducing pain or improving function, increased risk for serious adverse events or opioid use disorder
- Patient agreement and interest in tapering is a key to success
- Is the goal to discontinue opioid therapy or reduce dosage?

## How long should it take?

- Longer duration of opioid therapy (e.g., ≥ 1 year) may require a longer taper; tapers can be completed over several months to years depending on individual patient goals
- Tapers of 10% per month or slower are likely to be better tolerated
- Tapers may need to be paused and restarted

Dowell D, et al. *MMWR Recomm Rep*. 2022;71(No. RR-3):1-95.

# Monitoring & Support During Tapering

| | |
|---|---|
| **Safety** | • Discuss the risk of overdose if patients quickly return to a higher dose<br>• Offer naloxone for overdose prevention |
| **Consult** | • Coordinate with or refer to specialists and treatment experts as needed—especially for patients at high risk of harm |
| **Switch Gears** | • Patients taking high-dose opioids who are unable to taper but not meeting criteria for OUD may benefit by transitioning to buprenorphine |
| **Support** | • Link patients to behavioral therapy and treatment for comorbid mental health conditions<br>• Watch for signs of anxiety, depression, and OUD during the taper |
| **Encourage** | • Let patients know that most people have improved function without worse pain after tapering opioids<br>• Some patients have improved pain after a taper, even though pain might briefly get worse at first |

Dowell D et al. *MMWR Recomm Rep*. 2022;71(No. RR-3):1-95.

# Opioid Use Disorder

# DSM-5 Criteria for Diagnosing OUD

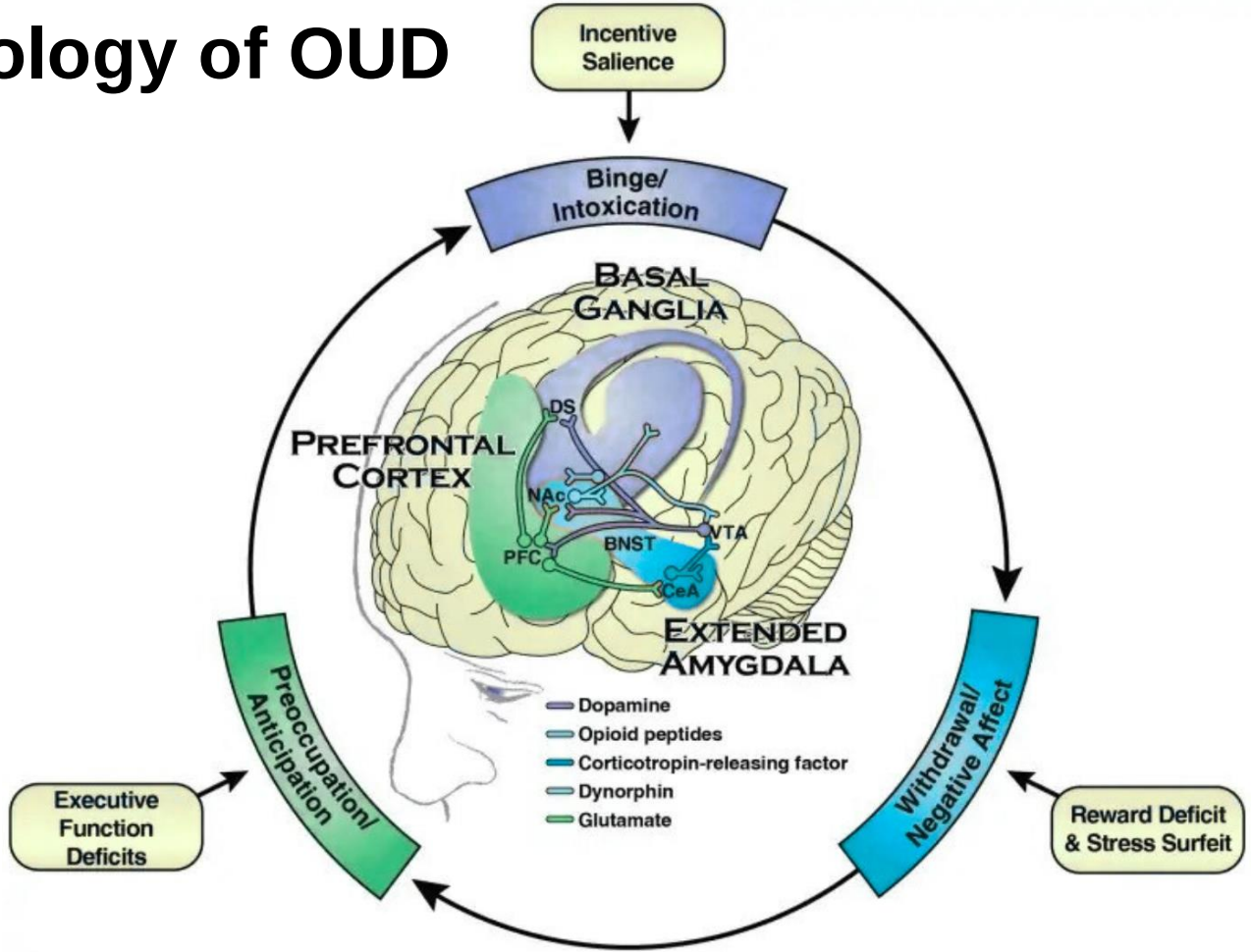
- ❑ Use in larger amounts/over longer period than intended
- ❑ Repeated unsuccessful attempts to cut down or control use
- ❑ Great deal of time spent obtaining, using, or recovering
- ❑ Craving or strong desire to use
- ❑ Recurrent use resulting in failure to fulfill major responsibilities
- ❑ Continued use despite social or interpersonal problems associated with effects of opioids
- ❑ Giving up important occupational or recreational activities to use
- ❑ Recurrent use in physically hazardous situations
- ❑ Continued use despite knowledge of physical or psychological problems caused by effects of opioids
- ❑ *Tolerance
  - Need for increased amounts to achieve desired effects, or
  - Diminished effects with same dose
- ❑ *Withdrawal
  - Characteristic opioid withdrawal syndrome, or using to relieve/avoid withdrawal)

*Does not apply if used solely under medical supervision

**Mild: 2-3** **Moderate: 4-5** **Severe: ≥ 6 criteria**

American Psychiatric Association (APA). In: *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. 2013: pp.541. https://psychiatry.org/psychiatrists/practice/dsm.

# Neurobiology of OUD




Webster LR. *Anesth Analg*. 2017;125(5):1741-1748. Uhl GR, et al. *Ann NY Acad Sci*. 2019;1451(1):5-28.

# Medications for OUD Treatment

| | | |
|---|---|---|
| **Buprenorphine or buprenorphine/ naloxone** (partial agonist)<br>Sublingual tablet, film, or 6-month subdermal implant | • Ceiling effects on respiratory depression, less potential for euphoria, more rapid induction to steady state (compared to methadone)<br>• Can precipitate opioid withdrawal with first dose<br>• Can be effective for pain symptoms and craving symptoms<br>• Blunts rewarding effect from other opioids | **Treatment program or office-based**<br>*As of December 2022, no specific training or DEA certification required to prescribed buprenorphine* |
| **Methadone** (full agonist)<br>Oral liquid | • Requires specialized training or extensive experience to safely use for OUD<br>• Does not require presence of withdrawal symptoms before initiation<br>• Can take weeks to reach therapeutic dose<br>• Can be effective for pain and craving symptoms | **FDA-licensed treatment program only** |
| **Naltrexone** (antagonist)<br>ER monthly injection only formulation approved for OUD | • Only recommended to prevent relapse following **complete** opioid withdrawal<br>• Can be helpful for concomitant alcohol use disorder | **Treatment program or office-based** |

DEA = Drug Enforcement Administration; ER = extended release.

Dowell D, et al. *MMWR Recomm Rep*. 2022;71(No. RR-3):1-95.

# SMART Goals

## Specific, Measurable, Attainable, Relevant, Timely

- Incorporate biopsychosocial and behavioral factors into comprehensive pain assessment to reduce bias and increase understanding of functional impairments
- Align treatment choice to pain origin—nociceptive, neuropathic, nociplastic—to maximize multi-modal treatment plans for patients with pain
- Limit new opioid prescribing to patients with acute and severe pain; Use short-acting agents at the lowest effective dose for the shortest duration possible
- Routinely assess and monitor the risks and benefits of opioid treatment and initiate individualized tapers when indicated
- Integrate the ***2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain*** into the assessment and management of patients with pain

# To Ask a Question

Please select the *Ask Question* tab below the slide viewer.

Please include the faculty member's name if the question is specifically for them.

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# AFTER THE SHOW

Questions & Answers

# Non-Opioid Pharmacotherapy for Pain: What is the Data?

| Medication | FDA Indication | Links to Clinical Studies |
|---|---|---|
| Buprenorphine Patch | Indicated for the management of pain severe enough to require daily, around-the- clock, long-term opioid treatment and for which alternative treatment options are inadequate. | https://pubmed.ncbi.nlm.nih.gov/39434504/ - **OA and LBP**<br>https://pubmed.ncbi.nlm.nih.gov/39098786/ - **postoperative pain** |
| Duloxetine | Indicated for MDD, GAD, DPNP, FM and Chronic musculoskeletal pain | https://pubmed.ncbi.nlm.nih.gov/39478733/- **CLBP**<br>https://pubmed.ncbi.nlm.nih.gov/39377458/ - **chronic non-specific back pain**<br>https://pmc.ncbi.nlm.nih.gov/articles/PMC8023424/ - **aromatase inhibitor associated arthalgias** |
| Gabapentin | Post-herpetic neuralgia (PHN) | https://pubmed.ncbi.nlm.nih.gov/29486015/ - **CNP** |
| Meloxicam | OA, RA, JRA in pts 2 years of age or older | https://pubmed.ncbi.nlm.nih.gov/12387696/ - **OA** |
| Celecoxib | OA, RA, JRA in pts 2 years and older, AS, AP, PD | https://pubmed.ncbi.nlm.nih.gov/35234840/ - **OA**<br>https://pubmed.ncbi.nlm.nih.gov/24150982/ - **postoperative pain** |

OA = osteoarthritis, LBP = low back pain, MDD = major depressive disorder, GAD = generalized anxiety disorder, DPNP = diabetic neuropathic pain, FM = fibromyalgia, JRA = juvenile rheumatoid arthritis, AP = acute pain, AS = ankylosing spondylitis, PD = primary dysmenorrhea

# Non-Opioid Pharmacotherapy for Pain: What is the Data?

| Medication | FDA Indication | Links to Clinical Studies |
|---|---|---|
| Baclofen | Indicated for the treatment of spasticity resulting from MS, particularly for the relief of flexor spasms and concomitant pain, clonus, and muscular rigidity. May also be of value in patients with SCI and other spinal cord diseases.<br>Is **not** indicated in the treatment of skeletal muscle spasm resulting from rheumatic disorders | https://pubmed.ncbi.nlm.nih.gov/30252293/ - **spasticity**<br>https://pubmed.ncbi.nlm.nih.gov/39257325/ - **CRPS** |
| Capsaicin Patch | Indicated for the treatment of NP associated with postherpetic neuralgia (PHN) and neuropathic pain associated with diabetic peripheral neuropathy (DPN) of the feet | https://pmc.ncbi.nlm.nih.gov/articles/PMC8500721/ - **in NP initial nonresponders**<br>https://pmc.ncbi.nlm.nih.gov/articles/PMC3823063/ - **PNP** |
| Naltrexone | Indicated in the treatment of alcohol dependence and for the blockade of the effects of exogenously administered opioids | https://pubmed.ncbi.nlm.nih.gov/39523052/ - **AUD**<br>https://pubmed.ncbi.nlm.nih.gov/32845365/ - **low dose naltrexone for chronic pain** |

MS = multiple sclerosis, SCI = spinal cord injuries NP = neuropathic pain, CRPS = chronic regional pain syndrome, AUD = alcohol use disorder

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**https://www.cmeoutfitters.com/rx4pain/**

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