**5 A’s – Opioid therapy monitoring tool**

Once initiating opioid therapy, it should be monitored regularly by assessing what has been called the “5As” of Analgesia therapy. This monitoring tool, will assist you in adapting the treatment and management plan of your patient by evaluating whether the patient has a reduction in pain (Analgesia), has demonstrated an improvement in level of function (Activity), is experiencing significant Adverse effects, whether there is evidence of Aberrant substance-related behaviours, and mood of the individual (Affect).

1. **Activity**
   - What progress has been made in the patient’s functional goals?
     - Sitting tolerance
     - Standing tolerance
     - Walking ability
     - Ability to perform activities of daily living

2. **Analgesia**
   - How does the patient rate the following over the last 24 hours?
     Eg) on a scale from 0 to 10, where 0 = no pain, 10 = worst pain imaginable
     - Average pain?
     - Worst pain?
     - How much relief have pain medications provided? e.g. 10%, 20%, 30% or more?

3. **Adverse effects**
   - Has the patient experienced any adverse effects from medication?
     Eg) constipation, nausea, dizziness, drowsiness

4. **Aberrant behaviours**
   - Has the patient been taking medication/s as prescribed?
   - Has the patient exhibited any signs of problematic behaviours or medication abuse/misuse?
     - Signs of drug and alcohol use
     - Unsanctioned dose escalations
     - Has the patient reported lost prescriptions or requested early repeats?

5. **Affect**
   - Have there been any changes to the way the patient has been feeling?
     - Is pain impacting on the patient’s mood?
     - Is the patient depressed or anxious?

BOX 1. CDC recommendations for prescribing opioids for chronic pain outside of active cancer, palliative, and end-of-life care

Determining When to Initiate or Continue Opioids for Chronic Pain

1. 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.

2. 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 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. 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.

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

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

5. 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 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. 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.

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Assessing Risk and Addressing Harms of Opioid Use

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepines use, are present.

9. Clinicians 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 dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

*All recommendations are category A (apply to all patients outside of active cancer treatment, palliative care, and end-of-life care) except recommendation 10 (designated category B, with individual decision making required); see full guideline for evidence ratings.
CHECKLIST

When CONSIDERING long-term opioid therapy

☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
☐ Check that non-opioid therapies tried and optimized.
☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
☐ Evaluate risk of harm or misuse:
  • Discuss risk factors with patient.
  • Check prescription drug monitoring program (PDMP) data.
  • Check urine drug screen.
☐ Set criteria for stopping or continuing opioids.
☐ Assess baseline pain and function (eg, PEG scale).
☐ Schedule initial reassessment within 1–4 weeks.
☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

☐ Check that return visit is scheduled ≤3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

☐ Assess pain and function (eg, PEG); compare results to baseline.
☐ Evaluate risk of harm or misuse:
  • Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  • Check PDMP.
  • Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - If yes: Refer for treatment.
☐ Check that non-opioid therapies optimized.
☐ Determine whether to continue, adjust, taper, or stop opioids.
☐ Calculate opioid dosage morphine milligram equivalent (MME).
  • If ≥50 MME/day total (≥50 mg hydrocodone; ≥33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  • Avoid ≥90 MME/day total (≥90 mg hydrocodone; ≥60 mg oxycodone), or carefully justify; consider specialist referral.
☐ Schedule reassessment at regular intervals (≤3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

• Benefits of long-term opioid therapy for chronic pain not well supported by evidence.
• Short-term benefits small to moderate for pain; inconsistent for function.
• Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

• Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
• Physical treatments (eg, exercise therapy, weight loss).
• Behavioral treatment (eg, CBT).
• Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

• Illegal drug use; prescription drug use for nonmedical reasons.
• History of substance use disorder or overdose.
• Mental health conditions (eg, depression, anxiety).
• Sleep-disordered breathing.
• Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores (30% improvement from baseline is clinically meaningful)

Q1: What number from 0–10 best describes your pain in the past week?
  0 = “no pain”, 10 = “worst you can imagine”
Q2: What number from 0–10 describes how, during the past week, pain has interfered with your enjoyment of life?
  0 = “not at all”, 10 = “complete interference”
Q3: What number from 0–10 describes how, during the past week, pain has interfered with your general activity?
  0 = “not at all”, 10 = “complete interference”

TO LEARN MORE

www.cdc.gov/drugoverdose/prescribing/guideline.html

March 2016
Excerpts from the 2016 CDC Guideline:

Regarding use of extended release or long acting (ER/LA) formulations:
“….there are serious risks of ER/LA opioids, and the indication for this class of medications is for management of pain severe enough to require daily, around-the-clock, long-term opioid treatment in patients for whom other treatment options…are ineffective, not tolerated, or would be otherwise inadequate…” (p. 13)

Regarding dosage limits:
“….opioid overdose risk increases in a dose-response manner, that dosages of 50 - <100 MME/day have been found to increase risks for opioid overdose by factors of 1.9 to 4.6 compared with dosages of 1 - <20 MME/day.” (p. 23)

“….a single dosage threshold for safe opioid use could not be identified.” (p. 23)

“Most experts agreed that, in general, increasing dosages to 50 or more MME/day increases overdose risk without necessarily adding benefits for pain control or function…..” (p. 23)

“….opioid dosages should not be increased to >/= 90 MME/day without careful justification based on diagnosis and on individualized assessment of benefits and risks.” (p. 23)

“Before increasing total opioid dosage to >/= 50 MME/day, clinicians should reassess whether opioid treatment is meeting the patient’s treatment goals. If a patient’s opioid dosage for all sources of opioids combined reaches or exceeds 50 MME/day, clinicians should implement additional precautions, including increased frequency of follow-up and considering offering naloxone and overdose prevention education to both patients and the patients’ household members.” (p. 23)

“Established patients already taking high dosages of opioids, as well as patients transferring from other clinicians, might consider the possibility of opioid dosage reduction to be anxiety-provoking, and tapering opioids can be especially challenging after years on high dosages because of physical and psychological dependence. However, these patients should be offered the opportunity to re-evaluate their continued use of opioids at high dosages in light of recent evidence regarding the association of opioid dosage and the overdose risk. Clinicians should explain in a nonjudgmental manner (emphasis added) to patients already taking high opioid dosages (>/= 90 MME/day) that there is now an established body of evidence showing that overdose risk is increased at higher opioid dosages. Clinicians should empathically (emphasis added) review benefits and risks of continued high-dosage opioid therapy and should offer to work with the patient to taper opioids to safer dosages. For patients who agree to taper opioids to lower dosages, clinicians should collaborate with the patient on a tapering plan. Experts noted that patients tapering opioids after taking them for years might require very slow opioid tapers as well as pauses in the taper to allow gradual accommodation to lower opioid dosages. Clinicians should remain alert to signs of anxiety, depression, and opioid use disorder that might be unmasked by an opioid taper…. ” (p. 23-24)
### Odds Ratio of Overdose by Opiate Dosage (relative to 1-19 MME/day)

<table>
<thead>
<tr>
<th>Opiate Dosage Ranges (MME/day)</th>
<th>OR of Any OD Event</th>
<th>OR of OD Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-49</td>
<td>1.44</td>
<td>1.32</td>
</tr>
<tr>
<td>50-99</td>
<td>3.73</td>
<td>1.92</td>
</tr>
<tr>
<td>100-199</td>
<td>8.87</td>
<td>2.04</td>
</tr>
<tr>
<td>&gt;200</td>
<td>2.88</td>
<td></td>
</tr>
</tbody>
</table>

### Call to Action

- Recommendations vs Mandatory Limits
- Dosage limits (# pills vs MME/d)
- Documentation requirements
- No refills without an appointment
- Dedicated refill appointments
- Use of CSDB every time
- UDS
- Medication specifics
- Provide support resources as much as possible

### Contact Info

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