Affinia Health Network

Controlled Substance (Schedule II, III, & IV) Monitoring Frequencies for Patients ≥ 13 years of age

Frequencies	New Starts	Opiate Low Risk OR Stimulant Use	Opiate Moderate Risk OR Benzodiazepine Use	Opiate High Risk OR Opiate + Benzodiazepine Use*
Office Visit[1]	Patients who are initiated on controlled substance therapy should be evaluated within 1 to 4 weeks.	At least every 3 to 6 months	At least every 1 to 3 months	At least every 1 to 2 months
MAPS[2]	Before initiating controlled substances	At least every 3 to 6 months	At least every 1 to 3 months	At least every 1 to 2 months
Urine Drug Screen (UDS)[3]	Before initiating controlled substances	At least annually	At least every 6 to 12 months	At least every 3 to 6 months
Overdose Precautions[4]			Consider Naloxone RX	Naloxone RX
Refill[5, 6]	Every 7 to 28 days (1 to 4 weeks)	Every 7 to 28 days[6] (1 to 4 weeks)	Every 7 to 28 days[6] (1 to 4 weeks)	Every 7 to 28 days (1 to 4 weeks)
Med Counts			Consider at each office visit	Each office visit
Additional Considerations				Avoid or carefully justify use Consider behavioral health/pain clinic/specialist referral Consider advanced abuse deterrent formulations

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Opiate Risk Assessment

1. Perform the Opioid Risk Tool (ORT) at 1st available visit
2. Perform CAGE-AID at 1st available visit and every follow up visit
3. Determine Morphine Milligram Equivalent Dose (MME)[a,*]
4. Evaluate risk of harm or misuse

	Low Risk	Moderate Risk	High Risk
Opioid Risk Tool Score	**0-3**	**4-7**	**> 8**
CAGE-AID <2	**< 2**	**< 2**	**≥ 2**
MME Dose[a,*]	**< 50 mg/day[a,*]**	**< 90 mg/day[a,*]**	**≥ 90 mg/day[a,*]**
Buprenorphine Patch[b]	< 20 mcg/hr	N/A	N/A
Hydrocodone	< 50 mg/day	< 90 mg/day	≥ 90 mg/day
Oxycodone	< 30 mg/day	< 60 mg/day	≥ 60 mg/day
Hydromorphone	< 12 mg/day	< 22 mg/day	> 22 mg/day
Oxymorphone	< 15 mg/day	< 30 mg/day	≥ 30 mg/day
Fentanyl patch	< 12 mcg/hr	< 37 mcg/hr (25+12)	≥ 50 mcg/hr
Methadone	< 15 mg/day	< 30 mg/day	≥ 30 mg/day
Tapentadol[c]	< 125 mg/day	< 225 mg/day	≥ 225 mg/day
Additional Risk Factors			**Concurrent benzodiazepine use***
			Sleep-disordered breathing
			Hx of overdose or substance abuse disorder

Summary of CDC Guidelines recommendations:

1. 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.
2. Clinicians should review PDMP (MAPS in Michigan) data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
3. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually.
4. 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 benzodiazepine use, are present.

Prescription Refills and Potential Payer limitations:

5. Insurance restrictions my limit to a 15 day supply on immediate release opiates for patients who have not recently filled an opiate prescription (BCBS). Furthermore, insurance may limit opiate prescriptions to a 30 day supply.
6. For the low opiate risk and stimulant use category or the moderate opiate risk and benzodiazepine use category, consider 1 to 3, 28 day prescriptions on the same day; date the prescriptions with the day it is written but place in the pharmacy comments "Do not fill until (insert date)". Instruct the patient to bring all prescriptions to the pharmacy so they do not get lost.

***Data on Risk Assessment for Morphine Milligram Equivalent Dose Tables (MME)**

MME = 50-99 mg/day have a 4-fold higher risk for overdose compared to < 20 mg/day
MME ≥ 100 mg/day have a 9-fold higher risk for overdose compared to < 20 mg/day
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3000551/
Concurrent benzodiazepine opioid use has a 10-fold higher risk for opioid-related overdose death compared to opioid use alone
http://painmedicine.oxfordjournals.org/content/17/1/85.long

Important Notes on the MME Dose Tables

a. The MME dose conversions should not be used to determine doses to use when converting from one opioid to another due to incomplete cross tolerance.
   Please use the calculator found at http://www.globalrph.com/opioidconverter2.htm to determine the MME when multiple opiates are prescribed.
   For convenience, doses were rounded to the nearest available dosage size. It is important to note that if a patient is using a combination of opioids, these must be added together to determine the MME. Please use the calculator found at http://www.globalrph.com/opioidconverter2.htm to determine the MME when multiple opiates are prescribed.
b. The highest recommended dose of Buprenorphine patch (20 mcg/hr) is equivalent to 36 MME/day. Higher doses are not recommended due to the risk of QT prolongation.
c. Note the maximum recommended dose of Tapentadol per the package labeling is 600 mg/day.