



College of Physicians and Surgeons of British Columbia

# Professional Standards and Guidelines

## Safe Prescribing of Drugs with Potential for Misuse/Diversion

### Preamble

This document establishes both professional standards as well as guidelines of the Board of the College of Physicians and Surgeons of British Columbia.

A **standard** reflects the minimum standard of professional behaviour and ethical conduct on a specific topic or issue expected by the College of all physicians in British Columbia. Standards also reflect relevant legal requirements and are enforceable under the [Health Professions Act](#), RSBC 1996, c.183 (*HPA*) and College [Bylaws](#) under the *HPA*.

A **guideline** reflects a recommended course of action established based on the values, principles and duties of the medical profession. Physicians may exercise reasonable discretion in their decision to act on the guidance provided, but should support a decision to follow a different action with a comprehensively documented rationale.

### College's Position

The public health crisis of prescription drug misuse has developed in part due to the prescribing of physicians. The profession has a collective ethical responsibility to mitigate its contribution to the problem of prescription drug misuse, particularly the over-prescribing of opioids, sedatives and stimulants.

The College acknowledges the appropriate role of aggressive pharmacotherapy in the context of active cancer, palliative, and end-of-life care.

Every physician is professionally responsible for the prescription that they provide to a patient.

Long-term opioid treatment (LTOT) refers to the prescribing of daily opioid medications on a continuous, and not as-required, schedule.

## Standards

### Physicians **must**:

1. Review patients' current medications (using PharmaNet profiles when access is available) before prescribing opioids, sedatives or stimulants.
2. Base long-term treatment with medications with known risks, including opioids, sedatives and stimulants, upon a clinical diagnosis and objective evidence. Continuing to prescribe medication solely on the basis that they have been previously prescribed is not acceptable.
3. Document discussion with patients that non-pharmacologic therapy and non-opioid analgesics are preferred for chronic non-cancer pain (CNCP) and that potential benefit of LTOT is modest and risk significant.
4. Advise patients that LTOT is not indicated for certain medical conditions including headache disorders, fibromyalgia and axial low back pain.
5. Always prescribe the lowest effective dosage of opioid medication, document careful reassessment if increasing the dose to >50 morphine milligram equivalents (MME) per day and avoid increasing the dose to >90 MME per day.
6. When treating patients with acute pain conditions, prescribe only immediate release opioids in quantities that the patient will need before community follow-up will be resumed (three to seven days is usually appropriate).
7. When discharging patients from acute-care settings, or post-operatively, prescribe only the quantities of opioids, sedatives or stimulants that the patient will need before community follow-up will be resumed.
8. Base decisions to prescribe long-term psychoactive medications, including LTOT, on well-documented, comprehensive initial assessments and frequent (at least every three months) reassessments. These assessments and reassessments must include documented history and physical examination of the patient. There must also be documentation that the patient has been screened for mental health and substance use disorders and risk factors and advised about safety-sensitive occupational risks, child care responsibilities and driving.
9. Document the offer of a take-home naloxone prescription to all patients who are at risk of respiratory depression as a consequence of receiving opioid medications.
10. Order at least annual random urine drug testing (rUDT) and/or random pill counts for all patients on long-term opioids, sedatives or stimulants.

### Further, physicians **must not**:

1. Initiate treatment with drugs with a high risk-profile such as methadone and fentanyl without relevant training and experience.
2. Prescribe combinations of prescription drugs that are pharmacologically irrational, such as combinations of stimulants, opioids and/or sedatives.
3. Provide prescriptions allowing dispenses of opioids, sedatives and stimulants which exceed a one-month supply or 250 tablets, whichever is less.

4. Prescribe benzodiazepines, or other sedative/hypnotic medications to patients on LTOT, other than as a documented taper, and must document direction that the patient abstain from alcohol and non-prescription sedatives.

## **Guidelines**

1. Physicians who prescribe opioids, sedatives or stimulants will be expected in the future to have PharmaNet access in all clinical locations and to use it appropriately. In situations where PharmaNet access is not currently available, physicians are expected to consult colleagues, including pharmacists and prescribe only necessary medications until the patient's dispensing history is available. (Walk-in, urgent care, multi-physician clinics and methadone clinics must have on-site access to PharmaNet.)
2. If starting opioid therapy for chronic non-cancer pain (CNCP) physicians should prescribe immediate release (IR) opioids only. Extended release (ER) and long-acting (LA) preparations should not be prescribed for an opioid-naïve patient and should be reserved for patients experiencing severe continuous pain.
3. LTOT should always be described as a trial, to be discontinued if functional improvement cannot be objectively demonstrated or harms emerge. Where benefits do not outweigh harms patients should be empathetically advised that the medication will be tapered to a lower dose or to discontinuation. Opioid tapering protocols should be slow enough to minimize symptoms of withdrawal (a 10% dose reduction every one to two weeks is considered reasonable). Tapering is not necessary if the patient has not been taking the opioid medication (which can be confirmed by urine drug testing).
4. LTOT is generally not appropriate for high-risk groups, including patients with addiction, major psychiatric illness or personality disorders, young people, and those with functional somatic syndromes. When patient assessment or reassessment reveals a diagnosis of a substance use disorder or other mental health diagnosis physicians should consider consultation with a physician with experience in addiction medicine regarding appropriate management.
5. The prevalence of an opioid use disorder may be as high as 26% among primary care patients receiving opioids for CNCP. Patients with a diagnosis of an opioid use disorder should be offered treatment including medication assisted treatment with methadone or buprenorphine, as well as abstinence-based treatment where appropriate.
6. Other concurrent medical conditions which should be carefully considered in the context of decisions to prescribe or continue LTOT include obesity, congestive heart failure, sleep apnea, chronic lung disease and renal or hepatic insufficiency. Elderly patients are more likely to suffer from these concurrent diagnoses and to be taking multiple medications and suffer from cognitive impairment all of which significantly increase risk.
7. When providing prescriptions for opioids, sedatives or stimulants, consider the possibility that other household members (including young children) might accidentally or deliberately take those medications. Prescription medications, especially opioids, should be securely stored, preferably locked, and unused medications disposed of at a pharmacy.

8. Tolerance to benzodiazepines and sedative hypnotics develops quickly. They do not improve sleep architecture or quality. They should be prescribed for short-term use only and not in quantities that exceed the manufacturer's recommended maximum.
9. It is recommended that all emergency rooms, urgent care and multi-physician clinics have a consistent policy around the prescribing (and dispensing) of opioids, sedatives and stimulants.
10. Assessing risks of misuse or diversion based only on patient assessment and self-report without objective contextual information is difficult. Supervised urine drug testing (UDT) may be performed in the office as point-of-care testing or sent to the laboratory, but physicians should understand the results and limitations of the test they are using. Even when risks seem low random urine drug testing (rUDT) and/or random pill counts can provide important information. The requirement for UDT should be discussed non-judgmentally at the initiation of the treatment relationship, in order to minimize the perception of stigmatization. (Supervised UDT urine drug testing means a reasonable level of supervision but not necessarily witnessed provision of the sample. Random UDT using a 24-hour phone call protocol is more informative than predictable UDT at the time of a scheduled office visit. Random pill counts are a non-intrusive method of assessing patient compliance.)
11. The advice to avoid concurrent prescribing of opioids and sedative hypnotics such as benzodiazepines is based on the significantly increased risk of overdose death in this patient population. However, physicians should be aware that other CNS depressants (including muscle relaxants, anticonvulsants, sedating antidepressants, antipsychotics, some over-the-counter medications and alcohol) may also potentiate CNS and respiratory depression. If LTOT is clinically appropriate, benzodiazepines should be tapered and discontinued. Benzodiazepine tapering should be gradual because of the significant risks of benzodiazepine withdrawal.

## References

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