Approaches to Opioid Prescribing with High-Risk Behavior and Opioid Use Disorder in Oncology

Taylor Butler, PharmD, BCOP, BCPS Clinical Pharmacy Specialist Vanderbilt-Ingram Cancer Center



Disclosures

• Dr. Butler has no relevant financial relationships with ineligible companies to disclose.



1

3

Objectives

- · List strengths and weaknesses of monitoring oncology patients initiated on opioid therapy
- Select analgesic options appropriate for individuals with high-risk opioid behaviors
- Discuss how to empathize and approach patients with concerning behavior



2

Oncology Pain

- Pain from cancer and/or its treatments
- Incidence
 - Active Treatment: 55%
 - Metastatic Disease: 66.4%
 - Survivorship: 39.3%
- Cancer Pain Management
 - Moderate to severe pain utilize opioid therapy

Source: Copenhaver DJ et al. Fundamentals of Cancer Pain Management 2021.; NCCN 2023.



Oncology Pain

- Importance of Pain Management
 - Quality of life
 - Eligibility for treatment
 - Cancer Outcomes??



Tennessee (TN) Chronic Pain Guidelines

- Experts in the state of TN released a clinical practice guideline for the outpatient management of chronic non-malignant pain
 - Published in January 2020
- The guideline reviews many aspects of outpatient pain management including risk assessment, disposal, dosing, tapering, etc.

Tennessee laws reference following the Tennessee Chronic Pain Guidelines

Source: TN Dept of Health, 2020.

5

Centers for Disease Control and Prevention (CDC) Opioid Prescribing Guidelines

- · CDC noted issues with opioid prescribing and wanted to review the available evidence to examine benefit and risk
 - Released in 2016, updated in 2022
- Systematic review developed to answer common questions and concerns, including benefit, opioid monitoring, risk considerations, etc.



Source: Dowell D. MMWR Recomm Rep 2022.

Opioid Monitoring

Opioid Monitoring Tools

- These are the tools that are available to monitor patients on opioid therapy
 - Office visits
 - Controlled Substance Monitoring Database
 - Drug Screens
 - Opioid Risk Assessments
 - Pill and Patch Counts



Source: TN Dept of Health, 2020.; Dowell D. MMWR Recomm Rep 2022.

Office Visits

· Office visits are utilized for history and physical assessments

Office Visits

TN Pain Guidelines - No formal recommendation

CDC Opioid Therapy Guidelines

- Clinicians should regularly reassess all patients receiving long-term opioid therapy, including patients who are new to the clinician but on long-term opioid therapy, with a suggested interval of every 3 months or more frequently for most patients.

Source: TN Dept of Health, 2020.; Dowell D. MMWR Recomm Rep 2022.

TOPA

10

Office Visits

Strengths

9

- Physical assessment of pain
- Develop a relationship
- Weaknesses
 - Patient logistics
- Scheduling
- Tips think of the significance of bringing the patient into clinic



Controlled Substance Monitoring Database (CSMD)

• CSMD is where every opioid *filled* is documented

TN Pain Guidelines

- Clinicians should review the patient's history of controlled substance prescriptions using the Controlled Substance Monitoring Database (CSMD) data to determine whether the patients receiving opioid dosages or potentially dangerous combinations

CDC Opioid Therapy Guidelines

Ideally, PDMP data should be reviewed before every opioid prescription for acute. subacute, or chronic pain. This practice is recommended in all jurisdictions where PDMP availability and access policies, as well as clinical practice settings, make it practicable (e.g., clinician and delegate access permitted).

Source: TN Dept of Health, 2020.; Dowell D. MMWR Recomm Rep 2022.

11

CSMD

- · Strengths
 - Evidence of prescription fills
 - Limits doctor shopping
 - Helps with refill dates
- Weaknesses
 - Prescription reporting errors
 - Does not connect with all other states
- Tips most patients who violate are unaware of consent so always educate well

Source: TN Dept of Health, 2020.; Dowell D. MMWR Recomm Rep 2022

13

Drug Screens

- Types of Drug Screens
 - Immunoassay uses antibodies to detect the presence of selected drugs and/or their metabolites based on a predetermined cutoff threshold
 - Chromatography detects the presence of specific drugs and/or metabolites
 - GC/MS gas chromatography/mass spectrometry
 - LC/MS/MS liquid chromatography/tandem mass spectrometry
 - · High-performance liquid chromatography

Source: Raouf M et al. Fed Pract 2018.



15

Opioid Risk Assessments

• Multiple risk assessments have been created to help evaluate patient risk for aberrant behavior

17

The prescriber shall assess the patient's risk for misuse, abuse, diversion, and $% \left(1\right) =\left(1\right) \left(1\right)$ addiction using a validated risk assessment tool prior to initiating opioid therapy

CDC Opioid Therapy Guidelines

- Clinicians should ask patients about their drug and alcohol use and use validated tools or consult with behavioral specialists to screen for and assess mental health and substance use disorders.

Source: TN Dept of Health, 2020.; Dowell D. MMWR Recomm Rep 2022.



Drug Screens

- Collecting blood, urine, or hair to test concentrations of drug in the body
 - Randomized preferred over planned schedule

Drug Screen

14

TN Pain Guidelines

- Providers must continually monitor the patient for signs of abuse, misuse or diversion. A urine drug screen (or a comparable oral fluids screen or test) should be done twice a year at a minimum

CDC Opioid Therapy Guidelines

When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances

Source: TN Dept of Health, 2020.; Dowell D. MMWR Recomm Rep 2022

Drug Screens

- Strengths
 - Objective evidence that patient is utilizing their medications
- Weaknesses
 - Sensitivity/specificity issues
 - Expensive

Source: Webster LR et al. Pain Med 2005.

18

- Patient can manipulate results
- Tips get to know your toxicologist

Source: TN Dept of Health, 2020.; Dowell D. MMWR Recomm Rep 2022.; Raouf M et al. Fed Pract 2018.



TOPA

16

Opioid Risk Tool Family History of substance abuse - Illegal Drugs - Prescription Drugs Personal history of substance abuse - Illegal Drugs - Prescription Drugs Age (if 16-45) History of preadolescent sexual abuse Psychological disease deficit disorder, obsessive-compulsive disorder, bipolar, schizophrenia - Depression Low risk = 0-3; Moderate risk = 4-7; High risk = >8

Opioid Risk Assessments • Strengths • Easy to administer • Screens and identifies risk factors to consider • Weaknesses • Limited data on application in clinical practice and patient outcomes • Based on patient reporting • Tips – unsure of the utility

Source: TN Dept of Health, 2020.; Dowell D. MMWR Recomm Rep 2022

Pill and Patch Counts
A randomized count of medications in between visits to determine utilization
No formal recommendations provided per the state of Tennessee or CDC

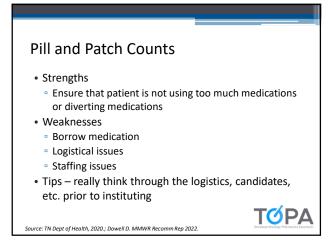
Source: TN Dept of Health, 2020.; Dowell D. MMWR Recomm Rep 2022

20

23

19

21



Which of the following statements are true?

Opioid risk assessments were developed to exclude patients from opioid therapy

0%

Immunoassays are more specific urine drug screenings than mass spectrometry

0%

CSMD may have reporting errors

0%

Pill and patch counts will always catch overuse and diversion

0%

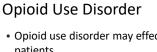
Managing Cancer Pain with Co-morbid Opioid Use Disorder Opioid Use Disorder

Qualitative interviews conducted by Wood et al of oncology providers indicated that the majority did not view opioid misuse as a problem

Evidence exists that cancer patients are a statistically significant higher risk to have drug use disorder (Adjusted Odds Ratio = 1.64; 95% CI = 1.13-3.39)

Prevalence is unknown but has been reported up to 23.5%

24 25

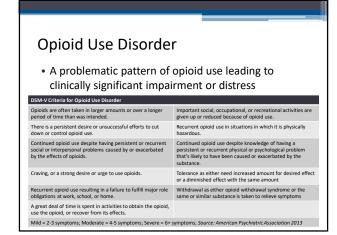


- Opioid use disorder may effect outcomes in cancer patients
 - Increase in distress, morbidity, and mortality (including opioid-related deaths)

2021.; Preux C et al. J Clin Med 2022.



26



27

Guidance on Opioid Management for Opioid Misuse or Use Disorder

- The authors recruited participants from various addiction and palliative care organizations to administer cases and examine using the Delphi
- Goal to provide guidance on 3 common clinical scenarios in cancer-pain management



28

Cases - Jones et al.

• Man in his 50s with advanced cancer on active cancer treatment and comorbid pain from cancer and/or its treatment. Noted to be maximized on alternative analgesics and provided appropriate opioid education

Source: Jones KF et al. JAMA Oncol 2023.

TOPA

29

Case #1 - Jones et al.

• Patient has recent history of opioid use disorder and not currently on OUD treatment or opioids for pain management



Source: Jones KF et al. JAMA Oncol 2023

Case #2 - Jones et al.

• Patient has no history of OUD. He repeatedly takes more opioids than prescribed for pain. Urine drug screens negative.

Source: Jones KF et al. JAMA Oncol 2023.

TOPA

30

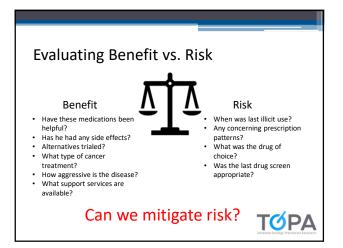
Case #3 – Jones et al.

 Patient has no history of OUD. He is prescribed opioids and tests positive for unprescribed benzodiazepines.



Source: Jones KF et al. JAMA Oncol 2023

32 33



Evaluating Benefit vs. Risk

Benefit

Work fast and well acutely
No ceiling effect
No deleterious effect on organ function
May improve performance status
May improve quality of life
Patient satisfaction?

Risk

Nay increase risk of substance use disorder relapse
May increase risk of mortality
Diversion
Frequent monitoring

Fentanyl

- Convert opioids to fentanyl patches alone
 - No fentanyl transmucosal products
- · Patch counts
- Difficult to abuse
 - A case report of fentanyl patch abuse

Source: TN Dept of Health, 2020.; Dowell D. MMWR Recomm Rep 2022.; Guan W et al. Prim Care Companion CNS Disord 2011. TOPA

35

Buprenorphine

34

- Partial Opioid Agonist
 - May include opioid antagonist (naloxone)
- FDA approved for Opioid Use Disorder and Pain
 - Available as a sublingual film, sublingual tablet, injectable, and transdermal patch
- Per the state of Tennessee, buprenorphine products must be used for FDA-approved indications

Source: TN Dept of Health, 2020.; Dowell D. MMWR Recomm Rep 2022.



Buprenorphine Considerations

- Highest affinity to the opioid receptor
 - Clinical Significance → Blocks illicit substances; may displace current full opioid agonist
- Analgesic activity is shorter than suppression of opioid withdrawal
 - □ Clinical Significance → Once daily dosing insufficient
- Dose correlates with receptor saturation
 - Clinical significance → there are still some opioid receptors available if need supplementation with full opioid agonist

Buprenorphine	2 mg	16 mg	32 mg
μ-Opioid Receptors Available	59%	8-15%	2-6%

Source: Alford DP et al. Ann Intern Med 2007.

Buprenorphine Considerations

- · Buprenorphine films
- Opioid naïve or <30 MME/day 75 mcg film daily or every 12 hours
- 30-89 MME/day 150 mcg film every 12 hours 90-160 MME/day 300 mcg film every 12 hours
- Maximum dose is 900 mcg every 12 hours
- Buprenorphine patches
 - Opioid naïve or <30 MME/day initiate patch at 5 mcg/hr; change patch every 7 days
 - 30-80 MME initiate patch at 10 mcg/hr, change patch every 7 days
 - Maximum dose is 20 mcg/hr patch
- Note recommended to taper prior to initiation if above MME range

Source: Belbuca [package insert], 2015.; Butrans [package insert], 2019.

Methadone

- Full opioid agonist
 - Alternative mechanism of antagonizing NMDA
- Limited to no euphoria
- Available as oral and injectable
- Per Federal Law, must be prescribed by a methadone clinic for opioid use disorder

Source: Davis MP. Ann Palliat Med 2020.; TN Dept of Health, 2020.; Dowell D. MMWR Recomm Rep 2022.



38

Methadone

- Methadone clinic
 - Strengths
 - · Supervised administration
 - May provide support services
 - · Patient may not be allowed a home supply
 - Weaknesses
 - · Logistics of daily visits
 - · Analgesia does not last 24 hours
 - · May not change dose for pain report

Source: TN Dept of Health, 2020.; Dowell D. MMWR Recomm Rep 2022.



40

Case #1 - Jones et al.

Source: Jones KF et al. JAMA Oncol 2023.

- Patient has recent history of opioid use disorder and not currently on OUD treatment or opioids for pain management
 - Initiate buprenorphine standard induction therapy
 - Prognosis may factor into deciding to utilize full opioid
 - · Increased monitoring (possibly weekly)
 - · Consider fentanyl patches alone



41

39

Case #2 - Jones et al.

- Patient has no history of OUD. He repeatedly takes more opioids than prescribed for pain. Urine drug screens negative.
 - Increased monitoring
 - Consider
 - · Caution on opioid dose escalations
 - · Buprenorphine products
 - Do not taper opioid doses



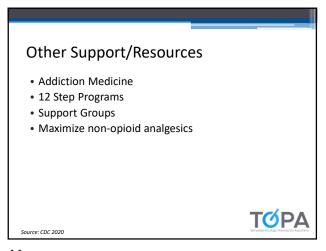
Source: Jones KF et al. JAMA Oncol 2023.



Case #3 - Jones et al.

- Patient has no history of OUD. He is prescribed opioids and tests positive for unprescribed benzodiazepines.
 - Increased monitoring
 - Do not taper opioids or transition to buprenorphine products





A 55 yo M pt with a hx of substance use disorder presents to the cancer clinic with pancreatic adenocarcinoma. He is having sever pain related to his mass. Currently on buprenorphine/naloxone 16 mg daily. What would be the next step to manage his pain?

Discontinue buprenorphine/naloxone and start oxycodone 5 mg every 4 hours as needed

0%

Start oxycodone 5 mg every 4 hours as needed

0%

Start gabapentin 300 mg every 8 hours

0%

Increase buprenorphine to 32 mg daily

0%

46

48

44

47

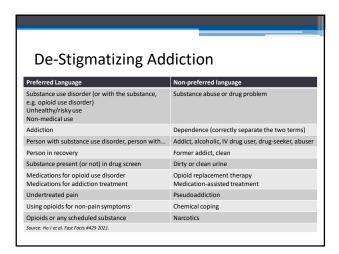
Approaching Aberrant Behavior

Aberrant Behavior • Opioid misuse – may be intentional or unintentional Aberrant Behavior per Webster et al. Forged prescription Sold prescription Seeking euphoria from opioids Using opioids for nonmedical uses Overdose Injected drugs Abnormal drug screen Doctor shopping Alcohol abuse Unauthorized ER visits Resisted alternatives Lost or stolen prescriptions Missing appointments Requesting early refills TOPA Source: Webster LR et al. Pain Med 2005.

Empathy Ask permission and provide options Let them know that you care and want to partner with them in getting any help they need. Normalize the conversation Tell them that discomfort is normal and they are Explain that it is important to ask specific Be transparent questions to make sure they are safe Work collaboratively with patients Remind your patients that recovery is possible and a variety of resources are available Address confidentiality concerns Tell patients your respect their privacy and will comply with protections required by law Establish trust and show empathy Active listening, non-judgmental language, respect patient, address their disorder as a disease Source: CDC 2022.

Evaluating Benefit vs. Risk Benefit Risk When was last illicit use? helpful? Any concerning prescription Has he had any side effects? patterns? Alternatives trialed? . What was the drug of What type of cancer choice? Was the last drug screen treatment? How aggressive is the disease? appropriate? What support services are available? TOPA

49 50



Case #1 - Jones et al.

· Patient has recent history of opioid use disorder and not currently on OUD treatment or opioids for pain management

Source: Jones KF et al. JAMA Oncol 2023.: CDC 2022.

Ask permission and provide options	"I see you were recently diagnosed with opioid use disorder. May I ask you a few personal questions?"
Normalize the conversation	"I know this conversation may be awkward, that is normal."
Be transparent	"I need you to be specific so it can help us come up with the best plan to manage your pain."
Work collaboratively with patients	"I just want the best outcome from you. It can be hard to manage pain and opioid use disorder. Let's see if we can find what works for you."
Address confidentiality concerns honestly	"I will never disclose any of your information without your consent."
Establish trust and show empathy	"Thank you for sharing that information with me. That is very hard and this is a challenging situation. I am here to help walk you through it."

52

51

A patient presents with a urine drug screen positive for benzovlecgonine and his prescribed opioids. What would be an appropriate approach to this patient? Confront the patient about drug use and that they can never have pain Discharge the patient from clinic Offer active listening about the results, supportive services, and develop an appropriate safe analgesic plan Ignore the results and continue to prescribe as is Start the presentation to see live content. For screen share software, share the entire screen. Get help at poll

Conclusion

- · Opioid monitoring is a vital part of prescribing
- Patients with comorbid opioid use disorder have tools to manage their pain with or without opioid
- Provider-patient relationship is an important aspect and there are ways



54

55

References

- Alford DP, Compton P, and Samet JH. Acute Pain Management for Patients Receiving Maintenance Methadone or Buprenorphine Therapy. Ann Intern Med 2006; 144(2): 127-34.

- Methadone or Buprenorphine Inerapy, Ann Intern Med 2006; 144(2): 127-34.

 American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Washington Dc. American Psychiatric Association 2013: 541.

 Belbuca (Buprenorphine) [package insert]. Malwern, APE. Endo Pharmaceuticals, Inc. 2015.

 Butrans (buprenorphine) [package insert]. Stamford, CT. Purdue Pharma L.P. 2019.

 Butter TW. Importance of Cancer Pain Management. HOPA News 2023; 20(2): 3-5.

 Centers for Disease Control and Prevention. Empathy: Talking to Patients About Substance Use Disorder. Updated 7/1/2022. Accessed on 10(6):7023. A https://www.cdc.gov/opioids/addiction.medicine/conversation-starters/falking-to-patients.html

 Centers for Disease Control and Prevention. Onloids Heln and Resources. Updated 1/18/2020.

- medicine/conversation-starters/talking-to-patients.html>
 Centers for Disease Control and Prevention. Opioids Help and Resources. Updated 1/28/2020. Accessed on 10/6/2023. https://www.cdc.gov/opioids/s/addiction-medicine/conversation-starters/talking-to-patients.html
 Copenhaver DJ, Huang M, Singh J, and rishman SM. History and Epidemiology of Cancer Pain. Fundamentals of Cancer Pain Management 2021; CTAR (82): 3-15.
 Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain United States, 2022. MMWR Recomm Rep 2022;71/INO. RR -31:1–95.
 Greenwald MK, Johanson CE, Moody DE, et al. Effects of Buyrenorphine Maintenance Dose on μ-Opioid Receptor Availability, Blasma Concentrations, and Antagonist Blockade in Heroin-Dependent Volunteers. Neuropsychopharmacology 2003; 28: 2000-9.

References

- Guan W, Schneider R, and Patterson J. "I Am in Pain!"—A Case Report of Illicit Use of Transdermal Fentanyl Patches. Prim Care Companion CNS Disord 2011; 13(5): PCC. 11101196.
- Fentanyi Patches. Prim Care Companion CNS Disord 2011; 13(5): P.C. 11101196.
 Ho J.), Jones KY, Sager Z, Wakeman S, and Merilla IS. De-stigmating the language of addiction. Fast Fact #429. Palliative Care Network of Wisconsin. Accessed on 10/6/2023. https://www.mycnow.org/fast-fact/de-stigmatring-the-language-of-addiction/
 Preux C, Bertin M, Tarot A, et al. Prevalence of Opioid Use Disorder among Patients with Cancer-Related Pain: A Systematic Keylew. J Clin Med. 2022;11.
 Raouf M, Bettlinger JJ, and Fudin J. A Practical Guide to Urine Drug Monitoring. Fed Pract 2018; 35(4): 38-44.

- 35(4): 38-44.

 Th Dept of Health. Tennessee Chronic Pain Guidelines. 3-TR Edition: 1-76.

 Webster LR and Webster RM. Predicting Aberrant Behaviors in Opioid-Treated Patients: Preliminary Validation of the Opioid Risk Fool. Pain Med 2005; 6(6): 432-4.

 Wood T, Cheung W, Ruether D, et al. Safe Prescribing Practices: Clinicians' Views on Prescribing Opioids to Patients With Early-Stage Cancer. 100 Oncol Pract 2023; 19(7): 456-4.

 Venourajalingam S, Arthur J, Reddy S, et al. Frequency of and Factors Associated With Nonmedical Opioid Use Behavior Among Patients With Cancer Receiving Opioids for Cancer Pain. JAMA Oncol. 2021;7:404-411.