Opioids, Benzos, and Tapering, Oh My!

Melissa B. Weimer, DO, MCR
March 10, 2016

Disclosures

Dr. Weimer is a paid consultant for INFORMed and a speaker for IMPACT education. Dr. Weimer is the medical director of CODA, Inc.
Objectives

• List talking points to help educate patients about the risks of opioid therapy
• Understand how to calculate morphine equivalents per day
• Understand the steps necessary to plan a successful opioid taper
• Understand the steps necessary to plan a successful benzodiazepine taper

STEP 1: Secure Commitment & Educate

• Why the sudden shift in practice?
• Know the background
  – Poor evidence
  – Harms
  – Options
  – Empathy
Use a Risk-Benefit Framework

NOT...
- Is the patient good or bad?
- Does the patient deserve opioids?
- Should this patient be punished or rewarded?
- Should I trust the patient?

RATHER...
Do the benefits of opioid treatment outweigh the untoward effects and risks for this patient (or society)?

Judge the opioid treatment – NOT the patient

Background #1: There is Insufficient Evidence for Long Term Effectiveness

- “No study of opioid therapy versus no opioid therapy evaluated long-term (>1 year) outcomes related to pain, function, quality of life, opioid abuse or addiction.”
- Increased opioid dose does not improve pain control, especially past certain doses
- The expected improvement of pain is 20-30% and some patients don’t respond

Background #2: Opioids are the most dangerous medications I prescribe and could seriously harm you.

Mortality by cause, white non-Hispanics ages 45–54.

Anne Case, and Angus Deaton PNAS 2015;112:15078-15083
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Background #3: Unintentional opioid overdose increases exponentially at morphine equivalent doses > 50mg
Background #4: The rate of opioid use disorder increases at higher doses prescribed over longer periods of time

| Incidence rate of Opioid Use Disorders after Initiation of Rx opioids* |
|---------------------------------|-----------------------------|
|                                  | Incidence Rate | Adjusted OR(95% CI) |
| No opioids                       | 0.004%          | 1.0                |
| Acute, low dose                  | 0.12%           | 3.31 (2.54-4.31)   |
| med dose                         | 0.12%           | 3.04 (2.30-4.01)   |
| high dose                        | 0.12%           | 2.68 (1.45-4.98)   |
| Chronic, low dose                | 0.72%           | 17.63 (12.33-25.20) |
| med dose                         | 1.28%           | 35.19 (24.75-50.02) |
| high dose                        | 6.1%            | 171.95 (105.97-279.00) |

*Tramadol only deaths included in 2009, but not in prior years.
Source: Washington State Department of Health, Death Certificates

Chronic: >90 days; low dose =<36 mg; med dose =36-120 mg; high dose >=120 mg
Background #5: Physical Dependence is a side effect of opioids


Background #6: Reducing or stopping opioids is hard, but you can do it and there are options. You might even feel better!

“Withdrawal hyperalgesia and anhedonia may explain the worsening of pain and mood that is seen during an opioid taper... Withdrawal symptoms are powerful drivers of opioid seeking, which in turn can be induced by factors that change tolerance.”

Pain or Fear of Withdrawal?


**Reasons for opioid use among patients with dependence on prescription opioids: the role of chronic pain.**


*Author information*

**Abstract**

The number of individuals seeking treatment for prescription opioid dependence has increased dramatically, fostering a need for research on this population. The aim of this study was to examine reasons for prescription opioid use among 653 participants with and without chronic pain, enrolled in the Prescription Opioid Addiction Treatment Study, a randomized controlled trial of treatment for prescription opioid dependence. Participants identified initial and current reasons for opioid use. Participants with chronic pain were more likely to report pain as their primary initial reason for use. Avoiding withdrawal was rated as the most important reason for current use in both groups. Participants with chronic pain rated using opioids to cope with physical pain as more important, and using opioids in response to social interactions and craving as less important, than those without chronic pain. Results highlight the importance of physical pain as a reason for opioid use among patients with chronic pain.

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**Patient feedback post-taper**

- “It was hard to do, but I’ll never go back.”
- “I feel like myself again. My family says I seem alive again.”
- “My pain is no better, but also no worse. Opioids weren’t doing anything but causing side effects.”
- “Thank you for helping me see that I was on an unhealthy path. I’m a mom again...I can play with my kids again....I can work again....I’m a totally different person.”
You have a lot of boring health issues, so I’m prescribing medical marijuana for myself.”

STEP 2: Diagnose & Calculate MED

- Substance Use Disorder
  - including opioids, alcohol, etc
- Diversion
- At risk for immediate harms
  - Aspiration, hypoxia, bowel obstruction, overdose, etc
  - Refusing monitoring (urine drug testing, abstain from marijuana or alcohol, etc)
- Therapeutic Failure of opioids
- At risk for future harms (>120 MED, benzos)
  - High dose chronic use without misuse
  - Concomitant benzos
Enduring adaptation produced by established behaviors
Opioid use disorder criteria may be different for pain patients on chronic opioids

- For the illicit user
  - Procurement behaviors
- For the patient with pain – much more complex
  - Continuous opioid therapy may prevent opioid seeking
  - Memory of pain, pain relief and possibly also euphoria
  - Even if the opioid seeking appears as seeking pain relief, it becomes an adaptation that is difficult to reverse
  - It is hard to distinguish between drug seeking and relief seeking


Calculating Morphine Equivalent Dose
**DO NOT USE FOR OPIOID ROTATION**

<table>
<thead>
<tr>
<th>Name of Opioid</th>
<th>Morphine equivalent conversion factor (mg)*</th>
<th>Dose equivalence to 120mg of morphine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine (Buprenex)</td>
<td>1.8</td>
<td>n/a</td>
</tr>
<tr>
<td>Codeine</td>
<td>0.17</td>
<td>700mg</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>3.6</td>
<td>33mcg</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>1.0</td>
<td>120mg</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>4.0</td>
<td>30mg</td>
</tr>
<tr>
<td>Methadone*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morphine</td>
<td>1.0</td>
<td>120mg</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>1.5</td>
<td>80mg</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>3.0</td>
<td>40mg</td>
</tr>
<tr>
<td>Tapentadol</td>
<td>0.2</td>
<td>600mg</td>
</tr>
<tr>
<td>Tramadol</td>
<td>0.25</td>
<td>400mg</td>
</tr>
</tbody>
</table>

* Methadone conversion to morphine is complicated, use 60mg of methadone as the dose limit.
**Tramadol dose above 400mg is not recommended.
Morphine to methadone conversion

<table>
<thead>
<tr>
<th>24 hour total oral morphine</th>
<th>Oral morphine to methadone conversion ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30 mg</td>
<td>2:1</td>
</tr>
<tr>
<td>31-99 mg</td>
<td>4:1</td>
</tr>
<tr>
<td>100-299 mg</td>
<td>8:1</td>
</tr>
<tr>
<td>300-499 mg</td>
<td>12:1</td>
</tr>
<tr>
<td>500-999 mg</td>
<td>15:1</td>
</tr>
<tr>
<td>&gt;1000 mg</td>
<td>20:1</td>
</tr>
</tbody>
</table>


Calculating Morphine Equivalent Dose

- Fentanyl 25mcg/hr patch
  - $25 \times 3.6$ conversion factor (CF) = $90\text{mg MED}$
- Hydromorphone 2mg every 4 hours + Oxycodone 60mg BID
  - $2\text{mg} \times 6 = 12\text{mg} \times 4 \text{ CF} = 48\text{mg MED}$
  - $60\text{mg} \times 2 = 120\text{mg} \times 1.5 \text{ CF} = 180\text{mg MED}$
  - **TOTAL 228\text{mg MED}**
- Methadone 20mg TID
  - $20\text{mg} \times 3 = 60\text{mg} \times 8.0^* \text{ CF} = 480\text{mg MED}$
  - $20\text{mg} \times 3 = 60\text{mg} \times 12.0^* \text{ CF} = 720\text{mg MED}$
  - *seek expert advice*
**STEP 3: Taper plan and start taper**

- Discuss goals of taper — how and when will we know if it is successful?
- Establish dose target and timeframe
- Maintain current level of analgesia (*may not be possible in short term*)
- Discuss potential withdrawal symptoms
  - Temporary increase in pain
  - Discuss how to contact
  - Schedule follow-up or nurse check ins
- Identify at least one self-management goal

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### How to approach an opioid taper/cessation

<table>
<thead>
<tr>
<th>Issue</th>
<th>Recommended Length of Taper</th>
<th>Degree of Shared Decision Making about Opioid Taper</th>
<th>Intervention/Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Use Disorder</td>
<td>No taper, immediate referral</td>
<td>None – provider choice alone</td>
<td><strong>Intervention:</strong> Detoxification with medication assisted treatment (buprenorphine or methadone), Naloxone rescue kit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Setting:</strong> Inpatient or Outpatient Buprenorphine (OBOT)</td>
</tr>
<tr>
<td>Diversion</td>
<td>No taper*</td>
<td>None – provider choice alone</td>
<td>Determine need based on actual use of opioids, if any</td>
</tr>
<tr>
<td>At risk for immediate harms</td>
<td>Weeks to months</td>
<td>Moderate – provider led &amp; patient views sought</td>
<td><strong>Intervention:</strong> Supportive care Naloxone rescue kit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Setting:</strong> Outpatient opioid taper</td>
</tr>
<tr>
<td>Therapeutic failure</td>
<td>Months</td>
<td>Moderate – provider led &amp; patient views sought</td>
<td><strong>Intervention:</strong> Supportive care Naloxone rescue kit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Setting:</strong> Outpatient opioid taper</td>
</tr>
<tr>
<td>Option</td>
<td></td>
<td></td>
<td><strong>Option:</strong> Buprenorphine (OBOT)</td>
</tr>
<tr>
<td>At risk for future harms</td>
<td>Months to Years</td>
<td>Moderate – provider led &amp; patient views sought</td>
<td><strong>Intervention:</strong> Supportive care Naloxone rescue kit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Setting:</strong> Outpatient opioid taper</td>
</tr>
<tr>
<td>Option</td>
<td></td>
<td></td>
<td><strong>Option:</strong> Buprenorphine (OBOT)</td>
</tr>
</tbody>
</table>
Use a Risk-Benefit Framework

NOT...

- Is the patient good or bad?
- Does the patient deserve opioids?
- Should this patient be punished or rewarded?
- Should I trust the patient?

RATHER...

Do the benefits of opioid treatment outweigh the untoward effects and risks for this patient (or society)?

Judge the opioid treatment – NOT the patient

Outpatient Tapering Options

• Gradual taper:
  – 5-10% decreases of the original dose every 5-28 days until 30% of the original dose is reached, then weekly decreases by 10% of the remaining dose
  – You may elect to taper Extended release (ER) or Immediate release (IR) first, though I generally taper ER first and use IR for breakthrough pain
  – Provide the patient a copy of the taper plan for reference and to help keep patient moving forward

www.hca.wa.gov/medicaid/pharmacy/Documents/taperschedule.xls
Outpatient Tapering Options

- **Rapid taper:**
  - Daily to every other day reductions over 1-2 weeks as appropriate

- **Medication assisted taper:**
  - Adjuvant opioid withdrawal medications only
  - Office based buprenorphine detoxification or maintenance transition
  - Methadone maintenance treatment

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### Adjuvant Opioid Withdrawal Medications

<table>
<thead>
<tr>
<th>Adjuvant Opioid Withdrawal Medications</th>
<th>Geriatric (&gt;65 years) Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>For sweating, anxiety, agitation</td>
<td>Do not use if baseline SBP &lt; 110</td>
</tr>
<tr>
<td>Clonidine 0.1mg by mouth three times daily PRN anxiety</td>
<td>Caution with patients who are at risk for falls (on Beers list*)</td>
</tr>
<tr>
<td>Hold for sedation or dizziness</td>
<td></td>
</tr>
<tr>
<td>For anxiety</td>
<td>Hydroxyzine 12.5-25 mg by mouth every 8 hours PRN anxiety</td>
</tr>
<tr>
<td>Hydroxyzine 25-50 mg by mouth every 4-6 hours PRN anxiety</td>
<td>Increased potential for anti-cholinergic side effects (on Beers list)</td>
</tr>
<tr>
<td>For nausea or vomiting</td>
<td>Alternative: Zolfin 4mg by mouth every 12 hours PRN for nausea or vomiting</td>
</tr>
<tr>
<td>Phenergan 12.5-25 mg by mouth every 4-6 hours PRN nausea/vomiting</td>
<td>Phenergan associated with anticholinergic side effects and somnolence in older adults (on Beers list)</td>
</tr>
<tr>
<td>Zofran 4mg every 12 hours PRN nausea/vomiting</td>
<td>Caution with patients who are at risk for falls</td>
</tr>
<tr>
<td>For abdominal cramping/distress</td>
<td>Avoid use in this age group due to potential anticholinergic side effects and uncertain effectiveness (on Beers list).</td>
</tr>
<tr>
<td>Hyoscyamine 0.125mg by mouth every 4-6 hours PRN abdominal cramping</td>
<td></td>
</tr>
<tr>
<td>For increased pain with taper and from opioid withdrawal</td>
<td>Alternative: Acetaminophen 1000 mg by mouth three times daily if not contraindicated</td>
</tr>
<tr>
<td>Buprenorphine 400-600 mg by mouth three times daily PRN with food and water for pain</td>
<td>Buprenorphine contraindicated in chronic kidney disease, history of GI bleed, chronic warfarin use, etc. (on Beers list)</td>
</tr>
<tr>
<td>Tylenol 500mg by mouth every 4-6 hours PRN pain (Maximum dose 3,250mg in 24 hours)</td>
<td></td>
</tr>
</tbody>
</table>

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*The AGS 2012 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults (AGS 2012 Beers Criteria J Am Geriatr Soc. 2012 Apr;60(4):616-31)

**It is not legal or safe to prescribe Methadone for opioid withdrawal in the outpatient setting.

**It is not advised to prescribe Benzodiazepines for opioid withdrawal.
**STEP 3.5: Provider Self-Care**

- Check in with a colleague
- Process what went well and what was hard
- Develop an “opioid committee” to support you and the clinic

*You are abandoning the opioid therapy NOT the patient*

**STEP 4: Medication Assisted Treatment**

- Some patients will be “unable” to taper
  - Methadone >30mg
  - MED >200mg
  - Long term use > 5 years
  - Mental illness, distress intolerant, history of adverse childhood experiences, history of substance use disorder, weak social supports
- Buprenorphine/naloxone is an important resource for these patients
- Also consider interdisciplinary pain programs
Tightening the Lid on Pain Prescriptions

By BARRY MEIER  APRIL 8, 2012

Few programs are in place to deal with patients now on high opioid dosages who are not benefiting from them.

If the patients were taken off the medications, many would experience severe withdrawal or have to take addiction treatment drugs for years. Even avid believers in the new direction, like Dr. Ballantyne, suggest that it might be necessary to keep those patients on the opioids and to focus instead on preventing new pain patients from getting caught in the cycle.

“I think we are dealing with a lost generation of patients,” she said.


Case 1: Immediate Risks

• 50 yo man on opioids for LBP x 5 years develops severe constipation that is not amenable to treatments. You decide the risks outweigh the benefit of him remaining on morphine ER 15mg BID

• Taper Plan:
  – Step 1: convert his morphine to IR and reduce it to morphine IR 7.5mg Q8H for 2 weeks
  – Step 2: Reduce morphine IR 7.5mg BID for 2 weeks
  – Step 3: Morphine IR 7.5mg daily for 2 weeks
  – Step 4: stop morphine
Case 1: Immediate Risks

• What if that same 50 yo man on opioids for LBP x 5 years is prescribed fentanyl 75mcg/72 hours.
• Taper Plan:
  – Step 1: convert his fentanyl to a different opioid that is easier to taper like morphine ER or oxycodone ER. Ex. Morphine ER 90mg/60mg/60mg.
  – Step 2: Reduce morphine ER 60mg TID x 2 weeks-1 month
  – Step 3: Morphine ER 60/60/45mg TID x 2 weeks – 1 mo
  – Step 4: Continue in 10-20% reductions until done

Case 2: Substance Use Disorder

• 50 yo male prescribed hydromorphone 4mg every 3 hours and fentanyl 50mcg patch for chronic pancreatitis. You detect alcohol on a routine urine drug screening, and he admits that he has relapsed on alcohol.
• What do you do?

• Decide that the risks greatly outweigh the benefit
• Refer to detoxification from alcohol and opioids
• Stop prescribing opioids immediately
Case 3

- 28 yo female prescribed opioids for chronic abdominal pain. She states she has lost her opioid prescription for the third time. She has had two negative urine drug tests for the opioid that is prescribed and refuses to come in for a pill count.

- You suspect diversion.
- **Taper Plan:** None. You stop prescribing opioids immediately.

Case 4: “Lost Generation” with therapeutic alliance

- 68 yo female with rheumatoid arthritis pain. She is prescribed a total of 350mg MED for the last 5 years with no adverse events. She is moderately functional. Your clinic has developed a new opioid policy stating that patients prescribed doses >120mg MED need to attempt an opioid taper. She is concerned that she might develop serious harms from her opioids.

- **Taper plan:** Slow taper by 10% per month over a year. May elect to slow down the taper if she experiences periods of worsening pain and/or opioid withdrawal.
Case 5: “Lost Generation” with Hopelessness

63 yo man with history of low back pain and severe depression after a work injury in 1982. He has not worked since and spends most of his day being sedentary. He has been unwilling to engage in additional pain modalities despite multiple offers. He is prescribed oxycodone IR 30mg every 4 hours. You have tried other opioids but he has not had improvements. He refuses an opioid taper and states he will seek another provider if you start to taper his opioids.

Taper Plan: Offer buprenorphine OR a 1 month rapid taper

BENZODIAZEPINE TAPERS
Long term Benzodiazepines

• Similar issues as opioids of long term safety and effectiveness
• Clear associated risk with concomitant opioids
  – Unintentional overdose, mental clouding, impaired functional status
• Can cause a severe physical dependence and withdrawal syndrome that can be life threatening

Benzodiazepine Withdrawal

• True sedative withdrawal
  – Similar to alcohol, though less predictable
  – Anxiety, headache, sweating, concentration difficulties, insomnia, fatigue, anoxia, muscle twitching, increased sensory perception, depersonalization
  – Severe: delirium, grand mal seizure
  – Protracted symptoms
• Original symptom re-emergence and exacerbation
Benzodiazepine Withdrawal Severity

- **Most severe symptoms** – quickly eliminated, high potency
  - Alprazolam, lorazepam, triazolam
- **Intermediate severity** – quickly eliminated, low potency or slowly eliminated, high potency
  - Oxazepam, clonazepam
- **Mildest severity** – slowly eliminated, low potency
  - Diazepam, clorazepate, chlordiazepoxide

Wolf and Griffiths: Drug and Alcohol Dependence 1991

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Dose Equivalents for Benzodiazepines

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose (mg)</th>
<th>Onset</th>
<th>½ Life (hrs)</th>
<th>Metabolism</th>
<th>Potency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clonazepam (Klonopin)</td>
<td>0.25</td>
<td>Intermediate</td>
<td>18-50</td>
<td>Oxidation</td>
<td>High</td>
</tr>
<tr>
<td>Alprazolam (Xanax)</td>
<td>0.50</td>
<td>Intermediate</td>
<td>6-20</td>
<td>Oxidation</td>
<td>High</td>
</tr>
<tr>
<td>Triazolam (Halcion)</td>
<td>0.50</td>
<td>Fast</td>
<td>1.5-3</td>
<td>Conjugation</td>
<td>High</td>
</tr>
<tr>
<td>Lorazepam (Ativan)</td>
<td>1.0</td>
<td>Intermediate</td>
<td>10-20</td>
<td>Conjugation</td>
<td>High</td>
</tr>
<tr>
<td>Diazepam (Valium)</td>
<td>5.0</td>
<td>Fast</td>
<td>30-100</td>
<td>Oxidation</td>
<td>Intermediate</td>
</tr>
<tr>
<td>Chlordiazepoxide (Librium)</td>
<td>10.0</td>
<td>Fast</td>
<td>5-100</td>
<td>Oxidation</td>
<td>Low</td>
</tr>
<tr>
<td>Oxazepam (Serax)</td>
<td>15.0</td>
<td>Slow</td>
<td>5-12</td>
<td>Conjugation</td>
<td>Low</td>
</tr>
</tbody>
</table>

Benzodiazepine Dose Conversions (oral). Available at http://globalrph.com/benzodiazepine_calc.htm
Benzodiazepine Taper Principles

• Convert to a longer acting benzo, if needed
• Timeframe depends on the indication for taper
• Rapid tapers can safely and effectively occur over 10-14 days, but may elect inpatient detox
• Elective benzo tapers will probably need to occur over a 6 month period
• For gradual tapers, the first 50% of dose the easiest tolerated, approach more slowly after that

Withdrawal adjuvant medications

• Valproic Acid 250mg TID or Carbamazepine 200-800mg daily
  – Continue for 2-4 week post complete cessation
• Propranolol 20mg TID-QID
• Clonidine or Tizandine
• Hydroxyzine
• Trazodone for sleep
Case 1: Long term benzo use

- 60 yo woman with dissociative disorder and alcohol use disorder in remission prescribed clonazepam 1mg every 8 hours x 25 years, though she has been taking up to 4-6mg per day. The medications are no longer effective and she feels severely physically dependent on them. She wants to taper.
- Describes withdrawal symptoms
  - “severe sleep deprivation, burning spine, anxiety, tremor, nausea, constipation, anorexia, night and day confusion”, having continual “flashbacks”
- She is not interested in going to detox or formal treatment. She feels “abused” and “traumatized” by the mental health system. She states she is intolerant of all mental health medications.
- She reports that brand name lisinopril is the only effective treatment of her anxiety.

Case 1: Long term benzo use

- **Taper plan:**
  - Convert to Diazepam 5mg TID and give a 1 week prescription with close follow up
  - Continue 1mg decreases every 2-4 weeks
  - Start Depakote and propranolol
  - Engage with mental health and addiction, if possible
- **Outcome:**
  - Completely tapered over the following 11 months
  - She was very engaged with Smart Recovery
  - Unable to tolerate any mental health engagement or medications
  - Post Acute Withdrawal symptoms persisted for several months
Case 2: The case of concomitant opioids

- 21 yo man with hx of anxiety and low back pain who has been using 1mg of alprazolam TID for the last 2 years. He sometimes takes more than prescribed. He is also prescribed oxycodone 30mg four times a day.
- Which taper do you start first?
- Taper plan: Prescriber’s choice
  - Convert to clonazepam 1mg TID and reduce by 0.25mg every 3-5 days over a 4-6 week time
  - Limit Rx to 1 week Rx at a time
  - Other option is to alternate benzo and opioid taper

Beware of other sedative-hypnotics

- High dose sedative-hypnotic use is on the rise
- Serious withdrawal syndromes can accompany the abrupt cessation of sedative-hypnotics like zolpidem (ambien), zaleplon (sonata), eszopiclone (lunesta), carisoprodol (soma)
- Slow tapers of these medications OR referral for detoxification may be needed
Questions:
weimerm@ohsu.edu

Free Buprenorphine Prescription Training
April 29, 2016
8:30am-1:00pm

If you are interested in registering for this course, please contact Marie Payment (payment@ohsu.edu).

Exhibit 4-8 Addiction Behaviors Checklist

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>Not Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient uses illicit drugs or evidence problem drinking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Patient has endorsed medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Patient used more opioids than prescribed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Patient ran out of medications early</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Patient has increased use of opioids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Patient used opiate subcutaneous when prescription is for time-contingent use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Patient received opioids from more than one provider</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Patient bought medications on the streets</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Non-prescribed use of opioids is the predominant issue of use.
“You should just feel a tiny prick, and then a lifetime of morphine addiction.”