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OPINION: The Use of Controlled Substances for the Treatment of Chronic Pain
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Within the Scope of Practice of ___ LPN ___ RN X RNP

ADVISORY OPINION

THE USE OF CONTROLLED SUBSTANCES FOR THE TREATMENT OF CHRONIC PAIN

STATEMENT OF SCOPE

It is within the Scope of Practice of the Registered Nurse Practitioner (RNP) to prescribe controlled substances for the population focus in which the nurse is certified and if the RNP has obtained prescribing and dispensing authority from the Board of Nursing, and is granted authority from the U.S. Drug Enforcement Agency. An RNP shall only provide health care services within the nurse practitioner's scope of practice for which the RNP is educationally prepared and for which competency has been established and maintained. **Prior to prescribing opioids for chronic pain, the nurse practitioner shall complete at least 2 hours of continuing education in the use of opioid therapy for chronic pain.**

I. GUIDELINES FOR THE USE OF CONTROLLED SUBSTANCES FOR THE TREATMENT OF CHRONIC PAIN

For the purposes of these guidelines, chronic pain is defined as: A pain state, which is persistent and in which the cause of the pain cannot be removed or otherwise treated. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease. When efforts to remove the cause of pain or to treat it with appropriate referrals and/or other modalities have been unsuccessful, the prescribing of controlled substances for patients with chronic non-cancer pain may be beneficial.

A. Evaluation of the Patient

Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. Opioid therapy should be combined with non-pharmacologic therapy. Prior to prescribing long-term opioid medications for chronic non-

malignant pain, it is standard of care for an RNP to conduct an appropriate evaluation of the pain problem and identify the pain generator. This evaluation includes the RNP taking a comprehensive pain history, reviewing the patient's medical records (including previous provider, if applicable), conducting a targeted physical exam, taking a drug history including verification of current prescriptions and considering concomitant medical/psychiatric problems that may impact pain management. Each patient's treatment plan should be individualized, and include consideration of a multidisciplinary approach/collaboration with other medical experts, as appropriate and risk assessment for use of chronic opioid therapy (COT).

Pain assessment should occur during initial evaluation, after each new report of pain, at appropriate intervals after each pharmacological intervention, and at regular intervals during treatment. The evaluation should include: A medical history and physical examination conducted and documented in the medical record, diagnostic evaluations such as blood test; radiologic exams, neurophysiologic exams, and psychological evaluations as indicated; the pain source, nature, and intensity/severity of the pain, current and past treatments for pain, underlying or coexisting diseases, or conditions, the effect of the pain on physical and psychological function and history of substance abuse; document the presence of one or more recognized indications for the use of a controlled substance; should be corroborated by reviewing the patient's health care records and/or speaking with the patient's former health care providers and documented in the medical record.

B. Psycho-Social Assessment

Evaluation of the chronic pain patient should include a psycho-social assessment, which may include, but is not limited to the patient's understanding of the diagnosis, expectations about pain relief and pain management methods, concerns regarding the use of controlled substances, and coping mechanisms for pain. Additionally, an assessment of changes in mood, which have occurred secondary to pain (i.e., anxiety, depression); and the meaning of pain to the patient and his/her family.

C. Exclusion Criteria

Exclusion criteria for controlled substance management by the RNP may include: A history of chemical dependency, major psychiatric disorder, unstable social situation, or a planned pregnancy. These patients should be referred to the appropriate specialists.

D. Establish And Measure Goals For Pain And Function

Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain/function and should consider how opioid 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.

E. Discuss Benefits, Risks, And Availability Of Non-Opioid Therapies With Patient

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. The patient shall be counseled on the importance of regular visits, taking medications as prescribed and the impact of recreational drug use and avoiding the use of

multiple pharmacies and providers for prescriptions. The RNP and the patient shall enter into a written pain treatment agreement that specifically states the patient's responsibilities for the treatment plan and the consequences of breaching the agreement treatment plan.

F. Consultation

The RNP may refer the patient as necessary for additional evaluation to achieve treatment objectives. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care, monitoring, documentation, and consultation with or referral to an expert in the management of such patients, such as an addictionologist.

G. Immediate Release

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

H. When Opioids Are Started, Clinicians Should Prescribe Lowest Effective Dosage

Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering 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.

I. 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.

J. Evaluate Benefits And Risk Of Continued Therapy

Clinicians should evaluate benefits and risks with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and risks of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh risks 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.

K. Assess Risk and Address Harms of Opioid Use

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 benzodiazepine use, are present.

L. Review Of Controlled Substance Prescription Monitoring Program (CSPMP)

A.R.S. § 36-2606 requires each medical practitioner who is licensed under Title 32 and who possesses a DEA license to register with the CSPMP through the Arizona State Board of Pharmacy . Each DEA license should have an associated registration. Clinicians shall review the patient's history of controlled substance prescriptions using the (CSPMP) 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 the CSPMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

M. Urine Drug Testing

When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and periodically to assess for adherence to prescribed medications as well as presence of other controlled prescription drugs and illicit drugs.

N. Avoid Opioids And Benzodiazepines Concurrently

Concurrent use or abuse of alprazolam and opioids puts patients at significant risk of fatal overdose. Written treatment agreements should be utilized to clarify treatment expectations and to specifically educate about the risk for overdose including when opioids and benzodiazepines are combined. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

O. Evidence-Based Treatment

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.

P. Documentation

The RNP shall document the following, as applicable:

- a. The health history and physical examination;
- b. Diagnostic, therapeutic, and laboratory results;
- c. Diagnosis; should include the pain source
- d. Evaluations and consultations;
- e. Treatment objectives; including functional goals
- f. Discussion of risks and benefits;
- g. Treatments;
- h. Medications (including date, type, dosage, and quantity prescribed);
- i. Instructions and agreements;
- j. Initial assessment and re-assessment of the pain and efficacy of treatment with rationale for any dosage changes, such as improved or decreased patient function, and patient non-compliance;
- k. Whether-or-not the patient is a candidate for controlled substance medications, based on the provider's safety and control assessment, including review of CSPMP.

Q. Counting and Destroying Medication

The RNP may request to see and count a patient's medication to assist in determining if the patient is taking the medication as prescribed. The patient should display and count the medication in front of the RNP. Under no circumstance should the RNP touch a patient's controlled substances. If the medication must be destroyed, it should be destroyed in accordance with federal guidelines. The RNP should document this fact in the patient record.

R. Post-Dated Prescriptions

Post-dated prescriptions are illegal in the State of Arizona. Therefore, RNPs may not issue post-dated prescriptions. Multiple prescriptions can be provided to the patient complying with the DEA regulations.

S. Referral of Patients with Active Substance Abuse Problems

Patients discovered to have an active substance abuse problem should be referred to either a detoxification and rehabilitation program or to an appropriate maintenance program for substance abusers.

T. Assessment For Aberrant Behaviors

Common behaviors in misuse or abuse include prescriber shopping, multiple pharmacies, frequent provider visits, escalating dosages and large quantities, high M.E.D, early refills, lost or stolen prescriptions, abnormal drug screens/tests, combined controlled substance cocktails, sharing of medications, fraudulent demographics, requesting of specific medications, uninterested in diagnosis or alternative treatments, refuses tests repeatedly, misses follow-up appointments, absence of objective findings, symptom magnification, inconsistency or textbook presentations. When aberrant behaviors are detected, documentation in the medical record should address the behaviors and future consequences.

U. Nurse Practitioners May Prescribe Methadone For Pain Management Only

Methadone should only be prescribed by healthcare professionals knowledgeable in use of potent opioids for chronic pain management, proper dosing and titration essential to decreased respiratory depression risk. Prior to prescribing methadone, the practitioner should have at least 2 continuing education hours completed on prescribing methadone for chronic pain.

V. Universal Precautions

The application of “universal precautions” in the initial assessment and treatment of a patient may reduce the risk of accidental overdose, abuse, and misuse.

10 Recommended Steps in Universal Precautions

Step 1. Diagnosis. Identify the pathophysiology for the pain. Identify the pain generator through appropriate diagnostic imaging and other testing.

Step 2. Psychological assessment. Psychological screening including risk of addictive disorders, depression, and anxiety; positive findings may require referral to specialist.

Step 3. Informed consent. Discuss the risks and benefits of opiate therapy, including side effects and risk of addiction.

Step 4. Treatment agreement. This agreement details the conditions under which the opioid will be continued or discontinued. Both the provider and patient should agree on the contents prior to entering into a long-term opioid treatment plan.

Step 5. Pre and post intervention assessment of pain level and function. Pain scores and level of functionality should be recorded in the medical record to support continuation of therapy.

Step 6. Appropriate trial of opioid therapy with or without adjunctive medication. If no improvement, the treatment should be titrated down and discontinued.

Step 7. Reassessment of pain score and level of function. Reassessment should be completed at each visit and support the need for continued treatment.

Step 8. Regularly assess the "A's" of pain medicine. Routine assessment of Analgesia, Activities of daily living, Adverse side effects, Aberrant drug-taking behaviors. Adherence (urine toxicology) and Affect (observed mood), support the need for continued therapy.

Step 9. Periodically review pain diagnosis and comorbid conditions, including addictive disorders. Refer to specialist if underlying addiction disorder or aberrant behaviors are present.

Step 10. Documentation. Complete and accurate documentation of the initial and each follow up visit. Documentation of a physical assessment should be completed with each dosage adjustment.

II. COMPLIANCE WITH LAWS AND REGULATIONS

A. Prescribing Controlled Substances

To prescribe controlled substances, RNPs must comply with all applicable laws, including the following:

1. Possess a valid current RN license and certification as an RNP with prescribing and dispensing authority in the State of Arizona;
2. Possess a valid and current controlled substances Drug Enforcement Administration registration for the schedules being prescribed; and
3. Comply with A.A.C. R4-19-511 and R4-19-512.

B. Dispensing Controlled Substances

To dispense controlled substances, RNPs must comply with all applicable laws, including the following:

1. Possess a valid current RN license and certification as an RNP with prescribing and dispensing authority in the State of Arizona;
2. Possess a valid and current controlled substances Drug Enforcement Administration registration for the schedules being dispensed;
3. Comply with A.A.C. R4-19-511, R4-19-512 and R4-19-513; and
4. Comply with 22 CFR 1306.07(a) if controlled substances are dispensed for detoxification.

III. PRESCRIBING AND DISPENSING OPIOID ANTAGONIST; IMMUNITY; GOOD FAITH STATEMENT

A. RNPs may directly or by a standing order prescribe or dispense naloxone hydrochloride or any other opioid antagonist that is approved by the United States Food and Drug Administration for use according to the protocol specified by the RNPs to a person who is at risk of experiencing an opioid-related overdose, to a family member of that person to a community organization that provides services to persons who are at risk of an opioid related overdose or to any other person who is in a position to assist a person who is at risk of experiencing an opioid related overdose.

B. RNPs who prescribe or dispense naloxone hydrochloride or any other opioid antagonist pursuant to this section, shall instruct the individual to whom the opioid antagonist is dispensed to summon emergency services as soon as practicable either before or after administering the opioid antagonist.

- C. Except in cases of gross negligence, willful misconduct or intentional wrongdoing, RNPs who are in good faith prescribe or dispense an opioid antagonist pursuant to this section are immune from professional liability and criminal prosecution for any decision made, act or omission or injury that results from that act if the RNPs act with reasonable care and in good faith.

- D. Before prescribing an opioid antagonist pursuant to this section, RNPs may require the person receiving the prescription, as an indicator of good faith, to provide in writing a factual basis for a reasonable conclusion that the person or entity meets the description of this section of a person or entity who is able to receive an opioid antagonist under this section

RATIONALE:

Controlled substances are high-risk medications with misuse and abuse potential. This advisory opinion is intended to improve understanding among advanced practice nurses about the risks and benefits of opioid therapy for chronic pain, improve the safety and efficacy of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death.

The nurse practitioner is responsible and accountable to ensure that a patient receives appropriate evidence-based nursing assessment and intervention, which effectively treats the patient's pain and meets the recognized standard of practice and care. "Clinical practice guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances" (Institute of Medicine, 1990).

RNPs who prescribe controlled substances for treatment of patients with chronic pain are held accountable to current evidenced based practice guidelines. Guidelines are intended to assist the RNP in the responsible use of controlled substances, including but not limited to: 1) When to initiate or continue opioids for chronic pain; 2) Guide the RNP in making decisions regarding opioid and other controlled drug selections, dosage, duration, follow-up, and discontinuation; and 3) assess risk and address harms of opioid and other controlled substance use.

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