

Opioid Risk Tool

Introduction

The Opioid Risk Tool (ORT) is a brief, self-report screening tool designed for use with adult patients in primary care settings to assess risk for opioid abuse among individuals prescribed opioids for treatment of chronic pain. Patients categorized as high-risk are at increased likelihood of future abusive drug-related behavior. The ORT can be administered and scored in less than 1 minute and has been validated in both male and female patients, but not in non-pain populations.

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk tool. Pain Med. 2005; 6 (6) : 432

Appendix 5. Risk Assessment Tool - Score Diagnosis, Intractability, Risk Efficacy (D.I.R.E.)

D.I.R.E. Score: Patient Selection for Chronic Opioid Analgesia

For each factor, rate the patient's score from 1-3 based on the explanations in the right hand column

Score	Factor	Explanation
	<u>Diagnosis</u>	1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, non-specific back pain. 2 = Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain. 3 = Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis.
	<u>Intractability</u>	1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process. 2 = Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness). 3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response.
	<u>Risk</u>	(R= Total of P+C+R+S below)
	<u>Psychological:</u>	1 = Serious personality dysfunction or mental illness interfering with care. Example: personality disorder, severe affective disorder, significant personality issues. 2 = Personality or mental health interferes moderately. Example: depression or anxiety disorder. 3 = Good communication with clinic. No significant personality dysfunction or mental illness.
	<u>Chemical Health:</u>	1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse. 2 = Chemical copper (uses medications to cope with stress) or history of CD in remission. 3 = No CD history. Not drug-focused or chemically reliant.
	<u>Reliability:</u>	1 = History of numerous problems: medication misuse, missed appointments, rarely follows through. 2 = Occasional difficulties with compliance, but generally reliable. 3 = Highly reliable patient with meds, appointments & treatment.
	<u>Social Support:</u>	1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles. 2 = Reduction in some relationships and life roles. 3 = Supportive family/close relationships. Involved in work or school and no social isolation.
	<u>Efficacy score</u>	1 = Poor function or minimal pain relief despite moderate to high doses. 2 = Moderate benefit with function improved in a number of ways (or insufficient info- hasn't tried opioid yet or very low doses or too short of a trial). 3 = Good improvement in pain and function and quality of life with stable doses over time.

_____ Total score = D + I + R + E

Score 7-13: Not a suitable candidate for long-term opioid analgesia

Score 14-21: Good candidate for long-term opioid analgesia

Reproduced with permission from Miles Belgrade⁴

APPENDIX 3
SAMPLE OPIOID TREATMENT AGREEMENT

Patient Name: _____

Date: _____

Opioid (narcotic) treatment for chronic pain is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment. Vocational counseling may be provided to assist in your return to work effort.

To the doctor: Keep signed originals in your file; give a photocopy to the patient. Renew at least every 6 months.

I, _____, understand that compliance with the following guidelines is important in continuing pain treatment with Dr. _____.

1. I understand that I have the following responsibilities:
 - a. I will take medications only at the dose and frequency prescribed.
 - b. I will not increase or change medications without the approval of this doctor.
 - c. I will actively participate in RTW efforts and in any program designed to improve function (including social, physical, psychological and daily or work activities).
 - d. I will not request opioids or any other pain medicine from physicians other than from this doctor. This doctor will approve or prescribe all other mind and mood altering drugs.
 - e. I will inform this doctor of all other medications that I am taking.
 - f. I will obtain all medications from one pharmacy, when possible known to this doctor with full consent to talk with the pharmacist given by signing this agreement.
 - g. I will protect my prescriptions and medications. Only one lost prescription or medication will be replaced in a single calendar year. I will keep all medications from children.
 - h. I agree to participate in psychiatric or psychological assessments, if necessary.

- i. If I have an addiction problem, I will not use illegal or street drugs or alcohol. This doctor may ask me to follow through with a program to address this issue. Such programs may include the following:

- 12-step program and securing a sponsor
- Individual counseling
- Inpatient or outpatient treatment
- Other: _____

2. I understand that in the event of an emergency, this doctor should be contacted and the problem will be discussed with the emergency room or other treating physician. I am responsible for signing a consent to request record transfer to this doctor. No more than 3 days of medications may be prescribed by the emergency room or other physician without this doctor's approval.
3. I understand that I will consent to random drug screening. A drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking.
4. I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment.
5. I understand that this doctor may stop prescribing opioids or change the treatment plan if:
 - a. I do not show any improvement in pain from opioids or my physical activity has not improved.
 - b. My behavior is inconsistent with the responsibilities outlined in #1 above.
 - c. I give, sell or misuse the opioid medications.
 - d. I develop rapid tolerance or loss of improvement from the treatment.
 - e. I obtain opioids from other than this doctor.
 - f. I refuse to cooperate when asked to get a drug screen.
 - g. If an addiction problem is identified as a result of prescribed treatment or any other addictive substance.
 - h. If I am unable to keep follow-up appointments.

Patient Signature

Date

Physician Signature

Date

SAMPLE OPIOID TREATMENT AGREEMENT (continued)

YOUR SAFETY RISKS WHILE WORKING UNDER THE INFLUENCE OF OPIOIDS:

You should be aware of potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness and tolerance. Also, you should know about the possible danger associated with the use of opioids while operating heavy equipment or driving.

SIDE EFFECTS OF OPIOIDS:

- Confusion or other change in thinking abilities
- Nausea
- Constipation
- Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles
- Sleepiness or drowsiness
- Aggravation of depression
- Breathing too slowly – overdose can stop your breathing and lead to death
- Vomiting
- Dry mouth

THESE SIDE EFFECTS MAY BE MADE WORSE IF YOU MIX OPIOIDS WITH OTHER DRUGS, INCLUDING ALCOHOL.

RISKS:

- Physical dependence. This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following:
 - Runny nose
 - Diarrhea
 - Sweating
 - Rapid heart rate
 - Difficulty sleeping for several days
 - Abdominal cramping
 - 'Goose bumps'
 - Nervousness
- Psychological dependence. This means it is possible that stopping the drug will cause you to miss or crave it.
- Tolerance. This means you may need more and more drug to get the same effect.
- Addiction. A small percentage of patients may develop addiction problems based on genetic or other factors.
- Problems with pregnancy. If you are pregnant or contemplating pregnancy, discuss with your physician.

PAYMENT OF MEDICATIONS:

State law forbids L&I from paying for opioids once the patient reaches maximum medical improvement. You and your doctor should discuss other sources of payment for opioids when L&I can no longer pay.

RECOMMENDATIONS TO MANAGE YOUR MEDICATIONS:

- Keep a diary of the pain medications you are taking, the medication dose, time of day you are taking them, their effectiveness and any side effects you may be having.
- Use of a medication box that you can purchase at your pharmacy that is already divided in to the days of the week and times of the day so it is easier to remember when to take your medications.
- Take along only the amount of medicine you need when leaving home so there is less risk of losing all your medications at the same time.

I have read this document, understand and have had all my questions answered satisfactorily. I consent to the use of opioids to help control my pain and I understand that my treatment with opioids will be carried out as described above.

Patient Signature

Date

Physician Signature

Date

COMM[®] -

Assessment tool for chronic pain patients using opioids

Sometimes opioids can cause more harm than benefits. This assessment can help you and your physician or nurse practitioner identify if you benefit from opioids or if they have a negative impact on your quality of life.

The tool was developed with help from pain and addiction experts and pain management clinicians.

The tool has 17 questions. They can be completed in less than 10 minutes. The tool is only useful if you answer the questions as honest as possible.

Each answer has a rating. To calculate your score you can add up the rating of all the questions.

If you have a score that is 9 or higher, this might suggest that opioids may cause you significant problems. We strongly recommend you bring the test to your physician or nurse practitioner. They can help you manage your chronic pain medication.

Current Opioid Misuse Measure (COMM)[®]

Please answer each question as honestly as possible. Keep in mind that we are only asking about the **past 30 days**. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	<input type="radio"/>				
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	<input type="radio"/>				
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	<input type="radio"/>				
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	<input type="radio"/>				
5. In the past 30 days, how often have you seriously thought about hurting yourself?	<input type="radio"/>				
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	<input type="radio"/>				

©2015 Inflexxion, Inc. Permission granted solely for use in published format by individual practitioners in clinical practice. No other uses or alterations are authorized or permitted by copyright holder. Permissions questions: PainEDU@inflexxion.com. An online version of this tool is included in [PainCAS](#). The Current Opioid Misuse Measure (COMM)[®] was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
7. In the past 30 days, how often have you been in an argument?	<input type="radio"/>				
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	<input type="radio"/>				
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	<input type="radio"/>				
10. In the past 30 days, how often have you been worried about how you're handling your medications?	<input type="radio"/>				
11. In the past 30 days, how often have others been worried about how you're handling your medications?	<input type="radio"/>				
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	<input type="radio"/>				
13. In the past 30 days, how often have you gotten angry with people?	<input type="radio"/>				
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	<input type="radio"/>				
15. In the past 30 days, how often have you borrowed pain medication from someone else?	<input type="radio"/>				
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	<input type="radio"/>				
17. In the past 30 days, how often have you had to visit the Emergency Room?	<input type="radio"/>				

©2015 Inflexxion, Inc. Permission granted solely for use in published format by individual practitioners in clinical practice. No other uses or alterations are authorized or permitted by copyright holder. Permissions questions: PainEDU@inflexxion.com. An online version of this tool is included in [PainCAS](#). The Current Opioid Misuse Measure (COMM)[®] was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

Table 1. Examples of Instruments Assessing Opioid and Nonopioid Risk

Category	Items, No.	Administered By
Patients considered for long-term opioid therapy:		
DRT: Opioid Risk Tool ⁷	5	Patient
SOAPP ⁸ : Screeners and Opioid Assessment for Patients with Pain ⁸	24, 14, and 5	Patient
SISAP: Screening Instrument for Substance Abuse Potential ⁹	5	Patient
DIRE: Diagnosis, Intractability, Risk, and Efficacy Score ¹⁰	7	Clinician
Assess misuse once opioid treatment initiated:		
PDUD-p: Prescription Drug Use Questionnaire-patient ¹¹	31	Patient
COMM: Current Opioid Misuse Measure ¹³	17	Patient
PMQ: Pain Medication Questionnaire ¹⁴	26	Patient
PAOT: Pain Assessment and Documentation Tool ¹⁵	41	Clinician
ABC: Addiction Behavior Checklist ¹⁶	20	Clinician
Nonopioid general substance abuse:		
CAGE-AID: Cut Down, Annoyed, Guilty, Eye-Opener Tool. Adjusted to Include Drugs ¹⁸	4	Clinician
RAFFT: Relax, Alone, Friends, Family, Trouble ²⁰	5	Patient
DAST: Drug Abuse Screening Test ²¹	28	Patient
SBIAT: Screening, Brief Intervention, and Referral to Treatment ²²	Varies	Clinician
AUDIT-C: Alcohol Use Disorders Identification Test: Consumption ²³	3	Patient
DUDIT-E: Drug Use Disorders Identification Test: Extended ²⁴	54	Patient

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

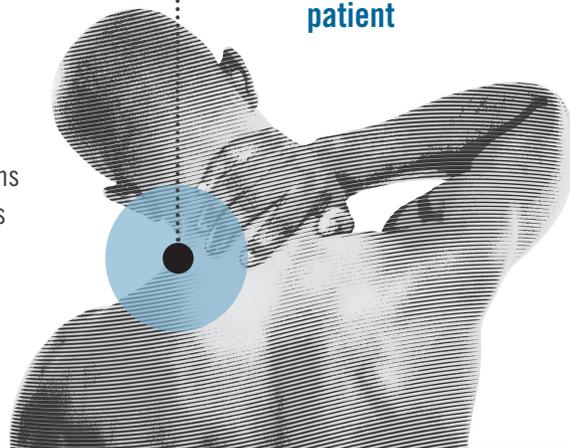
CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

- 1 Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
- 2 Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and 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.
- 3 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.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- **Use immediate-release opioids when starting**
- **Start low and go slow**
- **When opioids are needed for acute pain, prescribe no more than needed**
- **Do not prescribe ER/LA opioids for acute pain**
- **Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed**

4

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

5

When opioids are started, clinicians should prescribe the 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.

6

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. Three days or less will often be sufficient; more than seven days will rarely be needed.

7

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. If benefits do not outweigh harms 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.



ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8

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.

9

Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) 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 PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10

When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11

Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12

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.

CLINICAL REMINDERS

- **Evaluate risk factors for opioid-related harms**
- **Check PDMP for high dosages and prescriptions from other providers**
- **Use urine drug testing to identify prescribed substances and undisclosed use**
- **Avoid concurrent benzodiazepine and opioid prescribing**
- **Arrange treatment for opioid use disorder if needed**



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

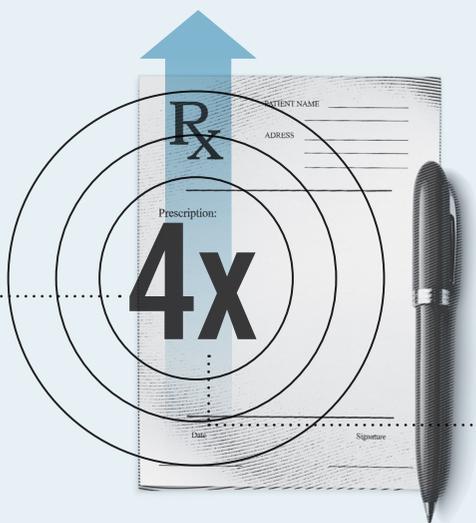
CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

Effective and Responsible Chronic Pain Management

THE EPIDEMIC

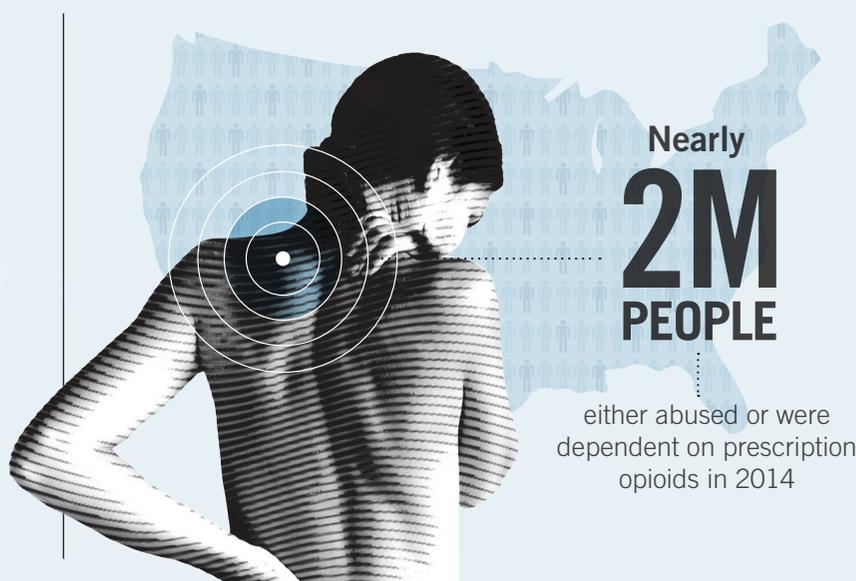
CDC cares about the health, safety, and well-being of patients with chronic pain. CDC is committed to ensuring that these patients get the best possible care. There is not enough science to know whether opioids control chronic pain long term, but it is clear that they have very serious risks and side effects.

The amount of opioid prescriptions dispensed has **QUADRUPLED** since 1999



but the amount of pain that Americans report remains **UNCHANGED**

Since 1999, more than **165,000** PEOPLE HAVE DIED FROM OVERDOSE related to prescription opioids.



OTHER WAYS TO MANAGE PAIN

Consider ways to manage chronic pain without prescription opioids. Some options may work better and have fewer risks and side effects:



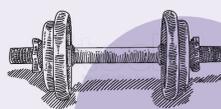
PAIN RELIEVERS

Nonopioid pain relievers such as Tylenol, Motrin, or Naprosyn



ANTIDEPRESSANTS & ANTICONVULSANTS

Certain medications that also have benefits for depression and seizures



EXERCISE

Physical therapy and exercise



COGNITIVE BEHAVIORAL THERAPY

Changing thoughts and behaviors related to pain

PRESCRIBING GUIDELINE

The *Guideline for Prescribing Opioids for Chronic Pain* was developed because CDC recognized that providers need current recommendations for prescribing opioids to improve pain management and patient safety. The guideline and corresponding clinical tools help providers and patients:

1 ASSESS.

Assess the risks and benefits of using opioids for chronic pain.

2 DISCUSS.

Set realistic goals for pain and function and make informed decisions about starting or continuing opioid therapy.

3 CONSIDER.

Exercise caution and consider the safest and most effective treatments for pain.

4 MONITOR.

Follow-up regularly to reassess progress and consider how opioid therapy will be discontinued if benefits do not outweigh risks.

To support widespread implementation of these recommendations, CDC developed user-friendly materials including: **CHECKLISTS | FACT SHEETS | CLINICAL TOOLS | POSTERS**



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs)

Checking the PDMP: An Important Step to Improving Opioid Prescribing Practices

WHAT IS A PDMP?

A PDMP is a statewide electronic database that tracks all controlled substance prescriptions. Authorized users can access prescription data such as medications dispensed and doses.

PDMPs improve patient safety by allowing clinicians to:

- Identify patients who are obtaining opioids from multiple providers.
- Calculate the total amount of opioids prescribed per day (in MME/day).
- Identify patients who are being prescribed other substances that may increase risk of opioids—such as benzodiazepines.

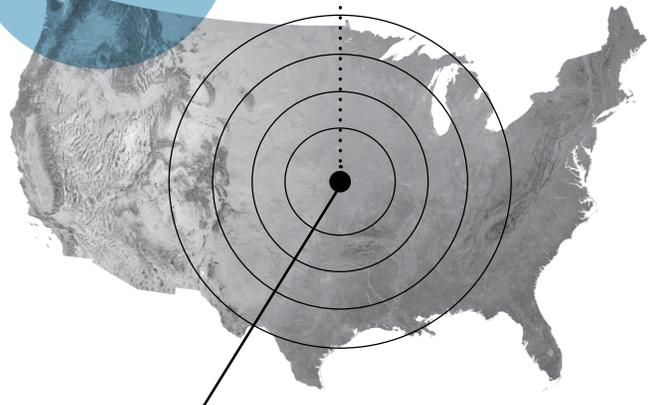
Improving the way opioids are prescribed will ensure patients have access to safer, more effective chronic pain treatment while reducing opioid misuse, abuse, and overdose. Checking your state's PDMP is an important step in safer prescribing of these drugs.



R_x

249M

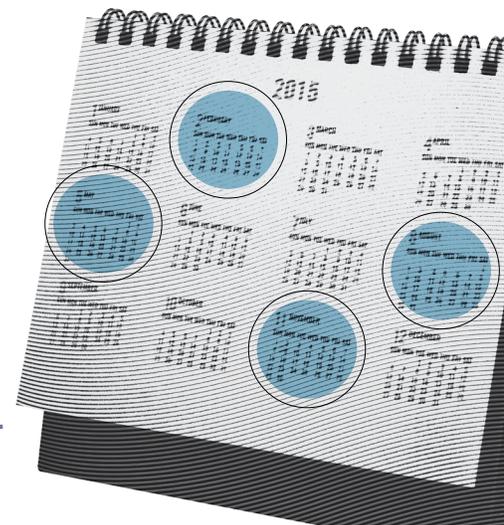
prescriptions for opioids were written by healthcare providers in 2013



enough prescriptions for every American adult to have a bottle of pills

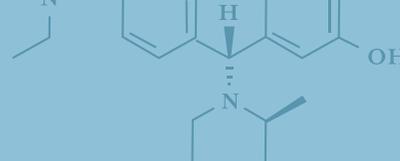
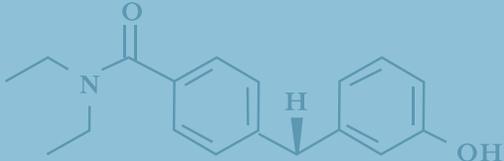
WHEN SHOULD I CHECK THE PDMP?

State requirements vary, but CDC recommends checking at least once every **3 months** and consider checking **prior to every opioid prescription.**

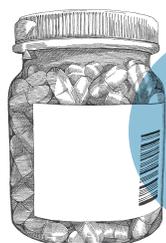


U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html



WHAT SHOULD I CONSIDER WHEN PRESCRIBING OPIOIDS?



High Dosage

Talk to your patient about the risks for respiratory depression and overdose. Consider offering to taper opioids as well as prescribing naloxone for patients taking 50 MME/day or more.



Multiple Providers

Counsel your patient and coordinate care with their other prescribers to improve safety and discuss the need to obtain opioids from a single provider. Check the PDMP regularly and consider tapering or discontinuation of opioids if pattern continues.



Drug Interactions

Whenever possible, avoid prescribing opioids and benzodiazepines concurrently. Communicate with other prescribers to prioritize patient goals and weigh risks of concurrent opioid and benzodiazepine use.

WHAT SHOULD I DO IF I FIND INFORMATION ABOUT A PATIENT IN THE PDMP THAT CONCERNS ME?

Patients should not be dismissed from care based on PDMP information. Use the opportunity to provide potentially life-saving information and interventions.

1

Confirm that the information in the PDMP is correct.

Check for potential data entry errors, use of a nickname or maiden name, or possible identity theft to obtain prescriptions.

2

Assess for possible misuse or abuse.

Offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients who meet criteria for opioid use disorder. If you suspect diversion, urine drug testing can assist in determining whether opioids can be discontinued without causing withdrawal.

3

Discuss any areas of concern with your patient and emphasize your interest in their safety.

HOW CAN I REGISTER AND USE THE PDMP IN MY STATE?

Processes for registering and using PDMPs vary from state to state.

For information on your state's requirements, check The National Alliance for Model State Drug Laws online: ●

www.namsdl.org/prescription-monitoring-programs.cfm

