6. The patient should be informed of the risks, benefits, and terms for continuation of opioid treatment, ideally using a written and signed treatment agreement.
7. Opioids should be initiated as a short-term trial to assess the effects of opioid treatment on pain intensity, function, and quality of life. In most instances, the trial should begin with a short-acting opioid medication.
8. Regular visits for evaluation of progress toward goals should be scheduled during the period when the dose of opioids is being adjusted (titration period). During the titration period, and until the patient is clinically stable and judged to be compliant with therapy, it is recommended that the health care provider check the Oklahoma PMP more frequently.
9. Once a stable dose has been established (maintenance period), regular monitoring should be conducted at face-to-face visits during which treatment goals, analgesia, activity, adverse effects, and aberrant behaviors are monitored. The Oklahoma PMP should be queried at least once per year for patients receiving opioid treatment for chronic pain.
10. Continuing opioid treatment should be a deliberate decision that takes into consideration the risks and benefits of chronic opioid treatment for that patient. Patients and health care providers should periodically reassess the need for continued opioid treatment, weaning whenever possible, as part of the comprehensive pain care plan. A second opinion or consultation may be useful in making that decision.
11. Opioid treatment should be discontinued if adverse effects outweigh benefits or if aberrant, dangerous, or illegal behaviors are demonstrated.
12. Health care providers treating chronic pain patients with opioids should maintain records, in accordance with state and federal law, documenting patient evaluation, treatment plan, discussion of risks and benefits, informed consent, treatments prescribed, results of treatment, and any aberrant behavior observed.
13. Health care providers should consider consultation for patients with complex pain conditions, serious co-morbidities and mental illness, a history or evidence of current drug addiction or abuse, or when the provider is not confident of his/her ability to manage the treatment.
14. Health care providers should generally not provide replacement prescriptions for opioids that have been lost, stolen, or destroyed.
15. The administration of intravenous and intramuscular opioids for the relief of exacerbations of chronic pain is discouraged, except in special circumstances.
16. Long-acting opioids are associated with an increased risk of overdose death, and should only be prescribed by health care providers familiar with their indications, risks, and need for careful monitoring.
17. When opioids are prescribed for treatment of chronic pain, the patient should be counseled to store the medications securely and never to share with others. In order to prevent non-medical use of the medications, it is also recommended that patients dispose of medications when the pain has resolved.

Oklahoma Society of Interventional Pain Physicians