8.1 Face-to-face follow-up visits should occur at least every 2-4 weeks during the titration period. More frequent follow-up visits may be advisable and caution should be used when prescribing an opioid medication if the patient has a known addiction problem, suspected drug-behavior problems, or co-existing psychiatric or medical problems. Frequency of visits should also be based on risk stratification (e.g., as determined by a screening tool) and the clinician's judgment (taking into account the volume of the drug being prescribed and how likely it is to be abused).[15]

8.2 When pain and function have not sufficiently improved on a current opioid dose, a trial of a slightly higher dose could be considered.[14,15]

The rate at which the dosing is increased should balance the risk of leaving the patient in a painful state longer than necessary by increasing too slowly with the risk of causing harm, including fatal overdose, by increasing too fast. Ideally, only one drug at a time should be titrated in an opioid-naïve patient.[14] Age, health, and severity of pain should be taken into consideration when deciding on increments and rates of titration. Particular caution should be used in titrating dosing of methadone.

Evidence and other guidelines are not in agreement regarding the risks and benefits of high daily doses of opioid measured in morphine milligram equivalents (MMEs). It is likely that the risk-benefit ratio is less favorable at higher doses. Clinical vigilance is needed at all dosage levels of opioids, but is even more important at higher doses. Health care providers who are not experienced in prescribing high doses of opioids should consider either referring the patient or obtaining a consultation from a qualified provider for patients receiving high dosages. No clear threshold for a high dose has been established based on evidence. The Washington State guidelines suggest a threshold of 120 MME per day. It is important to increase clinical vigilance at doses exceeding 120 MME per day. Patients receiving 100 MME or more per day had a 9-fold increase in overdose risk. Most overdoses were medically serious, 12% were fatal.[9]

During titration, all patients should be seen frequently until dosing requirements have stabilized. Patients should be instructed to use medication only as directed, that is, not to change doses or frequency of administration without specific instructions from the health care provider.

8.3 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 Prescription Monitoring Program more frequently, such as monthly or quarterly.

Tools to accompany *Recommendation 8:*

- Dosing Guidelines
  http://health.utah.gov/prescription/pdf/guidelines/dosing_guidelines.pdf
- Electronic MME Dosing Calculator
  http://agencymeddirectors.wa.gov/mobile.html
- Prescription Monitoring Program
  http://www.ok.gov/obndd/Prescription_Monitoring_Program/

Maintenance of Opioid Treatment

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.[13,15]

9.1 The health care provider is advised to consider baseline drug testing at the initiation of opioid treatment, compliance monitoring one to three months later, and random monitoring every 6-12 months. In the event of unexpected drug screens or suspicious patient behavior, additional monitoring can be performed. Health care