providers may consider each of the following four areas of concern at each visit: Analgesia, Activity, Adverse effects, and Aberrant behavior. These assessments can be remembered as the "four A's": [21]

- Analgesia: inquire about level of pain (current, recent, trends, etc.)
- Activity: assess the patient's function and overall quality of life
- Adverse events: determine whether the patient is having medication side effects
- Aberrant behavior: evaluate for possible drug abuse-related behavior

9.2 During the maintenance period, the Oklahoma Prescription Monitoring Program should be checked at least annually.

After the titration period is complete and the maintenance period is underway, the frequency of checks of the Oklahoma PMP can be based on clinical judgment, but should be done no less than annually. The Oklahoma PMP should be checked more often for high risk patients and patients exhibiting aberrant behavior.

9.3 Continuation or modification of treatment should depend on the health care provider's evaluation of progress towards stated treatment goals.[13]

Treatment goals include reduction in a patient's pain scores and improved physical, psychological, and social function. If patient compliance with agreed-upon activity levels, are not being achieved despite medication adjustments, the health care provider should re-evaluate the appropriateness of continued treatment with the current medications.[9,17]

A frequent need for dose adjustments after a reasonable time interval of titration is an indication to re-evaluate the underlying condition and consider the possibility the patient has developed opioid hyperalgesia, substantial tolerance, or psychological/physical dependence.

9.4 Adjustments to previously stable maintenance treatment may be considered if the patient develops tolerance, a new pain-producing medical condition arises or an existing one worsens, or if a new adverse effect emerges or becomes more clinically significant.[14]

Options for adjustment include reducing the medication or rotating opioid medications. If it is documented that the patient is compliant with agreed-upon recommendations such as exercise, working, etc., the addition of supplemental short-acting medications for control of break-through pain (e.g., as related to an increase in activity, end-of-dose pain, weather-related pain exacerbation, or specific medical conditions) can be considered as well. If patients do not achieve effective pain relief with one opioid, rotation to another frequently produces greater success.[22] If rotating among different opioid medications, refer to a standard dosing equivalence table, taking into account the current drug's half-life and potency.

If the patient's situation has changed permanently and consideration is given to the increased risk of adverse events, it is reasonable to consider an ongoing increase in maintenance dosing. In general, if the patient's underlying medical condition is chronic and unchanging, and if opioid-associated problems (hyperalgesia, substantial tolerance, important adverse effects) have not developed, it is recommended that the effective dose achieved through titration not be lowered once the patient has reached a plateau of adequate pain relief and functional level.[14]

9.5 Dosing changes should generally be made during a clinic visit.[14]

If the patient's underlying, pain-producing, chronic medical condition improves, it is expected that the health care provider will begin tapering the patient off the opioid medication. (See *Recommendation 11* for guidelines on discontinuation.)

Tapering an opioid medication with or without the goal of discontinuation may be performed as described below (*Recommendation 11*) or as described in the *Strategies for Tapering and Weaning Tool*.