plan for coordinated care of both the chronic pain and psychiatric condition(s).

Tools to accompany *Recommendation 13:*

- Strategies for Tapering and Weaning
  http://health.utah.gov/prescription/pdf/guidelines/Strategies_tapering_weaning.pdf

14. Health care providers should generally not provide replacement prescriptions for opioids that have been lost, stolen, or destroyed.

Patients misusing controlled substances frequently report their opioid medications as having been lost or stolen. Pain specialists routinely stipulate in pain agreements with patients that lost or stolen controlled substances will not be replaced. Most written agreements between chronic pain patients and pain management physicians, including the Health Resources and Services Administration (HRSA) toolkit sample pain agreement, state that prescriptions for opioids will not be replaced.[10]

The diversion of prescribed opioids is common. One study looked at completed patient surveys and determined that 45% of respondents reported some form of drug diversion at least once. Stolen medication was the most prevalent method of drug diversion, and 30% of respondents reported at least one incident of stolen medication.[11] Another survey study found that among persons 12 years and older who abused opioid pain medications (2009-2010), 71.2% came from friends or relatives; 55% were given to the abuser, while 11.4% were purchased, and 4.8% were stolen.[12,13]

15. The administration of intravenous and intramuscular opioids for the relief of exacerbations of chronic pain is discouraged, except in special circumstances.

Parenteral opioids should be generally avoided for the treatment of chronic pain because of their short duration and potential for addictive euphoria. For chronic pain, oral opioids are superior to parenteral opioids in duration of action and provide a gradual decrease in the level of pain control. When there is evidence or reasonable suspicion of an acute pathological process causing the acute exacerbation of chronic pain, parenteral opioids may be appropriate.

Tools to accompany *Recommendation 15:*

- Dosing Guidelines
  http://health.utah.gov/prescription/pdf/guidelines/dosing_guidelines.pdf
- Current Opioid Misuse Measure (COMM)
  http://health.utah.gov/prescription/tools.html (see *Tools to Screen for Risk of Complications*)

Methadone and Extended Release/Long-Acting Opioids

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.

16.1 The prescription use of methadone remains controversial due to concerns about its efficacy and safety. During the past two decades methadone-related death rates increased in Oklahoma and the U.S. From 2007-2011, methadone was listed in the cause of death in 21% of prescription drug-related unintentional poisoning deaths in Oklahoma.[1]

The half-life of methadone is long and unpredictable, increasing the risk of inadvertent overdose. The peak respiratory depressant effect of methadone occurs later and lasts longer after treatment initiation or dosage change than does the peak analgesic effect. Conversion tables that have been established to assist with converting a patient from another opioid medication to methadone are considered by many experts to be unreliable.