The Pharmacist’s Role in Combatting the Opioid Crisis in Pain Management

Chris Herndon, PharmD, BCPS, CPE
Associate Professor
Department of Pharmacy Practice
Southern Illinois University Edwardsville
Director
NIH Center of Excellence in Pain Education
Edwardsville, Illinois

Educational Objectives
At the completion of this activity, the participant will be able to:
• Identify the conditions, disease, and comorbidities in which opioid therapy is essential to control pain and maintain quality of life
• Explore strategies to prevent opioid abuse by counseling patients on proper storage and disposal practice
• Examine the processes used to validate valid prescriptions for pain medication
• Express monitoring strategies and compliance to ensure appropriate use of opioid prescriptions

The Problem
Receiving Opioids (Acute and Chronic)

Meet Richard
PMHx: Chronic low back pain
Hypertension
Generalized Anxiety Disorder
Bipolar Type 2

Meds: Tramadol 50 mg tablets (2 tabs Q6)
Lisinopril 20 mg tablets (1 tab QAM)
Sertraline 100 mg tablets (1 tab QAM)

SHx: + Tob (1 pack/day), denies rec drugs
denies alcohol

Meet Richard
Richard consistently presents to your pharmacy requesting early refills of his prescription for tramadol which he takes for chronic low back pain. You are concerned but are not sure how to proceed. He tells you the tramadol “used to work for his pain but are not effective any longer.”
Is Richard “Addicted?”

- Aberrant drug taking behavior
  - Any departure from prescription
- Misuse
  - Departure with therapeutic intent
- Abuse
  - Departure without therapeutic intent
- Addiction
  - Now called substance use disorder
  - Neurobiologic disease characterized by cravings, compulsion, withdrawal syndrome and loss of control
- Tolerance
  - Requiring increasing doses to garner the same effect
- Hyperalgesia
  - When noxious stimuli produces a heightened and non-proportional nociceptive response


Diagnosis of Substance Use Disorder

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 2</td>
<td>No disorder</td>
</tr>
<tr>
<td>2-3</td>
<td>Mild disorder</td>
</tr>
<tr>
<td>4-5</td>
<td>Moderate disorder</td>
</tr>
<tr>
<td>&gt; 6</td>
<td>Severe disorder</td>
</tr>
</tbody>
</table>

Wanting to cut down or stop using, but not managing to
Spending a lot of time to get, use, or recover from use
Craving
Inability to manage commitments due to use
Continuing to use, even when it causes problems in relationships
Giving up important activities because of use
Continuing to use, even when physical or psychological problems are worsened
Increasing tolerance
Withdrawal symptoms
Using in larger amounts or for longer than intended


The “Addiction” Cycle


Prescription Opioids and Heroin

- Quantitative questionnaire using street outreach, venue recruitment, and needle-exchange advertisement (n = 123)
- Median age 29 yrs (75% male, 53% white, 28% Hispanic, 19% black or other)
- 39.8% reported problematic prescription opioid use prior to first heroin use
- We are lacking data on true risk for first-time exposure to opioids for an indication of pain


Risk Mitigation Strategies

- Prescription drug monitoring programs (PDMP)
- Screening tools (prior to and during therapy)
- Random drug screening
- Opioid agreements
- Pill counts
- COMMUNICATION with prescribers, nurses, AND patients
  - Early requests
  - Erratic behaviors


The End Result

Validated Risk Assessment Tools

<table>
<thead>
<tr>
<th>Acronym of tool</th>
<th>Number of questions</th>
<th>Completion</th>
<th>Time to complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOAPP-R</td>
<td>24 items</td>
<td>Self-report</td>
<td>&lt; 10 minutes</td>
</tr>
<tr>
<td>DIRE</td>
<td>7 items</td>
<td>Clinician administered</td>
<td>&lt; 5 minutes</td>
</tr>
<tr>
<td>ORT</td>
<td>5 items</td>
<td>Clinician administered</td>
<td>&lt; 5 minutes</td>
</tr>
<tr>
<td>CASE</td>
<td>4 items</td>
<td>Editor</td>
<td>&lt; 5 minutes</td>
</tr>
<tr>
<td>PUSG</td>
<td>7 items</td>
<td>Clinician administered</td>
<td>20 minutes</td>
</tr>
<tr>
<td>STARS</td>
<td>4 items</td>
<td>Self-report</td>
<td>&lt; 5 minutes</td>
</tr>
<tr>
<td>PMQ</td>
<td>5 items</td>
<td>Clinician administered</td>
<td>&lt; 5 minutes</td>
</tr>
</tbody>
</table>

α = SOAPP-R (Screen and Opioid Assessment for Patients in Pain - Revised); DIRE (Diagnosis, Intractability, Risk, and Efficacy; ORT (Opioid Risk Tool); CASE (Cut, Annoyed, Guilt, Eye Opener); PUSG (Prescription Drug Use Questionnaire); STARS (Screening Tool for Addiction Risk); PMQ (Pain Medication Questionnaire)

Urine Drug Screening

- **Immunoassay**
  - Fast results
  - Inexpensive
  - High sensitivity, low specificity
- **Gas chromatography/mass spectrometry**
  - Slower results
  - Expensive
  - High sensitivity, high specificity

**Interpretation**

- Pharmacists ideally positioned to interpret presence or absence of metabolites
- What would you expect if patient is on hydrocodone? Oxycodone?

The Brushwood VIGIL System: A Proposed System for Community Pharmacists

**Red Flags**

- Male between ages of 16 and 45 +2
- Immediate family member also uses opioids +2
- Not legal resident in this country +2
- Opioid Rx from emergency room within past 6 months +2
- Opioid, benzo, carisoprodol at same time +4
- Lost or stolen meds, more than once in past year +3
- More than 20% too each, more than once in past 6 months +2
- More than 2 prescribers of opioids in past 6 months +2

**Green Flags**

- Non-problematic POMR Report -2
- Written med use agreement with prescriber -2
- Family member or friend willing to accept responsibility -2
- Prescriber board certified pain mgmt specialist known to pharmacist -2
- Regular Rx from licensed mental health professional -2
- At least one non-CS monthly for past 6 months -3
- Willing to accept generics -2
- Uses insurance and never pays cash -2

Modified Risk Assessment Using VIGIL

- **Score**
  - 0-4 Low
  - 5-9 Moderate
  - 10+ High
- **Care Level**
  - Standard
  - Special
  - Extra
- **Approach**
  - Verify RX, ID patent
  - Limit to 7 day supply, communicate with prescriber
  - Communicate with prescriber, hold RX until legitimate medical purpose verified

Unacceptable risk: Do not fill RX. Medication denied.

UDS Interpretation

Decision tree may be downloaded free of charge from the Society of Palliative Care Pharmacists

www.palliativepharmacist.org
**Opioid Agreements**

- No data to support their efficacy in reducing misuse/abuse
- Standard of care
- Many include stipulations for patient conduct
- Should be used as informed consent
- Why aren’t pharmacists incorporating these?

**Abuse-Deterrent Technology**

- Physical and chemical barriers
  - Prevents destruction of drug or increases difficulty to extract drug from dosage form
- Agonist – antagonist combinations
  - Antagonist meant to reduce euphoria from consumption of adulterated dosage form
- Noxious substance
  - Produces an aversive effect if tampered dosage form used
- Produg
  - Drug is inactive until reaches intestine and must be biconverted through first pass

**Abuse-Deterrent Technology Examples**

- OxyConform – oxycodone hydrochloride, crush/extraction resistant
- Zohydro ER – hydrocodone bitartrate, crush/extraction resistant
- Tar欣 ER – oxycodone hydrochloride and naloxone hydrochloride
- Embedia – morphine sulfate and nalbuphine hydrochloride
- Hyzainga ER – hydrocodone bitartrate, crush/extraction resistant
- MorphaBond – morphine sulfate
- Xampaza ER – oxycodone hydrochloride
- TrinyCA – ER oxycodone hydrochloride and naloxone hydrochloride
- Aryno ER – morphine sulfate
- Vantrela ER – hydrocodone bitartrate

**CDC Guidelines for Opioid Prescribing**

Consists of 12 primary recommendations categorized into 3 practice areas:

1. Determining when to initiate or continue opioids for chronic pain
2. Selection of opioid dosage, treatment duration, follow-up, and discontinuation
   - Avoid MONO > 90 mg
   - Avoid duration longer than 7 days
3. Assessing risk and addressing harms of opioid use
   - Avoid concurrent benzodiazepine use

**CDC Key Recommendations**

- Nonpharmacologic therapy and non-opioid 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, as appropriate.

- 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.

- Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and harms of opioid therapy, including unrealistic expectations of treatment outcomes, development or worsening of physical or psychological dependence, and the possibility of serious, including lethal, outcomes.

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

- 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 or until pain is controlled. The quantity prescribed should not exceed 90 morphine milligram equivalents (MME)/day, and clinicians should review urine drug testing if MME/day ≥ 90.

- When prescribing opioids for chronic pain, clinicians should combine opioid pharmacologic therapy with nonpharmacologic therapy, as appropriate.

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

- 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.

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

- Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapy) for patients with opioid use disorder.
Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both patient and clinician responsibilities for managing therapy outweigh risks to the patient. 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 harms when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥30 MME/day or consider restarting a decision to titrate dosage to ≥90 MME/day.

### CDC Key Recommendations

1. Nonpharmacologic therapies and nonopioid pharmacologic therapies are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both patient and clinician responsibilities for managing therapy outweigh risks to the patient.
2. 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 harms when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥30 MME/day or consider a decision to titrate dosage to ≥90 MME/day.

### Assessing Morphine Equivalents

<table>
<thead>
<tr>
<th>Drug</th>
<th>Parenteral</th>
<th>Oral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>0.3</td>
<td>0.4</td>
</tr>
<tr>
<td>Codeine</td>
<td>100</td>
<td>200</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>0.1</td>
<td>NA</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>NA</td>
<td>30</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>1.5</td>
<td>7.5</td>
</tr>
<tr>
<td>Mepiridine</td>
<td>100</td>
<td>350</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>NA</td>
<td>20</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Tramadol</td>
<td>NA</td>
<td>120</td>
</tr>
</tbody>
</table>


### What Adjuvant Modalities Could We Offer Richard?

- Acupuncture
- Cognitive Behavioral Therapy (CBT)
- Chiropractic
- Physical Therapy
- Psychological counseling
- SMRs
- SNRIs
- TCA
- IGADs
- Antidepressants
- Anticonvulsants
- Gabapentin
- Lamotrigine
- Levetiracetam
- Topiramate
- Valproic acid
- Zonisamide

### Commonly Encountered Chronic Pain Syndromes

- **Centrally-mediated pain**
  - Complex regional pain syndrome
  - Fibromyalgia
  - Opioid-induced hyperalgesia
- **Inflammation-mediated pain**
  - Rheumatoid arthritis
  -ankylosing spondylitis
- Psoriatic arthritis
- Systemic lupus erythematosus

Avoid epidural in myofascial syndrome and opioid-induced hyperalgesia

### Back to Richard

Richard takes 8 tramadol 50 mg tablets PO daily.

What is his MEDD?

\[
x/30 \text{ mg} = 400 \text{ mg} / 120 \text{ mg} \\
x = 100 \text{ mg} \text{ of MEDD}
\]

Richard’s tramadol use is equivalent to 100 mg MEDD

### Back to Richard

Richard rates his pain as follows:
- Now = 8/10
- Least = 5/10
- Average = 7/10
- Worst = 9/10

Relief from current modalities: 20%

Descriptors: aching, shooting, radiating, stabbing, burning (in legs), spasms (in lumbar region only)
Opioid analgesics possess numerous risks, including substance use disorder within the law. Much of the prescription opioid doses diverted come from family or friends under lock and key. Safe storage and disposal (some require receipt for lock box). Quickly discard unused opioid doses. Avoid public administration or fentanyl patches in plain view.

Numerous screening tools exist to predict problematic opioid use prior to the correct patient. For the correct patient, pharmacists have a corresponding responsibility to ensure safe and legitimate use of opioid analgesics. Numerous non-opioid analgesics are available when risks of opioids outweigh their anticipated benefit.

Opportunities for Pharmacists

- Talk to your patients first
  - Quiet private location using open-ended questions and avoiding stigmatizing
    - Do not refuse to fill prescription without discussion with patient
- Verify the prescription
  - Within the law
  - Within the scope (of prescriber)
  - For the correct patient
- Patient assessment
- Clarification of patient responsibilities
  - As directed
  - Safe storage and disposal (some require receipt for lock box)
  - Behavior expectations
- Risk assessment and management of chronic pain. Updated November 2013

Safe Storage and Disposal

- Under lock and key – treat opioid prescriptions like a hundred dollar bill
- Quickly discard unused opioid doses
  - Much of the prescription opioid doses diverted come from family or friends
  - Drug take backs, law enforcement locations, or step up at your pharmacy (Secure and Responsible Drug Disposal Act of 2010)
  - Pills vs patches
- Avoid public administration or fentanyl patches in plain view

Conclusion

- Opioid analgesics possess numerous risks, including substance use disorder
- Numerous screening tools exist to predict problematic opioid use prior to developing substance use disorder
- Pharmacists have a corresponding responsibility to ensure safe and legitimate use of opioid analgesics
- Numerous non-opioid analgesics are available when risks of opioids outweigh their anticipated benefit

Additional Resources

- Opioid analgesics possess numerous risks, including substance use disorder within the law. Much of the prescription opioid doses diverted come from family or friends under lock and key. Safe storage and disposal (some require receipt for lock box). Quickly discard unused opioid doses. Avoid public administration or fentanyl patches in plain view.

Numerous screening tools exist to predict problematic opioid use prior to the correct patient. For the correct patient, pharmacists have a corresponding responsibility to ensure safe and legitimate use of opioid analgesics. Numerous non-opioid analgesics are available when risks of opioids outweigh their anticipated benefit.

Opportunities for Pharmacists

- Talk to your patients first
  - Quiet private location using open-ended questions and avoiding stigmatizing
    - Do not refuse to fill prescription without discussion with patient
- Verify the prescription
  - Within the law
  - Within the scope (of prescriber)
  - For the correct patient
- Patient assessment
- Clarification of patient responsibilities
  - As directed
  - Safe storage and disposal (some require receipt for lock box)
  - Behavior expectations
- Risk assessment and management of chronic pain. Updated November 2013

Safe Storage and Disposal

- Under lock and key – treat opioid prescriptions like a hundred dollar bill
- Quickly discard unused opioid doses
  - Much of the prescription opioid doses diverted come from family or friends
  - Drug take backs, law enforcement locations, or step up at your pharmacy (Secure and Responsible Drug Disposal Act of 2010)
  - Pills vs patches
- Avoid public administration or fentanyl patches in plain view

Conclusion

- Opioid analgesics possess numerous risks, including substance use disorder
- Numerous screening tools exist to predict problematic opioid use prior to developing substance use disorder
- Pharmacists have a corresponding responsibility to ensure safe and legitimate use of opioid analgesics
- Numerous non-opioid analgesics are available when risks of opioids outweigh their anticipated benefit

Additional Resources

- Opioid analgesics possess numerous risks, including substance use disorder within the law. Much of the prescription opioid doses diverted come from family or friends under lock and key. Safe storage and disposal (some require receipt for lock box). Quickly discard unused opioid doses. Avoid public administration or fentanyl patches in plain view.

Numerous screening tools exist to predict problematic opioid use prior to the correct patient. For the correct patient, pharmacists have a corresponding responsibility to ensure safe and legitimate use of opioid analgesics. Numerous non-opioid analgesics are available when risks of opioids outweigh their anticipated benefit.

Opportunities for Pharmacists

- Talk to your patients first
  - Quiet private location using open-ended questions and avoiding stigmatizing
    - Do not refuse to fill prescription without discussion with patient
- Verify the prescription
  - Within the law
  - Within the scope (of prescriber)
  - For the correct patient
- Patient assessment
- Clarification of patient responsibilities
  - As directed
  - Safe storage and disposal (some require receipt for lock box)
  - Behavior expectations
- Risk assessment and management of chronic pain. Updated November 2013

Safe Storage and Disposal

- Under lock and key – treat opioid prescriptions like a hundred dollar bill
- Quickly discard unused opioid doses
  - Much of the prescription opioid doses diverted come from family or friends
  - Drug take backs, law enforcement locations, or step up at your pharmacy (Secure and Responsible Drug Disposal Act of 2010)
  - Pills vs patches
- Avoid public administration or fentanyl patches in plain view

Conclusion

- Opioid analgesics possess numerous risks, including substance use disorder
- Numerous screening tools exist to predict problematic opioid use prior to developing substance use disorder
- Pharmacists have a corresponding responsibility to ensure safe and legitimate use of opioid analgesics
- Numerous non-opioid analgesics are available when risks of opioids outweigh their anticipated benefit

Additional Resources

- Opioid analgesics possess numerous risks, including substance use disorder within the law. Much of the prescription opioid doses diverted come from family or friends under lock and key. Safe storage and disposal (some require receipt for lock box). Quickly discard unused opioid doses. Avoid public administration or fentanyl patches in plain view.

Numerous screening tools exist to predict problematic opioid use prior to the correct patient. For the correct patient, pharmacists have a corresponding responsibility to ensure safe and legitimate use of opioid analgesics. Numerous non-opioid analgesics are available when risks of opioids outweigh their anticipated benefit.

Opportunities for Pharmacists

- Talk to your patients first
  - Quiet private location using open-ended questions and avoiding stigmatizing
    - Do not refuse to fill prescription without discussion with patient
- Verify the prescription
  - Within the law
  - Within the scope (of prescriber)
  - For the correct patient
- Patient assessment
- Clarification of patient responsibilities
  - As directed
  - Safe storage and disposal (some require receipt for lock box)
  - Behavior expectations
- Risk assessment and management of chronic pain. Updated November 2013

Safe Storage and Disposal

- Under lock and key – treat opioid prescriptions like a hundred dollar bill
- Quickly discard unused opioid doses
  - Much of the prescription opioid doses diverted come from family or friends
  - Drug take backs, law enforcement locations, or step up at your pharmacy (Secure and Responsible Drug Disposal Act of 2010)
  - Pills vs patches
- Avoid public administration or fentanyl patches in plain view

Conclusion

- Opioid analgesics possess numerous risks, including substance use disorder
- Numerous screening tools exist to predict problematic opioid use prior to developing substance use disorder
- Pharmacists have a corresponding responsibility to ensure safe and legitimate use of opioid analgesics
- Numerous non-opioid analgesics are available when risks of opioids outweigh their anticipated benefit

Additional Resources

- Opioid analgesics possess numerous risks, including substance use disorder within the law. Much of the prescription opioid doses diverted come from family or friends under lock and key. Safe storage and disposal (some require receipt for lock box). Quickly discard unused opioid doses. Avoid public administration or fentanyl patches in plain view.

Numerous screening tools exist to predict problematic opioid use prior to the correct patient. For the correct patient, pharmacists have a corresponding responsibility to ensure safe and legitimate use of opioid analgesics. Numerous non-opioid analgesics are available when risks of opioids outweigh their anticipated benefit.

Opportunities for Pharmacists

- Talk to your patients first
  - Quiet private location using open-ended questions and avoiding stigmatizing
    - Do not refuse to fill prescription without discussion with patient
- Verify the prescription
  - Within the law
  - Within the scope (of prescriber)
  - For the correct patient
- Patient assessment
- Clarification of patient responsibilities
  - As directed
  - Safe storage and disposal (some require receipt for lock box)
  - Behavior expectations
- Risk assessment and management of chronic pain. Updated November 2013

Safe Storage and Disposal

- Under lock and key – treat opioid prescriptions like a hundred dollar bill
- Quickly discard unused opioid doses
  - Much of the prescription opioid doses diverted come from family or friends
  - Drug take backs, law enforcement locations, or step up at your pharmacy (Secure and Responsible Drug Disposal Act of 2010)
  - Pills vs patches
- Avoid public administration or fentanyl patches in plain view

Conclusion

- Opioid analgesics possess numerous risks, including substance use disorder
- Numerous screening tools exist to predict problematic opioid use prior to developing substance use disorder
- Pharmacists have a corresponding responsibility to ensure safe and legitimate use of opioid analgesics
- Numerous non-opioid analgesics are available when risks of opioids outweigh their anticipated benefit

Additional Resources

- Opioid analgesics possess numerous risks, including substance use disorder within the law. Much of the prescription opioid doses diverted come from family or friends under lock and key. Safe storage and disposal (some require receipt for lock box). Quickly discard unused opioid doses. Avoid public administration or fentanyl patches in plain view.

Numerous screening tools exist to predict problematic opioid use prior to the correct patient. For the correct patient, pharmacists have a corresponding responsibility to ensure safe and legitimate use of opioid analgesics. Numerous non-opioid analgesics are available when risks of opioids outweigh their anticipated benefit.

Opportunities for Pharmacists

- Talk to your patients first
  - Quiet private location using open-ended questions and avoiding stigmatizing
    - Do not refuse to fill prescription without discussion with patient
- Verify the prescription
  - Within the law
  - Within the scope (of prescriber)
  - For the correct patient
- Patient assessment
- Clarification of patient responsibilities
  - As directed
  - Safe storage and disposal (some require receipt for lock box)
  - Behavior expectations
- Risk assessment and management of chronic pain. Updated November 2013

Safe Storage and Disposal

- Under lock and key – treat opioid prescriptions like a hundred dollar bill
- Quickly discard unused opioid doses
  - Much of the prescription opioid doses diverted come from family or friends
  - Drug take backs, law enforcement locations, or step up at your pharmacy (Secure and Responsible Drug Disposal Act of 2010)
  - Pills vs patches
- Avoid public administration or fentanyl patches in plain view

Conclusion

- Opioid analgesics possess numerous risks, including substance use disorder
- Numerous screening tools exist to predict problematic opioid use prior to developing substance use disorder
- Pharmacists have a corresponding responsibility to ensure safe and legitimate use of opioid analgesics
- Numerous non-opioid analgesics are available when risks of opioids outweigh their anticipated benefit

Additional Resources
Additional Resources (continued)

- www.prescribetoprevent.org
- Opioid Use Disorders: Interventions for Community Pharmacists, College of Psychiatric and Neurologic Pharmacists