UCONN | SCHOOL OF DENTAL MEDICINE

ORAL AND FACIAL PAIN MANAGEMENT TOOLKIT

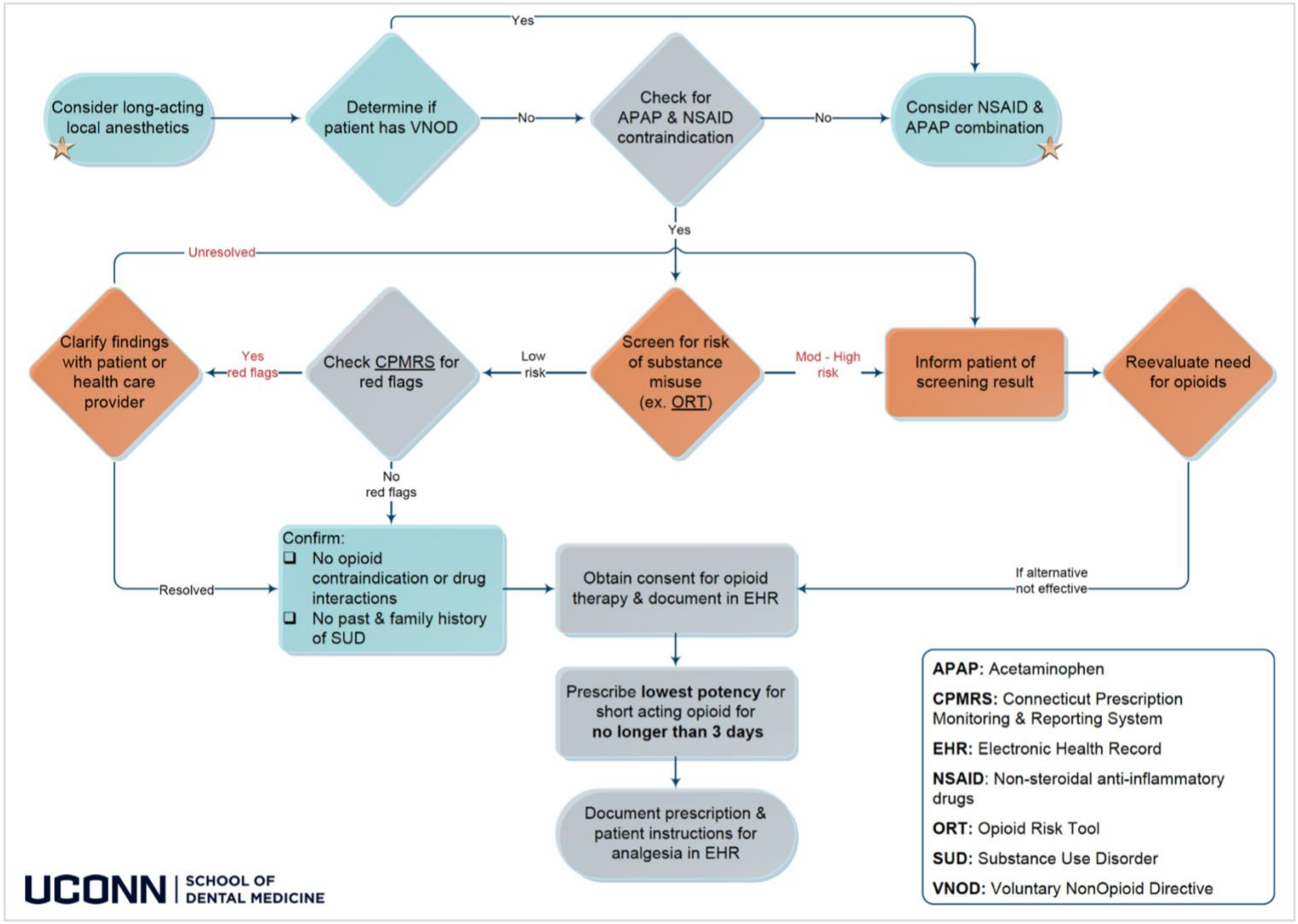
August 2021

Table of Contents

Table of Figures

Recommended Workflow: Acute Oral, Facial and Postoperative Pain Management in Adult Patients

Figure 1. Acute, Oral, Facial and Postoperative Pain Management in Adult Patients: Recommended Workflow



Opioid Alternatives

Comparison Chart: NSAIDS & Other Analgesics

Comparison Chart: NSAIDS & Other Analgesics Prepared by: Loren Regier, Sharon Downey - ***The RxFiles***, **AUG/2000**

***Class* / Agent**		**Comments / Products**	**Usual Dosage Range**	**Max /day**	**Cost x30 days [#] (comparative dose)**
Salicylates					
ASA-Plain **ASA-Enteric Coated**	ASPIRIN® ENTROPHEN®	**OTC**; 650mg supp; 80,325mg tab; 81,325,650,975mg EC tab; irreversible platelet inhibition	325-650mg q4-6h 325-975mg QID	4g	650mg po QID **$11**
Diflunisal	DOLOBID®	250,500mg tab	250-500mg BID	1.5g	250mg po BID $37
Non-acetylated Salicylates - less adverse GI reactions, less cross-allergy in NSAID (& CSI?) allergic patients; available, but not commonly used					
Salsalate	DISALCID® ✘	500,750mg tab	1000mg TID	3g	1500mg po BID $54
Choline Mg Trisalicylate	TRILISATE® ✘	500mg tab	1-1.5g BID	3g	1000mg po BID $36
Indole Acetic Acids					
Indomethacin	INDOCID®	25,50mg cap; 50,100mg supp	25-50mg TID	200mg	25mg po TID $17
Sulindac	CLINORIL®	150,200mg tab; PD	150-200mg BID	400mg	150mg po BID $34
Tolmetin	TOLECTIN®	200,600mg tab; 400mg cap	200-600mg TID-QID	2g	400mg po TID $53
Phenylacetic Acids					
Diclofenac [###]	VOLTAREN®	25,50mg EC tab; 50,100mg supp; 75,100mg SR tab	25-50mg BID-TID	200mg	50mg po TID $22
Diclofenac+Misoprostol	ARTHROTEC-50® ARTHROTEC-75®	(50mg + 200µg) tab (75mg + 200µg) tab	1 tab BID-TID 1 tab OD-BID	200mg/ 800µg	One tab po BID **$47** One tab po BID $61
Pyrolizine Carboxylic Acids					
Ketorolac	TORADOL® ✘	##; 10mg tab; 30mg injectable IM formulation available	10mg po q6h x7d max 10-30mg **IM** q4-6h	40mg 120mg	10mg po QID [##] $67 [##]
Pyranocarboxylic Acids					
Etodolac	ULTRADOL®	~COX-2 selective; 200,300mg cap	200-600mg BID	1.2g	300mg po BID $50
Propionic Acids					
Fenoprofen	NALFON®	300mg cap; 600mg tab	300-600mg TID-QID	3.2g	600mg po TID $63
Flurbiprofen	ANSAID®	50, 100mg tab	50-100mg TID-QID	300mg	100mg po BID $32
Ibuprofen	MOTRIN®	**OTC:** 200mg tab; 100mg/5ml **susp**.; Rx. 300,400,600mg tab	200-800mg TID-QID	3.2g	400mg po QID **$13**
Ketoprofen	ORUDIS®	50,100mg EC; 200mg SR tab 50mg cap; 50,100mg supp	25-100mg TID-QID	300mg	50mg po TID $25
Naproxen [###]	NAPROSYN®	125,250,375,500mg; 750mg SR; 125mg/5ml **susp**; 500mg supp; (EC available non-formulary)	125-500mg BID	1.5g	375mg po BID **$16**
Oxaprozin	DAYPRO® ✘	600mg caplet; long t1/2 (50h)	600-1800mg OD	1.8g	600mg po OD $30
Tiaprofenic Acid	SURGAM®	200,300mg tab	200-300mg BID	600mg	200mg po BID $32
Oxicams - long t1/2 (>50h)					
Piroxicam	FELDENE®	10,20mg cap & supp	10-20mg OD	20mg	20mg po OD $33
Piroxicam-beta-cyclodextrin	BREXIDOL® ✘	20mg tab (may give 40mg x1 initially)	20mg OD x 7d max	20mg	20mg po OD [###] $97 [##]
Tenoxicam	MOBIFLEX® ✘	20mg tab	20-40mg OD	40mg	20mg po OD $51
Naphthylalkanones - long t1/2 (>24h)					
Nabumetone	RELAFEN®	~COX-2 selective; PD; 500mg tab	1-2g OD	2g	1g po OD $43
Anthranilic Acids					
Floctafenine	IDARAC®	200,400mg tab	200-400mg TID-QID	1.2g	200mg po QID $59
Mefenamic Acid	PONSTAN®	250mg cap; (initially 500mg x1)	250mg QID x 7d max	1.5g	250mg po QID [##] $37 [##]
***COX-2 Specific Inhibitors* (CSIs)** - similar efficacy to NSAIDs but less GI upset/ulceration & no effect on platelets; lack long-term/published data					
Celecoxib	CELEBREX®	100,200mg cap	100mg BID (OA) - 200mg BID (RA;**$97**)	400mg	100mg BID 200mg OD **$52**
Rofecoxib	VIOXX®	12.5, 25mg tab; 12.5mg/ml susp; **methotrexate DI** if for acute pain: 50mg X1, then 25-50mg od (X 5d)	12.5-25mg OD (OA)	50mg	12.5mg OD 25mg OD **$52**
Analgesics: Non-Anti-inflammatory - least GI risk; recommended as first-choice option in osteoarthritis; monitor LFTs in chronic use					
Acetaminophen	TYLENOL®	**OTC;** 325,500mg tab; 120, 325,650mg supp; syrup/elixir	325-1000mg TID-QID	4g	650mg po QID not anti-inflammatory **$12**

= **EDS** = **E**xception **D**rug **S**tatus; ✘ Not currently approved for Provincial Formulary coverage in Saskatchewan; **NA** = not yet available; **PD** = Pro-drug; **OTC** = over the counter; **Rx** = by prescription; **OA** = osteoarthritis; **RA** rheumatoid arthritis; **susp** = suspension; **supp** = suppository; **DI** = drug interaction

Approximate retail cost to consumer based on applicable acquisition cost, markup, and dispensing fee. Lowest generic price used where available.
Cost comparison based on **lowest anti-inflammatory dose** (as per Micromedex). Lower doses of NSAIDs often effective for analgesia (except CSIs).

Monthly cost for ketorolac, mefenamic acid, & Brexidol® shown for comparison only; Recommended maximum length of oral treatment is **7 days.**

**Fast-acting formulations** available but non-formulary in SK (Anaprox® 275, 550mg tabs; Voltaren Rapide® 50mg tabs); slightly faster onset, but more expensive.

Non-Medication Alternatives to Care for Pain

TYPICALLY COVERED BY INSURANCE

Physical therapy

Occupational therapy

Mental health treatment

Chiropractic therapy

Nerve stimulation

Injections

Specialist pain care

Surgery

Pain classes

SOMETIMES COVERED BY INSURANCE

Acupuncture

Massage

Reiki

TYPICALLY NOT COVERED BY INSURANCE

Heat and cold therapy (heating pads, ice packs)

Attention to proper sleep

Stretching

Exercise

Weight loss

Relaxation or stress reduction training

Music therapy

Self-care techniques

Counseling and coaching

Meditation

Rehabilitation

Support Group

Source: UConn Health Opioid Task Force. 2019. Chronic Opioid Therapy Toolkit. Farmington, CT.

Patient Handout: Managing Pain After Dental Care

Available for download and customization with your organization's logo at: https://michigan-open.org/patient-community-education/

DENTAL

OVER-THE-COUNTER
MEDICATION SAFETY

- Discuss all medications, minerals, vitamins and supplements with your dentist or pharmacist before you take them.
- Do not take more than the maximum dose allowed, which is listed on the bottle.

ACETAMINOPHEN:
- Do not use if you have liver disease.
- Do not drink alcohol while taking acetaminophen.

IBUPROFEN:
- Prior to taking ibuprofen, discuss with your dentist or pharmacist if you have:
  - A history of stomach ulcers or bleeds
  - A heart condition
- Take ibuprofen with food
- Ask your dentist about celecoxib if you cannot use ibuprofen.

Information in this brochure was developed by Michigan OPEN for the typical patient with your condition. It does not replace medical advice from your health care provider as your experience may differ from the typical patient. Questions about this document, your condition or your treatment should be discussed with your health care provider.

Michigan-OPEN.org

Michigan OPEN is partially funded by the Michigan Department of Health and Human Services

MANAGING PAIN AFTER DENTAL CARE

OPEN
OPIOID PRESCRIBING ENGAGEMENT NETWORK

UCONN
SCHOOL OF DENTAL MEDICINE

DISCUSS
WITH YOUR DENTIST:

- ALL medications you are taking, including:
  - Antidepressants (like Prozac® or Celexa®)
  - Opioids (like Vicodin® or Norco®)
  - Sedatives (like Ambien® or Seroquel®)
  - Benzodiazepines (like Valium, Xanax, or Klonopin®)
  - Other prescription pain medications
  - Illegal Drugs
- If you can use over-the-counter medications, acetaminophen (Tylenol®) ibuprofen (Motrin® or Advil®) to manage your pain.
- What you should do if your pain is not controlled.

UNDERSTANDING
PAIN AFTER A PROCEDURE

THINGS TO KNOW:
- Dental pain is mostly caused by tissue inflammation (swelling) from the procedure or the dental issue.
- This is called acute pain. Acute pain does not last a long time.
- This acute, dental pain is *normal* and is usually worst the first 1-3 days.
- Your pain should be well controlled with a schedule of over-the-counter acetaminophen (Tylenol) and ibuprofen (Motrin or Advil)

If you have severe pain that is not managed by the **regular use** of both acetaminophen and ibuprofen, please call your dentist.

MANAGING PAIN

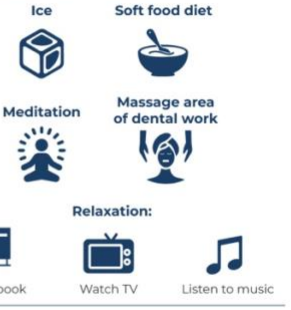
For the First 3 Days
After your procedure, use acetaminophen and ibuprofen **together** at *regular, scheduled* times:

9 AM	Acetaminophen & Ibuprofen	1000 mg *(2 pills of 500 mg)* 600 mg *(3 pills of 200 mg)*
3 PM	Acetaminophen & Ibuprofen	1000 mg *(2 pills of 500 mg)* 600 mg *(3 pills of 200 mg)*
9 PM	Acetaminophen & Ibuprofen	1000 mg *(2 pills of 500 mg)* 600 mg *(3 pills of 200 mg)*

After 3 days
Only take medications if you have pain.

Medication is only **one** part of your pain management plan. Continue using **non-drug options** to help manage pain:

NON-DRUG OPTIONS



Screening Tools

SBIRT Pre-Screening Form

SBIRT guides clinicians to provide brief, early intervention and referrals to treatment for individuals identified as “at-risk” of, or currently suffering from, substance use disorders.

It is recommended that the pre-screening form be administered to all adult patients prior to considering prescribing of opioids for pain. It rules out patients who are at low or no-risk using one pre-screening question for alcohol and one pre-screening question for drugs.

Available for download at: https://www.sbirt.care/pdfs/tools/Pre-Screen-Annual%20Screen.PDF

Annual questionnaire

Once a year, all our patients are asked to complete this form because drug and alcohol use can affect your health as well as medications you may take.
Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

Are you currently in recovery for alcohol or substance use? ☐ Yes ☐ No

Alcohol: One drink = 

12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

Drugs: Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	○	○

Developed by SBIRT Oregon, http://www.sbirtoregon.org/resources/annual_forms/Annual%20-%20English.pdf

Opioid Risk Tool (ORT)

The ORT is a questionnaire developed by Lynn R. Webster, MD to screen patients for risk of opioid misuse. The ORT is designed to help practitioners with clinical decision-making.

Available for download at: https://www.drugabuse.gov/sites/default/files/opioidrisktool.pdf

Online ORT calculator available at: https://www.mdcalc.com/opioid-risk-tool-ort-narcotic-abuse

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk tool. Pain Med. 2005; 6(6): 432.

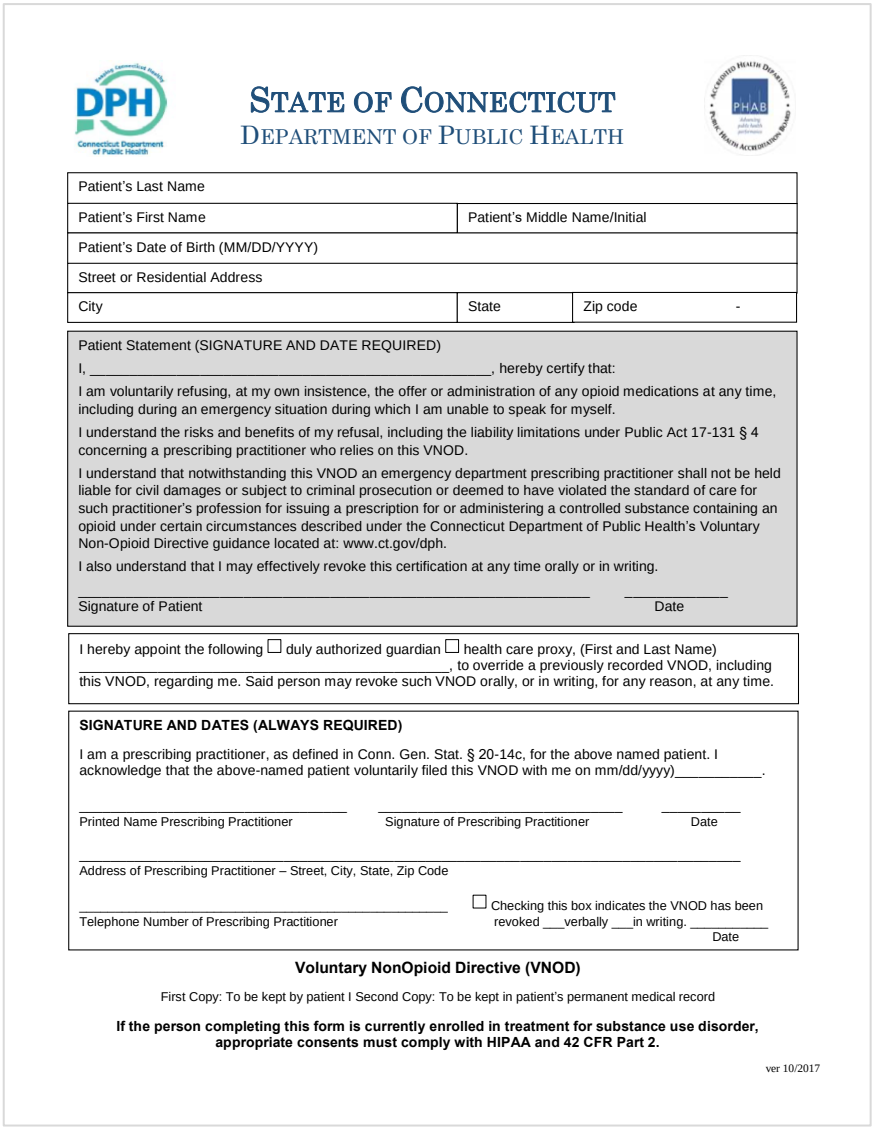
Voluntary NonOpioid Directive (VNOD)

Voluntary NonOpioid Directive Form

A "voluntary nonopioid directive form" (the "Form"), as established under and defined in section 4 of Public Act 17-131, an act Preventing Opioid Diversion and Abuse (the "Act"), available at: https://www.cga.ct.gov/2017/ACT/pa/2017PA-00131-R00HB-07052-PA.htm, enables an individual to voluntarily request that prescribing practitioners not prescribe opioid drugs and not issue a medication order for opioid drugs for such individual. This form is also known as an "opioid opt-out form."

For details about liabilities under the act, see Appendix II

It is recommended that providers make this form available to patients and that an alert is evident a non-opioid directive is chosen. It is recommended that providers include the option of a VNOD in the medical history.



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Patient's Last Name			
Patient's First Name	Patient's Middle Name/Initial		
Patient's Date of Birth (MM/DD/YYYY)			
Street or Residential Address			
City	State	Zip code	-

Patient Statement (SIGNATURE AND DATE REQUIRED)

I, _____, hereby certify that:

I am voluntarily refusing, at my own insistence, the offer or administration of any opioid medications at any time, including during an emergency situation during which I am unable to speak for myself.

I understand the risks and benefits of my refusal, including the liability limitations under Public Act 17-131 § 4 concerning a prescribing practitioner who relies on this VNOD.

I understand that notwithstanding this VNOD an emergency department prescribing practitioner shall not be held liable for civil damages or subject to criminal prosecution or deemed to have violated the standard of care for such practitioner's profession for issuing a prescription for or administering a controlled substance containing an opioid under certain circumstances described under the Connecticut Department of Public Health's Voluntary Non-Opioid Directive guidance located at: www.ct.gov/dph.

I also understand that I may effectively revoke this certification at any time orally or in writing.

_____ _____
Signature of Patient Date

I hereby appoint the following ☐ duly authorized guardian ☐ health care proxy, (First and Last Name) _____, to override a previously recorded VNOD, including this VNOD, regarding me. Said person may revoke such VNOD orally, or in writing, for any reason, at any time.

SIGNATURE AND DATES (ALWAYS REQUIRED)

I am a prescribing practitioner, as defined in Conn. Gen. Stat. § 20-14c, for the above named patient. I acknowledge that the above-named patient voluntarily filed this VNOD with me on mm/dd/yyyy)_____.

_____ _____ _____
Printed Name Prescribing Practitioner Signature of Prescribing Practitioner Date

_____
Address of Prescribing Practitioner – Street, City, State, Zip Code

_____ ☐ Checking this box indicates the VNOD has been revoked ___verbally ___in writing. _____
Telephone Number of Prescribing Practitioner Date

Voluntary NonOpioid Directive (VNOD)

First Copy: To be kept by patient I Second Copy: To be kept in patient's permanent medical record

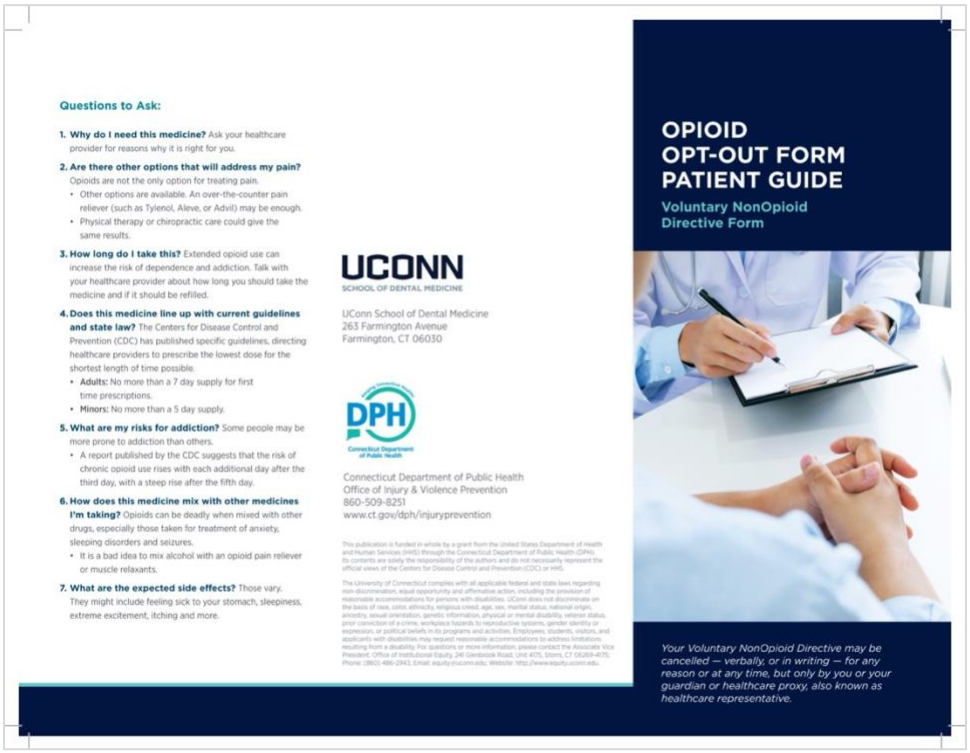
If the person completing this form is currently enrolled in treatment for substance use disorder, appropriate consents must comply with HIPAA and 42 CFR Part 2.

ver 10/2017

Available for download at: https://business.ct.gov/-/media/DPH/CT-VNOD-Form_FINAL.pdf

Patient Guide: Opioid Opt-Out Form

Download and share this printable patient guide to educate patients about opioid analgesics, their option to opt-out of being prescribed opioids, and questions to ask their provider.



Questions to Ask:

1. **Why do I need this medicine?** Ask your healthcare provider for reasons why it is right for you.
2. **Are there other options that will address my pain?** Opioids are not the only option for treating pain.
   - Other options are available. An over-the-counter pain reliever (such as Tylenol, Aleve, or Advil) may be enough.
   - Physical therapy or chiropractic care could give the same results.
3. **How long do I take this?** Extended opioid use can increase the risk of dependence and addiction. Talk with your healthcare provider about how long you should take the medicine and if it should be refilled.
4. **Does this medicine line up with current guidelines and state law?** The Centers for Disease Control and Prevention (CDC) has published specific guidelines, directing healthcare providers to prescribe the lowest dose for the shortest length of time possible.
   - **Adults:** No more than a 7 day supply for first time prescriptions.
   - **Minors:** No more than a 5 day supply.
5. **What are my risks for addiction?** Some people may be more prone to addiction than others.
   - A report published by the CDC suggests that the risk of chronic opioid use rises with each additional day after the third day, with a steep rise after the fifth day.
6. **How does this medicine mix with other medicines I'm taking?** Opioids can be deadly when mixed with other drugs, especially those taken for treatment of anxiety, sleeping disorders and seizures.
   - It is a bad idea to mix alcohol with an opioid pain reliever or muscle relaxants.
7. **What are the expected side effects?** Those vary. They might include feeling sick to your stomach, sleepiness, extreme excitement, itching and more.

UCONN
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DPH
Connecticut Department of Public Health

Connecticut Department of Public Health
Office of Injury & Violence Prevention
860-509-8251
www.ct.gov/dph/injuryprevention

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OPIOID OPT-OUT FORM PATIENT GUIDE

Voluntary NonOpioid Directive Form

Your Voluntary NonOpioid Directive may be cancelled — verbally, or in writing — for any reason or at any time, but only by you or your guardian or healthcare proxy, also known as healthcare representative.

The Opioid Crisis

What are opioids?

Opioids are drugs that act on the nervous system to relieve pain. Opioids are types of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl, and prescription pain relievers, such as codeine, morphine, oxycodone, hydrocodone, and many others.

What are the risks?

When opioids are used continuously, it may lead to physical dependence and withdrawal symptoms. The opioid epidemic has come with many devastating results, such as opioid misuse and overdoses. According to statistics from the National Survey on Drug Use and Health, in 2016, 116 people died every day from opioid-related drug overdoses, 11.5 million people misused prescription opioids, and 42,249 people died that year from overdosing on opioids.

Don't Want to be Prescribed an Opioid Drug? We've got you covered.

- The opioid opt-out form, also known as, Voluntary NonOpioid Directive Form, tells your healthcare provider that you **DO NOT** wish to be issued a prescription or medication order for an opioid drug.
- Complete and file the form provided with your healthcare provider. Upon receipt of this form from you, a healthcare provider shall document receipt of the form in your health record.
- The Connecticut Department of Public Health (DPH) recommends completing the form with your primary care providers or substance use disorder (SUD) treatment providers; however, such consultation is not required for the form to be valid.
- This form will be valid even if you cannot tell them yourself. This could happen if you are: **in a coma, seriously injured, terminally ill, or having severe dementia.**

It is best if you carry a paper or electronic copy of this form with you at all times!

- If you go to an emergency room or are admitted to a hospital, the staff may ask if you have a Voluntary NonOpioid Directive or they may have a form there for you to fill out.
- Your healthcare provider will sign the form to accept when they receive it and will place it in your medical record. Be sure that each of your healthcare providers has a copy of the form. This is very important if you receive health care from an out-of-state provider.
- If you need to assign a health care representative, visit the Office of the Attorney General's web site for more information: **www.portal.ct.gov/AG/Health-Issues/Connecticuts-Living-Will-Laws.**
- If you travel out-of-state, be sure to carry a paper or electronic copy of your Voluntary NonOpioid Directive. Make sure your healthcare representative has a copy which they can share with your healthcare provider if needed.

Talk with your Healthcare Provider

Every patient should ask questions when getting a new medication. This is important when your healthcare provider prescribes you medicine for pain, which may include an opioid, such as: hydrocodone, hydrocodone/acetaminophen, oxycodone, tramadol, hydromorphone, oxymorphone, methadone, or codeine.

What should you ask to find out exactly what you are getting for pain relief?

Your conversation could begin like this:

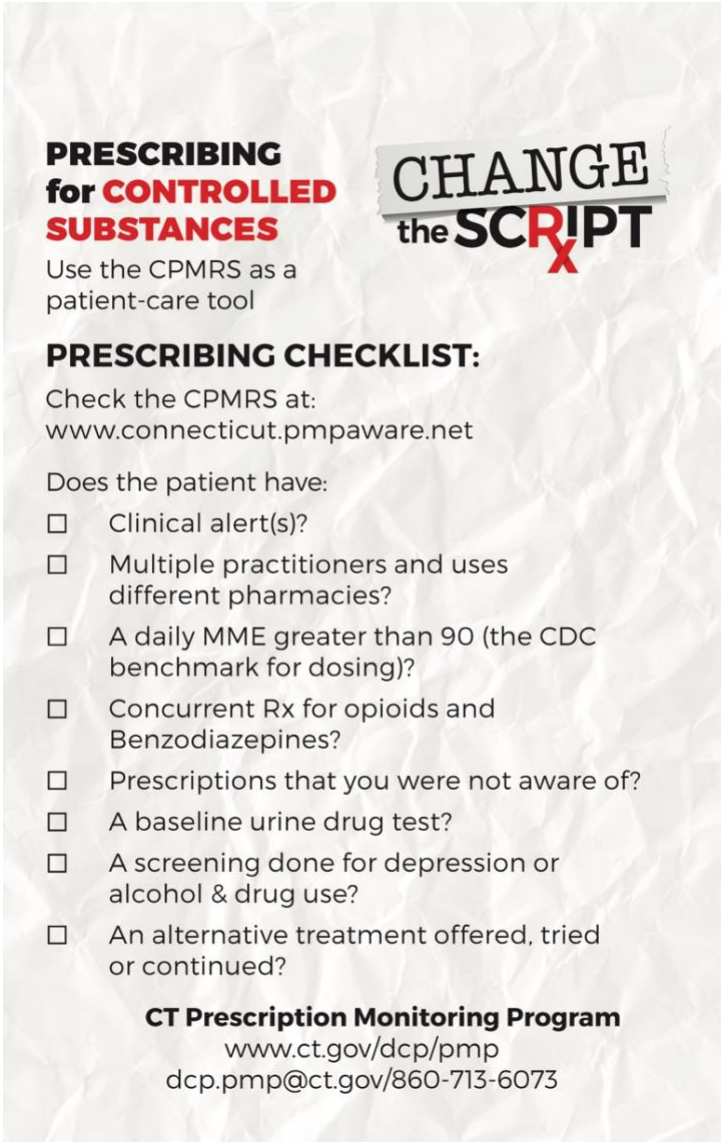
- "My condition is causing pain."
- "How long should I expect the pain to last?"
- "What medication are you giving me?"
- "Is it an opioid?"
- "What are the side effects?"
- "Are there other non-opioid options that can help with pain relief while I recover?"

Available for download at: https://health.uconn.edu/pain-center/resources/materials/

Opioid Prescribing Tools

CPMRS Checklist

Download and use this tool as a guide for pain management decision making when checking the CPMRS.



PRESCRIBING for CONTROLLED SUBSTANCES

CHANGE the SCRIPT

Use the CPMRS as a patient-care tool

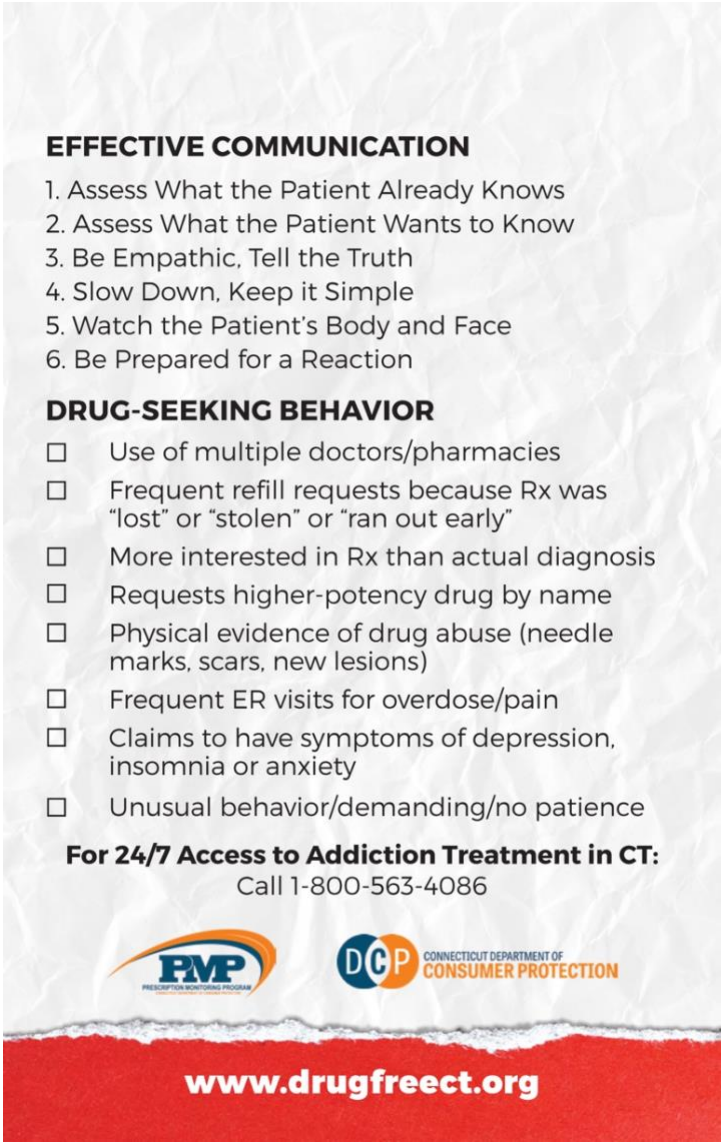
PRESCRIBING CHECKLIST:

Check the CPMRS at:
www.connecticut.pmpaware.net

Does the patient have:

- ☐ Clinical alert(s)?
- ☐ Multiple practitioners and uses different pharmacies?
- ☐ A daily MME greater than 90 (the CDC benchmark for dosing)?
- ☐ Concurrent Rx for opioids and Benzodiazepines?
- ☐ Prescriptions that you were not aware of?
- ☐ A baseline urine drug test?
- ☐ A screening done for depression or alcohol & drug use?
- ☐ An alternative treatment offered, tried or continued?

CT Prescription Monitoring Program
www.ct.gov/dcp/pmp
dcp.pmp@ct.gov/860-713-6073



EFFECTIVE COMMUNICATION

1. Assess What the Patient Already Knows
2. Assess What the Patient Wants to Know
3. Be Empathic, Tell the Truth
4. Slow Down, Keep it Simple
5. Watch the Patient's Body and Face
6. Be Prepared for a Reaction

DRUG-SEEKING BEHAVIOR

- ☐ Use of multiple doctors/pharmacies
- ☐ Frequent refill requests because Rx was "lost" or "stolen" or "ran out early"
- ☐ More interested in Rx than actual diagnosis
- ☐ Requests higher-potency drug by name
- ☐ Physical evidence of drug abuse (needle marks, scars, new lesions)
- ☐ Frequent ER visits for overdose/pain
- ☐ Claims to have symptoms of depression, insomnia or anxiety
- ☐ Unusual behavior/demanding/no patience

For 24/7 Access to Addiction Treatment in CT:
Call 1-800-563-4086

PMP PRESCRIPTION MONITORING PROGRAM

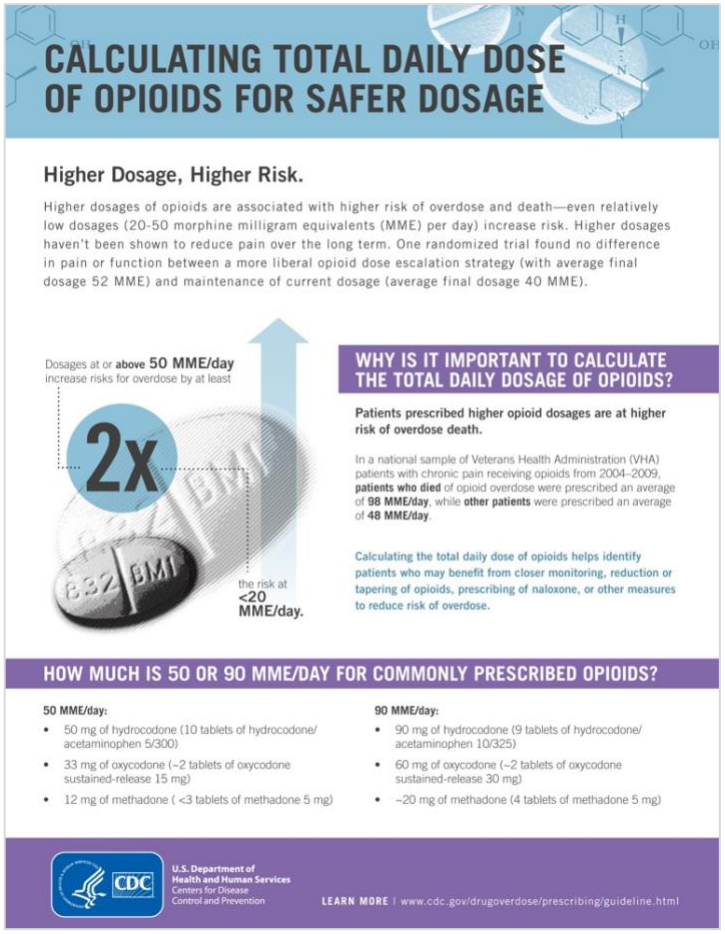
DCP CONNECTICUT DEPARTMENT OF CONSUMER PROTECTION

www.drugfreect.org

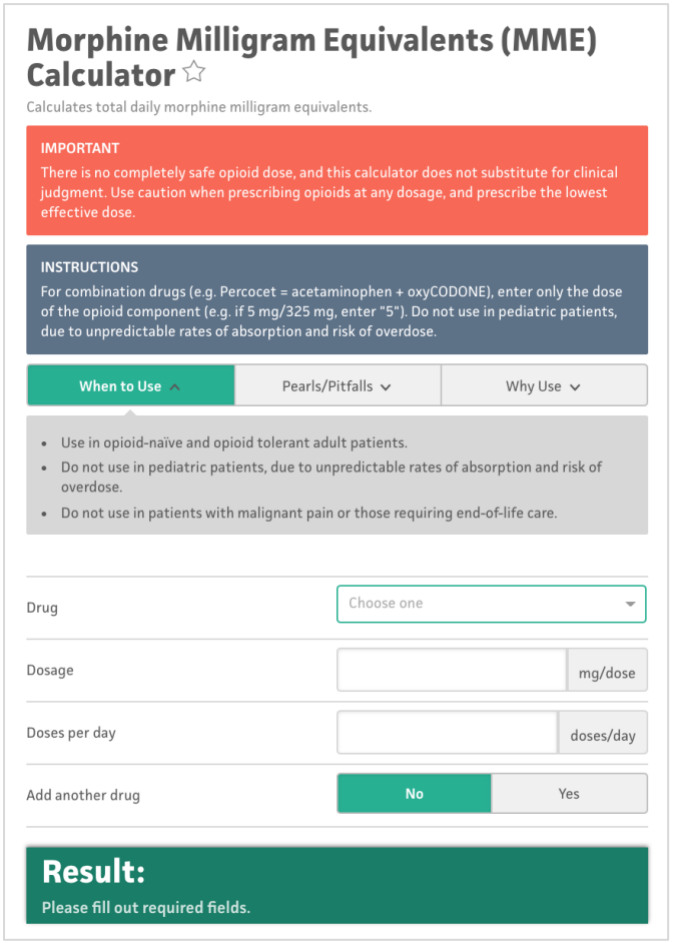
Available for download at: ***https://portal.ct.gov/-/media/DCP/drug_control/PMP/CHANGE-the-SCRxIPT/prescriber-card_nocrop.pdf***

Morphine Milligram Equivalent (MME)

Use this tool to calculate the daily morphine milligram equivalent dose when considering prescribing an opioid to opioid-naïve and opioid tolerant adult patients.



Tip sheet available for download at: ***https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf***

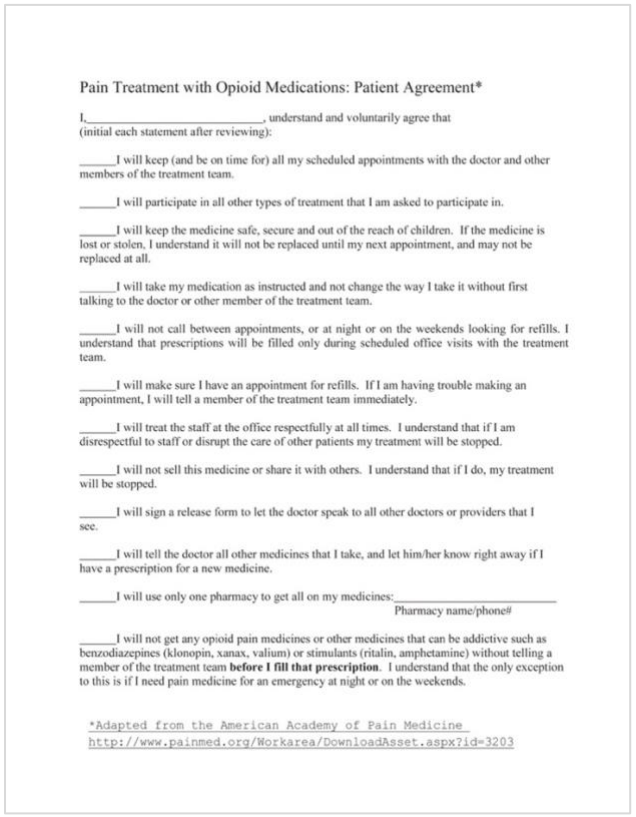


Online MME calculator available at: ***https://www.mdcalc.com/morphine-milligram-equivalents-mme-calculator#use-cases***

Pain Medication Agreement (PMA)

Pain Medication Agreements (PMA) are used by medical practitioners for patients beginning long-term treatment with opioid analgesics or other controlled substances. PMAs contain statements to help ensure patients understand their role and responsibilities regarding their treatment e.g. how to obtain refills, conditions of medication use, the conditions under which their treatment may be terminated, and the responsibilities of the health care provider. PMAs aim to facilitate communication between patients and healthcare providers and to resolve any questions or concerns before initiation of long-term treatment with a controlled substance.

We recommend that dental providers ask patients about PMAs in the medical history and that an alert is made evident to providers when a PMA is present.



Pain Treatment with Opioid Medications: Patient Agreement*

I,_____, understand and voluntarily agree that (initial each statement after reviewing):

_____I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.

_____I will participate in all other types of treatment that I am asked to participate in.

_____I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

_____I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

_____I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.

_____I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

_____I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

_____I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

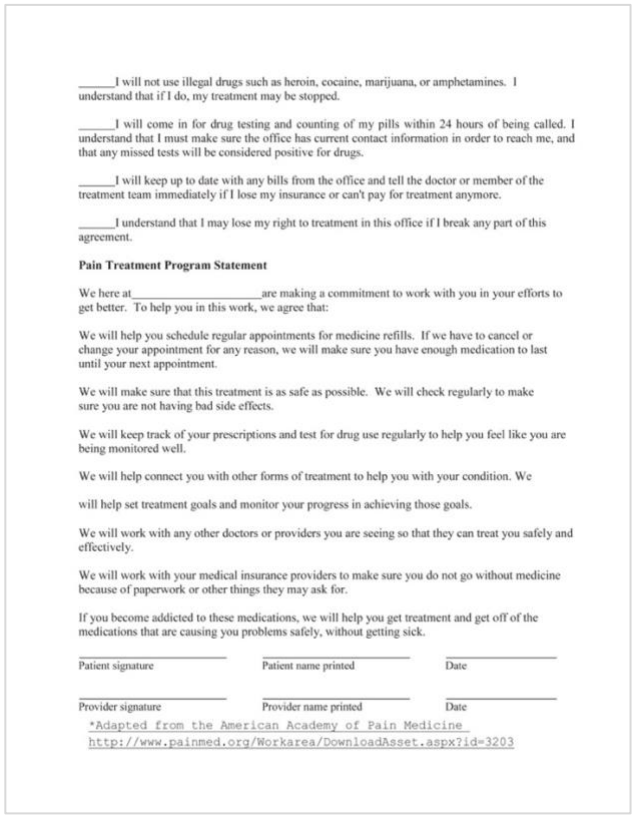
_____I will sign a release form to let the doctor speak to all other doctors or providers that I see.

_____I will tell the doctor all other medicines that I take, and let him/her know right away if I have a prescription for a new medicine.

_____I will use only one pharmacy to get all on my medicines:_____
Pharmacy name/phone#

_____I will not get any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (klonopin, xanax, valium) or stimulants (ritalin, amphetamine) without telling a member of the treatment team **before I fill that prescription**. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

*Adapted from the American Academy of Pain Medicine
http://www.painmed.org/Workarea/DownloadAsset.aspx?id=3203



_____I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.

_____I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs.

_____I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore.

_____I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Pain Treatment Program Statement

We here at_____are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

We will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.

We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects.

We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well.

We will help connect you with other forms of treatment to help you with your condition. We

will help set treatment goals and monitor your progress in achieving those goals.

We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.

We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.

If you become addicted to these medications, we will help you get treatment and get off of the medications that are causing you problems safely, without getting sick.

Patient signature | Patient name printed | Date

Provider signature | Provider name printed | Date

*Adapted from the American Academy of Pain Medicine
http://www.painmed.org/Workarea/DownloadAsset.aspx?id=3203

Sample Pain Medication Agreements available for download at: https://www.mndental.org/files/Sample-Patient-Agreement-Forms.pdf

Patient Handout: Medications to Avoid While on Opioids

This handout can be shared with patients with post-op instructions to encourage further discussion with the dispensing pharmacy.

Please note this list is not comprehensive and any medication changes should be discussed with your doctor or pharmacist prior to taking with your opioid.

Medications to Avoid While on Opioids

- Any medication or substance that makes you feel tired or sedated
- Alcohol

Opioids

Generic	Brand
Buprenorphine	Belbuca, Buprenex, Butrans, Probuphine Implant, Subutex
Butalbital (often combined with acetaminophen or aspirin)	Fioricet, Fiorinal
Butorphanol	Stadol
Codeine	Tylenol #3
Fentanyl	Actiq, Duragesic, Fentora, Lazanda, Sublimaze, Subsys
Hydrocodone	Hydromet, Hysingla, Lortab, Norco, Tussigon, Vicodin, Vicoprofen, Zohydro
Hydromorphone	Dilaudid, Exalgo
Levorphanol	Levo-Dromoran
Meperidine	Demerol
Methadone	Dolophine, Methadose
Morphine	Avinza, Duramorph, Embeda, Kadian, MS Contin, MS-IR,
Nalbuphine	Nubain, Raltrox
Oxycodone	Roxicodone, Endocet, Oxaydo, Oxycontin, Oxy-IR, Percodan, Percocet, Roxicet, Xtampza
Oxymorphone	Opana
Pentazocine	Talwin
Tapentadol	Nucynta
Tramadol	Conzip, Ultram, Ultracet

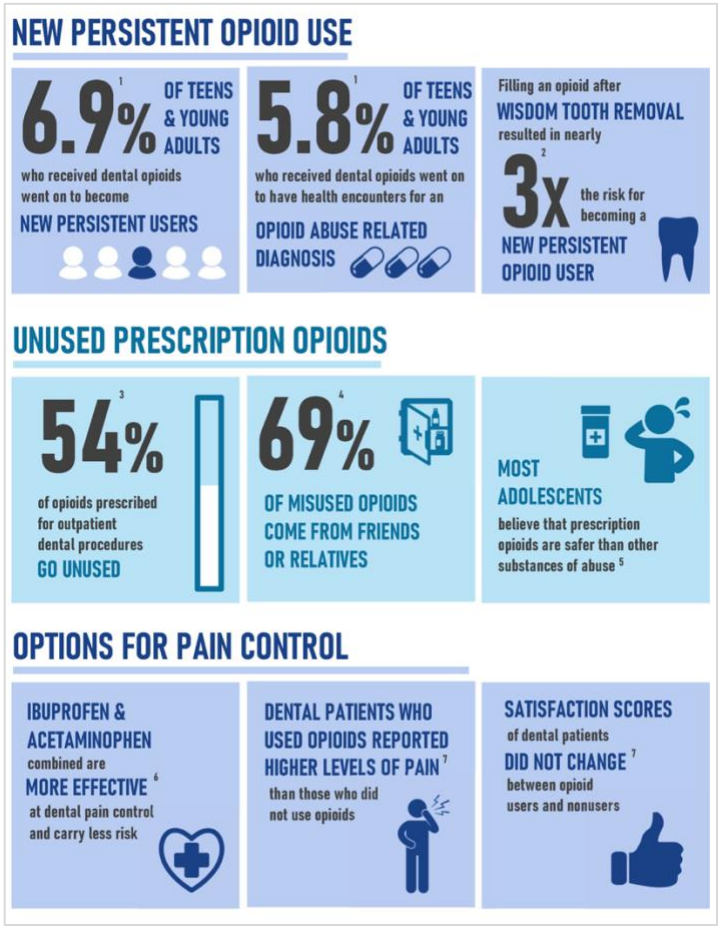
Non-Opioids

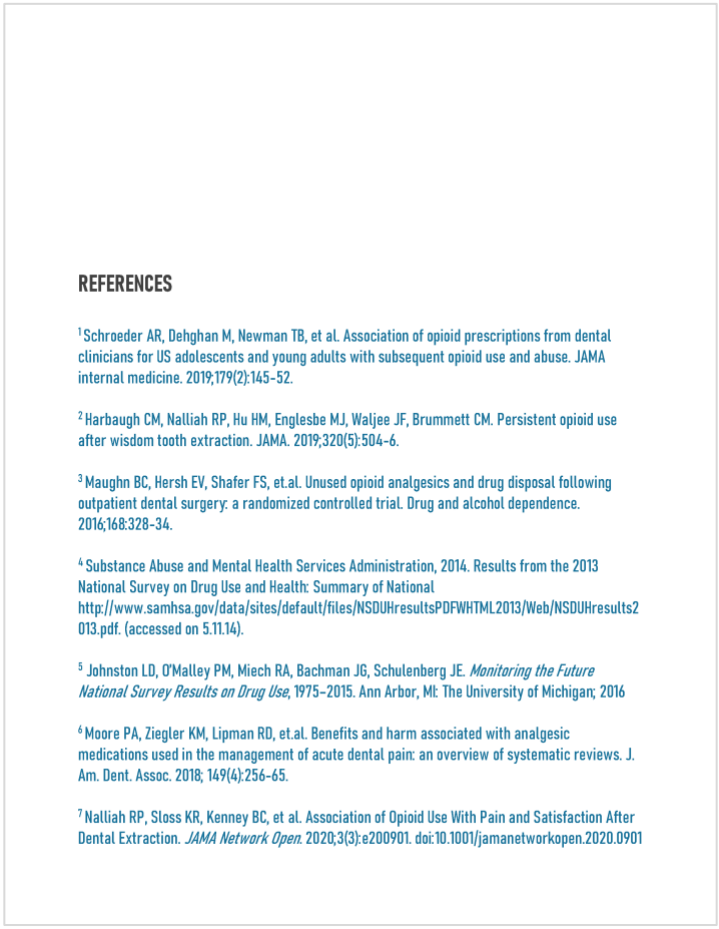
Generic	Brand
Alprazolam	Xanax
Baclofen	Gablofen, Lioresal
Carisoprodol	Soma
Chlorodiazepoxide	Librium
Clonazepam	Klonopin
Cyclobenzaprine	Flexeril
Dantrolene	Dantrium
Diazepam	Valium
Dronabinol	Marinol, Syndros
Estazolam	ProSom
Eszopiclone	Lunesta
Gabapentin	Gralise, Horizant, Neurontin
Lorazepam	Ativan
Metaxalone	Metaxall, Skelaxin
Methocarbamol	Robaxin
Orphenadrine	Norflex
Oxazepam	Serax
Pentobarbital	Nembutal
Phenobarbital	Luminal, Phenobarb
Pregabalin	Lyrica
Temazepam	Restoril
Tetrahydrocannabinol	Medical Marijuana
Tizanidine	Zanaflex
Triazolam	Halcion
Zaleplon	Sonata
Zolpidem	Ambien

Relevant Literature for Dental Providers

New Persistent Opioid Use – Dental One Page Infographic

This infographic provides a quick overview of current evidence relevant to dental providers on new persistent opioid use, unused prescription opioids and alternative options for pain control.





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[2] Harbaugh CM, Nalliah RP, Hu HM, Englesbe MJ, Waljee JF, Brummett CM. Persistent opioid use after wisdom tooth extraction. JAMA. 2019;320(5):504-6.

[3] Maughn BC, Hersh EV, Shafer FS, et.al. Unused opioid analgesics and drug disposal following outpatient dental surgery: a randomized controlled trial. Drug and alcohol dependence. 2016;168:328-34.

[4] Substance Abuse and Mental Health Services Administration, 2014. Results from the 2013 National Survey on Drug Use and Health: Summary of National http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf. (accessed on 5.11.14).

[5] Johnston LD, O'Malley PM, Miech RA, Bachman JG, Schulenberg JE. *Monitoring the Future National Survey Results on Drug Use*, 1975–2015. Ann Arbor, MI: The University of Michigan; 2016

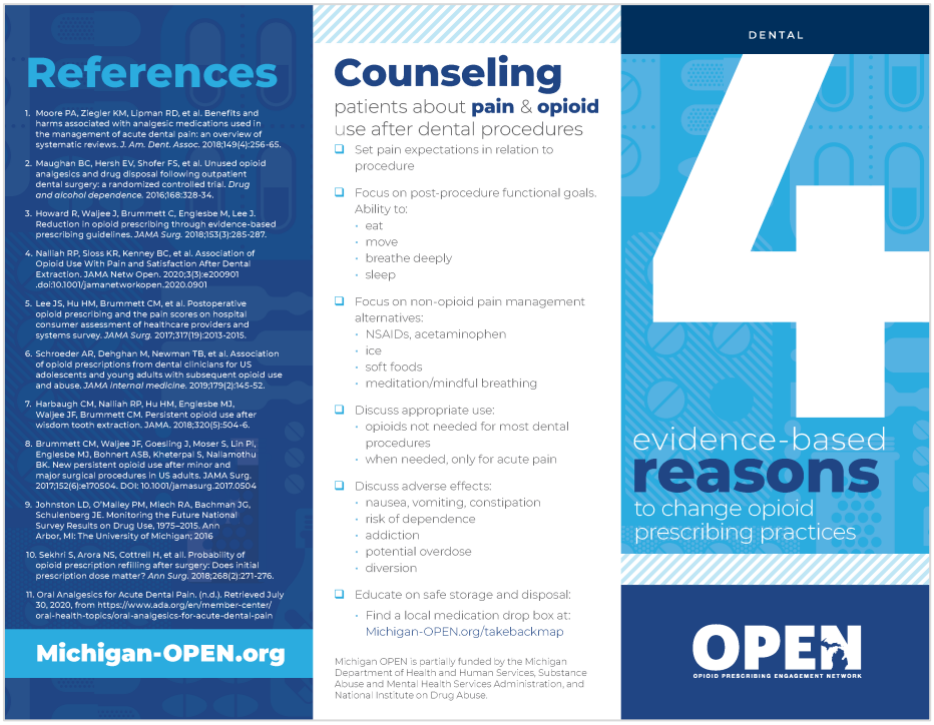
[6] Moore PA, Ziegler KM, Lipman RD, et.al. Benefits and harm associated with analgesic medications used in the management of acute dental pain: an overview of systematic reviews. J. Am. Dent. Assoc. 2018; 149(4):256-65.

[7] Nalliah RP, Sloss KR, Kenney BC, et al. Association of Opioid Use With Pain and Satisfaction After Dental Extraction. *JAMA Network Open.* 2020;3(3):e200901. doi:10.1001/jamanetworkopen.2020.0901

Available for download at: https://michigan-open.org/wp-content/uploads/2020/06/Dental-one_pager.pdf

4 Reasons Why (Dental)

This provider reference, created for health care professionals, uses recently published data to compel prescribers to optimize their opioid prescribing practice.



References

1. Moore PA, Ziegler KM, Lipman RD, et al. Benefits and harms associated with analgesic medications used in the management of acute dental pain: an overview of systematic reviews. *J. Am. Dent. Assoc.* 2018;149(4):256-65.
2. Maughan BC, Hersh EV, Shofer FS, et al. Unused opioid analgesics and drug disposal following outpatient dental surgery: a randomized controlled trial. *Drug and alcohol dependence.* 2016;168:328-34.
3. Howard R, Waljee J, Brummett C, Englesbe M, Lee J. Reduction in opioid prescribing through evidence-based prescribing guidelines. *JAMA Surg.* 2018;153(3):285-287.
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6. Schroeder AR, Dehghan M, Newman TB, et al. Association of opioid prescriptions from dental clinicians for US adolescents and young adults with subsequent opioid use and abuse. *JAMA internal medicine.* 2019;179(2):145-52.
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10. Sekhri S, Arora NS, Cottrell H, et all. Probability of opioid prescription refilling after surgery: Does initial prescription dose matter? *Ann Surg.* 2018;268(2):271-276.
11. Oral Analgesics for Acute Dental Pain. (n.d.). Retrieved July 30, 2020, from https://www.ada.org/en/member-center/oral-health-topics/oral-analgesics-for-acute-dental-pain

Michigan-OPEN.org

Counseling

patients about **pain** & **opioid** use after dental procedures

- Set pain expectations in relation to procedure
- Focus on post-procedure functional goals. Ability to:
  - eat
  - move
  - breathe deeply
  - sleep
- Focus on non-opioid pain management alternatives:
  - NSAIDs, acetaminophen
  - ice
  - soft foods
  - meditation/mindful breathing
- Discuss appropriate use:
  - opioids not needed for most dental procedures
  - when needed, only for acute pain
- Discuss adverse effects:
  - nausea, vomiting, constipation
  - risk of dependence
  - addiction
  - potential overdose
  - diversion
- Educate on safe storage and disposal:
  - Find a local medication drop box at: Michigan-OPEN.org/takebackmap

Michigan OPEN is partially funded by the Michigan Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, and National Institute on Drug Abuse.

DENTAL

4

evidence-based **reasons** to change opioid prescribing practices

OPEN
OPIOID PRESCRIBING ENGAGEMENT NETWORK

The **Evidence** shows

6.9%

of adolescents & young adults receiving dental opioids become new persistent opioid users. [7]

(often their first exposure to opioids)

In comparison to opioids, over-the-counter **NSAIDS** and **acetaminophen** proved **as effective** at acute dental pain management with **less risk.** [1]

(ADA: use NSAIDS as the first line therapy)

In outpatient dental surgery,

54% of prescribed opioids go unused. [2]

NO correlation between probability of refill or patient satisfaction scores and amount of opioids prescribed

Becoming a new chronic opioid user is one of the most common surgical complications.

- In adolescents and young adults who received dental opioids, 6.9% went on to become new persistent opioid users and 5.8% had an opioid abuse or overdose related encounter. [6]
- Filling an opioid after wisdom tooth removal resulted in more than three times the risk of becoming a new persistent opioid user. [7]
- Many patients continue to use their opioids for reasons other than surgical pain. [8]
- New persistent opioid use after surgery is an underappreciated surgical complication that warrants increased attention. [8]
- Most adolescents believe that prescription opioids are safer than other substances of abuse. [9]

Acetaminophen and ibuprofen are as effective as opioids in managing pain.

- A combination of ibuprofen and acetaminophen is more effective at dental pain control than combinations with opioid medications and this combination carries less risk of adverse events. [1]
- In outpatient dental surgery, 54% of prescribed opioids go unused. [2]
- Patients who were prescribed fewer opioids reported *using* fewer opioids with no change in pain scores. [3]

Opioids do not improve patient satisfaction.

- Patients who used opioids for pain management after tooth extractions reported significantly higher levels of pain as compared to non-users. [4]
- Dental patients' satisfaction scores did not change between pain management opioid users and nonusers. [4]
- No correlation was found between HCAHPS pain measures and postoperative opioid prescribing. [5]
- Prescribers can feel empowered to reduce their initial opioid prescription without impacting patient satisfaction. [5]
- Prescribers could prescribe smaller opioid prescriptions without influencing the probability of a refill request. [10]
- Implementation of evidence-based prescribing guidelines reduced post-laparoscopic cholecystectomy opioid prescribing by 63% without increasing the need for medication refills. [3]

These prescribing recommendations, developed by Michigan OPEN for patients with no preoperative opioid use, were informed by patient-reported data from our Collaborative Quality Initiative (CQI) partners, dental quality improvement projects, published studies and expert opinion.

point camera here

Download in either PDF or Excel, sign up for notifications of updated recommendations and additional procedures.

*No opioid use in the year prior to surgery

Available for download at: *https://michigan-open.org/wp-content/uploads/2020/09/FINAL-4-Reasons_Dental-09.08.2020.pdf*

Community Referrals and Resources for Substance Use Disorder

The table below includes information for persons seeking treatment facilities and resources in Connecticut for substance use disorders.

Table 1. Community Referrals and Resources for Substance Use Disorder in Connecticut

Organization	Title
ABH	Behavioral Health Recovery Program
CT BHP	Connecticut Behavioral Health Partnership
CT DCF	CT DCF Substance Use Services
CT DCF	CT Connection Brochure (Resources for Teens)
DMHAS	DMHAS Programs and Services – How to Find Services in Your Area
DMHAS	Substance Use Disorder Treatment Resource Guide
SAMHSA	Behavioral Health Treatment Service Locator
United Way	2-11 of Connecticut
Advanced Behavioral Health, Inc. CT BHP: Connecticut Behavioral Health Partnership CT DCF: Connecticut Department of Children and Families DMHAS: Department of Mental Health and Addiction Services SAMHSA: Substance Abuse and Mental Health Services Administration	

Board Certified Specialists of Orofacial Pain and TMD in Connecticut

The American Board of Orofacial Pain maintains an Orofacial Pain Diplomate Directory that lists board certified diplomates across the country that have trained and specialized in Orofacial Pain. As of August 2021, there are 270 credentialed Orofacial Pain diplomates in the United States; 3 of which practice in Connecticut and are listed alphabetically in the table below.

Table 2. Board Certified Specialists of Orofacial Pain and TMD in Connecticut

Diplomat Name	Address	Contact	University / Hospital Affiliation
Brijesh P. Chandwani	493 Westport Ave, Westport, CT 06851	203-842-8658	St. Barnabas Hospital, Bronx NYU Winthrop Tufts University
Seema Kurup	University of Connecticut Health Center, School of Dental Medicine 263 Farmington Ave Farmington, CT 06030	860-679-2852 kurup@uchc.edu	University of Connecticut Health Center
Bruce R. Sofferman	100 Bridgeport Ave Shelton, CT 06484	203-712-7727	

Orofacial Pain Consult Request Template

This Oral and Facial Pain Consult Request Form was developed to support dental practitioners with an asynchronous e-consult service by UConn Dental Faculty. The intention of this service is to provide support to clinicians treating cases that have not responded following use of established guidelines.

UCONN
SCHOOL OF DENTAL MEDICINE

Oral and Facial Pain Consult Request
[Provider to Provider]

Please send completed form via secure email to oralpainconsult@uchc.edu

Date:

Requesting Provider Name: **Patient Name:**

Organization/Practice: **Patient DOB:**

Provider Phone #:

Provider Secure Email:

1. Provide the primary reason/clinical question for the consult:

2. What are your expected outcome(s) following the completion of the consult? [check all that apply]

- Devising a differential/definitive diagnosis
- Recommendations for management/treatment
  - Recommendations for pharmacological modalities
  - Recommendations for non-pharmacological modalities
  - Recommendations for co-management with other health care professionals
- Other (specify)

3. Background patient information necessary for the consult. Please include the following attachments with the consult request:

- Labs and imaging pertaining to the consult
- Current and past medication list
- Current and past treatments
- Relevant medical history

This form is for provider to provider communication and is not to be provided to the patient.
This pilot consult service will be available through 8/31/21

CT State Legislation Related to Opioid Prescribing

Table 3. CT State Legislation Related to Opioid Prescribing

CT Public Act 19-191: An Act Addressing Opioid Abuse ♦ Person's prescribed opioids for pain for 12 weeks or more must have documentation in their medical record by their provider in the form of an agreement or plan that includes risks, the need for urine drug screening, what would cause the prescription to be discontinued, and options for treating pain other than opioids.	2019
CT Public Act 17-131: An Act Preventing Opioid Diversion and Abuse ♦ Limits opioid prescribing for minors to a 5 day supply of medications. ♦ Requires education for adult or minor patients that are prescribed an opioid drug regarding the risks associated with such opioid drug including but not limited to the risks of addiction and overdose associated with opioid drugs and the danger of taking opioid drugs with alcohol, benzodiazepines and other central nervous system depressants, and the reason the prescription is necessary, and if applicable with the custodial parent, guardian or other person having legal custody of the minor if such parent, guardian or other person is present at the time of issuance of the prescription. ♦ Requires electronic prescribing of controlled substances.	2017
CT Public Act 16-43: An Act Concerning Opioids and Access to Overdose Reversal Drugs ♦ This law set a 7-day limit on opioid prescribing, but left room for exceptions which must be documented in the patient's medical record by the prescriber. ♦ Practitioner's authorized agent, licensed or unlicensed, may register for their own CPMRS user account. ♦ Whenever a prescribing practitioner prescribes greater than a 72-hour supply of any *Schedule V* controlled substance for the treatment of any patient, such prescriber, or such prescriber's authorized agent, shall review, not less than annually, the patient's records in the CPMRS.	2016
CT Public Act 15-198: An Act Concerning Substance Abuse and Opioid Overdose Prevention ♦ This legislation requires prescribers to check the CT Prescription Monitoring and Reporting System (CPMRS) if they want to prescribe more than a 72-hour supply of any controlled substance (including opioids).	2015
CT Public Act 13-172: An Act Concerning the Electronic Prescription Drug Monitoring Program ♦ All prescribers in possession of a Connecticut Controlled Substance Registration issued by the State of Connecticut, Department of Consumer Protection, will be required to register as a user with the Connecticut Prescription Monitoring and Reporting System (CPMRS) at https://connecticut.pmpaware.net. ♦ Any prescribers who dispense controlled substances from their practice or facility, etc., will be required to upload dispensing information into the CPMRS Data Collection website at https://pmpclearinghouse.net.	2013

Opioid Related Guidelines and Recommendations Relevant to Dentists

Table 4. Opioid Related Guidelines and Recommendations Relevant to Dentists

Organization	Title	Year
Commonwealth of Pennsylvania	Prescribing Guidelines for Pennsylvania: Opioids in the Dental Practice	2019
American Dental Association	ADA Policy on Opioid Prescribing	2018
CORE (Center for Opioid Research and Education) at Johns Hopkins University	Dental Opioid Guidelines	2018
Bree Collaborative/Washington State Agency Medical Directors' Group	Dental Guidelines on Prescribing Opioids for Acute Pain Management	2017
New Jersey Dental Association	Resources for Safe Prescribing of Opioids and Non-Opiate Alternatives	2017
American Dental Association	ADA Statement on the Use of Opioids in the Treatment of Dental Pain	2016
Centers for Disease Control and Prevention	CDC Guidelines for Prescribing Opioids for Chronic Pain – United States, 2016	2016
Compendium of Education in Dentistry	Prescribing Recommendations for the Treatment of Acute Pain in Dentistry	2011

Appendices

Appendix I: Voluntary NonOpioid Directive Fact Sheet

Appendix II: Opioid Onset of Action

Appendix III: Morphine Milligram Equivalent (MME) Conversion Factors

Appendix IV: CPMRS Registration Policy and Procedures Manual

Appendix V: Ohio State Board of Pharmacy. Media Release: Dentist Enters Plea for Misuse of Ohio Prescription Monitoring System; October 8, 2013.

Appendix I: Voluntary NonOpioid Directive Fact Sheet

Voluntary NonOpioid Directive

Office of Injury Prevention • July 2018

Use of the Form under the Act

A "voluntary nonopioid directive form" (the "Form"), as established under and defined in section 4 of Public Act 17-131, an act Preventing Opioid Diversion and Abuse (the "Act"), available at: https://www.cga.ct.gov/2017/ACT/pa/2017PA-00131-R00HB-07052-PA.htm, enables an individual to voluntarily request that prescribing practitioners not prescribe opioid drugs and not issue a medication order for opioid drugs for such individual. This form is also known as an "opioid opt-out form."

A person who does not wish to be issued a prescription or medication order for an opioid drug may file this Form with a prescribing practitioner. Upon receipt of the Form from the patient, a prescribing practitioner shall document receipt of the Form in the patient's medical record. The patient and the patient's duly authorized guardian or health care proxy or representative may revoke the directive contained in said Form, orally or in writing, for any reason, at any time.

CT DPH encourages patients to complete the Form in consultation with their primary care providers or substance use disorder (SUD) treatment providers; however, such consultation is not required for the Form to be valid.

Liability under the Act

Pharmacists: An electronically transmitted prescription to a pharmacy shall be presumed to be valid. A pharmacist shall not be held in violation of the Act for dispensing a controlled substance in contradiction to a person's Form.

Prescribing Practitioners: A prescribing practitioner who willfully fails to comply with a patient's voluntary nonopioid directive form may be subject to disciplinary action pursuant to section 19a-17 of the general statutes. No prescribing practitioner acting with reasonable care shall be liable for damages in a civil action, subject to criminal prosecution or deemed to have violated the standard of care for such prescribing practitioner's profession for refusing to issue a prescription or medication order for an opioid pursuant to a person's Form.

Emergencies: No emergency department prescribing practitioner acting with reasonable care as the patient's practitioner or as the medical control officer for emergency medical services personnel, shall be liable for damages in a civil action, subject to criminal prosecution or deemed to have violated the standard of care for a prescribing practitioner's profession for issuing a prescription for or administering a controlled substance containing an opioid to a person who has a voluntary nonopioid directive form, when, in such prescribing practitioner's professional medical judgment, a controlled substance containing an opioid is necessary and such prescribing practitioner had no knowledge of the patient's voluntary nonopioid directive form at the time of issuance or administration.

Guardian or Health Care Proxy or Representative: No person acting in good faith as a patient's duly authorized guardian or health care proxy or representative shall be liable for damages in a civil action or subject to criminal prosecution for revoking or overriding a voluntary nonopioid directive form.

Resources

- CDC Guideline Information for Prescribers: http://www.cdc.gov/drugoverdose/prescribing/providers.html
- CDC Guideline for Prescribing Opioids for Chronic Pain: https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

Connecticut Department of Public Health
410 Capitol Avenue, Hartford, CT 06134
Office of Injury Prevention • 860-509-8251 • www.ct.gov/dph/injuryprevention

Available for download at: https://business.ct.gov/-/media/DPH/fact_sheet_VNOD-guidance-72018.pdf

Appendix II: Opioid Onset of Action

Opioid (oral)	Onset of Action (minutes)	Duration of Action (hours)	Peak Effect (hours)
Codeine	30-60	4-6	0.5-1
Hydrocodone	15-60	4-6	0.5-1
Hydromorphone	15-30	4-6	1.5-2
Methadone	30-60	6-8	1-2
Morphine (IR)	30-60	3-6	1
Oxycodone (IR)	10-45	4-6	1-2
Oxymorphone	5-15	3-6	0.5-1
Tramadol (IR)	60	3-6	2-3

Appendix III: Morphine Milligram Equivalent (MME) Conversion Factors

Calculating morphine milligram equivalents (MME)

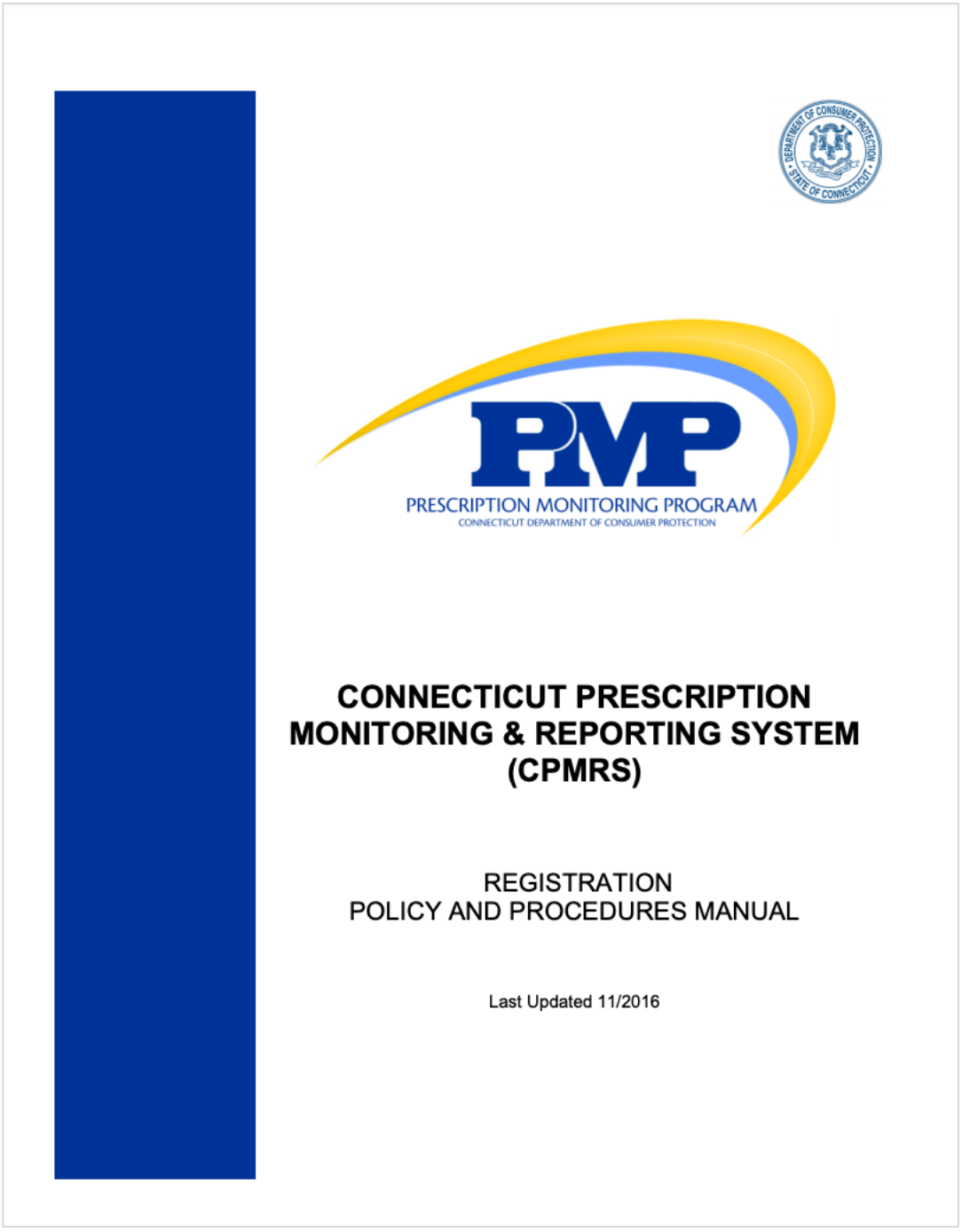
OPIOID (doses in mg/day except where noted)	**CONVERSION FACTOR**
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.

Source: https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

Appendix IV: CPMRS Registration Policy and Procedures Manual

For CT providers, read the following:



Source: https://portal.ct.gov/-/media/DCP/drug_control/PMP/pdf/CPMRSRegPolicyandProceduresManual112016pdf.pdf?la=en

Appendix V: Ohio State Board of Pharmacy. Media Release: Dentist Enters Plea for Misuse of Ohio Prescription Monitoring System; October 8, 2013.

Practitioners can only search PMP databases for active patients of record: searching the databases for individuals who are not active patients constitutes a breach of privacy with results in serious legal consequences that potentially jeopardize, among other things, professional licensure.

OHIO STATE BOARD OF PHARMACY
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Media Release

Dentist Enters Plea for Misuse of Ohio Prescription Monitoring System

Solon, Ohio (Cuyahoga County) - On October 7, 2013, Ohio State Board of Pharmacy Executive Director Kyle Parker, announced that Dr. Fred S. Glick, 55, has entered into a plea agreement with the Cuyahoga County Prosecutor's Office for his misuse of the Ohio Automated Rx Reporting System (O.A.R.R.S.).

The Ohio State Board of Pharmacy initiated an investigation in January 2013, after receiving a complaint that Dr. Glick allegedly ran an O.A.R.R.S. report inappropriately. As a result of the investigation, it was discovered that Dr. Glick accessed the O.A.R.R.S. database twenty one times and illegally obtained prescription data from the time period of February 2012 through December 2012. At the time he accessed the database, the person was not a patient of Dr. Glick. Therefore, he had no legal authority or reason to access the information.

A Cuyahoga County Grand Jury indicted Dr. Glick on April 16, 2013, on twenty-one felony counts of the misuse of the O.A.R.R.S. database. Prior to Dr. Glick's trial scheduled on October 7, 2013, he entered a plea of guilty to only one felony count, and was subsequently sentenced to six months probation and ordered to pay a $2,500.00 fine.

"This is a great accomplishment, as this is the first conviction in Ohio for the improper use of O.A.R.R.S," said Ohio State Board of Pharmacy Spokesman, Jesse Wimberly.

The Ohio State Board of Pharmacy is the governing agency of the Ohio Automated Rx Reporting System, which is a prescription monitoring program established in 2006 as a tool to assist healthcare professionals and law enforcement agencies to quickly identify drug seeking behaviors and patterns of improper prescribing by physicians. Misuse of the O.A.R.R.S. data is a criminal offense under Ohio Revised Code 4729.86.

The Ohio State Board would like to thank Cuyahoga County Prosecutor Timothy McGinty, and Cuyahoga County Assistant Prosecutors Denise Salerno and Nicholas Reif, for their support with this investigation.