Appendix B – Scripting Support for Saying No to a Patient and an Opioid Prescription

Sit down.
Putting yourself on the same level with the patient creates a different experience for him or her. Instead of an authority figure, you are now a little closer to him or her, to his or her experience, and to being a genuine and caring friend sitting at the bedside.

Get the story from the patient.
If you haven't listened to the pain story, you need to do so with empathy. Jot notes. Ask questions. Summarize to make sure that you've heard; this can also be used to move a patient through his or her story if it is extensive.

"After examining you and thinking through everything we've talked about, I don't feel that I could safely recommend a narcotic for your pain. I'd like to talk about the alternatives that could help and would like to review them with you."

If the patient is hostile and demands pain meds, draw on the emotional words that the patient uses to demonstrate that you're listening: "The pain is killing me," "I can't stand the pain," "I'm on edge all the time."

"The pain is making you feeling desperate and edgy and I hear that, but I can't safely and in good conscience prescribe medication that could harm you or kill you."

Use the story to list the things that warrant this decision.
"You've told me a lot about your pain. You've told me about what you've tried and what doesn't work. You've told me about the stress in your life and the pressures you feel. You've told me about your attempts to destress with drinks after work and your use of marijuana. Stress is adding to your pain. All of those things tell me that adding a narcotic would be asking for trouble. It would be dangerous to you and maybe those around you, and a big part of my job is to make sure that the treatment we agree upon will keep you safe."

And as necessary, talk about the organizational policy or legal ramifications that prevent you from prescribing.

Use the teaching opportunity.
Teach about compounding factors and opioids. Use drawings or brochures. Don't ever assume that the patient knows and take the time again to explain, for example, how his or her apnea in combination with opioids would slow breathing down even more, to the point of stopping, or that opioids changes the brain and its response to pain.

Have strong ideas for an alternative plan.

"We've talked about some of the things that may help you control your pain. Out of all those, what would you like to try?"

Or

"The complex needs you have really tell me that we need additional support for your pain. Would you be willing to talk to one of our pain specialists?"

Or

"There are strong connections with feeling down and discouraged and pain, so would you be willing to schedule an appointment with our behavioral health therapist?"

If at any time you feel threatened or need to diffuse the situation, you can excuse yourself to consult a colleague or get additional help.

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Adapted from:

Thorson D, Biewen P, Bonte B, Epstein H, Haake B, Hansen C, Hooten M, Hora J, Johnson C, Keeling F, Kokayeff A, Krebs E, Myers C, Nelson B, Noonan MP, Reznikoff C, Thiel M, Trujillo A, Van Pelt S, Wainio J. Institute for Clinical Systems Improvement. Acute Pain Assessment and Opioid Prescribing Protocol. Published January 2014.

Appendix F: Diagnosis-based Pharmacotherapy for Pain and Associated Conditions

Best Used For...	Adjuvant Drug	Key Points
Minor arthritis, backache, muscle and joint pain	Topical menthol, methyl salicylate, trolamine salicylate or capsaicin	May experience burning, stinging or itching sensations during and following application but high concentration capsaicin or repeat applications will produce a loss of responsiveness to stimuli. **Caution:** Wash hands or use gloves when handling capsaicin.
Minor to moderate pain	Acetaminophen (APAP)	APAP 325 mg + ibuprofen 200 mg provides better pain relief than oral opioids. **Caution:** Hepatotoxicity increases with dose, age, use of alcohol, and co-occurring liver disease. Keep to < 2 grams daily if at risk for hepatotoxicity. Some manufacturers have voluntarily revised their label to recommend a lower maximum of 3 grams daily.
Pain from spasticity (spinal cord injury or multiple sclerosis)	Tizanidine or baclofen	**Caution:** Do not abruptly discontinue baclofen due to potential for severe rhabdomyolosis and fever.
Neuropathic pain conditions (diabetic peripheral neuropathy, post-herpetic neuralgia, spinal cord injury, cauda equina syndrome, phantom limb pain, HIV neuropathy, chemotherapy-induced peripheral neuropathy, etc.)	Tricyclic antidepressants (amitriptyline, nortriptyline, doxepin, desipramine), serotonin norepinephrine reuptake inhibitors (duloxetine, venlafaxine), anticonvulsants (gabapentin, pregabalin)	Low dose TCAs and gabapentin are good first line therapy options especially helpful with sleep disturbance. **Caution:** Gabapentin and pregabalin can cause cognitive slowing, weight gain, and edema. Also, pregabalin is a controlled substance.
Trigeminal neuralgia	Carbamazepine	**Caution:** Monitor for hematologic (aplastic anemia, agranulocytosis) and dermatologic (toxic epidermal necrolysis, Stevens-Johnson syndrome) complications. Because there is a strong association between dermatologic complication and the presence of human leukocyte antigen (HLA-B*1502), the FDA and the manufacturers of carbamazepine recommend that patients with ancestry in genetically at-risk populations be screened for the presence of the HLA-B*1502 allele prior to initiating carbamazepine therapy.
Neuropathic pain condition + depression or anxiety	Tricyclic antidepressants (amitriptyline, nortriptyline, doxepin, desipramine) or serotonin norepinephrine reuptake inhibitors (duloxetine, venlafaxine)	**Caution:** Monitor for dose related QTc prolongation (TCAs > SNRIs). Also, SNRIs can provoke leg movement disorders.
Non-specific low back or nociceptive pain or pain from traumatic, infectious, or degenerative conditions, or pain from connective tissue disorders	Nonsteroidal anti-inflammatory drugs (naproxen, ibuprofen, meloxicam, diclofenac, etodolac, nabumetone, ketoprofen, piroxicam, sulindac, tolmetin, etc.)	Naproxen 500 mg or naproxen sodium 550 mg alone and ibuprofen 200 mg + acetaminophen 500 mg are as effective, or more effective than opioids. **Caution:** Monitor patients for potential renal, gastrointestinal (GI), and cardiac side effects. Risk increases with age and dose.

Best Used For...	Adjuvant Drug	Key Points
Fibromyalgia	Duloxetine, gabapentin or pregabalin	**Caution:** Serotonin syndrome has been reported with SNRIs (e.g. duloxetine) when taken alone or concurrently with other serotonergic agents (e.g. triptans, tramadol, fentanyl, TCAs, etc.)
Localized neuropathic pain (HIV polyneuropathy, postherpetic neuralgia)	Topical lidocaine or capsaicin	May experience burning, stinging or itching sensations during and following capsaicin application but high concentration or repeat applications will produce a loss of responsiveness to stimuli. **Caution:** Wash hands or use gloves when handling capsaicin.
Insomnia	• Melatonin 1-5mg • Tricyclic antidepressants (TCAs) • Trazodone • Benzodiazepine receptor agonists or Z-drugs (e.g. zolpidem, zaleplon, zopiclone, eszopiclone)	Melatonin side effects include drowsiness, dizziness, headache, nausea, and nightmares. **Caution:** Trazodone is not advised when patient is taking SSRIs or SNRIs. **Caution:** Z-drugs can potentially induce unsafe behaviors like sleep-driving or preparing and eating food when not fully awake; have limited value with reducing chronic pain.

Interagency Guidelines on Prescribing Opioids for Pain. Agency Medical Directors Group, State of Washington. 3rd Edition, June 2015.