Universal Precautions Revisited: Managing the Inherited Pain Patient

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ABSTRACT

“Universal Precautions in Pain Medicine: A Rational Approach to the Treatment of Chronic Pain” was published in 2005. In it, a unified 10-step approach to the assessment and management of patients suffering from chronic pain was proposed. As well, a triage scheme of risk stratification was offered. By placing patients into risk categories of low, medium, or high (Groups I, II, and III), it became possible to recommend to primary care practitioners those patients whom they might confidently manage on their own, comanage with specialty support, or refer to specialty clinics with more experience and resources to tackle these often challenging cases.

It is important to note that Universal Precautions is not simply about opioid prescribing, although the use of opioids does highlight the value inherent in managing risk in all patients. Moreover, it should serve to remind health care professionals that the presence of significant psychiatric comorbidities, including substance-use disorders, may represent treatable conditions that must be addressed in order to optimize outcomes.

Universal Precautions as a concept should be based upon mutual trust and respect between patient and practitioner, both of whom should be committed to setting and achieving realistic goals in both cancer and noncancer pain patients.

The goal of this article is to explore the application of a Universal Precautions approach to manage the care of patients with chronic pain who no longer have an appropriate source of the medications upon which they have become physically dependent—so-called inherited pain patients.

Key Words. Universal Precautions; Inherited Pain Patient; Opioid Rotation; Urine Drug Testing

Introduction

In 2005, an article titled “Universal Precautions in Pain Medicine: A Rational Approach to the Treatment of Chronic Pain” proposed a unified, 10-step approach to the assessment and management of patients suffering from chronic pain [1] (Table 1). Common ground was identified between those clinicians treating patients with potentially deadly infectious diseases and those who treat chronic pain, sometimes in individuals who suffer from serious comorbidities including substance abuse and addiction. In both patient populations, recognition of the impossibility of accurate risk assessment at the initial visit led to the inevitable application of risk management strategies to all.

Additionally, a triage scheme of risk stratification was also proposed [1] (Table 2). By placing patients into risk categories of low, medium, or high (Groups I, II, and III), it became possible to recommend to primary care practitioners those patients whom they might confidently manage on their own (“Who are my patients?”), comanage with specialty support (“Who are our patients?”), or those who should be best referred to specialty clinics with more experience and resources to

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Managing the Inherited Pain Patient

With the advent of more aggressive use of controlled substances in the management of chronic pain, a challenging problem has arisen. Sometimes patients who have become physically dependent on the opioid class of medications may find themselves without their usual prescriber, either due to practitioner retirement, fear of regulatory intervention, or even death. As a result, patients may be left to their own devices to solve the potential crisis situation resulting from a failure to obtain the medications on which they have become physically dependent. Even in pain that is not well served by the opioid class of medications, the absence of drug in the physically dependent user will often result in an amplification of pain through a withdrawal-mediated mechanism caused by incurring an “agonist debt.”

At one level, this is a patient problem, but on an even deeper level, this is a societal problem that requires proper assessment and management. When legitimate pain patients are deprived of the opioid medication they have been taking, this can lead to an immediate crisis situation; acute withdrawal due to abrupt discontinuation of a class of medication on which they have become reliant can occur. Patients traveling long distances to obtain medication, frequenting multiple emergency departments or walk-in clinics, or engaging in frank criminal behavior may be a direct result of these patients trying to solve this problem. In this context, the application of Universal Precautions to identify and manage risk will allow clinicians to safely treat this often challenging patient population. By ensuring that both the treating health care professional and patient have choices, neither party will feel forced into a course of action without having a variety of options to explore. One of the goals of this article is to propose such an approach to this often challenging patient population.

Table 1 The 10 principles of Universal Precautions

1. Diagnosis with appropriate differential
2. Psychological assessment including risk of addictive disorders
3. Informed consent (verbal or written/signed)
4. Treatment agreement (verbal or written/signed)
5. Pre-/post-intervention assessment of pain level and function
6. Appropriate trial of opioid therapy ± adjunctive medication
7. Reassessment of pain score and level of function
8. Regularly assess the “Four As” of pain medicine: Analgesia, Activity, Adverse Reactions, and Aberrant Behavior
9. Periodically review pain and comorbidity diagnoses, including addictive disorders
10. Documentation

Adapted from Gourlay et al. [1].

Table 2 Triage of the chronic pain patient

Group I: Primary Care Patients
This group has no past or current history of substance-use disorders. They have a noncontributory family history with respect to substance-use disorders and lack major or untreated psychopathology. This group clearly represents the majority of patients who will present to the average primary care practitioner.

Group II: Primary Care Patients With Specialist Support
In this group, patients may have a past history of a treated substance-use disorder or a significant family history of problematic drug use. They also may have a past or concurrent psychiatric disorder. These patients, however, are not actively addicted but do represent increased risk that may be managed in consultation with appropriate specialist support. This consultation may be formal and ongoing (comanaged) or simply with the option for referral back for reassessment should the need arise.

Group III: Specialty Pain Management
This group of patients represents the most complex cases to manage because of an active substance-use disorder or major, untreated psychopathology. These patients are actively addicted and pose significant risk both to themselves and to the practitioners who often lack the resources or experience to manage them. The prescription of controlled substances should generally be left to those persons with the experience and resources to manage the active addict.

Adapted from Gourlay et al. [1].

Tackle these often challenging cases (“Who are your patients?”).

It is important to note that Universal Precautions is not simply about opioid prescribing [2], although its use does highlight the value inherent in managing risk in all patients. Moreover, it should serve to remind health care professionals that the presence of significant psychiatric comorbidities, including substance use disorders, might represent treatable comorbid conditions that must be addressed in order to optimize outcomes.

Universal Precautions as a concept is based on mutual trust and respect between patient and practitioner alike, both of whom should be committed to setting and achieving realistic goals [1,2]. Because the prescription and receipt of controlled substances are a privilege and not a right, Universal Precautions is about these shared responsibilities [1,3]. Because there are no reliable data to support the arbitrary separation of cancer from noncancer pain in the assessment and management of potentially co-occurring abuse, misuse, or addiction [4], Universal Precautions should be considered in the treatment of patients with cancer as well, especially when potentially dangerous and divertible drugs are involved.
Using Federal Regulations to Assist with Challenging Patients

Federal regulations for the prescription of controlled substances should not be seen as a barrier to their appropriate use by clinicians who knowledgeably apply them. Understanding federal regulations is essential in formulating an effective and rational treatment plan for all patients, especially those who might be new to the prescriber or who are less than stable.

The purpose behind interval dispensing is to offer the boundary-challenged patient a manageable “pill load,” a term defined later in this article. The prescriber can take advantage of the amendments to the Federal Register (21 CFR §1306.12[b]) that became effective November 19, 2007. These regulations allow prescribers to issue multiple, sequential prescriptions for the same schedule II medication ("Do Not Fill Until") to reduce the total number of pills a patient is given at any point in time without requiring unnecessary visits to the prescriber’s office. A secondary but important use for this rule is to allow stable patients the opportunity to receive multiple prescriptions, up to 90 days at a time, of medications that their insurer would otherwise only cover for a 1-month interval. Each prescription must be dated as of, and signed on, the day it was issued. (21 CFR §1306.05). It is important to note that the concept of “Do Not Fill Until” is not the same as postdating a prescription, which remains an unlawful practice under federal regulation [6].

Opioid Rotation: Why Opioid Therapy Must Be Individualized

In most cases, the rationale for opioid rotation is related to one or more of the following reasons: loss of analgesic efficacy, toxicity, or patient preference [7]. More commonly, in noncancer pain, it is to improve analgesia and/or to lower the dose of the prescribed medication. In cancer pain, it is usually more often related to toxicity (i.e., to decrease side effects) [8,9]. As research evolves, it is apparent that genetic variations of µ-opioid receptors can alter µ-receptor ligand binding and receptor activation. Genetic variations in opioid metabolism also exist [10]. As such, certain individuals may respond better to some medications than to others. The potency and efficacy of different opioid analgesics can vary significantly and unpredictably among patients. Side effects, particularly nausea and vomiting, from individual opioids vary within an individual and among patients. Clinically, patients often show incomplete cross-tolerance when rotated from one analgesic to another, as illustrated in Figure 1.

For example, many tables of analgesic equivalence exist; however, all should be conservatively interpreted in the context of individual genetics. Pharmacologic equivalence is an inexact science. With equianalgesic tables of opioids, it is important to recognize that dose estimates were typically based on single-dose studies using opioid-naïve subjects who were not on any other medications [7]. This should be contrasted to the vast majority of patients with pain who are neither opioid-naïve nor on simple pharmacologic regimens of management.

This is particularly clear when one examines morphine equivalence to methadone [11,12]. When the morphine dose is low, the equivalence in methadone may be 2.5:1; however, when the morphine dose is very high (i.e., gram quantities of morphine), the equivalence in methadone shifts to 14.3:1 [13]. In the authors’ view, this may be a function of the dual role of methadone. Although both the R- and S-enantiomers appear to bind to the N-methyl-D-aspartic acid (NMDA) receptor, the S-enantiomer is minimally active at the µ-receptor [11,14,15]. In the former case of low-dose morphine, the dominant role of methadone is likely µ-analgesic, whereas in the latter case of high-dose morphine, reversal of tolerance through NMDA receptor antagonist activity may well be the dominant effect at work [15].

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**Figure 1** Opioid tolerance/incomplete cross-tolerance.

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**Opioid A**

**Opioid B**

| Drugs A and B have incomplete cross-tolerance |
| Neither Drug A nor B occupies this genetic version of the µ-receptor sites |
| Drugs A and B are active at shared µ-receptor sites |

<table>
<thead>
<tr>
<th>10-20 µ-receptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid A</td>
</tr>
<tr>
<td>Opioid B</td>
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</tbody>
</table>

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**One µ-gene for opioids**

- At least 10-20 (?) genetic versions of the µ-receptors

**Cross-tolerance**

- Depending on ligand binding and receptor activation
When opioids are less effective than expected or a new patient presents with “irrational pharmacotherapy,” then opioid rotation or taper (in some cases, to the point of discontinuation) should be considered. In both cases, the following questions must be answered: 1) are opioids part of the optimum course of therapy? 2) if opioids are part of the solution, is it due to their analgesic effect or are they fulfilling an unintended maintenance role in the now physically dependent patient by preventing withdrawal-mediated pain through fluctuating serum levels? The importance of distinguishing between simple physical dependence and addiction, in this particular case, cannot be overstated. Failure to identify and appropriately treat the physically dependent pain patient, whose pain worsens in the context of avoidable opioid withdrawal, can destine the patient to a life of opioid use, even in the context of often unacceptable side effects. A well thought-out trial of opioid therapy must include a carefully thought-out “entrance” as well as an equally important “exit” strategy before the first prescription is written [16].

In fact, a very real barrier to undertaking the care of a new patient who is on a complex regimen of medications, especially opioids, is the fear that once they accept the patient into their practice, they will have no choice but to continue on with this course of therapy, even if all reasonable assessments would suggest that it is not optimal. Having a controlled-substances discontinuation plan in place, before accepting new patients, can go a long way to reducing such fears.

One of the more challenging places that a patient-centered clinical team may find itself is at the crossroads of a pharmacologic disagreement. In some cases, there may be ambivalence about continuing on with a particular choice of therapy. In others, the decision to change may be more pressing. Regardless, when possible, it is important for practitioner and patient alike to have choices. Appendix 1 provides a sample “Termination of Controlled-Substances Agreement,” which clearly sets forth the steps that might be taken at a point in the doctor–patient relationship when a class of drugs may need to be stopped. In some cases, the decision will be clear: the continued use of a particular drug poses an immediate threat to the patient’s well-being. More often, however, the decision to discontinue is based on lack of efficacy, and so a patient who disagrees may reasonably request time to find another practitioner to continue prescribing. In this case, giving a patient a reasonable but finite period to find another prescriber might be reasonable. It is important to remember that the responsibility to find a new prescriber rests with the patient. In some cases, shortly before the end of the agreed upon time, the patient may request an extension. Again, it is important for the original doctor to stick with the agreement as written, because allowing an extension means running the risk of invalidating the agreement.

In the practice of medicine, the ability to match services with need remains an elusive goal. This problem presents challenges at the patient, practitioner, and societal levels. One particularly difficult problem arises when a community-based pain practitioner closes his or her practice, either because of retirement, illness, or in rare cases, as a result of regulatory interdiction. The net effect is that a group of patients, many of whom are physically dependent on prescription medications, have lost their reliable supply of drug. This heterogeneous group, comprised of patients doing well on rational management strategies as well as those patients whose use of opioids is at least problematic, in some cases abusive, and even addictive, must be managed in a thoughtful and compassionate manner. This uncertainty poses significant challenges to potential health care professionals willing to undertake the care of this often difficult population. Failure to address these issues relegates many to a life of drug-seeking behaviors through multiple visits to emergency rooms or walk-in clinics, which does not serve the patient, practitioner, or community well.

In some cases, the drug-seeking behavior is driven by an untreated substance-use disorder. Rarely, criminal intent may underpin efforts by these patients to obtain drugs. However, the majority are patients with legitimate pain, at least in part, may be seeking relief from withdrawal-mediated exacerbations of their underlying painful conditions [5]. Failure to meet the daily opioid requirements of a physically dependent opioid user will create an “opioid debt” (i.e., “agonist debt”) that may result in frank withdrawal symptoms but, in some cases, manifests largely as exacerbations in pain.

In keeping with the tenets of Universal Precautions in Pain Medicine, the new patient must be properly assessed and categorized into one of the following three groups.

1. Patients who are doing well and are being managed on a course of therapy that is both
reasonable and appropriate for the diagnosis. These patients are essentially being managed with a course of therapy that fits with the new health care professional’s experience and resources. Nothing new needs to be done, with the possible exception of tightening limits and boundaries until the patient is better known to the new prescriber. Interval dispensing of smaller quantities of medication with more frequent follow-up, pill counts, and urine drug testing (UDT) will, in a relatively short period of time, confirm or refute the initial assessment of clinical stability.

2. The patient has been managed in a fashion that is not totally consistent with the new caregiver’s experience and resources, and may reflect a clinical picture that can be optimized. In this case, some variation of the presented treatment plan may be followed with minor or major modifications.

For example, a patient presents with a treatment plan that is largely based on short-acting, immediate-release combination opioids. Upon review of the patient’s history, it becomes apparent that this patient is suffering from withdrawal-mediated pain, especially noticed in the morning on wakening. The next question to ask and answer is whether the patient is willing to undertake the changes that might reasonably be proposed to bring the course of therapy into line with the caregiver’s established practice. Rotating to a modified-release opioid or a truly long-acting agent such as methadone may serve to eliminate any withdrawal-mediated component to the patient’s complaints of pain. In some cases, the patient may actually be better served by a non-opioid course of therapy; however, this is usually best explored after achieving pharmacologic stability rather than simply trying to discontinue the offending agent. The patient’s previous experience with worsening pain when he or she has inadvertently run out of medication serves to reinforce the seeming appropriateness of the current course of treatment and may serve to undermine any recommendations to the contrary.

3. In the final case, the patient’s course of therapy is, for a variety of reasons, indefensible, and so not something the new physician feels he or she is able to support. For example, a patient who has been managed on Demerol® (Sanofi-Aventis, Bridgewater, NJ), but is also known to be suffering from chronic renal failure, should not continue on with this course of treatment, if only because of the risk of seizures secondary to normeperidine accumulation [11,17]. Although the patient may adamantly deny a history of seizures related to this course of therapy, the person who agrees to continue prescribing this drug despite its contraindication must assume the risk. In this case, the patient will either see this as an opportunity (“The Golden Moment”) to change and improve his or her care or elect to seek out alternate options, including finding a health care professional unwisely willing to comply with the patient’s request.

Even as far back as 1988, Vincent Dole recognized that methadone could serve the purpose of stabilizing endogenous opioid-receptor systems, thereby returning dysregulated interacting physiologic and behavioral systems to normalcy [18]. In many respects, the introduction of, and evolution in, modified-release delivery systems for the opioid class of drugs has served to address this pharmacologic principle.

It is important to remember that the initial visit is really one of mutual fact finding. There should be no expectation on the part of either party to assume the current course of therapy. In some respects, this is one of the most important points to make to a potential patient even before the patient is given an appointment. Health care professionals must remember that they are under no obligation to prescribe all or any part of the current course of therapy on demand. In some cases, the first visit may be a nonprescribing consultation during which the patient will be assessed and the practice philosophy will be shared to ensure that mutual interests are identified and preserved.

In order to safely assume the care of these often complex patients, a basic and consistent approach such as the one recommended here may be helpful to reduce the risk that complexity will make a common sense approach difficult or impossible to see. Failure to address these issues may increase the risk that a simple “common sense” solution will be missed.

**Pill Load and Interval Prescribing**

“Pill load” refers to the total number of unit doses available to a patient over any given dispensing interval. For example, a prescription for controlled-release oxycodone, 80 mg, one tablet twice a day, is equivalent to 20-mg tablets, four tablets twice a day. This can pose a significant
challenge to some patients from a behavioral perspective, because in the former case, the patient is given only 60 tablets per month, whereas in the latter case, the patients will have 240 tablets per month. With more tablets available, the possibility of “borrowing from tomorrow to pay for today” is greater. This may eventually cause some patients to run out of medication early or “short” themselves during the later part of the prescription interval by taking considerably less medication per day to make the script “last.” Regardless, the pharmacologic and behavioral instability that results does not serve the patient or the prescriber well.

“No Ceiling” vs “No Limit”

One of the unfortunate casualties of the war on pain has been, on occasion, unacceptably high doses of scheduled agonist medications resulting in excessive sedation, opioid-induced hyperalgesia, hormonal effects, immunosuppression, as well as unknown cognitive and motor effects [9,15,17]. The argument has been made that because the opioid agonist class of drugs has “no ceiling,” which is a pharmacological principle characterized by an ever-increasing effect with increased dose, these medications have no limit. Unfortunately, this pharmacologic truism has been confused with the clinical reality of excessive prescribing. The limit to any therapeutic intervention has always been the adverse-effect profile. When a drug is doing more “to you” than “for you,” it is time to reconsider the course of therapy. The key goals of pain management should always be to decrease pain and improve function while minimizing adverse effects.

UDT in a Patient-Centered Model of Care

UDT can play a key role in managing risk in the chronic pain population [19,20]. Unlike drug testing that is forensically based, such as workplace testing, drug testing in clinical practice should be used to improve patient care. Unfortunately, a test may come back with unexpected results. For example, when a sample is negative for a prescribed drug or drug class or positive for an unprescribed one, the treating clinician must have an approach to resolve this apparent conflict. One of the first steps in interpreting these unexpected results is to contact the laboratory to ensure that no clerical errors have been made. Occasionally, a urine sample is falsely reported as positive either due to a simple clerical error (laboratory technician wrote positive when he or she meant negative) or the patient has taken some other product or medication that interferes with the ability to obtain an accurate result. In these cases, more definitive testing can often be recommended by the laboratory to clarify these results, but they should never be ignored. There must be a process to follow, which ultimately should include discussing the unexpected result with the patient [19,20).

Occasionally, UDT may yield results that appear to be at odds with the patient’s apparent stable clinical status. Once accuracy of the test’s results has been ensured, it is important to speak with the patient, carefully documenting the results and ensuing discussion in the medical record. If the patient acknowledges recreational use of prohibited substances, then he or she should be advised of the consequences of continued use. These may include adverse drug–drug interactions, a re-examination of the treatment plan, a referral to a specialist in substance-use disorders, or, if the patient indicates an unwillingness to stop using, then a rapid taper or an abrupt discontinuation of opioids may be indicated and no further prescriptions may be given. When the patient indicates that he or she will no longer use prohibited substances, then UDT should be done more frequently and, when possible, randomly, in order to ensure that drug misuse has indeed stopped. There are far more illicit/prescription drug users who think they are recreational users than actually are recreational users.

Frequently, a patient will attempt to explain an abnormal UDT result as a consequence of unremitting pain. Again, debating the motive behind the abnormal result is far less useful than getting an agreement that such behavior, regardless of what drives it, is problematic. Thus, by separating the motive from the behavior, the clinical team, including the patient, may begin to unravel the root cause of the problem.

The differential diagnosis for this behavior is long and includes “chemical coping”, drug misuse or addiction, pseudoaddiction, comorbid psychopathology, and even criminal behavior such as drug diversion [16,19,21,22]. Unfortunately, although acute pain may lend itself to treatment in the context of an untreated substance-use disorder, the treatment of chronic pain, in the absence of a stable recovery (when necessary), is rarely successful [1].

UDT can be an objective test in an otherwise subjective world of clinical uncertainty. Sometimes, simply asking the patient for assistance in the interpretation of the test results will improve communication based on mutual trust and honesty in order to reach the previously agreed upon goals.
of decreased pain and, when possible, improved function.

To assist the health care professional in properly interpreting a UDT result, Table 3 and Figure 2, respectively, provide retention times of common analytes and several key opioid metabolic pathways. More complete information about UDT is beyond the scope of this text; however, readers wishing more information should examine the following resources for a more complete treatment of the topic [19,20].

**Conclusion**

The application of Universal Precautions to the management of the inherited pain patient is not about management of risk associated with a particular class of molecule (i.e., an opioid), but rather the evaluation and management of treatable concurrent disorders, such as chemical coping, drug misuse, addiction, or other psychiatric disorders. As more patients are exposed to reinforcing and dependence-producing medications, underlying predispositions to problematic behavior will become apparent. Regrettably, as time goes on, a cohort of patients are emerging who are unable to reliably secure the medications on which they have become reliant. Regardless of the motivation behind such behavior, its identification as a problem and subsequent solutions that might be applied to address them will challenge the individual patient, practitioner, and the health care system as a whole. Universal Precautions has become a template to approach this sometimes difficult challenge of optimizing patient care while compassionately addressing risk in both cancer and noncancer pain populations.

Patient care strategies must be defensible, rational, and compassionate. This is especially true in the palliative case, where end of life is not some distant issue on the horizon but rather a proximate reality that challenges both patient and practitioner on a daily basis. While the decision to persist with the use of controlled substances may be the consequence of a moral imperative to offer the patient death with dignity, it does not alter the fundamental “need to know” if and when an active substance use disorder exists. As more orphaned patients find their way to caring clinicians, these challenges will only become more apparent. Hopefully, the proposed approach will offer a starting point to address some of these problems.

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**Table 3** Detection times of common drugs of misuse

<table>
<thead>
<tr>
<th>Drug</th>
<th>Approximate Retention Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamines</td>
<td>48 hours</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>Short-acting (e.g., secobarbital), 24 hours; Long-acting (e.g., phenobarbital), 2–3 weeks</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>3 days if therapeutic dose is ingested; Up to 4–6 weeks after extended dosage (i.e., 1 year or more)</td>
</tr>
<tr>
<td>Cannabinoids</td>
<td>Moderate smoker (4 times/week), 5 days; Heavy smoker (daily), 10 days; Retention time for chronic smokers may be 20–28 days</td>
</tr>
<tr>
<td>Cocaine (metabolized)</td>
<td>2–4 days</td>
</tr>
<tr>
<td>Ethanol</td>
<td>2–4 hours</td>
</tr>
<tr>
<td>Methadone</td>
<td>Approximately 30 days</td>
</tr>
<tr>
<td>Opiates</td>
<td>2 days</td>
</tr>
<tr>
<td>Phencyclidine</td>
<td>Approximately 8 days</td>
</tr>
<tr>
<td></td>
<td>Up to 30 days in chronic users (mean value = 14 days)</td>
</tr>
<tr>
<td>Propoxyphene</td>
<td>6–48 hours</td>
</tr>
</tbody>
</table>

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**Figure 2** Metabolism of opioids.
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References


Appendix 1 Termination of Controlled-Substances Agreement

Dr. ___ has informed me that my trial of opioid therapy has failed to reach previously agreed upon treatment goals and so must be discontinued. Although every effort will be made to reduce the risk of withdrawal symptoms from occurring, which may include a temporary increase in my pain level, I understand that this may not be entirely possible. During the taper period, I may be offered, at the doctor’s discretion, medications that might help reduce the symptoms of opioid...
withdrawal. Although distressing, I have been advised that these withdrawal symptoms are unlikely to be life-threatening and will subside over time, with or without treatment.

A. For this reason, the doctor has indicated that over the next 1 month (or other time period), my dose of ______ will be gradually tapered and discontinued.

   Initials: ______

B. Alternately, at my request, I have elected to remain on my current dose of medication and will attempt to find my own prescriber for these controlled substances. I realize that if I have not been able to find a new prescriber over this period of time, I may be offered a rapid taper of ______ and/or referral to other health care professionals for further assessment.

   Initials: ______

Initial the applicable paragraph and stroke out the other.

Patient:______ Date: ______

Witness:______ Date:______