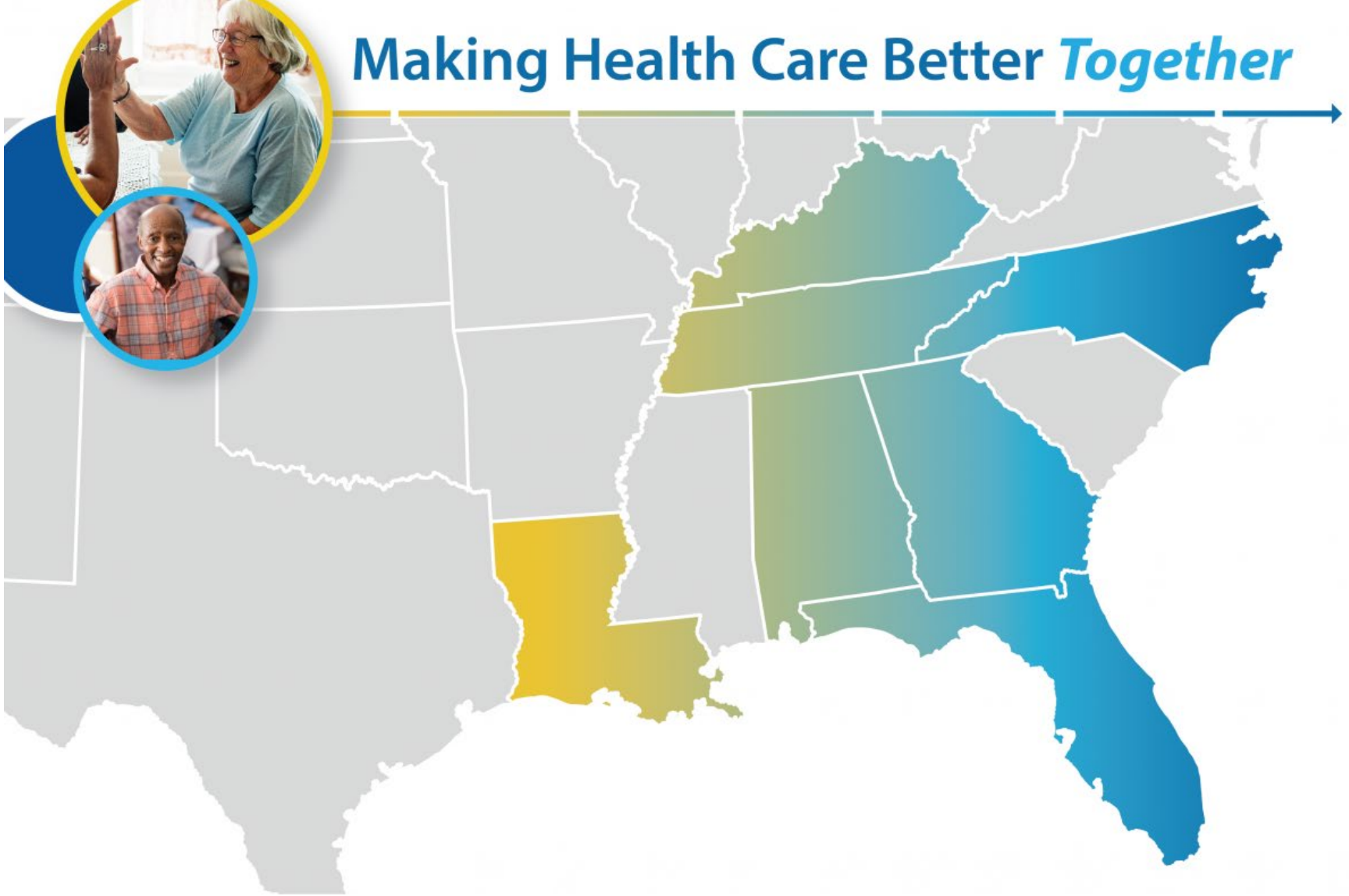
# Pain Management: What's New?

Jacqueline Cleary, PharmD, BCACP
Associate Professor of Pharmacy Practice
Albany College of Pharmacy and Health Sciences

July 19, 2023

ALLIANT HEALTH SOLUTIONS
QIN–QIO
Quality Innovation Network - Quality Improvement Organizations
CENTER S FOR MEDICARE & MEDICAI D SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP




# About Alliant Health Solutions

ALLIANT HEALTH SOLUTIONS | QIN-QIO
Quality Innovation Network - Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
IQUALITY IMPROVEMENT & INNOVATION GROUP

# Tanya Vadala, Pharm.D.

## MEDICATION SAFETY PHARMACIST

Tanya is an IPRO pharmacist with 20 years of clinical pharmacy, community pharmacy, academia, quality improvement and medication safety experience. Prior to joining IPRO, she worked at various community pharmacies and taught at the Albany College of Pharmacy and Health Sciences in Albany, N.Y. She specializes in Medication Therapy Management (MTM), medication reconciliation, opioids, immunizations and patient self-care. Her formal teaching experience includes courses in pharmacy practice and clinical experiential teaching.

**Contact: TVadala@ipro.org**

# Dr. Jacqueline Cleary, Pharm.D.

## CLINICAL PHARMACY SPECIALIST

Dr. Cleary is an associate professor at the Albany College of Pharmacy and Health Sciences (ACPHS) in the Department of Pharmacy Practice. Her current practice site is the Saratoga Hospital Community Health Center in Saratoga Springs, N.Y. Dr. Cleary is a clinical pharmacy specialist in primary care with a focus on pain management and addiction. She precepts students and residents and practices as part of an interdisciplinary primary care team.

While her clinical interests focus on pain and opioid stewardship, Dr. Cleary also strongly advocates for the pharmacy profession. In addition to her clinical work, Dr. Cleary serves as the program director for the ACPHS Pharmacogenomic Certificate Program and as the clinical director of naloxone distribution for the college.

# Objectives

- Review the 2022 CDC guideline update on chronic pain management
- Summarize guideline changes and relevance to pharmacy practice
- Examine newly approved medications for the treatment of pain, such as Seglentis®, Dsuvia®, and Olinvyk®…AND Opvee® and Brixadi® (*Hysingla® went generic!)
- Discuss what is coming in new drug development to prepare the pharmacist for the next phase of the opioid epidemic

# CDC Guideline Review

# 2016 CDC Pain Management Guidelines

## CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

Prepared by
Deborah Dowell, MD[1]
Tamara M. Haegerich, PhD[1]
Roger Chou, MD[1]
[1]Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, CDC, Atlanta, Georgia

### Summary

*This guideline provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. The guideline addresses 1) when to initiate or continue opioids for chronic pain; 2) opioid selection, dosage, duration, follow-up, and discontinuation; and 3) assessing risk and addressing harms of opioid use. CDC developed the guideline using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework, and recommendations are made on the basis of a systematic review of the scientific evidence while considering benefits and harms, values and preferences, and resource allocation. CDC obtained input from experts, stakeholders, the public, peer reviewers, and a federally chartered advisory committee. It is important that patients receive appropriate pain treatment with careful consideration of the benefits and risks of treatment options. This guideline is intended to improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death. CDC has provided a checklist for prescribing opioids for chronic pain (http://stacks.cdc.gov/view/cdc/38025) as well as a website (http://www.cdc.gov/drugoverdose/prescribingresources.html) with additional tools to guide clinicians in implementing the recommendations.*

# How Were The Guidelines Formed?

- Grading of Recommendations Assessment, Development and Evaluation (GRADE) method
  - Level of evidence type 1-4 and I (insufficient)
  - ACIP translation Category A, B, C, D, and I (insufficient)
- Solicitation of Expert Opinion (*no pharmacist)
- Stakeholder Comment-> used for revising draft guideline
- Clinician and patient comment (>1200 comments collected)
- Peer Reviewed (*no pharmacist)
- Public Comment (>4350 comments collected)

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016 | MMWR

# How Were The Guidelines Formed? Cont'd

Summary from 2016: (five clinical questions)

- Opioid effectiveness- **LOE I**
- Opioid harm- **LOE 3**
- Opioid dosing- **LOE 4**
- Risk Assessment and Mitigation- **LOE 3**
- Effects of Opioid Therapy for Acute Pain on Long-Term Use- **LOE 3**

- LOE 3 = observational studies or randomized clinical trials with notable limitations
- LOE 4 = clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016 | MMWR

# Concerns From 2016: 12 Recommendations

- https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm#guidelinedevelopmentmethods
- Application of dosing ceiling and hard limits of prescription durations (90mg MME, 72 hrs., 7 days etc.)
- Abrupt opioid taper or cessation-> no plans on how to taper or guidance on how to treat withdrawal
- Lack of access (cost, availability etc.) to recommended opioid alternatives
- Barriers to OUD treatments
  - Buprenorphine not mentioned
  - OUD diagnosis unclear

Pain Medicine, 0(0), 2019, 1–12. doi: 10.1093/pm/pny307
Pergolizzi, J.V., Rosenblatt, M. & LeQuang, J.A. Three Years Down the Road: The Aftermath of the CDC Guideline for Prescribing Opioids for Chronic Pain. *Adv Ther* **36**, 1235–1240 (2019). https://doi.org/10.1007/s12325-019-00954-1

# Concerns From 2016

- Incomplete overdose death statistics
- No mention of patient or provider education
- No mention of abuse-deterrent formulations despite FDA call for development
- No mention of harm reduction (naloxone access, needle exchange, OTC naloxone)
- **Misapplication of guideline use**:
  - Excludes cancer, palliative care and end-of-life patients
  - Post-operative pain management beyond the guideline's scope

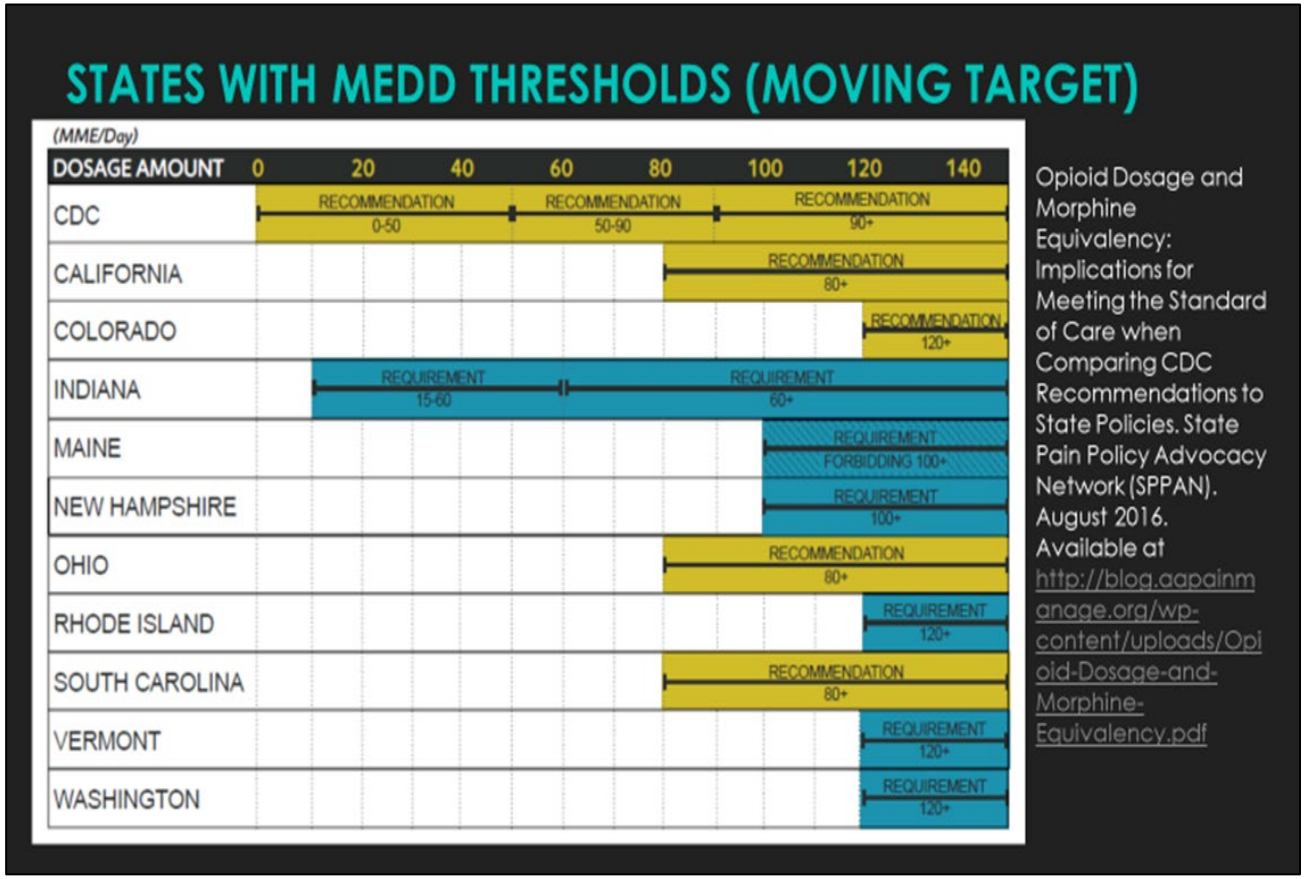
Pain Medicine, 0(0), 2019, 1–12. doi: 10.1093/pm/pny307
Pergolizzi, J.V., Rosenblatt, M. & LeQuang, J.A. Three Years Down the Road: The Aftermath of the CDC Guideline for Prescribing Opioids for Chronic Pain. *Adv Ther* **36**, 1235–1240 (2019). https://doi.org/10.1007/s12325-019-00954-1

ALLIANT HEALTH SOLUTIONS | QIN–QIO Quality Innovation Network - Quality Improvement Organizations CENTER S FOR MEDICARE & MEDICAI D SERVICES IQUALITY IMPROVEMENT & INNOVATION GROU P

# What Happened?

How have these guidelines affected you, your practice or your patients?

28 states passed legislation that placed limits on opioid prescribing




- 2017 US Department of Health and Human Services declared a public health emergency
- In 2019, CMS established new regulations limiting the prescribing and dispensing of opioids
  - >90 MME "safety edit" -> require pharmacist discussion
  - >200 MME "hard edit" -> involvement of the insurer
- Concern for illegal use of opioids
- Concern about suicide

Pergolizzi, J.V., Rosenblatt, M. & LeQuang, J.A. Three Years Down the Road: The Aftermath of the CDC Guideline for Prescribing Opioids for Chronic Pain. Adv Ther 36, 1235–1240 (2019). https://doi.org/10.1007/s12325-019-00954-1

# 2022 Update

- https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s_cid=rr7103a1.htm_w

- 12 recommendations total
- Four areas:
  1. Whether or not to initiate opioids
  2. Selecting opioids and determining dosages
  3. Deciding the duration of the initial opioid prescription and follow-up
  4. Assessing risk and addressing harms of use

# Five Guiding Principles

1. Acute, subacute, and chronic pain needs to be appropriately assessed and treated independently of whether opioids are part of a treatment regimen
2. Recommendations are voluntary and are intended to support, not supplant individualized, person-centered care. Flexibility to meet the care needs and the clinical circumstances of a specific patient is paramount.
3. A multimodal and multidisciplinary approach to pain management attending to the physical health, behavioral health, long-term services and supports, and expected health outcomes and well-being of each person is critical.
4. Special attention should be given to avoid misapplying this clinical practice guideline beyond its intended use or implementing policies purportedly derived from it that might lead to unintended and potentially harmful consequences for patients.
5. Clinicians, practices, health systems, and payers should vigilantly attend to health inequities; provide culturally and linguistically appropriate communication, including communication that is accessible to persons with disabilities; and ensure access to an appropriate, affordable, diversified, coordinated, and effective nonpharmacologic and pharmacologic pain management regimen for all persons.

# Let's Summarize The Four Areas

1. Whether or not to initiate opioids
    - Non-opioid therapies are typically preferred
    - Decision-making process should include the following:
        - Duration of symptoms
        - Condition being treated
        - Alternative treatment options
        - Special populations

*Risk and benefits of opioid use should be discussed with the patient.*

Not to be used for common nonsurgical pain conditions such as low back pain, neck pain, and MSK injuries.

https://www.practicalpainmanagement.com/resources/clinical-practice-guidelines/CDC-opioid-prescribing-for-pain-revise

2. Selecting opioids and determining dosages:

- Use the lowest dose for the shortest amount of time needed
- Benefit may not be seen at >**50 MME**, and clinicians should evaluate
- ER/LA opioids reserved for severe continuous pain or large doses of IR opioids

*Opioid therapy should not be discontinued abruptly and should be tapered down slowly when reducing opioid dosages.*

*NO SPECIFIC LIMITATIONS ON DOSE OR DURATION

3. Deciding the duration of the initial opioid prescription and follow-up.
    - More patient-centered approach
    - Opioids for acute pain follow-up every two weeks
    - Opioids for subacute and chronic pain follow-up every four weeks
    - First ER/LA opioid AN >50MME dosage increase follow up in two weeks
    - Methadone three-day follow-up window
    - Reassessment every three months

*Clinicians should regularly reevaluate the benefits and risks of continued opioid therapy.*

THOUGHTS ON THESE TIME FRAMES? PRACTICALLY…

https://www.practicalpainmanagement.com/resources/clinical-practice-guidelines/CDC-opioid-prescribing-for-pain-revise

4. Assessing risk and addressing harms of use
    - Use of the PDMP
    - Ask about drug and alcohol use
    - Provide education about the risk of overdose, endocrine effects and pregnancy risk
    - Management of other comorbidities (i.e., depression, anxiety)
    - Follow up on common opioid-related side effects
    - Utilization of toxicology testing
    - Offer naloxone

*Detoxification on its own, without medications for opioid use disorder, is not recommended.*

https://www.practicalpainmanagement.com/resources/clinical-practice-guidelines/CDC-opioid-prescribing-for-pain-revise

# Other Points To Note

PROs

- Evidence of health equity and disparities in the treatment of pain
- Encouragement for the utilization of telemedicine to improve access
- "Legacy patients" warrant close monitoring
- No change in the "reasons to taper" a patient off opioids -> emphasis on avoiding blind tapers/abrupt discontinuations

CONs

- Lack of consensus on tapering strategy
- Opioid alternatives mentioned (NSAIDs, exercise, etc.) but lack emphasis and data supporting other non-opioid pain modalities
- No mention of opioid stigma

https://www.practicalpainmanagement.com/resources/clinical-practice-guidelines/CDC-opioid-prescribing-for-pain-revise

# Summary

- Removal of limits/durations
- Expansion of pain types (acute and subacute)
- Multimodal approach that is patient-centered

THOUGHTS/QUESTIONS?

DO THESE CHANGE YOUR CURRENT PRACTICE AT ALL?

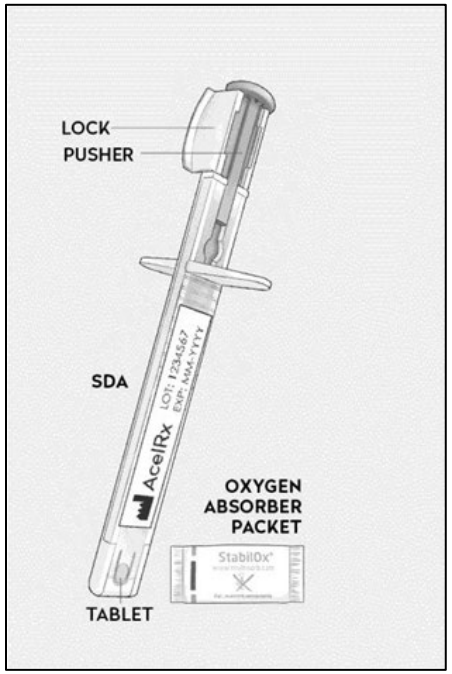
# What's Newly Approved & What May Be Coming

2020 and onward

ALLIANT HEALTH SOLUTIONS | QIN–QIO
Quality Innovation Network - Quality Improvement Organizations
CENTER S FOR MEDICARE & MEDICAI D SERVICES
IQUALITY IMPROVEMENT & INNOVATION GROU P

# Dsuvia® (SL sufentanil)

| Outcome | Non- SST (n=80) | SST (n=47) | |
|---|---|---|---|
| Intraoperative opioid use | 97.5% | 61.7% | P<0.001 |
| Total preoperative and intraoperative mean opioid dose | 20mg MME | 10.9mg MME | P<0.001 |
| Required postoperative opioids | 63.0% | 10.6% | P<0.001 |
| Mean opioid requirement | 4.4mg MME | 0.9mg MME | P<0.001 |
| PACU time | 54.9 minutes | 36.3 minutes | P<0.001 |

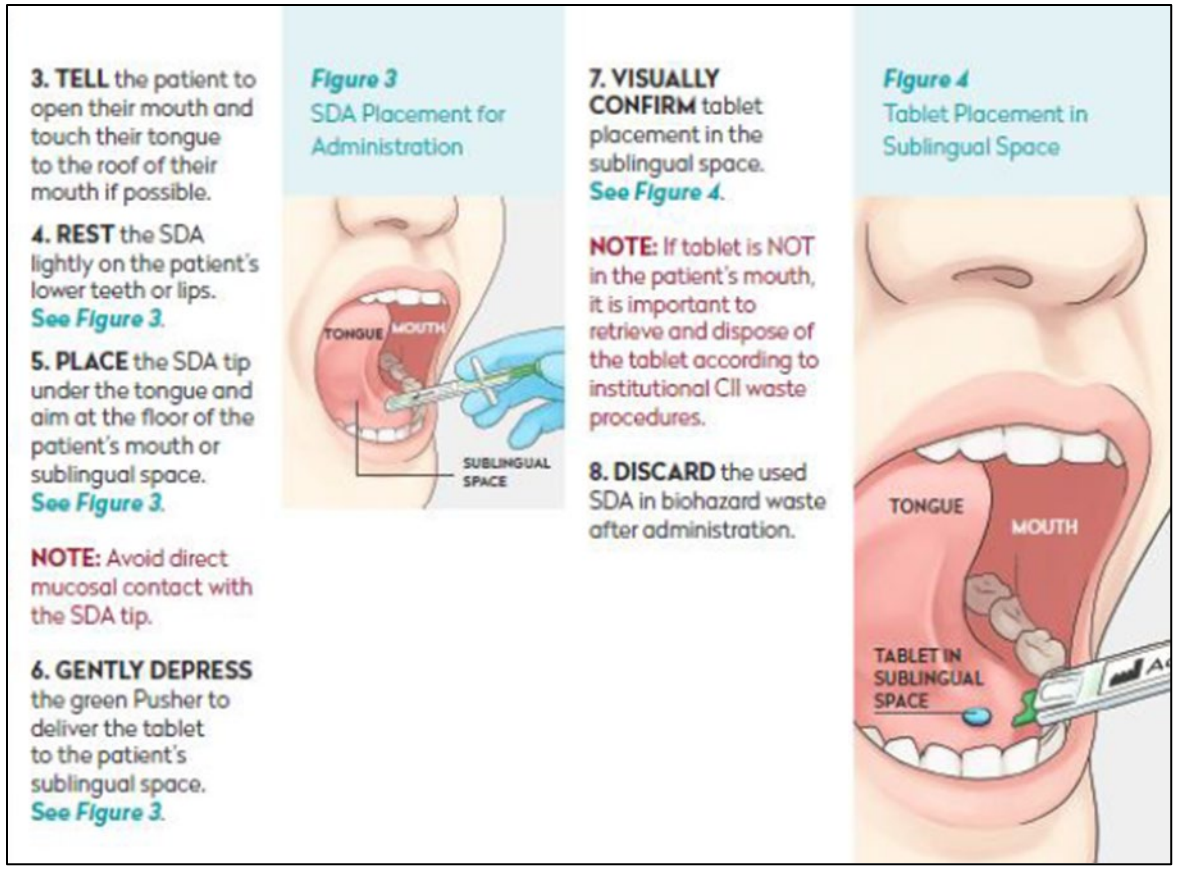



- 30mcg dose in a health care setting
- SL tablet
- Metabolized by 3A4
- Sublingual depot PK → rapid-acting, non-invasive

Reductions in Opioid Use and Reduced Time in the PACU Following Pre-Op dosing of sublingual sufentanil 30 mcg (Dsuvia) JCAPM publication accepted

ALLIANT HEALTH SOLUTIONS | QIN-QIO Quality Innovation Network - Quality Improvement Organizations
CENTER S FOR MEDICARE & MEDICAI D SERVICES IQUALITY IMPROVEMENT & INNOVATION GROU P

# SL sufentanil



3. **TELL** the patient to open their mouth and touch their tongue to the roof of their mouth if possible.

4. **REST** the SDA lightly on the patient's lower teeth or lips. See *Figure 3*.

5. **PLACE** the SDA tip under the tongue and aim at the floor of the patient's mouth or sublingual space. See *Figure 3*.

**NOTE:** Avoid direct mucosal contact with the SDA tip.

6. **GENTLY DEPRESS** the green Pusher to deliver the tablet to the patient's sublingual space. See *Figure 3*.

*Figure 3*
SDA Placement for Administration



7. **VISUALLY CONFIRM** tablet placement in the sublingual space. See *Figure 4*.

**NOTE:** If tablet is NOT in the patient's mouth, it is important to retrieve and dispose of the tablet according to institutional CII waste procedures.

8. **DISCARD** the used SDA in biohazard waste after administration.

*Figure 4*
Tablet Placement in Sublingual Space



- 5-10 times more potent than fentanyl
- Caution with bradyarrhythmia and hypotension
- Controversy over approval
- Approved with RESMS program
- 2021 FDA warning: "Tongue and Done"

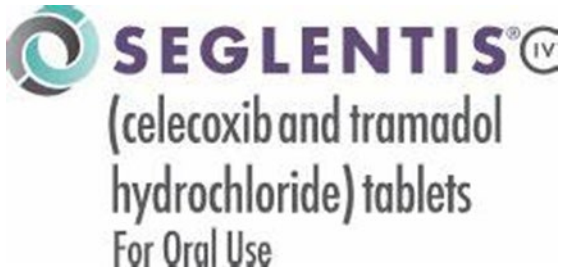
# Olinvik®(olicerdine)

- Novel IV G-protein biased μ-opioid receptor agonist
- Reduced β-arrestin recruitment compared to traditional opioids
  - Receptors are linked to adverse effects associated with opioids -> less GI and respiratory depression
  - Same BBWs as all opioids
- 3A4 and 2D6
- Large VD (126L)
- Rapid onset
- Only for use in a supervised health care setting
- 5X more potent than morphine


Bergese SD. Athena: A Phase 3, open-label study of the safety and effectiveness of Oliceridine (TRV130), A G-protein selective agonist at the mu-opioid receptor, in-patient with moderate to severe acute pain requiring parenteral opioid therapy. J Pain Res. 2019 Nov 14;12:3113-3126. doi: 10.2147/JPR.S217563. eCollection 2019

# Seglentis® (celecoxib and tramadol)

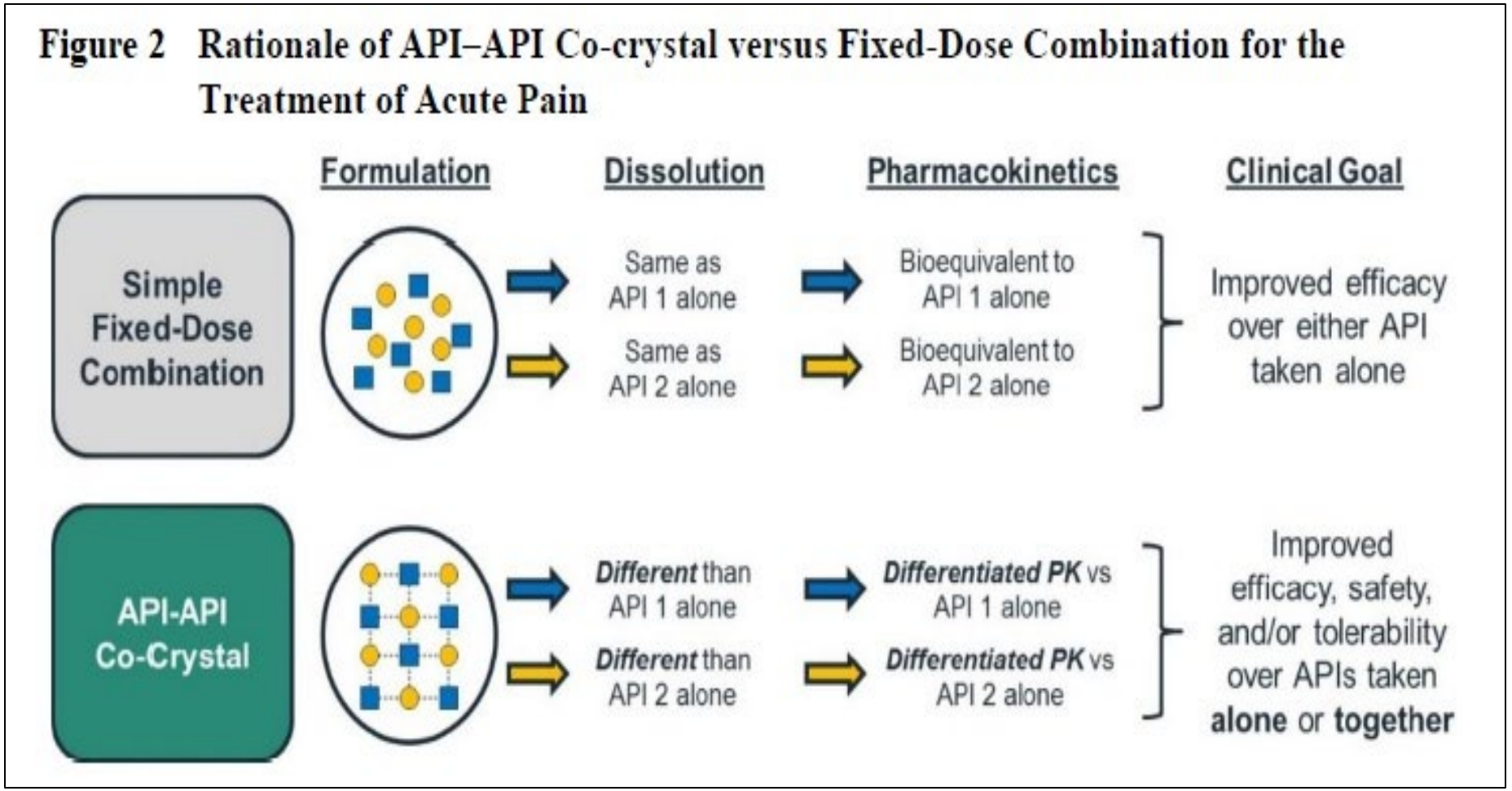
- Approved 10/18/2021
- 56mg of celecoxib and 44mg of tramadol (Schedule IV)-> dosed at two tablets every 12 hours
- Celecoxib normally 100mg BID
- Tramadol, usually 50-100mg every six hours
- Showed significantly better pain control after bunionectomy than standard dose celecoxib or tramadol used alone




SAME NSAID PRECAUTIONS AS BEFORE!

Co-crystal E-58425 vs Tramadol and Celecoxib for Moderate to Severe Acute Pain After Bunionectomy. Phase III Clinical Trial. (2019, January 24). Retrieved November 09, 2020, from https://clinicaltrials.gov/ct2/show/NCT03108482?cond=Co-crystal+E-58425

# Co-Crystal Celecoxib/Tramadol




Litman RS. Anesthetic and Analgesic Drug Products Advisory Committee Activity and Decisions in the Opioid-crisis Era. Anesthesiology. 2020 Oct 1;133(4):740-9

ALLIANT HEALTH SOLUTIONS | QIN-QIO Quality Innovation Network - Quality Improvement Organizations CENTERS FOR MEDICARE & MEDICAID SERVICES IQUALITY IMPROVEMENT & INNOVATION GROUP

# Meanwhile Narcan…

- 2020 shelf life extended from two years to three years
- 2021 8mg dose of naloxone nasal spray approved (2mg and 4mg already to market)
- 2022 4mg Narcan nasal spray approved OTC
- 2023 Opvee® enters the market

# Opvee® (nalmefene)

- Analog of naltrexone, competitive opioid receptor antagonist-> reversing respiratory depression
- LONGER duration of action
- Higher affinity for opioid receptors

# Opvee® (nalmefene) VS. Naloxone

**nalmefene**

- Half-life: 11 hours
- IM or IV use
- RX required
- 12 years and older
- Brand name only

**naloxone**

- Half-life: 0.5-1.5 hours
- Available OTC
- Generic Available

# Bridaxi® (buprenorphine)

- FDA approved May 2023-> expected availability in September
- Still waiting on a final monograph
- ER injection either weekly (8mg, 16mg, 24mg, 32mg) or monthly (64mg, 96mg, 128mg)
- REMS program
- Indicated for OUD patients who have previously been treated with buprenorphine
- SubQ injection requiring no refrigeration with a 23G needle
  - Fluid crystal injection depot

# Bridaxi® Pros & Cons?

# What Could Still Be Coming?

- IV tramadol-?> Avenue therapeutics appealing to the FDA March 2023
  - Concerns for opioid stacking, the need for a rescue opioid and compromising safety
- Clinical practice guidelines for the safe tapering of benzodiazepines
- Appropriate opioid prescribing for OB patients postoperatively

# What Does This Mean For Me?

**Opioid Stewardship**

- Opioid selection
- Non opioid therapies
- Application of best practices

**Reduce opioid induced respiratory depression**

- In-home naloxone products
- Novel opioid products
- Risk mitigation

**New Drug Development**

- Complex PK/PD
- Abuse deterrent formulations
- Affordability

# Questions?

# Nursing Home and Partnership for Community Health:
## CMS 12th SOW GOALS

### OPIOID UTILIZATION AND MISUSE

Promote opioid best practices

•

Reduce opioid adverse drug events in all settings

### PATIENT SAFETY

Reduce hospitalizations due to c. diff

•

Reduce adverse drug events

•

Reduce facility acquired infections

### CHRONIC DISEASE SELF-MANAGEMENT

Increase instances of adequately diagnosed and controlled hypertension

•

Increase use of cardiac rehabilitation programs

•

Reduce instances of uncontrolled diabetes

•

Identify patients at high-risk for kidney disease and improve outcomes

### CARE COORDINATION

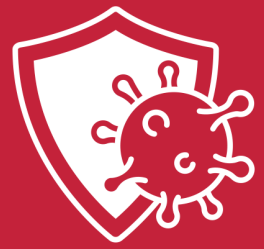
Convene community coalitions

•

Reduce avoidable readmissions, admissions to hospitals and preventable emergency department visits

•

Identify and promote optimal care for super utilizers



### COVID-19

Support nursing homes by establishing a safe visitor policy and cohort plan

•

Provide virtual events to support infection control and prevention

•

Support nursing homes and community coalitions with emergency preparedness plans

### IMMUNIZATION

Increase influenza, pneumococcal, and COVID-19 vaccination rates

### TRAINING

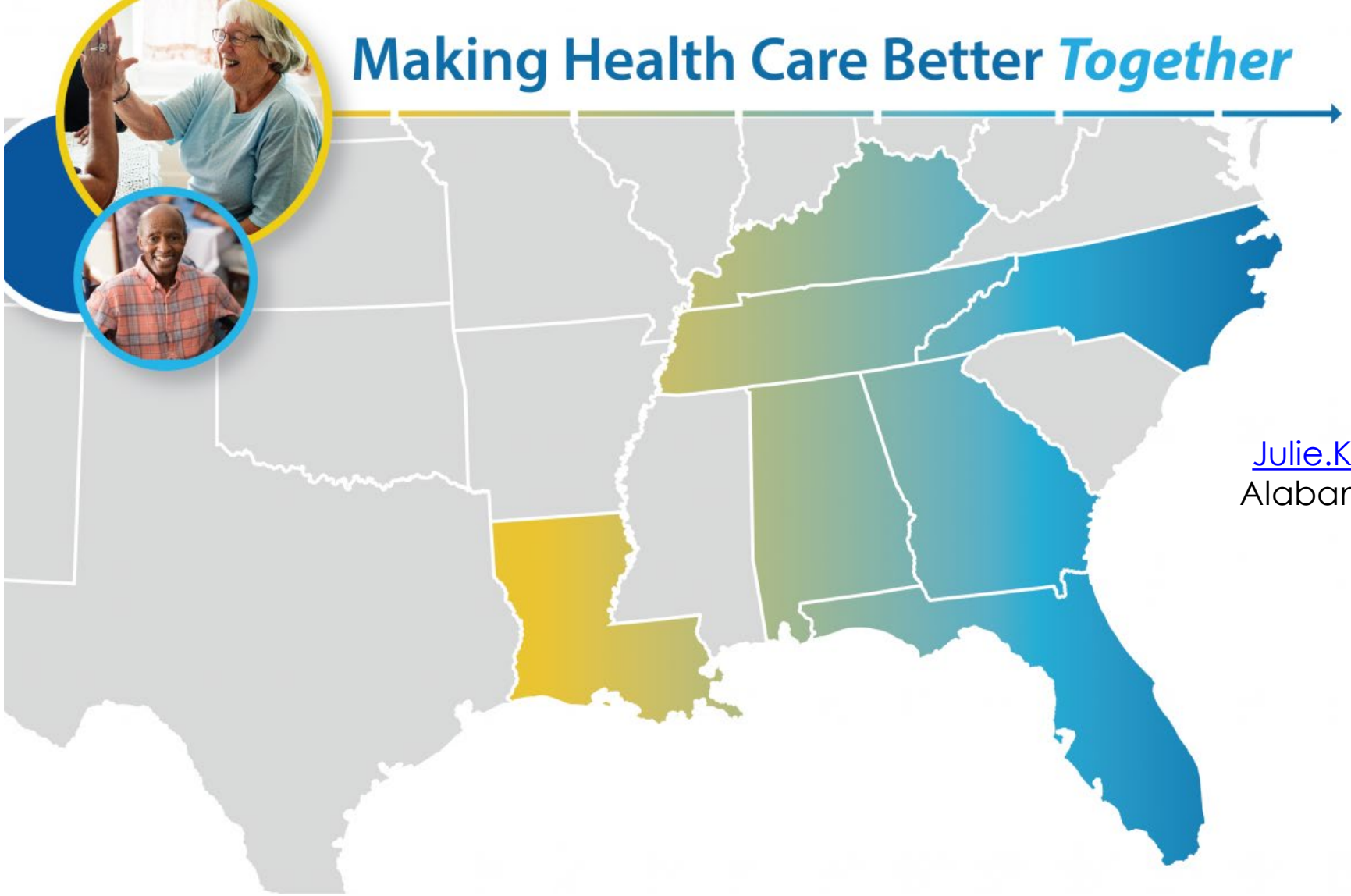
Encourage completion of infection control and prevention trainings by front line clinical and management staff

ALLIANT HEALTH SOLUTIONS | QIN-QIO
Quality Innovation Network - Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES
IQUALITY IMPROVEMENT & INNOVATION GROUP

## Nursing Home and Partnership for Community Health:

# CMS 12TH SOW GOALS ICONS FOR USE

ALLIANT HEALTH SOLUTIONS | QIN–QIO
Quality Innovation Network - Quality Improvement Organizations
CENTER S FOR MEDICARE & MEDICAI D SERVICES IQUALITY IMPROVEMENT & INNOVATION GROU P




Julie Kueker
Julie.Kueker@AlliantHealth.org
Alabama, Florida and Louisiana

Leighann Sauls
Leighann.Sauls@AlliantHealth.org
Georgia, Kentucky, North Carolina and Tennessee

# Program Directors

ALLIANT HEALTH SOLUTIONS | QIN-QIO Quality Innovation Network - Quality Improvement Organizations CENTERS FOR MEDICARE & MEDICAID SERVICES IQUALITY IMPROVEMENT & INNOVATION GROUP

# Making Health Care Better *Together*

ALABAMA • FLORIDA • GEORGIA • KENTUCKY • LOUISIANA • NORTH CAROLINA • TENNESSEE

@AlliantQIO

Alliant Health Solutions

@AlliantQIO

AlliantQIO

This material was prepared by Alliant Health Solutions, a Quality Innovation Network – Quality Improvement Organization (QIN – QIO) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication No. 12SOW-AHS-QIN-QIO TO1-NH TO1-PCH--3978-06/21/23

ALLIANT HEALTH SOLUTIONS | QIN–QIO
Quality Innovation Network - Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES IQUALITY IMPROVEMENT & INNOVATION GROUP