Arizona Opioid Compliance Toolkit for Hospitals and Outpatient Surgery Centers

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SUMMARY OF CONTENT

INTRODUCTION

This July 2018 edition of the Opioid Compliance Toolkit for Hospitals and Outpatient Surgery Centers provides template policies and procedures for compliance with recent Arizona laws relating to opioid prescribing and treatment practices. Current Arizona law includes:

- The Arizona Opioid Epidemic Act of 2018
- The Arizona Opioid Prescribing and Treatment Regulations
- The Arizona Opioid Poisoning Related Reporting Regulations
- The Arizona Opioid Prescribing Guidelines
- The Arizona Emergency Department Prescribing Guidelines

This Toolkit should assist licensed health care institutions to comply with the requirement that they have policies and procedures to protect the health and safety of patients when opioids are prescribed, ordered or administered as part of treatment, including medication-assisted treatment for substance use disorders. We have supplemented these policies and procedures with relevant material from the Arizona Opioid Epidemic Act of 2018 (such as the opioid prescription limitations) and the Arizona Opioid Poisoning Related Reporting Regulations.

Health care institutions will need to take additional compliance measures to satisfy other legal requirements relating to opioid use. For example, the recent changes to Arizona law also require that:

- **Quality Management (QM) Program.** All health care institutions that prescribe, order or administer opioids as part of treatment must include plans in their QM program for reviewing known incidents of opioid-related adverse reactions, other negative outcomes and opioid-related deaths. The QM program also must have a process for surveillance and monitoring of adherence to the opioid policies and procedures provided in this Toolkit.

- **Discharge Planning.** Health care institutions may need to update existing discharge planning policies and procedures to require that, if continuing control of a patient's pain after discharge is medically indicated, a method to do so is addressed as part of discharge planning. For example, an outpatient surgical center may need to update its discharge planning policies and procedures to require use of an actual discharge plan (in addition to the otherwise required discharge instructions and summary).

Because different legal requirements apply depending on whether opioids are prescribed, ordered or administered, as well as the setting and circumstances in which they are used, we have created separate toolkits—one for hospitals/outpatient surgery centers, and another for outpatient clinics. This approach permitted us to draft practical policy templates that are relevant to the medical personnel using opioids in these different settings. This is the Toolkit for hospitals and outpatient surgery centers.

A note about format:

This Toolkit is provided in Word (.docx) format to allow the user to customize the content for the user's specific health care institution. Where appropriate, we have inserted "instructions" and "notes" (italicized and in blue) to assist with customization. This explanatory material should be deleted before the health care institution adopts and uses the policy.

Additionally, we separately provided all the definitions that support the policies and procedures in this Toolkit. Health care institutions may choose to either implement a separate definitions policy that supports all the institution's opioid compliance policies and procedures, or incorporate relevant definitions into each policy adopted by the institution.

Sections of the template policies can be significantly shortened if an institution decides it will only permit opioid use in certain situations. For example, if an outpatient surgery center decides that providers will only be permitted to prescribe a schedule II opioid for acute pain to a patient for use following a surgical procedure for less than 5 days, the "CSPMP Review" section of the Opioid Prescribing Policy could be modified to state:

> If a schedule II opioid prescription is written for less than 5 days, providers may choose to check the CSPMP for patient evaluation and treatment purposes. Prescriptions that exceed 5 days may require providers to check the CSPMP before prescribing, as provided for in the CSPMP Review and Reporting Policy.

In that instance, the remainder of the CSPMP Review section could be omitted.

Similarly, these policies can be shortened if an institution takes the most restrictive approach with respect to all patients that may be prescribed, ordered or administered an opioid.

Because institutions may arrive at different conclusions regarding what practices are best for their patient populations, we drafted the template policies to reflect potential variations permitted under Arizona law with respect to opioid use in a hospital or outpatient surgery setting.

An important caveat:

This Toolkit is not legal advice, and it does not take the place of legal advice. Please consult your legal counsel for advice and counseling in your particular circumstances.

DEFINITIONS & ACRONYMS

Acute pain. Acute pain is pain lasting less than 3 months.

Active malignancy. Active malignancy means a cancer for which:

- A patient is undergoing treatment (for example, a surgical procedure, chemotherapy or radiation treatment);
- There is no treatment; or
- The patient is refusing treatment.

ADHS. ADHS refers to the Arizona Department of Health Services.

Administer. Administer means the direct application of a specific medication, whether by injection, inhalation, ingestion or any other means, to the body of a patient by authorized medical personnel or by the patient at the direction of authorized medical personnel (for example: self-administration of a prescribed opioid).

Benzodiazepine. Benzodiazepine means any one of a class of sedative-hypnotic medications, characterized by a chemical structure that includes a benzene ring linked to a seven-membered ring containing two nitrogen atoms, that are commonly used in the treatment of anxiety.

Business Day. Business day means the period from 8:00 a.m. to 5:00 p.m. Monday through Friday, excluding state holidays.

Chronic pain. Chronic pain is pain persisting longer than 3-6 months and beyond the normal tissue healing time.

Community member. Community member means any person in position to assist an individual at risk of experiencing an opioid-related overdose. This includes emergency first responders, peace officers or other law enforcement personnel, fire department personnel, school district employees and personnel of a facility or center that provides services to individuals at risk of experiencing an opioid-related overdose.

CSPMP. CSPMP refers to Arizona's Controlled Substances Prescription Drug Monitoring Program, which is administered by the Arizona State Board of Pharmacy.

DEA. DEA refers to the United States Drug Enforcement Administration.

Dispense. Dispense means to deliver a specific medication to an ultimate user.

Episode of Care. An episode of care means medical services, nursing services or health-related services provided by a health care institution to a patient for a specific period of time, ending in discharge or the completion of the patient's treatment plan, whichever is later.

FDA. FDA refers to the United States Food and Drug Administration.

MAT. MAT refers to medication-assisted treatment. MAT means the use of pharmacological medications that are approved by the FDA, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of substance use disorders.

MEDSIS. MEDSIS refers to the Medical Electronic Disease Surveillance Intelligence System. MEDSIS is a secure web-based, centralized, person-based disease surveillance system that is hosted and supported by ADHS.

MME. MME refers to morphine milligram equivalent. MME is the equipotent dose of an opioid expressed as the equivalent dose of oral morphine.

Neonatal abstinence syndrome. Neonatal abstinence syndrome means a set of signs of opioid withdrawal occurring in an individual shortly after birth that indicate opioid exposure while in the womb.

OAR. OAR refers to the Arizona Opioid Assistance & Referral Line (1-800-222-1222). The OAR line is operated 24 hours a day 7 days a week and answered by medical experts at Arizona's Poison and Drug Information Centers to provide opioid-related information and support to medical providers and patients.

Opioid. An opioid is a controlled substance that has an addiction forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having addiction-forming or addiction-sustaining liability. It does not include the dextrorotatory isomer of 3-methoxy-n-methylmorphinan and its salts (dextromethorphan). It does include its racemic and levorotatory forms.

Opioid naïve patient. An opioid naïve patient is a patient who has not had an opioid prescription (for an opioid that is a schedule II controlled substance) covering the past 60 days.

Opioid overdose. Opioid overdose means respiratory depression, slowing heart rate or unconsciousness or mental confusion caused by the administration, including self-administration, of an opioid to an individual.

Order. Order means to issue written, verbal or electronic instructions for a specific dose of a specific medication in a specific quantity and route of administration to be obtained and administered to a patient in a health care institution.

Prescribe. Prescribe means to issue written or electronic instructions to a pharmacist to deliver to the ultimate user, or another individual on the ultimate user's behalf, a specific dose of a specific medication in a specific quantity and route of administration.

Schedule II controlled substance. A schedule II controlled substance is a controlled substance that has a high potential for abuse which may lead to severe psychological or physical dependence. Examples of opioids that are schedule II controlled substances include, but are not

limited to: hydromorphone (Dilaudid®); methadone (Dolophine®); meperidine (Demerol®); oxycodone (OxyContin®, Percocet®); and fentanyl (Sublimaze®, Duragesic®). A complete list of schedule II controlled substances is located at A.R.S. § 36-2513.

Sedative-hypnotic medication. Sedative-hypnotic medication means any one of several classes of drugs that have sleep-inducing, anti-anxiety, anticonvulsant and muscle-relaxing properties.

Short-acting opioid antagonist. Short-acting opioid antagonist means a drug approved by the FDA that, when administered, quickly but for a small period of time reverses, in whole or in part, the pharmacological effects of an opioid in the body. For example: naloxone.

Substance use disorder. Substance use disorder means a condition in which the misuse or dependence on alcohol or a drug results in adverse physical, mental or social effects on an individual.

Substance use risk. Substance use risk means an individual's unique likelihood for addiction, misuse, diversion or another adverse consequence resulting from the individual being prescribed or receiving treatment with opioids.

Substance use risk assessment. A substance use risk assessment is a tool used to determine a patient's substance use risk. ***[NOTE:*** *Arizona law gives health care institutions discretion to choose the type of substance use risk assessment tool used. Consider attaching (or linking) the assessment tool that will be used by the facility. Examples of substance use risk assessment tools can be found on a variety of state or federal websites, including the following: the National Institute on Drug Abuse website (https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf); or the Oregon Pain Guidance website (https://www.oregonpainguidance.org/app/content/uploads/2016/05/Opioid-Risk-Tool-ORT.pdf?x91687 or https://www.oregonpainguidance.org/app/content/uploads/2016/05/SOAPP-R.pdf?x91687). Appendix C to the 2018 Arizona Opioid Prescribing Guidelines also provides some tips on how to evaluate patients for opioid use disorders (https://www.azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/az-opioid-prescribing-guidelines.pdf).**]*

Tapering. Tapering means the gradual reduction in the dosage of a medication administered to a patient, often with the intent of eventually discontinuing the use of the medication for the patient.

OPIOID COMPLIANCE POLICIES AND PROCEDURES

Opioid Prescribing

Scope: Hospital (Inpatient / Inpatient Pharmacy / Emergency Department) and Outpatient Surgery

References: A.R.S. §§ 32-3248, 32-3248.01, 36-407
Ariz. Admin. Code § R9-10-120
Arizona Opioid Prescribing Guidelines
Arizona Emergency Department Prescribing Guidelines
[NOTE:** If other opioid guidelines are used to supplement this policy, list them here.**]

PURPOSE: To cover how, when, and by whom opioids may be prescribed for treatment purposes to a patient for use after discharge from a hospital or outpatient surgery setting. Prescribing is not same as ordering and administering. Ordering and administering is not covered in this policy. A separate policy addresses opioid ordering and administration to patient in a hospital or outpatient surgery setting (see the Opioid Ordering and Administration Policy).

POLICY: Providers will prescribe opioids for treatment purposes for use by the patient after discharge only as medically indicated and permitted by applicable laws. No provider will dispense opioids directly to a patient, except that an appropriately licensed MD, DO, PA, RNP or CNM may dispense an opioid for MAT or if it is part of an implantable device.

PROCEDURES:

Authority and Qualifications: The following providers may prescribe an opioid for treatment purposes to a patient for use after discharge. These providers may also review a patient's CSPMP report, perform a substance use risk assessment, obtain informed consent (including explaining potential risks, adverse outcomes, complications, and alternatives), conduct patient monitoring and document these actions in the medical record.

1. ***[INSTRUCTIONS:** In each paragraph below, insert which providers at the health care institution are permitted to prescribe opioids. Under Arizona law, only physicians, physician assistants and registered nurse practitioners with a current DEA registration may prescribe opioids. Include any prescribing limitations in the description of authority, as well as the health care institution's knowledge and qualification requirements for each provider.**]*

2. ***[FOR EXAMPLE:** An MD may prescribe an opioid for treatment purposes for use by a patient after discharge and perform the other duties described above. The MD must have*

*a current DEA registration to prescribe an opioid. This paragraph also must include the health care institution's other requirements regarding the physician's knowledge and qualifications.**]***

Opioid Prescribing Guidelines for Pain: The following guidelines may assist in decision making when prescribing opioids to a patient for use after discharge for non-cancer, non-terminal and non-surgical pain. Each patient and clinical presentation is unique. These guidelines will not supersede clinical assessment and medical judgment.
[NOTE:** Arizona law requires that a health care institution's policies and procedures be consistent with the Arizona Opioid Prescribing Guidelines or national opioid prescribing guidelines, as applicable and except when contrary to medical judgment. The guidelines incorporated into this policy are from the 2018 Arizona Prescribing Guidelines and the 2018 Arizona Emergency Department Prescribing Guidelines. An institution should modify these guidelines as appropriate to best fit the scope of service, patient population and services provided. However, any modifications should be consistent with the guidelines set forth in this template policy. Alternatively, an institution may choose to simply incorporate by reference a set of guidelines and attach a copy of (or include a hyperlink to) the guidelines in this policy.**]

1. Acute Pain Guidelines.

   a. Use non-opioid medications and therapies as first-line treatment for mild and moderate acute pain upon discharge.

      Examples of Non-Opioid Medications and Therapies: NSAIDs and/or acetaminophen; gabapentin or pregabalin; local/regional blocks with long acting medications such as liposomal bupivacaine; behavioral health therapy; acupuncture; massage; cold therapy; localized health and continuous passive motion.

   b. Prescribe opioid medications for treatment of severe acute pain post-discharge only if medically indicated and if non-opioid pain medications or therapies will not provide adequate pain relief.

   c. If opioids are indicated for severe acute pain, initiate therapy at the lowest effective dose for no longer than a 3-5 day duration. Reassess if pain persists beyond the anticipated duration. ***[NOTE:** Consider creating a procedure-specific opioid prescribing table and attaching it to this policy. **Appendix A** includes one example of such a table.**]***

   d. Do not use long-acting opioids for the treatment of acute pain.

   e. Prescribe opioids for children with moderate or severe pain only, or pain that is refractory to non-opioid analgesics. The FDA has issued warnings and contraindications for the use of codeine and tramadol for pain management in all children < 12 years old.

2. Chronic Pain Guidelines.

   a. Prescribe self-management strategies, non-pharmacologic treatments and non-opioid medications as the preferred treatment for chronic pain.

      Examples of Non-Pharmacologic Treatments: physical therapy; weight loss; psychological therapies; multidisciplinary rehabilitation; spinal manipulation; massage; acupuncture; and referral to pain medicine specialists.

      Examples of Non-Opioid Pharmaceuticals: acetaminophen; NSAIDs (ibuprofen and naproxen); gabapentin; alpha-2-agonists; low dose amitriptyline and lidocaine creases or patches; and selected antidepressants and anticonvulsants.

   b. Do not initiate long-term opioid therapy for most patients (particularly pediatric patients) with chronic pain.

   c. Do not prescribe opioids to a patient who is already on a long-term opioid therapy. If possible, one medical provider should provide all controlled substances to treat a patient's chronic pain.

   d. Coordinate interdisciplinary care for patients with high-impact chronic pain to address pain, substance use disorders and behavioral health conditions.

   e. If opioids are used to treat chronic pain, prescribe at the lowest possible dose and for the shortest possible time. Reassess the treatment regimen if prescribing doses $\geq$ 50 MMEs.

3. Additional Emergency Department (ED) Prescribing Guidelines.

   a. Emergency medical providers should not provide replacement prescriptions for controlled substances that were lost, destroyed or stolen.

   b. Emergency medical providers should not provide replacement doses of methadone for patients in a methadone treatment program.

   c. Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, and methadone) should not be prescribed from the ED.

   d. Prescriptions for controlled substances from the ED should state the patient is required to provide a government issued picture identification to the pharmacy filling the prescription.

e. For exacerbations of chronic pain, the emergency medical provider should attempt to contact the patient's primary controlled substances prescriber or pharmacy. The emergency medical provider should only prescribe enough pills (if medically necessary) to last until the office of the patient's primary controlled substances prescriber opens.

f. As necessary, consult with security when denying patient's requested controlled substances.

4. Other Risk Management Guidelines and Conditions that Impose a Higher Risk to Patients.

a. Do not use long-term opioid therapy in patients with untreated substance use disorders.

b. Avoid the use of opioids (particularly long-term opioid therapy) in patients with a history of substance use disorders and/or co-occurring behavioral health issues.

c. Do not provide enough pain medications to "tide someone over"; provide what is medically necessary only.

d. Avoid concurrent use of opioids and benzodiazepines or other sedative-hypnotic medications. If patients are currently prescribed both agents, evaluate tapering or an exit strategy for one or both medications.

e. Discuss reproductive plans and the risk of neonatal abstinence syndrome and other adverse neonatal outcomes before prescribing opioids to women of reproductive age.

f. Counsel patients who are taking opioids on safety, including safe storage and disposal of medications, not driving if sedated or confused while using opioids and not sharing opioids with others.

g. As appropriate, reevaluate patients on long-term opioid therapy at least every 90 days for functional improvements, substance use, high-risk behaviors and psychiatric comorbidities through face-to-face visits, CSPMP checks and urine drug tests.

h. Offer naloxone and provide overdose education for all patients at risk for overdose.

i. ***[NOTE:*** *Consider modifying this section to address other conditions that impose a higher risk to patients when ordering opioids as part of treatment.****]***

Physical Examinations and Substance Use Risk Assessments: Providers will either perform or review a physical examination and substance use risk assessment of the patient before prescribing an opioid for use by a patient after discharge, unless an exception applies.

1. Before prescribing an opioid, providers will either:

    a. Conduct a physical examination and substance use risk assessment of the patient; or
    b. Review a physical examination and substance use risk assessment of the patient that was completed during the same episode of care.

    ***[NOTE:** Arizona law gives health care institutions discretion to choose the type of substance use risk assessment tool used. Consider attaching (or linking) the assessment tool that will be used by the facility. Examples of substance use risk assessment tools can be found on a variety of state or federal websites, including the following: the National Institute on Drug Abuse website (https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf); and the Oregon Pain Guidance website (https://www.oregonpainguidance.org/app/content/uploads/2016/05/Opioid-Risk-Tool-ORT.pdf?x91687 or https://www.oregonpainguidance.org/app/content/uploads/2016/05/SOAPP-R.pdf?x91687). Appendix C to the 2018 Arizona Opioid Prescribing Guidelines also provides some tips on how to evaluate patients for opioid use disorders (https://www.azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/az-opioid-prescribing-guidelines.pdf).]*

2. The following licensed individuals are authorized to conduct an assessment of a patient's substance use risk:

    a. ***[INSTRUCTIONS:** Arizona law permits any individual licensed under Title 32 of the Arizona Revised Statutes, including a nurse, clinical social worker or a substance abuse counselor, to conduct a substance use risk assessment. The health care institution's policies and procedures must specifically authorize such individuals to conduct the substance use risk assessment. This assessment also must be reviewed by the provider who will prescribe the opioid. In each paragraph below, insert the other categories of licensed individuals who may perform a substance use risk assessment.]*
    b. ***[FOR EXAMPLE:** A substance abuse counselor]*

3. Providers are **NOT** required to conduct (or review) a physical examination or substance use risk assessment of the patient before prescribing an opioid under the following circumstances:

    a. The patient has a ≤ 6 months life expectancy;
    b. The patient has pain associated with an active malignancy (cancer); or

c. When a provider is only changing the type or dosage of an opioid previously prescribed in accordance with this policy, if:
   i. The change is made before the pharmacist dispenses the opioid under the prior prescription; or
   ii. The change is because of an adverse reaction experienced by the patient within 72 hours after the pharmacist dispensed the opioid.

CSPMP Review and Reporting: Providers will review the patient's CSPMP report before prescribing an opioid for use by the patient after discharge, and will report opioids dispensed for MAT, unless an exception applies. If an inpatient pharmacist will dispense a prescribed opioid that is a schedule II controlled substance for use by the patient after discharge, the pharmacist will review the patient's CSPMP report and report such opioids dispensed in accordance with the CSPMP Review and Reporting Policy.
[NOTE:** If the facility's EMR integrates CSPMP data into the EMR, a review of the EMR is compliant with the CSPMP review requirements.**]

1. CSPMP Review. Unless one of the exceptions listed below applies, providers will review a patient utilization report obtained from the CSPMP covering the last 12 months, before prescribing an opioid for use by the patient after discharge. EXCEPTIONS:

   a. The patient is receiving hospice or palliative care for a serious or chronic illness;
   b. The patient is receiving care for cancer or a cancer-related illness or condition;
   c. The patient is receiving dialysis treatment;
   d. Medical personnel will administer the opioid to the patient;
   e. The prescription is for ≤ 5 days for:
      i. An invasive medical procedure that results in acute pain to the patient;
      ii. An acute injury (other than back pain); or
      iii. A medical disease process (other than back pain) that is diagnosed in the emergency department and that results in acute pain to the patient; or
   f. The opioid is prescribed for MAT and:
      i. The patient has ≤ 6 months life expectancy; or
      ii. A provider is only changing the type or dosage of an opioid previously prescribed in accordance with this policy, so long as: (A) the change is made before the pharmacist dispenses the opioid under the prior prescription; or (B) the change is because of an adverse reaction experienced by the patient within 72 hours after the pharmacist dispensed the opioid.

   Providers also may need to review a CSPMP report to determine if the opioid prescription limitations for opioid naïve patients apply (see below). Providers and inpatient pharmacists may check the CSPMP as needed to provide medical or pharmaceutical care to the patient or to evaluate the patient.

2. CSPMP Clearinghouse Reporting. Unless one of the exceptions listed below applies, providers authorized to dispense an opioid for MAT will report this information to the

CSPMP clearinghouse in accordance with the CSPMP Review and Reporting Policy.
EXCEPTIONS:

a. The opioid is administered directly to the patient; ***[NOTE:*** *Providers do not need to report opioids dispensed as part of an implantable device because such devices are administered directly to the patient.****]***
b. Reporting is prohibited by 42 C.F.R. Part 2 (if needed, consult with <***insert name of appropriate personnel member***> to determine if 42 C.F.R. Part 2 applies); ***[NOTE****: If the provider who is authorized to dispense an opioid for MAT meets the definition of a "Part 2 Program" under 42 C.F.R. Part 2, s/he must NOT report this information to the CSPMP.****]***
c. The opioid is dispensed by a provider at the facility and is limited to an amount adequate to treat the patient for a maximum of 72 hours (with not more than 72 hour cycles within a 15 day period); or
d. The opioid is a sample only.

Informed Consent Process and Requirements: Providers will obtain specific informed consent for opioid treatment before prescribing an opioid for use by a patient after discharge, unless an exception applies.

1. Informed Consent Process. Unless an exception applies, providers will obtain specific informed consent from the patient (or representative) and will do the following before prescribing an opioid:

   a. Either explain to the patient (or representative) the risks and benefits associated with prescription opioids (including potential adverse outcomes and complications, such as death) or ensure their understanding, if the risks and benefits are explained by another individual authorized to do so by this policy;
   b. Explain alternatives to a prescribed opioid; and
   c. Address (as applicable) conditions that may impose a higher risk to a patient when prescribing an opioid as part of treatment (including concurrent use of a benzodiazepine or other sedative-hypnotic medications, a history of substance use disorder, co-occurring behavioral health issues or pregnancy).

2. Exceptions.

   a. The patient has a ≤ 6 months life expectancy;
   b. The patient has pain associated with an active malignancy (cancer); or
   c. When a provider is only changing the type or dosage of an opioid previously prescribed in accordance with this policy, if:
      i. The change is made before the pharmacist dispenses the opioid under the prior prescription; or
      ii. The change is because of an adverse reaction experienced by the patient within 72 hours after the pharmacist dispensed the opioid.

3. Authorized Individuals. The following licensed individuals are authorized to explain the risks and benefits associated with prescription opioid use to a patient (or representative):

   a. ***[INSTRUCTIONS:*** *Arizona law permits any individual licensed under Title 32 of the Arizona Revised Statutes, such as a clinical social worker, to explain the risks and benefits associated with opioid use. However, the health care institution's policies and procedures must specifically authorize such individuals to do so. Providers also must ensure that the patient (or representative) understands the explanation of risks and benefits. In each paragraph below, insert the other categories of licensed individuals who may explain the risks and benefits of prescription opioid use.****]***
   b. ***[FOR EXAMPLE:*** *A clinical social worker****]***

4. Informed Consent Form. The informed consent form used will contain the following elements:

   a. Patient name, date of birth or other patient identifier and condition for which the opioid is being prescribed;
   b. That an opioid is prescribed;
   c. The potential risks, adverse reactions, complications (including death) and medication interactions associated with opioid use;
   d. If applicable, the potential risks, adverse outcomes and complications associated with the concurrent use of an opioid and a benzodiazepine or another sedative-hypnotic medication;
   e. Alternatives to a prescribed opioid;
   f. Name and signature of the individual explaining the use of an opioid to the patient; and
   g. Signature of the patient (or representative) and the date signed.

   [INSTRUCTIONS: *Modify an existing informed consent form to satisfy these requirements and attach (or link) that form to this policy. Instead of listing the informed consent requirements, consider simply requiring use of that form when prescribing opioids.****]***

Schedule II Opioid Prescription Limitations for Opioid Naïve Patients: Providers will follow the opioid prescription limitations in this policy for all patients who have not had a prescription for an opioid (that is a schedule II controlled substance) which covers the past 60 days, as evidenced by the CSPMP report.

1. Dosage Limit Requirements for Opioid Naïve Patients. Providers will not prescribe an opioid (that is a schedule II controlled substance) > 90 MMEs per day to an opioid naïve patient for use after discharge, unless one of the following requirements is met:

   a. The prescription is for an opioid with a maximum approved total daily dose in the FDA-approved labeling;

b. The prescription is issued following a surgical procedure and the prescription is limited to ≤ 14 days;
c. The patient has an active oncology diagnosis (cancer);
d. The patient has a traumatic injury (not including a surgical procedure) or is receiving treatment for burns;
e. The patient is receiving hospice care, end-of-life care or palliative care;
f. The patient is receiving skilled nursing facility care;
g. The patient is receiving MAT for a substance use disorder;
h. The provider prescribing the opioid is a physician (MD or DO only) who is board-certified in pain;
i. The provider consults with a physician (MD or DO only) who is board certified in pain and the consulting physician agrees with the higher dose. The consultation must be in person, by phone or through telemedicine. If the consulting physician is not available to consult within 48 hours after the request, the medical professional may prescribe the amount s/he believes the patient requires, so long as the medical professional subsequently has the consultation;
j. The provider consults the Arizona OAR Line (1-800-222-1222) and the OAR expert agrees with the higher dose. ***[NOTE:*** *Arizona law permits providers to consult with any opioid assistance and referral call service designated by ADHS. Currently, the Arizona OAR Line is the only designated call service.****]***

2. Day Limit Requirements for Opioid Naïve Patients. Providers will not prescribe a > 5 day supply of an opioid (that is a schedule II controlled substance), or a > 14 day supply of an opioid (that is a schedule II controlled substance) following a surgical procedure, to an opioid naïve patient for use after discharge, unless the patient:

a. Has an active oncology diagnosis (cancer);
b. Has a traumatic injury (not including a surgical procedure) or is receiving treatment for burns;
c. Is receiving hospice care, end-of-life care or palliative care;
d. Is receiving skilled nursing facility care;
e. Is receiving MAT for a substance use disorder; or
f. Is an infant who is being weaned off opioids at the time of discharge.

[NOTE: *This policy does not address assistance with self-administration of a prescribed opioid because this is a service not typically provided in a hospital or outpatient surgery center setting. Assistance in the self-administration of a prescribed opioid means restricting a patient's access to the patient's prescribed opioid medication and providing support to the patient while the patient takes the prescribed opioid to ensure that it is taken as ordered by the provider. Such services are usually provided by outpatient clinics. Accordingly, the Opioid Compliance Toolkit for Outpatient Clinics covers assistance in the self-administration of a prescribed opioid.****]***

Discharge Planning and Patient Monitoring: As appropriate, providers will take steps to plan and monitor a patient's use of a prescribed opioid after discharge. Providers will use a discharge plan when prescribing an opioid for use by the patient after discharge.

1. If applicable, providers will specify in the patient's discharge plan how medically indicated pain control will occur after discharge to meet the patient's needs. This is not required if the patient has a ≤ 6 months life expectancy or an active malignancy (cancer).

2. If providers prescribe an opioid for use by the patient after discharge for > 30 days, providers:

    a. Will include in the patient's discharge plan that the patient will have a face-to-face visit with his/her primary care provider or primary controlled substances provider within 30 days of discharge. The patient's primary provider will be responsible for re-evaluating the patient's substance use risk, continuing or tapering the patient's opioid use, and monitoring the effectiveness of the patient's treatment.
    b. Will not renew a prescription or order an opioid without a face-to-face interaction with the patient. Opioids prescribed or ordered during a subsequent episode of care will be prescribed or ordered in accordance with applicable opioid policies and procedures.

    [NOTE:** Arizona law requires this policy to address the frequency of (a) face-to-face visits, (b) substance use risk assessments, (c) prescription renewals without face-to-face visits, and (d) monitoring the effectiveness of treatment, when an opioid is prescribed for > 30 days. This template policy offers one example of how to satisfy this requirement.**]

Criteria and Procedures for Co-Prescribing a Short-Acting Opioid Antagonist, Referring for Substance Use Disorder Treatment and Tapering Opioids: As appropriate, providers will use this criteria to determine whether a patient prescribed an opioid for use after discharge should be co-prescribed a short-acting opioid antagonist, referred for substance use disorder treatment or start opioid tapering.

1. Criteria for Co-Prescribing Short-Acting Opioid Antagonists.

    a. If a patient is prescribed an opioid for > 90 MME per day for use after discharge, providers also will prescribe an FDA approved opioid antagonist for the treatment of opioid-related overdoses (such as naloxone).

    b. ***[INSTRUCTIONS:** Develop with providers any other criteria for co-prescribing short-acting opioid antagonists.**]***

2. Criteria and Procedures for Substance Use Disorder Treatment Referrals.

    a. A provider will refer a patient who is discharged after receiving emergency services for a drug-related overdose to a behavioral health services provider.

b. ***[INSTRUCTIONS:*** *Develop with providers the other criteria and procedures for making substance use disorder treatment referrals. Consider adopting and referring to a "Screening, Brief Intervention, and Referral to Treatment (SBIRT) tool" that can be used with the health care institution's other opioid policies and procedures: https://www.integration.samhsa.gov/clinical-practice/sbirt; or http://sbirtarizona.org/health-care-professionals/screening-tools--guidelines. Adopting SBIRT may also satisfy the requirement that health care institutions perform a substance use risk assessment before prescribing opioids. Examples of other screening tools can be found on state and federal websites, including the National Institute on Drug Abuse (https://www.drugabuse.gov/sites/default/files/files/QuickScreen_Updated_2013%281%29.pdf) and Oregon's SBIRT App website (http://www.sbirtoregon.org/screening-app/).****]***

c. ***[INSTRUCTIONS:*** *Create an attachment that lists behavioral health service providers in your area.* ***Appendix B*** *includes step-by-step instructions regarding how to find local providers. Consider also attaching a list of statewide publicly funded detox locations in Arizona to this policy (****Appendix C****) and/or making available to patients a handout with contacts for treatment options (****Appendix D****).]*

3. Criteria and Procedures for Tapering Opioid Prescriptions.

a. Providers will address opioid tapering with a patient, if it is medically indicated and appropriate for that patient. Providers may defer to the patient's primary controlled substance provider, if applicable.

b. ***[INSTRUCTIONS:*** *Develop with providers the criteria and procedures for tapering opioid prescriptions. Consider referring to an "Opioid Tapering Chart" that can also be used with the health care institution's other opioid policies and procedures. Appendix E to the 2018 Arizona Opioid Prescribing Guidelines provides one approach for opioid tapering: https://www.azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/az-opioid-prescribing-guidelines.pdf. Other examples of opioid tapering criteria can be found on state and federal websites, such as the Department of Veterans Affairs (https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/52_Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf#) and Oregon Pain Guidance website (https://www.oregonpainguidance.org/guideline/tapering/). Additionally, the Arizona Opioid Assistance & Referral Line is a good resource that providers can contact 24/7 with tapering and other opioid-related questions (http://phoenixmed.arizona.edu/opioid/provider-faqs).]*

Documentation Requirements: Providers will document information regarding opioid treatment and prescriptions in the patient's medical record.
[NOTE:** If appropriate, a facility could choose to require providers to specifically document this information in the patient's treatment plan.**]

1. The following information will be recorded in the medical record:

    a. The patient's diagnosis;
    b. Medical history, including co-occurring disorder;
    c. The opioid prescribed;
    d. Other medications or herbal supplements taken by the patient;
    e. Documentation of patient monitoring;
    f. If applicable,
        i. Any discharge planning documentation of methods for continuing pain control if continuing pain control is medically indicated;
        ii. The effectiveness and duration of the patient's current treatment, and alternative treatments tried or planned for the patient;
        iii. The benefit of the new treatment compared with continuing the current treatment;
        iv. A provider's review of the CSPMP patient utilization report;
        v. The signed informed consent for opioid treatment and any other documentation that authorized personnel explained the risks and benefits of prescription opioid use, and that a provider explained the alternatives;
    g. The expected benefit of the treatment;
    h. Any other relevant factors.

2. Providers are **NOT** required to document items 1.f through 1.h in the medical record if:

    a. The patient has a ≤ 6 months life expectancy;
    b. The patient has pain associated with an active malignancy (cancer); or
    c. A provider is only changing the type or dosage of an opioid previously prescribed in accordance with this policy, if:
        i. The change is made before the pharmacist dispenses the opioid under the prior prescription; or
        ii. The change is because of an adverse reaction experienced by the patient within 72 hours after the pharmacist dispensed the opioid.

Opioid Ordering and Administration

Scope: Hospital (Inpatient / Inpatient Pharmacy / Emergency Department) and Outpatient Surgery

References: A.R.S. §§ 36-2606, 36-2608
Ariz. Admin. Code § R9-10-120
Arizona's Emergency Department Prescribing Guidelines
*[**NOTE:** If other opioid guidelines are used to supplement this policy, list them here.]*

PURPOSE: To cover how, when, and by whom opioids may be ordered and/or administered for treatment purposes in a hospital or outpatient surgery setting. Ordering and administering are not the same as prescribing. Prescribing is not covered in this policy. A separate policy addresses opioid prescribing for prescription opioid use by a patient after discharge from a hospital or outpatient surgery setting (see Opioid Prescribing Policy).

POLICY: Providers will only order and/or administer opioids as medically indicated and permitted by applicable laws.

PROCEDURES:

Authority and Qualifications: The following providers may order and administer an opioid for treatment purposes in the hospital or outpatient surgery center. These providers may also review a patient's profile on the CSPMP, perform a substance use risk assessment, obtain informed consent (including explaining potential risks, adverse outcomes, complications, and alternatives), conduct patient monitoring, and document these actions.

1. *[**INSTRUCTIONS**: In each paragraph below, insert which providers are permitted to order opioids. Under Arizona law, only physicians, physician assistants and registered nurse practitioners with a current DEA registration may order an opioid. Include any ordering or administration limitations in the description of authority, as well as the health care institution's knowledge and qualification requirements for each provider.]*

2. *[**FOR EXAMPLE:** An MD may order and administer an opioid for treatment purposes, as well as perform the other duties described above. The MD must have a current DEA registration to order an opioid. This paragraph also must include the health care institution's other requirements regarding the physician's knowledge and qualifications.]*

Opioid Ordering/Administration Guidelines for Pain: The following guidelines will assist in decision making when ordering and administering opioids for non-cancer, non-terminal, and

non-surgical pain. Each patient and clinical presentation is unique. These guidelines will not supersede clinical assessment and medical judgment.
***[NOTE:** Arizona law requires that a health care institution's opioid ordering policies and procedures be consistent with the Arizona Opioid Prescribing Guidelines or national opioid prescribing guidelines, as applicable and except when contrary to medical judgment. There are currently no Arizona guidelines that specifically address opioid ordering and administration by hospitals and outpatient surgical centers for non-cancer, non-terminal, and non-surgical pain. The guidelines included in this policy are from the relevant portions of the 2018 Arizona's Emergency Department Prescribing Guidelines.**]*

1. Emergency Department (ED) Administration Guidelines.

    a. If possible, avoid administration of intravenous and intramuscular controlled substances in the ED for the relief of acute or chronic pain.

    b. The administration of Demerol® (Meperidine) in the ED is discouraged.

    c. Patients who present in the ED for pain related complaints should be photographed if the patient does not have a government issued photo identification card.

    d. As necessary, consult with security when denying patient's requested controlled substances.

2. Other Risk Management Guidelines; Conditions that Impose a Higher Risk to Patients.

    a. Avoid the use of opioids in patients with a history of substance use disorders, an untreated substance use disorder, and/or co-occurring behavioral health issues.

    b. Avoid concurrent use of opioids and benzodiazepines or other sedative-hypnotic medications. If patients are currently using both agents, evaluate tapering or an exit strategy for one or both medications.

    c. Discuss reproductive plans and the risk of neonatal abstinence syndrome and other adverse neonatal outcomes before ordering opioids for women of reproductive age.

    d. ***[NOTE:** Consider modifying this section to address other conditions that impose a higher risk to patients when ordering opioids as part of treatment.**]*

Physical Examinations and Substance Use Risk Assessments: Providers will either perform or review a physical examination and substance use risk assessment of the patient before ordering an opioid, unless an exception applies.

1. Exceptions. Providers are **NOT** required to conduct (or review) a physical examination or substance use risk assessment of the patient before ordering an opioid under the following circumstances:

    a. When ordering an opioid as part of treatment for ≤ 3 days while the patient is at the facility and receiving continuous medical/nursing services;
    b. When ordering an opioid as part of treatment for a patient receiving a surgical procedure or other invasive procedure;
    c. To treat the patient in an emergency situation, so long as the physical examination and substance use risk assessment are performed after the emergency situation is over;
    d. The patient has a ≤ 6 months life expectancy;
    e. The patient has pain associated with an active malignancy (cancer); or
    f. When a provider is only changing the type, dosage or route of administration of a prior opioid ordered by a provider in accordance with this policy, to meet the patient's needs.

2. Physical Examination. If an exception does not apply, providers will do one of the following before ordering an opioid:

    a. Conduct a physical examination of the patient; or
    b. Review a physical examination of the patient that was completed either:
        i. During the patient's same episode of care; or
        ii. Within the previous 30 days either (A) at the transferring health care institution, or (B) by a medical practitioner (physician, physician assistant or registered nurse practitioner) who referred the patient for admission to the health care institution.

3. Substance Use Risk Assessment. If an exception does not apply, providers will do one of the following before ordering an opioid:

    a. Conduct a substance use risk assessment; or
    b. Review a substance use risk assessment of the patient that was conducted within the previous 30 calendar days by any of the following licensed individuals:

        i. ***[INSTRUCTIONS:*** *Arizona law permits any individual licensed under Title 32 of the Arizona Revised Statutes, such as a nurse, clinical social worker or licensed substance abuse counselor, to conduct a substance use risk assessment. However, the health care institution's policies and procedures must specifically authorize such individuals to conduct the substance use risk assessment. This assessment must be reviewed by the provider who will order the opioid. In each paragraph below, insert the other categories of licensed individuals who may perform a substance use risk assessment****.]***
        ii. ***[FOR EXAMPLE:*** *A substance abuse counselor****]***

*[**NOTE:** Arizona law gives health care institutions discretion to choose the type of substance use risk assessment tool used. Consider attaching (or linking) the assessment tool that will be used by the facility. Examples of substance use risk assessment tools can be found on a variety of state or federal websites, including the following: the National Institute on Drug Abuse website (https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf); or the Oregon Pain Guidance website (https://www.oregonpainguidance.org/app/content/uploads/2016/05/Opioid-Risk-Tool-ORT.pdf?x91687 or https://www.oregonpainguidance.org/app/content/uploads/2016/05/SOAPP-R.pdf?x91687). Appendix C to the 2018 Arizona Opioid Prescribing Guidelines also provides some tips on how to evaluate patients for opioid use disorders (https://www.azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/az-opioid-prescribing-guidelines.pdf).]*

CSPMP Review and Reporting: Providers and inpatient pharmacists may choose (but are NOT required) to check the CSPMP when ordering and/or dispensing an opioid for either (1) inpatient use, or (2) administration by medical personnel in the hospital or outpatient surgery setting. Providers and inpatient pharmacists are NOT required to report to the CSPMP clearinghouse opioids administered directly to the patient. The CSPMP review and reporting requirements are different for opioid prescriptions: consult the CSPMP Review and Reporting Policy.

Informed Consent Process and Requirements: Providers will obtain specific informed consent for opioid treatment before ordering an opioid, unless an exception applies.

1. Exceptions. Providers are **NOT** required to follow the specific consent requirements in this policy before ordering an opioid under the following circumstances:

    a. When ordering an opioid for ≤ 3 days while the patient is at the facility and receiving continuous medical/nursing services;
    b. When ordering an opioid for a patient receiving a surgical procedure or other invasive procedure;
    c. When ordering an opioid to treat a patient in an emergency situation, so long as informed consent is obtained after the emergency situation is over;
    d. The patient has a ≤ 6 months life expectancy;
    e. The patient has pain associated with an active malignancy (cancer); or
    f. When a provider is only changing the type, dosage or route of administration of an opioid previously ordered by a provider in accordance with this policy.

2. Informed Consent Process. If an exception does not apply, providers will obtain informed consent from the patient (or representative) and will:

    a. Either explain to the patient (or representative) the risks and benefits associated with the use of opioids (including potential adverse outcomes and complications,

such as death), or ensure their understanding, if the risks and benefits are explained by another individual authorized to do so by this policy;

b. If applicable, explain alternatives to an ordered opioid; and

c. Address (as applicable) conditions that may impose a higher risk to a patient when ordering an opioid as part of treatment (including concurrent use of a benzodiazepine or other sedative-hypnotic medications, a history of substance use disorder, co-occurring behavioral health issues or pregnancy).

3. Authorized Individuals. The following licensed individuals are authorized to explain the risks and benefits associated with opioid use to a patient (or representative):

a. ***[INSTRUCTIONS:*** *Arizona law permits any individual licensed under Title 32 of the Arizona Revised Statutes, such as a clinical social worker, to explain the risks and benefits associated with opioid use. However, the health care institution's policies and procedures must specifically authorize such individuals to do so. Providers also must ensure that the patient (or representative) understands the explanation of risks and benefits. In each paragraph below, insert the other categories of licensed individuals who may explain the risks and benefits of opioid use.****]***

b. ***[FOR EXAMPLE:*** *A clinical social worker.****]***

4. Informed Consent Form. The informed consent form used will contain the following elements:

a. Patient name, date of birth or other patient identifier and condition for which the opioid is being prescribed;

b. That an opioid is prescribed;

c. The potential risks, adverse reactions, complications (including death), and medication interactions associated with opioid use, including (if applicable) the same with respect to concurrent use of an opioid and a benzodiazepine or another sedative-hypnotic medication;

d. Alternatives to an ordered opioid;

e. Name and signature of the individual explaining the use of an opioid to the patient; and

f. Signature of the patient (or representative) and the date signed.

[INSTRUCTIONS*: Modify an existing informed consent form to satisfy these requirements and attach (or link) that form to this policy. Instead of listing the informed consent requirements, consider simply requiring use of that form when ordering opioids.****]***

Opioid Administration and Patient Monitoring: Unless an exception applies, providers or authorized personnel will identify and assess a patient's need for opioid administration before an opioid is administered to the patient in the hospital or outpatient surgery setting, monitor the patient's response and document the effects in the medical record.

1. Authorization to Administer. Providers and the following other authorized personnel may administer an opioid, identify and assess the patient's need for opioid administration, monitor the patient and document the effects:

    a. ***[INSTRUCTIONS:*** *Arizona law permits personnel—other than physicians, physician assistants and registered nurse practitioners—to administer opioids as part of treatment. However, the health care institution's policies and procedures must specifically authorize such personnel to administer an opioid. In each paragraph below, insert the other categories of personnel who may administer an opioid at the facility, including the required knowledge and qualifications of these personnel members.****]***

    b. ***[FOR EXAMPLE:*** *A LPN may administer opioids that have been ordered by a provider and perform the other duties identified above to the extent they are in the LPN's scope of practice. This paragraph must include the health care institution's requirements regarding the LPN's knowledge and qualifications.****]***

2. Need for Opioid Administration. Authorized personnel will identify a patient's need for the opioid before administering it. Authorized personnel will determine a patient's need in accordance with acceptable standards of medical practice in the community. The requirements of this paragraph will not apply to administration of an opioid for a patient with a ≤ 6 months life expectancy or pain associated with an active malignancy (cancer).

3. Patient Monitoring.

    a. Authorized personnel will monitor the patient's response to the opioid administered while the patient is at the facility. ***[NOTE:*** *Arizona's opioid treatment regulations do not require patient monitoring if the patient receiving the opioid has a ≤ 6 months life expectancy or pain associated with an active malignancy (cancer). However, it is a best practice to monitor a patient's response to any drug administered while the patient is physically present at the facility. Thus, this template policy does not include an exceptions to this requirement.****]***

    b. If a provider orders an opioid for >30 days:

        i. ***[INSTRUCTIONS:*** *Insert how frequently face-to-face interactions will occur.****]***

        ii. ***[INSTRUCTIONS:*** *Insert how frequently substance use risk assessments will be performed. The frequency should be no later than every 90 days for patients on long-term opioid therapy.****]***

        iii. ***[INSTRUCTIONS:*** *Insert how frequently the order will be renewed without a face-to-face interaction, if at all.****]***

        iv. ***[INSTRUCTIONS:*** *Insert how frequently monitor the effectiveness of the opioid treatment will be monitored. The frequency should be no later than every 90 days for patients on long-term opioid therapy.****]***

Criteria and Procedures for Co-Prescribing a Short-Acting Opioid Antagonist, Referring for Substance Use Disorder Treatment and Tapering Opioids: As appropriate, providers will use this criteria to determine whether a patient ordered an opioid should be prescribed a short-acting opioid antagonist, referred for substance use disorder treatment or start opioid tapering.

1. Criteria for Co-Prescribing Short-Acting Opioid Antagonists.

    a. ***[INSTRUCTIONS:*** *Develop with providers any criteria for co-prescribing short-acting opioid antagonists.****]***

2. Criteria and Procedures for Substance Use Disorder Treatment Referrals.

    a. Providers will refer a patient who is discharged after receiving emergency services for a drug-related overdose to a behavioral health services provider.

    b. ***[INSTRUCTIONS:*** *Develop with providers the other criteria and procedures for making substance use disorder treatment referrals. Consider adopting and referring to a "Screening, Brief Intervention, and Referral to Treatment (SBIRT) tool" that can be used with the health care institution's other opioid policies and procedures: https://www.integration.samhsa.gov/clinical-practice/sbirt; or http://sbirtarizona.org/health-care-professionals/screening-tools--guidelines.. Adopting SBIRT may also satisfy the requirement that health care institutions perform a substance use risk assessment before ordering opioids. Examples of other screening tools can be found on state and federal websites, including the National Institute on Drug Abuse (https://www.drugabuse.gov/sites/default/files/files/QuickScreen_Updated_2013%281%29.pdf) and Oregon's SBIRT App website (http://www.sbirtoregon.org/screening-app/).****]***

    c. ***[INSTRUCTIONS:*** *Create an attachment that lists behavioral health service providers in your area.* ***Appendix B*** *includes step-by-step instructions regarding how to find local providers. Consider also attaching a list of statewide publicly funded detox locations in Arizona to this policy (****Appendix C****) and/or making available to patients a handout with contacts for treatment options (****Appendix D****).****]***

3. Criteria and Procedures for Tapering Opioid Use.

    a. Providers will address opioid tapering with a patient, if it is medically indicated and appropriate for that patient. Providers may defer to the patient's primary controlled substance provider, if applicable.

    b. ***[INSTRUCTIONS:*** *Develop with providers the criteria and procedures for tapering opioid prescriptions. Appendix E to the 2018 Arizona Opioid Prescribing Guidelines provides one approach for opioid tapering:*

https://www.azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/az-opioid-prescribing-guidelines.pdf. Other examples of opioid tapering criteria can be found on state and federal websites, such as the Department of Veterans Affairs (https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/52_Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf#) and Oregon Pain Guidance website (https://www.oregonpainguidance.org/guideline/tapering/).]

Discharge Planning: If continuing control of pain after discharge is medically indicated, a provider will address a method for continuing pain control as part of discharge planning. If applicable, the discharge plan will specify the method for how pain control will occur after the patient's discharge. Providers may prescribe an opioid for use by the patient after discharge in accordance with the Opioid Prescribing Policy.

Documentation Requirements: Providers will document information regarding opioid ordering and administration in the patient's medical record.
***[NOTE:** If appropriate, a facility could choose to require providers to specifically document this information in the patient's treatment plan.]*

1. The following information will be recorded in the medical record:

    a. The patient's diagnosis;
    b. Medical history, including co-occurring disorder;
    c. The opioid ordered and/or administered and the reason for the order;
    d. Other medications or herbal supplements taken by the patient;
    e. Documentation of patient monitoring;
    f. If applicable,
        i. Any emergency situation that prevented a provider from obtaining informed consent and conducting a physical examination or substance use risk assessment before ordering and/or administering an opioid;
        ii. The patient's need for the opioid that was administered and its effect;
        iii. Any discharge planning documentation of methods for continuing pain control if continuing pain control is medically indicated;
        iv. The effectiveness and duration of the patient's current treatment, and alternative treatments tried or planned for the patient;
        v. The benefit of any new treatment compared with continuing the current treatment;
        vi. A provider's review of the CSPMP patient utilization report;
        vii. The signed informed consent for opioid treatment and any other documentation that authorized personnel explained the risks and benefits of opioid use, and that a provider explained alternatives;
    g. The expected benefit of the treatment; and
    h. Any other relevant factors.

2. Providers are **NOT** required to document items 1.f through 1.h in the medical record under the following circumstances:

   a. When ordering an opioid for ≤ 3 days while the patient is at the facility and receiving continuous medical/nursing services;
   b. When ordering an opioid for a patient receiving a surgical procedure or other invasive procedure;
   c. The patient has a ≤ 6 months life expectancy;
   d. The patient has pain associated with an active malignancy (cancer); or
   e. When a provider is only changing the type, dosage or route of administration of an opioid previously ordered by a provider in accordance with this policy.

CSPMP Review and Reporting

Scope: Hospital (Inpatient / Emergency Department), Outpatient Surgery and Pharmacy (Inpatient / Outpatient)

References: A.R.S. §§ 36-2601 through 2610
Ariz. Admin. Code §§ R4-23-501 through 505, R9-10-120

PURPOSE: To cover who reviews and reports to the CSPMP and when they do so.

POLICY: Providers, pharmacists and their delegates may use their respective CSPMP accounts to access CSPMP reports. Unless an exception applies, providers and pharmacists will review a patient utilization report obtained from the CSPMP covering the last 12 months before prescribing or dispensing any of the prescribed controlled substances specified in this policy for outpatient use. Providers prescribing an opioid analgesic (pain med) or benzodiazepine schedule II, III, or IV controlled substance will review the CSPMP at least quarterly thereafter while that prescription remains a part of treatment. Providers and pharmacists may (but are not required) to review a CSPMP report when ordering or dispensing medications for inpatient use or administration by medical personnel at the facility. Providers and pharmacists will access the CSPMP only to provide medical or pharmaceutical care to a patient or to evaluate a patient. Controlled substances dispensed for outpatient use will be reported to the CSPMP, unless an exception applies.

PROCEDURE:

CSPMP Review: Providers and pharmacists will review a patient utilization report obtained from the CSPMP covering the last 12 months when prescribing or dispensing any of the prescribed controlled substances specified in this policy for outpatient use, unless an exception applies. In other treatment circumstances (such as when ordering or administering opioids for use in the hospital or outpatient surgery setting), providers and pharmacists may exercise their discretion as to whether it is appropriate to check the CSPMP to provide medical or pharmaceutical care to a patient or to evaluate a patient. ***[NOTE:*** *If the facility's EMR integrates CSPMP data into the EMR, a review of the EMR is compliant with the CSPMP review requirements.****]***

1. Providers. Providers registered with the DEA to use controlled substances for treatment will register with the Arizona State Board of Pharmacy to be granted access to the CSPMP. Providers will use the CSPMP identifier assigned to them and may not use the CSPMP identifier of another person to access the CSPMP. Providers may have a delegate (such as a medical assistant) who is registered with the CSPMP look up a patient report

on the provider's behalf. The delegate will use the CSPMP identifier assigned to the delegate (see paragraph 4 below).

a. ***Mandatory Review: Prescriptions.*** Unless an exception applies (see paragraph 3 below), before prescribing an opioid analgesic (pain med) or benzodiazepine controlled substance listed in schedule II, III or IV for a patient for outpatient use, a provider will obtain a patient utilization report regarding the patient for the last 12 months from the CSPMP at the following intervals:
   i. The beginning of each new course of treatment; and
   ii. At least quarterly thereafter while that prescription remains a part of the patient's treatment.

b. ***Permissive Review.*** Providers may access the CSPMP to provide medical care to a patient or to evaluate a patient.

2. Pharmacists. Pharmacists will register with the Arizona State Board of Pharmacy to be granted access to the CSPMP. Pharmacists will use the CSPMP identifier assigned to them and may not use the CSPMP identifier of another person to access the CSPMP. Pharmacists may have a registered delegate look up a patient report on the pharmacist's behalf. The delegate will use the CSPMP identifier assigned to the delegate (see paragraph 4 below).

a. ***Mandatory Review: Prescriptions.*** Unless an exception applies (see paragraph 3 below), before dispensing a prescribed schedule II controlled substance for outpatient use, a pharmacist will obtain a patient utilization report regarding the patient for the last 12 months at the beginning of each new course of treatment.

b. ***Permissive Review.*** Pharmacists may access the CSPMP to provide medical or pharmaceutical care to a patient or to evaluate a patient.

3. Exceptions to Mandatory CSPMP Review.

a. Medical personnel will administer the controlled substance;
b. The patient is receiving the controlled substance during the course of inpatient or residential treatment in a hospital, nursing care facility, assisted living facility, correctional facility or mental health facility;
c. The prescription is for ≤ 5 days for:
   i. An invasive medical procedure that results in acute pain to the patient;
   ii. An acute injury (other than back pain); or
   iii. A medical disease process (other than back pain) that is diagnosed in the emergency department and that results in acute pain to the patient;
d. The patient is receiving hospice or palliative care for a serious or chronic illness;
e. The patient is receiving care for cancer or a cancer-related illness or condition; or
f. The patient is receiving dialysis treatment; or
g. The opioid is for MAT and any of the following apply:
   i. The patient has ≤ 6 months life expectancy; or

ii. A provider is only changing the type or dosage of an opioid previously prescribed in accordance with the Opioid Prescribing Policy, so long as: (A) the change is made before the pharmacist dispenses the opioid under the prior prescription; or (B) the change is because of an adverse reaction experienced by the patient within 72 hours after the pharmacist dispensed the opioid.

4. Delegates. Staff (such as the front office or medical assistants) may run patient utilization reports for review by providers or pharmacists. Such delegates will register with the CSPMP and access reports through their own accounts. ***[NOTE:*** *The Arizona Pharmacy Board's position with respect to delegate access is in flux. For example, delegates may access the CSPMP through an online web portal using their own account, but cannot access the same information if it is integrated into the facility's EMR. For more details on how to register delegates and integration, see: https://pharmacypmp.az.gov/frequently-asked-questions-faqs.****]***

Prohibited CSPMP Access: The CSPMP may be accessed by registered providers, pharmacists and their delegates only for purposes of providing medical or pharmaceutical care to the patient or to evaluate the patient. The CSPMP will not be accessed for any other purposes.

CSPMP Clearinghouse Reporting: Providers and pharmacists who dispense schedule II, III, IV or V controlled substances for outpatient use will report this information to the CSPMP clearinghouse, unless an exception applies. The facility or pharmacy may perform this reporting on behalf of all dispensing providers or pharmacists. There is no reporting requirement for controlled substances that are administered directly to a patient in a hospital or outpatient surgical setting.

1. Reporting Requirements. Unless an exception applies, providers and pharmacists who dispense schedule II, III, IV or V controlled substances for outpatient use will report this information to the CSPMP clearinghouse daily (including zero reports). ***[NOTE:*** *For more information regarding how to register for CSPMP clearinghouse reporting, see: https://pharmacypmp.az.gov/sites/default/files/Opioid%20Epidemic%20Act%20Pharmacy%20Notice_06052018.pdf and https://pharmacypmp.az.gov/sites/default/files/documents/files/AZ%20Data%20Submission%20Dispenser%20Guide_0.pdf. If the facility or pharmacy will report on behalf of all dispensing providers or facility, modify this provision to reflect that workflow.****]***

2. Exceptions to Reporting.

   a. The controlled substance is administered directly to the patient;
   b. If reporting is prohibited by 42 C.F.R. Part 2 (if needed, consult with ***<insert name of appropriate personnel member>*** to determine if 42 C.F.R. Part 2 applies); ***[NOTE:*** *If the provider who is authorized to dispense an opioid for MAT*

meets the definition of a "Part 2 Program" under 42 C.F.R. Part 2, s/he must NOT report this information to the CSPMP.]

c. The controlled substance is dispensed by medical personnel at the facility and is limited to an amount adequate to treat the patient for a maximum of 72 hours (with not more than 72 hour cycles within a 15 day period); or

d. The controlled substance is a sample.

Suspected Opioid Overdose Reporting

Scope: Hospital (Inpatient / Emergency Department), Outpatient Surgery and Pharmacy (Inpatient / Outpatient)

References: A.R.S. § 32-1979
Ariz. Admin. Code §§ R9-4-601 through 602, R9-10-120
MEDSIS User Guide for Healthcare Facilities: Overdose and Neonatal Syndrome Reporting

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PURPOSE: To cover the requirements to report to ADHS on opioid related matters, including suspected opioid overdose reporting, suspected neonatal abstinence reporting and naloxone/other opioid antagonist reporting.

POLICY: ***[Insert the designated position at the facility]*** (or his/her designee) will use MEDSIS to report to ADHS suspected opioid overdoses and suspected neonatal abstinence syndrome as required by law. ***[NOTE:*** *Either providers must report or, in a facility setting, the facility may report on behalf of all providers.**]*** Pharmacists will report to the CSPMP naloxone or other opioid antagonists dispensed in an outpatient (non-surgical) setting for opioid overdose-related purposes. Naloxone or other opioid antagonists administered in the hospital or outpatient surgery setting do not need to be reported.

PROCEDURE:

Suspected Opioid Overdose Reporting: Suspected opioid overdoses will be reported to ADHS through MEDSIS within the required timeframes, unless an exception applies or reporting is prohibited by 42 C.F.R. Part 2.

1. Death Reporting: Opioids Used for Treatment. Suspected opioid overdose deaths related to an opioid prescribed or ordered as part of a patient's treatment, will be reported to ADHS through MEDSIS within 1 business day of learning of the patient's death. This reporting requirement does not apply if:

    a. The patient had a ≤ 6 months life expectancy; or
    b. The patient was prescribed or ordered the opioid for pain associated with an active malignancy (cancer).

    [NOTE: *There is also an exception to this reporting requirement if 42 C.F.R. Part 2 prohibits reporting. However, 42 C.F.R. Part 2 expressly permits disclosure of protected substance use disorder treatment information relating to the cause of death of a patient if required by state law. 42 C.F.R. § 2.15(b). Thus, there should not be any circumstances*

*in which 42 C.F.R. Part 2 would prevent a hospital or outpatient surgery center from reporting a suspected opioid overdose death.**]***

2. Reporting Exception for **Non-Death** Overdoses Resulting from Opioids Administered at the Facility. The facility's quality management program addresses incidents of opioid-related adverse reactions and other negative outcomes, including opioid overdoses, which result from opioid administration to the patient at the facility. Accordingly, reporting of suspected opioid overdoses (other than deaths) resulting from the administration of an opioid to a patient at the facility is **NOT** required. ***[NOTE:** If the quality management program does not cover opioid overdoses, the facility must report these suspected opioid overdoses to ADHS.**]***

3. Prohibition on Reporting of **Non-Death** Overdoses Protected by 42 C.F.R. Part 2. Information will not be reported to ADHS if the reporting is prohibited by 42 C.F.R. Part 2. ***[Insert name of appropriate personnel member]*** may be consulted, as needed, to determine if 42 C.F.R. Part 2 prohibits reporting.

4. Other Opioid Overdose Reporting. All other suspected opioid overdoses (including deaths) occurring or pronounced at the facility will be reported to ADHS through MEDSIS within 5 days after the encounter with the patient experiencing the suspected opioid overdose.
[NOTE:** Paper reporting is also permitted. However, ADHS strongly recommends use of MEDSIS.**]

Suspected Neonatal Abstinence Syndrome Reporting: Suspected neonatal abstinence syndrome will be reported to ADHS through MEDSIS within 5 business days, unless reporting is prohibited by 42 C.F.R. Part 2. ***[Insert name of appropriate personnel member]*** may be consulted, as needed, to determine if 42 C.F.R. Part 2 prohibits reporting.

Naloxone Reporting for Opioid-Related Overdose: Pharmacists will report to the CSPMP naloxone or other opioid antagonists dispensed in an outpatient (non-surgical) setting to a person who is at risk of experiencing an opioid-related overdose or to a family/community member who is in a position to assist that person. Naloxone and other opioid antagonists administered to a patient in the hospital or outpatient surgery setting do NOT need to be reported at this time.
[NOTE:** Arizona law currently requires naloxone reporting only by a pharmacist who personally dispenses naloxone or another opioid antagonist under Dr. Cara Christ's (ADHS) standing order to a person who is at risk of experiencing an opioid-related overdose or to a family member or community member who is in a position to assist that person. Naloxone dispensed for other purposes, such as to reverse IV sedation or anesthesia, is not reportable. Nor is naloxone dispensed in connection with a surgical procedure or other invasive procedure performed in a health care institution.**]

APPENDIX

Appendix A. Procedure-Specific Prescribing Strategies

Source: Arizona Opioid Prescribing Guidelines (2018)

PROCEDURE-SPECIFIC OPIOID PRESCRIBING STRATEGIES		
Procedure	Hydrocodone (Norco) - 5 mg tablets Codeine (Tylenol #3) - 30 mg tablets Tramadol - 50 mg tablets	Oxycodone 5 mg tablets
Laparoscopic Cholecystectomy	15	10
Laparoscopic Appendectomy	15	10
Inguinal/Femoral Hernia Repair (Open/Laparoscopic/Robotic)	15	10
Open Incisional Hernia Repair	40	25
Laparoscopic Colectomy	35	25
Open Colectomy	40	25
Hysterectomy Vaginal Laparoscopic & Robotic Abdominal	 20 30 40	 15 20 25
Wide Local Excision +/- Sentinel Lymph Node Biopsy	30	20
Simple Mastectomy +/- Sentinel Lymph Node Biopsy	30	20
Lumpectomy +/- Sentinel Lymph Node Biopsy	15	10
Breast Biopsy or Sentinel Lymph Node Biopsy	15	10

Recommendations were based on patient-reported data from the Michigan Surgical Quality Collaborative and other published studies. Recommended amounts meet or exceed self-reported use of 75% of patients. Previous studies have shown that when patients are prescribed fewer pills, they consume fewer pills with no change in pain or satisfaction scores. Many patients use 0-5 pills. Recommendations are for patients with no preoperative opioid use. For patients taking opioids preoperatively, prescribers are encouraged to use their best judgment.

Appendix B. Finding Mental/Behavioral Health Providers

Source: Office of the Arizona Governor, Governor's Office of Youth, Faith and Family, Rethink Rx Abuse, Arizona Rx Drug Toolkit, Strategy 5, http://substanceabuse.az.gov/substance-abuse/strategy-5.

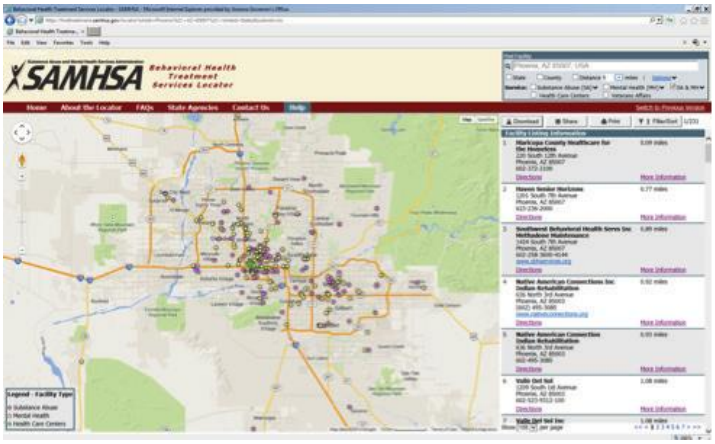
If you are a provider wishing to refer a patient to services, would like to compile a list of service providers in your area, or are looking for a provider for yourself, a friend, or family member, please refer to the Substance Abuse and Mental Health Services Administration's Behavioral Health Treatment Services Locator. It is designed as an easy-to-use tool to help you find treatment services for substance abuse and/or mental health issues.

Search by Location

Step 1. Go to http://findtreatment.samhsa.gov/ and enter a location in the search bar. You may include street, city, state, and zip code.

Step 2. Click the "Go" button.

➢ What appears will be similar to the picture below, depending upon the address you entered in the search bar. The Locator finds treatment programs in the area around the address. It displays a map of the facility locations and a list giving you information about each facility and a link for directions to the facility.



Step 3. Click on a dot on the map to get a pop-up with more information about the facility.

Search for Specific Services

You may want to search for facilities that offer specific services, like outpatient care or payment help. To do this:

Step 1. Go to http://findtreatment.samhsa.gov/ and search for providers by location. Step 2. Click the "Go" button.

Step 2. Click the "Go" button.

➢ When the results are populated on a map (see Step 2 above in "Searching by Location"), a "Find Facility" box in the upper right-hand corner of the screen will allow you to select for types of services.

Step 3. Click on the down arrow to make the menu of services appear.

Step 4. Select the services that best fit your needs by clicking the box next to each type of service in which you are interested in the menu of services.

➢ The list of facilities will filter as you add/delete services.

Additional Program Locators Found on the SAMHSA Treatment Locator Site

➢ Buprenorphine Physician and Treatment Program Locator

➢ Opioid Treatment Program Directory

Additional Resources

➢ To learn how to access behavioral health treatment services in Arizona, please visit: www.azahcccs.gov.

➢ You may also call 1-800-662-HELP, which offers 24-hour free and confidential information (in English and Spanish) on substance use disorder issues and referral to treatment. www.RethinkRxAbuse.org.

Appendix C. Statewide Publicly Funded Detox Locations

Source: Office of the Arizona Governor, Governor's Office of Youth, Faith and Family, Rethink Rx Abuse, Arizona Rx Drug Toolkit, Strategy 5, http://substanceabuse.az.gov/substance-abuse/strategy-5.

Provider Name	Address	City, State	State
SMMHC INC DBA MOUNTAIN HEALTH & WELLNESS	150 N OCOTILLO DR	APACHE JUNCTION	AZ
COMMUNITY BRIDGES INC	648 W UNION ST	BENSON	AZ
COMMUNITY BRIDGES INC	675 E COTTONWOOD LN STE 104	CASA GRANDE	AZ
VERDE VALLEY MEDICAL CENTER - BEHAVIORAL HEALTH UNIT	269 S CANDY LN	COTTONWOOD	AZ
THE GUIDANCE CENTER - PSYCHIATRIC ACUTE CARE	2187 N VICKEY ST	FLAGSTAFF	AZ
FLAGSTAFF MEDICAL CENTER - BEHAVIORAL HEALTH UNIT	1200 N BEAVER ST	FLAGSTAFF	AZ
THE GUIDANCE CENTER - ALCOHOL STABILIZATION UNIT	2187 N VICKEY ST	FLAGSTAFF	AZ
AURORA BEHAVIORAL HEALTHCARE - GLENDALE	6015 W PEORIA AVE	GLENDALE	AZ
BANNER BEHAVIORAL HEALTH NETWORK - THUDNERBIRD	5555 W THUNDERBIRD RD	GLENDALE	AZ
COMMUNITY BRIDGES INC	5734 E HOPE DRIVE	GLOBE	AZ
COMMUNITY BRIDGES INC	993 HERMOSA DR	HOLBROOK	AZ
MOHAVE MENTAL HEALTH CLINIC - SUBACUTE FACILITY	1741 E SYCAMORE AVE	KINGMAN	AZ
COMMUNITY COUNSELING CENTER - PINE VIEW	1920 W COMMERCE DR	LAKESIDE	AZ
COMMUNITY BRIDGES INC	554 S BELLVIEW	MESA	AZ
COMMUNITY BRIDGES INC	560 S BELLVIEW RM B AND C	MESA	AZ
COMMUNITY BRIDGES INC	1811 S ALMA SCHOOL RD	MESA	AZ
MARICOPA MEDICAL CENTER - DESERT VISTA BH	570 W BROWN RD	MESA	AZ
ENCOMPASS HEALTH SERVICES	32 N 10TH AVE #5	PAGE	AZ
COMMUNITY BRIDGES INC	803 W MAIN ST	PAYSON	AZ
RECOVERY INNOVATIONS OF ARIZONA (RIAZ)	11361 N 99TH AVE #402	PEORIA	AZ
COMMUNITY BRIDGES INC	2770 E VAN BUREN ST	PHOENIX	AZ
ST LUKES BEHAVIORAL HOSPITAL	1802 E VAN BUREN ST	PHOENIX	AZ
ST LUKES MEDICAL CENTER	1800 E VAN BUREN ST	PHOENIX	AZ
SOUTHWEST BEHAVIORAL SERVICES INC	1424 S 7TH AVE BLDG A	PHOENIX	AZ
BANNER BEHAVIORAL HEALTH NETWORK - GOOD SAMARITAN	1111 E MCDOWELL RD	PHOENIX	AZ
MARICOPA MEDICAL CENTER - DESERT VISTA BH	2619 E PIERCE ST	PHOENIX	AZ
PHOENIX CHILDREN'S HOSPITAL	1919 W THOMAS RD	PHOENIX	AZ
VALLEY HOSPITAL	3550 E PINCHOT AVE	PHOENIX	AZ
CONNECTIONS AZ	903 N 2ND ST	PHOENIX	AZ
WINDHAVEN PSYCHIATRIC HOSPITAL	3347 N WINDSONG DR	PRESCOTT VALLEY	AZ
BANNER BEHAVIORAL HEALTH NETWORK - SCOTTSDALE	7575 E EARLL DR	SCOTTSDALE	AZ
BANNER BEHAVIORAL HEALTH NETWORK - DEL WEBB	14502 W MEEKER BLVD	SUN CITY	AZ
AURORA BEHAVIORAL HEALTHCARE - TEMPE	6350 S MAPLE AVE	TEMPE	AZ
PASADERA DESERT HOPE	2499 E AJO WAY	TUCSON	AZ
CARONDELET - ST JOSEPH'S HOSPITAL	350 N WILMOT RD	TUCSON	AZ
PALO VERDE (UHS)	2695 N CRAYCROFT RD	TUCSON	AZ
SONORA BEHAVIORAL HEALTH	6050 N CORNOA	TUCSON	AZ
CONNECTIONS SOUTHERN AZ	2802 E DISTRICT ST	TUCSON	AZ
UNIVERSITY PHYSICIANS HEALTHCARE - SOUTH CAMPUS	2800 E AJO WAY	TUCSON	AZ
COMMUNITY BRIDGES INC	105 N COTTONWOOD AVE	WINSLOW	AZ
CROSSROADS MISSION	944 S ARIZONA AVE	YUMA	AZ
SMMHC INC DBA MOUNTAIN HEALTH & WELLNESS	3180 E 40TH ST	YUMA	AZ

Appendix D. Getting Help

Source: Office of the Arizona Governor, Governor's Office of Youth, Faith and Family, Rethink Rx Abuse, Arizona Rx Drug Toolkit, Strategy 5, http://substanceabuse.az.gov/substance-abuse/strategy-5.

AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Thomas J. Betlach, Director

Getting Help for Opioid Misuse, Abuse or Dependence

If you or someone you know is seeking help for opioid misuse, abuse or dependence, there are treatment options available in your area.

If you live in Maricopa County:

- Mercy Maricopa Integrated Care Member Services: 602-586-1841 or 1-800-564-5465
- Mercy Maricopa Integrated Care Crisis Line: 602-222-9444 or 1-800-631-1314

If you live in Yavapai, Gila, Mohave, Coconino or Apache Counties:

- Health Choice Integrated Care Customer Service: 800-640-2123
- Health Choice Integrated Care Crisis Line: 877-756-4090

If you live in La Pa, Yuma, Pinal, Pima, Graham, Greenlee, Cochise or Santa Cruz Counties:

- Cenpatico Integrated Care Customer Service: 866-495-6738
- Centpatico Integrated Care Crisis Line: 866-495-6735

24/7 Access to Care

Arizona also has five Opioid Treatment Centers of Excellence that are open 24 hours a day, 7 days a week to provide immediate access to opioid treatment to connect you to ongoing services. They serve AHCCCS members, individuals with no insurance, and individuals with insurance that may not cover some services like Medication Assisted Treatment or peer support services.

Southwest Behavioral Health Services, Kingman Recovery and Observation Unit
1301 W. Beale Street, Kingman, AZ 86401
928-263-6515

West Yavapai Guidance Clinic, Crisis Stabilization Unit
8655 E. Eastridge Drive, Prescott Valley, AZ 86314
928-445-5211

Community Medical Services
2301 W. Northern Avenue, Phoenix, AZ 85021
602-866-9378

Community Bridges, East Valley Addiction Recovery Center
560 S. Bellview, Mesa, AZ 85204
480-461-1711

CODAC Health, Recovery and Wellness
380 E. Ft. Lowell Road, Tucson, AZ 85705
520-202-1786

If you or someone you know needs help with opioid misuse, abuse or dependence please call, regardless of your insurance coverage. Contact the phone number listed above in your county.

Treating opioid misuse, abuse or dependence is a priority for providers who participate in:

- The Substance Abuse Block Grant
- The Opioid State Targeted Response Grant
- The Governor's Office Substance Use Disorder Service Funds

These providers offer a range of services, including residential and outpatient treatment, Medication Assisted Treatment and recovery supports. Call today to find treatment options that are best for you.

3/19/18