PEP Opiate Prescribing Guidelines July 2018

1. One medical provider should provide all opioids to treat a patient's chronic pain.

2. The administration of intravenous and intramuscular opioids in the ED for the relief of acute exacerbations of chronic pain is discouraged.

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

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

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

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

7. EDs should coordinate the care of patients who frequently visit the ED using an ED care coordination program.

8. EDs should maintain a list of clinics that provide primary care for patients of all payer types.

9. EDs should perform screening, brief interventions and treatment referrals for patients with suspected prescription opiate abuse problems.

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

11. Prescriptions for opioid pain medication from the ED for acute injuries, such as fractured bones, in most cases should not exceed 24 pills.

12. ED patients will be screened for substance abuse prior to prescribing opioid medication for acute pain.

13. The emergency physician is required by law to evaluate an ED patient who reports pain. The law allows the emergency physician to use their clinical judgment when treating pain and does not require the use of opioids.

14. All PEP providers will query INSPECT/Narxcare before prescribing any opiate or benzodiazepine medication.

These are clinical guidelines, and clinical judgement at the provider's discretion will at times require deviation from these guidelines.