Acute Dental Pain Management & the National Opioid Crisis

The Cost of the Opioid Crisis, The New Yorker, Sept. 18, 2017

VS.

OBJECTIVES

- Understand how dentists have historically contributed to the opioid crisis and why HOPE participation by dentists is critical
- Know that opioids are no longer a first line medication to address dental pain
- Know how to utilize IHS resources to more appropriately prescribe pain medications (EHR, medical staff, etc.)
- Know how to locate and utilize the "IHS Recommendations for Acute Dental Pain Management" and the "Pain Meds Selection Spreadsheet"

HOW DENTAL PRESCRIBING HAS IMPACTED RECREATIONAL OPIOID AND HEROIN USE

PSYCHOLOGY OF PRESCRIBING

ADA Survey Center (2004) – survey of 563 OMFS re: prescribing practices after 3rd molar extractions:

- 73.5% of OMFS said the most preferable post-operative pain reliever was ibuprofen
- 85% of OMFS said they almost always prescribed an opioid
- 64% of OMFS said the opioid of choice was hydrocodone with acetaminophen (Vicodin)
- The average number of Vicodin prescribed was 20 tablets

→ *"Why do we prescribe Vicodin?"* -- editorial in JADA, Oct. 2016

DENTAL RX MISUSE & DIVERSION

- > ½ of opioids prescribed after dental surgeries are not used by patients[4]
- 38% of dental patients at an academic outpatient dental clinic reported some form of non-medical use of prescription opioids & 6.5% of these respondents reported diverting their unused opioids[5]

→ DDS PRESCRIPTIONS RESULT IN OPIOIDS FOR MISUSE

4. Maughan BC, Hersh EV, et al. Unused opioid analgesics and drug disposal following outpatient dental surgery: a randomized controlled trial. Drug and Alcohol Dependence. 2016. 168:328-34.
5. Ashrafioun L, Edwards PC, Bohnert AS, et al. Nonmedical use of pain medications in dental patients. Am J Drug Alcohol Abuse. 2014;40:312–316.

Opioid-Prescribing Rates by Specialty, IMS Health, U.S., 2012

Specialty	Opioid Rx *n*, millions (%)	Total Rx *n*, millions (%)	Opioid Rx/Total Rx %
Family practice	52.5 (18.2)	946.9 (22.3)	5.6
Internal medicine	43.6(15.1)	913.9 (21.5)	4.8
Non-physician prescriber[a]	32.2 (11.2)	447.3 (10.5)	7.2
General practice[b]	32.2 (11.2)	431.2 (10.1)	7.5
Surgery[c]	28.3 (9.8)	77.6 (1.8)	36.5
Dentistry	18.5 (6.4)	64.0 (1.5)	29.0
Pain medicine[d]	14.5 (5.0)	29.8 (0.7)	48.6
Emergency medicine	12.5 (4.3)	60.5 (1.4)	20.7
Physical med and rehab	9.3 (3.2)	26.1 (0.6)	35.5
All Others[e]	45.3 (15.7)	1251.5 (29.5)	3.6
Total	289.0 (100.0)	4248.7 (100.0)	6.8

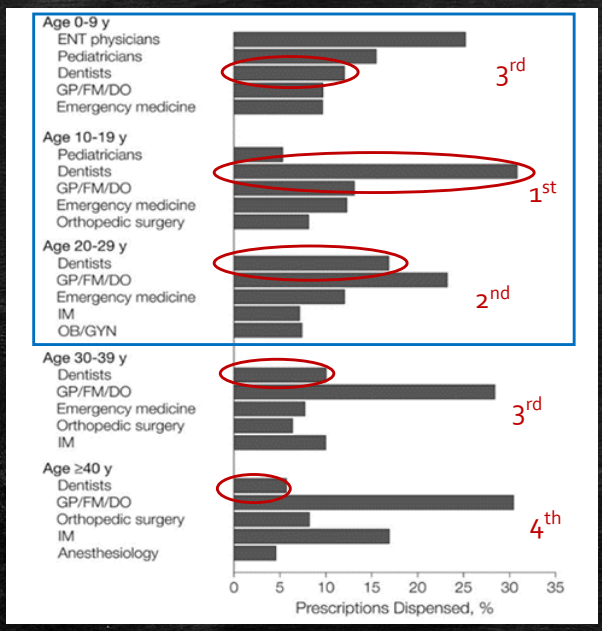
View Table in HTML

[a] Non-physician prescriber: nurse practitioner and physician's assistant.
[b] General practice: osteopathic medicine, general practice, and preventive medicine.
[c] Surgery: general, orthopedic, plastic, cardiothoracic, vascular, colorectal, spinal, and neurologic.
[d] Pain medicine: anesthesiology and pain medicine.
[e] All others: cardiology, critical care, dermatology, endocrinology, gastroenterology, geriatrics, hematology, infectious disease, neurology, obstetrics and gynecology, oncology, otolaryngology, palliative care, pathology, pediatrics, podiatry, psychiatry, pulmonology, radiology, rheumatology, urology, veterinary, and "unspecified" specialty types. Rx, prescriptions.

NUMBERS OF OPIOID RX

From 2007-2012, dentists ranked 4th in prescribers of opioids.

From: ***Trends in Opioid Analgesic–Prescribing Rates by Specialty, U.S., 2007–2012 -- American Journal of Preventive Medicine -- Sept. 2016.***



NUMBERS OF OPIOID RX

Percentage of Prescriptions Dispensed for Opioid Analgesics from Outpatient US Retail Pharmacies by Age and Physician Specialty, 2009

From: *Characteristics of Opioid Prescriptions in 2009 – Journal of American Medical Association -- April, 2011*

- 2000-2009, DDS prescribed 8% of the **overall** opioid prescriptions in the U.S. (18 million opioid prescriptions a year) and were 2nd only to PCP as opioid prescribers[1]
- 2000–2009, DDS prescribed 12.2% of all **immediate-release opioids** *(for comparison, family physicians prescribed 15%)*[2]
- 2012, DDS dropped from 2nd most prevalent prescriber of opioids to the 5th with 6.4% of *overall* opioid prescriptions, but still prescribed 18.5 million opioid prescriptions in 2012[3]

→ DDS PRESCRIBE A LOT OF OPIOIDS

1. Governale L. Outpatient Prescription Opioid Utilization in the US, Years 2000–2009. 2010.
2. Golubic et al. Opioid Prescribing in Dentistry. Compend CE Dent, 2011
3. Levy B, Paulozzi L, Mack KA, Jones CM. Trends in Opioid Analgesic-Prescribing Rates by Specialty, U.S., 2007-2012. Am J PrevMed. 2015 Sep;49(3):409-13.

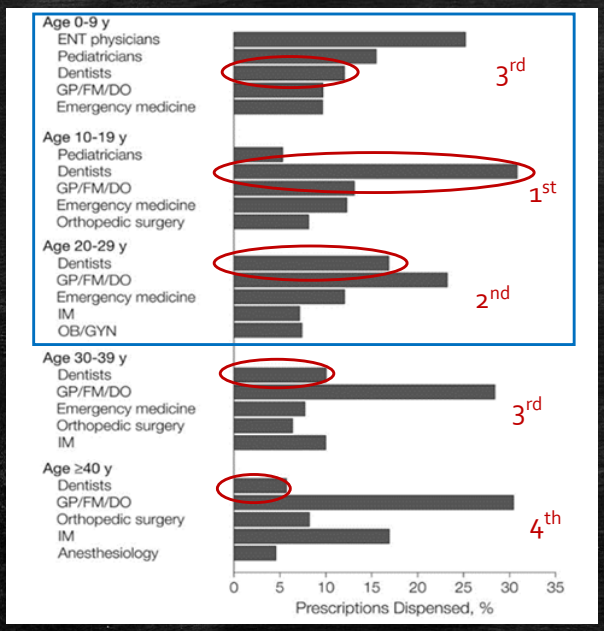
PATIENT'S FIRST EXPOSURE TO OPIOIDS

- 5 million people per year undergo 3rd molar extraction[6]
- This results in ~3.5 million **young adults** being exposed to opioid pain medications each year[7]
- Average age of patients receiving opioids for 3rd molar extractions is **14-24 years old**[8,9], with a mean **age of 20**[10,11]
- **Age 20** is also the average age at which people try using an opioid non-medically for the first time[10,11]

- OMFS in U.S. reported most commonly prescribing Vicodin, on average **20 tablets**, after third molar extractions[12]

→ 3rd MOLAR EXTRACTIONS ARE OFTEN A PATIENT'S 1ST INTRODUCATION TO AN OPIOID

6. Becker DE. Pain management: Part 1: Managing acute and postoperative dental pain. Anesthesia progress 2010; 57:67-78; quiz 9-80.
7. Friedman JW. The prophylactic extraction of third molars: a public health hazard. Am J Public Health. 2007;97:1554–1559.
8. McCabe SE, West BT, Boyd CJ. Leftover prescription opioids and nonmedical use among high school seniors: a multi-cohort national study. Journal of Adolescent Health 2013;52:480-5.
9. Miech R, Johnston L, O'Malley PM, Keyes KM, Heard K. Prescription opioids in adolescence and future opioid misuse. Pediatrics. 2015:1364.
10. Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Summary of National Findings. Rockville, Md.: U.S. Department of Health and Human Services; 2010:89-94. National Survey on Drug Use and Health series H-38A, HHS publication SMA 10-4486 Findings. Results from the 2009 National Survey on Drug Use and Health; vol 1.
11. Snyder M, Shugars DA, White RP, Phillips C. Pain medication as an indicator of interference with lifestyle and oral function during recovery after third molar surgery. J Oral Maxillofacial Surg 2005;63(8): 1130-1137.
12. Richard C. Denisco, MD, MPH; George A. Kenna, PhD, RPh; Michael G. O'Neil, PharmD; Ronald J. Kulich, PhD; Paul A. Moore, DMD, PhD, MPH; William T. Kane, DDS, MBA; Noshir R. Mehta, DMD, MDS, MS; Elliot V. Hersh, DMD, MS, PhD; Nathaniel P. Katz, MD, MS. Prevention of prescription opioid abuse: The role of the dentist. Journal of the American Dental Association (JADA). July, 2011. 142(7): 800-810.



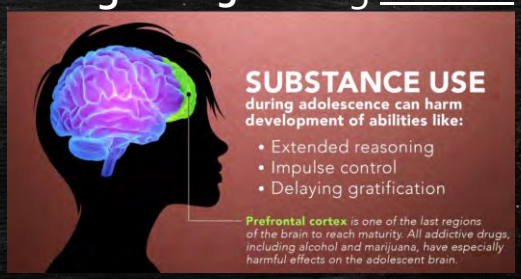
AGES OF PATIENTS RECEIVING DENTAL OPIOID RX

Percentage of Prescriptions Dispensed for Opioid Analgesics from Outpatient US Retail Pharmacies by Age and Physician Specialty, 2009

From: *Characteristics of Opioid Prescriptions in 2009 – Journal of American Medical Association -- April, 2011*

Brains don't fully develop until around age 25. Opioid use in patients under the age of 25 can alter brain development and patients that have been exposed to opioids in adolescence are more likely to develop substance use disorders and addiction as adults.

One study found that legitimate opioid use before high school graduation is independently associated with a **33%** increase in the risk of future opioid misuse by the **age of 23** among low risk individuals[15].



15. Richard Miech, Lloyd Johnston, Patrick M. O'Malley, Katherine M. Keyes, Kennon Heard. Prescription Opioids in Adolescence and Future Opioid Misuse. Pediatrics. 2017;139(6)

- In South Carolina in 2012-2013, dentists prescribed **44.9%** of initial fill opioid prescriptions even though they made up only **8.9%** of unique prescribers[13]
- For patients **aged 10 to 19 years**, dentists are the main prescribers (**30.8%**) and patients **aged 10 to 29** are the most likely to abuse drugs and develop addiction[14]

→ DDS ARE THE MOST LIKELY PROVIDER TO PRESCRIBE AN OPIOID TO A PATIENT WHOSE BRAIN IS NOT FULLY DEVELOPED.

13. Jenna L. McCauley, PhD, J. Madison Hyer, MS, V. Ramesh Ramakrishnan, PhD, Renata Leite, DDS, MS, Cathy L. Melvin, PhD, MPH, Roger B. Fillingim, PhD, Christie Frick, RPh, and Kathleen T. Brady, MD, PhD. Dental Opioid Prescribing and Multiple Opioid Prescriptions Among Dental Patients: Administrative data from the South Carolina Prescription Drug Monitoring Program. J Am Dent Assoc. 2016 Jul; 147(7): 537–544.
14. Nora D. Volkow, MD; Thomas A. McLellan, PhD; Jessica H. Cotto, MPH; Meena Karithanom, MPH; Susan R. B. Weiss, PhD; et al. Characteristics of Opioid Prescriptions in 2009. JAMA. 2011; 305 (13):1299-1301.

EXISTING EVIDENCE FOR ACUTE DENTAL PAIN MANAGEMENT

OPIOIDS + ACETAMINOPHEN vs. NSAID + ACETAMINOPHEN

- Studies have found that NSAIDs taken after a dental procedure are at least as effective (or superior to) opioid analgesics for reducing frequency and intensity of acute dental pain[16]
- Studies have also shown that NSAID + APAP are synergistic when combined and are more effective than opioids in treating dental pain[17]
- Due to dosing reductions of **APAP** in Hydrocodone + APAP formulations in 2013 (changed from 5/500 mg & 7.5/750 mg to 5/300 mg & 5/325 mg), the amount of APAP as most commonly dosed (1 Vicodin q4-6h) is often suboptimal[18]

16. Dionne RA, Gordon SM, Moore PA. Prescribing Opioid Analgesics for Acute Dental Pain: Time to Change Clinical Practices in Response to Evidence and Misperceptions. Compendium of Continuing Education in Dentistry. 2016;37:372.

17. Moore PA, Hersh EV. Combining ibuprofen and acetaminophen for acute pain management after third molar extractions: translating clinical research to dental practice. *J Am Dent Assoc* 2013; 144:898-908.

18. Moore PA, Dionne RA, Cooper SA, Hersh EV. Why do we prescribe Vicodin? JADA 10.2016;147(7):530-533.

OPIOIDS + ACETAMINOPHEN vs. NSAID + ACETAMINOPHEN

- For patients in the ED with acute extremity pain, no significant differences in pain reduction:
  - Oxycodone 5mg + 325mg Acetaminophen (4.4 pt. reduction)
  - Ibuprofen 400mg + 1,000mg Acetaminophen (4.3 pt. reduction)
  - Codeine 30mg + 300mg Acetaminophen (3.9 pt. reduction)
  - Hydrocodone 5mg + 300mg Acetaminophen (3.5 pt. reduction)

Pain re-accessed after 2 hours using 11-point numerical rating scale (NRS)[19]

19. Chang AK et al. Effect of a Single Dose of Oral Opioid and Non-opioid Analgesics on Acute Extremity Pain in the Emergency Department: a Randomized Clinical Trial. JAMA. 2017 Nov 7:318(17):1661-1667.

NNT to achieve 50% pain reduction over 4-6 hrs.

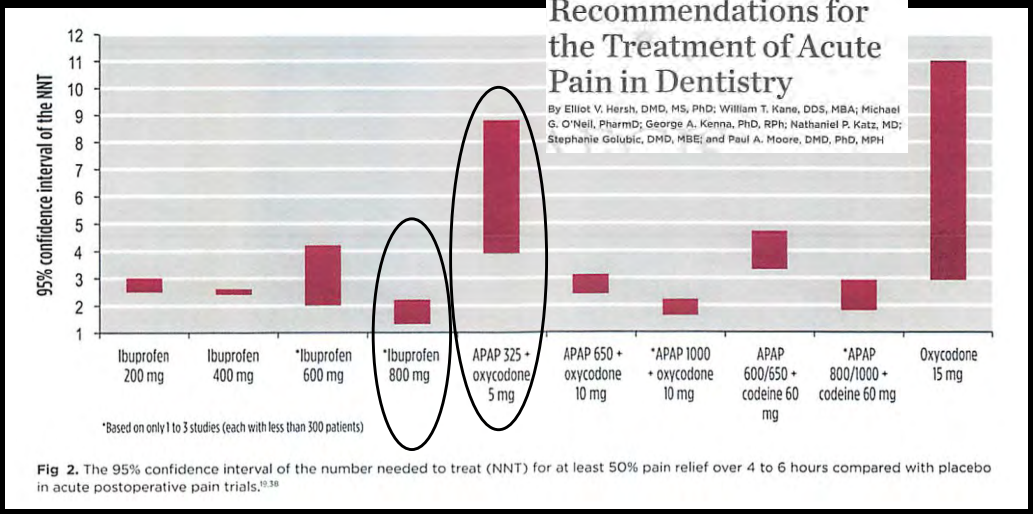


Fig 2. The 95% confidence interval of the number needed to treat (NNT) for at least 50% pain relief over 4 to 6 hours compared with placebo in acute postoperative pain trials.[19,38]

From: **Compendium** April 2011

- Publication was a collaboration of dentists, pharmacist, & physician

WHY RX OPIOIDS AT ALL IF THEY ARE LESS EFFECTIVE THAN NSAID + APAP?

- When NSAID may be contraindicated
  - allergies, kidney disease, some GI diseases, bleeding disorders, anticoagulant use, pregnancy, severe liver impairment *(most common reasons)*
- When anticipate severe pain and NSAID / APAP + Opioid indicated

CHALLENGES & OPPORTUNITIES UNIQUE TO IHS

CHALLENGES

1. Addiction disproportionately affects people in poverty
2. Addiction is harder to kick in poverty
3. Medically compromised population / disease rates are higher
4. Highly medicated population
5. We do a lot of extractions that require pain management

OPPORTUNITIES

UDS

- Can request a urinary drug screening if you are concerned that a patient may already by using an opioid, alcohol, narcotic, etc. to more safely prescribe opioid
- Consider that some patients self-medicate when they are in pain

EHR

- Can make more informed decision on prescribing than just relying on patients to self-report in health history questionnaire *(→ HHQ + EHR)*
- EHR problem list isn't always accurate or complete *(much like HHQ)*, but it often gives us the clues we need to f/u

OPPORTUNITIES

IN-HOUSE PHARMACY / NURSES / PROVIDERS

- Your medical co-workers can help you with prescribing when medical history or behavior gets complicated. They often know the complicated patients better than we do and can fill in gaps.
- Patients on chronic opioids generally have pain contracts and your facility will have policies about prescribing to these folks.
- Calling to inquire about labs is critical! EHR may say 'Kidney Disease' but you should call pharmacy / nursing and ask about renal labs for clarification. Sometimes diagnoses are outdated / wrong / missing. Often a patient had 1 high lab test 6 years ago *(that triggered a Dx)* but all labs since then are normal.

→ In IHS we have a real opportunity to make more informed decisions on prescribing!

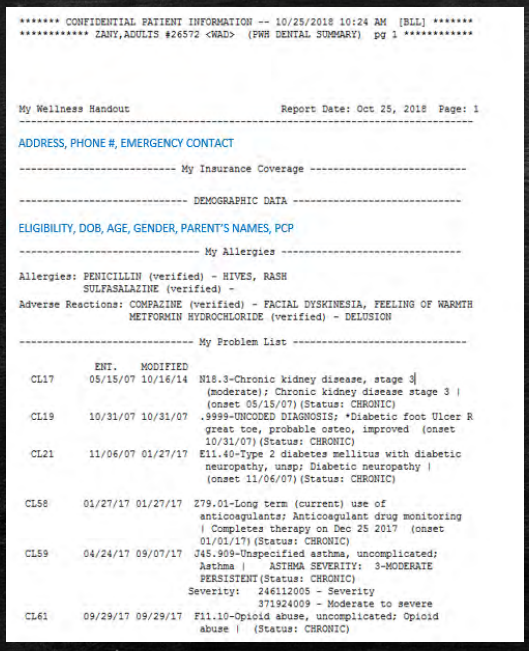
OPPORTUNITIES

EHR HEALTH SUMMARIES

CAC / IT can design an EHR dental health summary specific to your needs and can limit it to specific timeframes (each category):

1. **PCP**
2. **Allergies**
3. **Problem List** *(diagnoses)*
4. **Medications** *(dispensed at SU pharmacy)*
5. **Lab Results**
6. **Patient Postings** *(warnings, pain contracts)*
7. **Other requirements** *(eligibility, demographics, insurance info., etc.)*

→ *generally only helpful if patient gets his/her medical treatment at your SU*



******* CONFIDENTIAL PATIENT INFORMATION -- 10/25/2018 10:24 AM [BLL] *******
********** ZANY,ADULIS #26572 <WAD> (PWH DENTAL SUMMARY) pg 1 **********

My Wellness Handout Report Date: Oct 25, 2018 Page: 1

ADDRESS, PHONE #, EMERGENCY CONTACT

---------- My Insurance Coverage ----------

---------- DEMOGRAPHIC DATA ----------

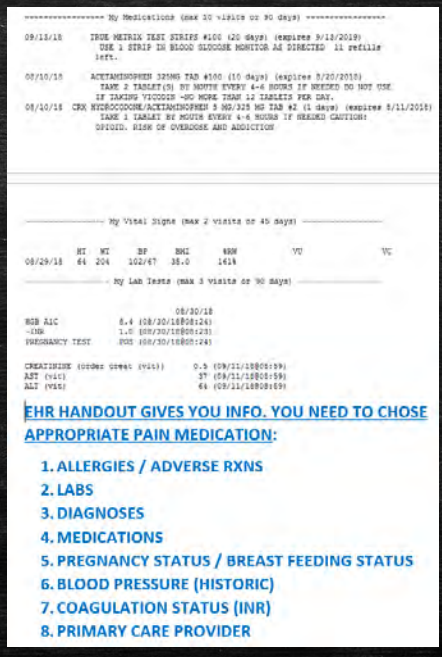
ELIGIBILITY, DOB, AGE, GENDER, PARENT'S NAMES, PCP

---------- My Allergies ----------

Allergies: PENICILLIN (verified) - HIVES, RASH
SULFASALAZINE (verified) -
Adverse Reactions: COMPAZINE (verified) - FACIAL DYSKINESIA, FEELING OF WARMTH
METFORMIN HYDROCHLORIDE (verified) - DELUSION

---------- My Problem List ----------

	ENT.	MODIFIED	
CL17	05/15/07	10/16/14	N18.3-Chronic kidney disease, stage 3 (moderate); Chronic kidney disease stage 3 | (onset 05/15/07)(Status: CHRONIC)
CL19	10/31/07	10/31/07	.9999-UNCODED DIAGNOSIS; *Diabetic foot Ulcer R great toe, probable osteo, improved (onset 10/31/07)(Status: CHRONIC)
CL21	11/06/07	01/27/17	E11.40-Type 2 diabetes mellitus with diabetic neuropathy, unsp; Diabetic neuropathy | (onset 11/06/07)(Status: CHRONIC)
CL58	01/27/17	01/27/17	Z79.01-Long term (current) use of anticoagulants; Anticoagulant drug monitoring | Completes therapy on Dec 25 2017 (onset 01/01/17)(Status: CHRONIC)
CL59	04/24/17	09/07/17	J45.909-Unspecified asthma, uncomplicated; Asthma | ASTHMA SEVERITY: 3-MODERATE PERSISTENT(Status: CHRONIC) Severity: 246112005 - Severity 371924009 - Moderate to severe
CL61	09/29/17	09/29/17	F11.10-Opioid abuse, uncomplicated; Opioid abuse | (Status: CHRONIC)



---------- My Medications (max 10 visits or 90 days) ----------

09/13/18 TRUE METRIX TEST STRIPS #100 (20 days) (expires 9/13/2019)
USE 1 STRIP IN BLOOD GLUCOSE MONITOR AS DIRECTED 11 refills left.

08/10/18 ACETAMINOPHEN 325MG TAB #100 (10 days) (expires 8/20/2018)
TAKE 2 TABLET(S) BY MOUTH EVERY 4-6 HOURS IF NEEDED DO NOT USE IF TAKING VICODIN -NO MORE THAN 12 TABLETS PER DAY.

08/10/18 CRX HYDROCODONE/ACETAMINOPHEN 5 MG/325 MG TAB #2 (1 days) (expires 8/11/2018)
TAKE 1 TABLET BY MOUTH EVERY 4-6 HOURS IF NEEDED CAUTION: OPIOID. RISK OF OVERDOSE AND ADDICTION

---------- My Vital Signs (max 2 visits or 45 days) ----------

	HT	WT	BP	BMI	HRN	VU	VC
08/29/18	64	204	102/67	35.0	1618		

---------- My Lab Tests (max 3 visits or 90 days) ----------

	08/30/18
HGB A1C	8.4 (08/30/18@08:24)
-INR	1.0 (08/30/18@08:23)
PREGNANCY TEST	POS (08/30/18@08:24)
CREATININE (other great (Vit))	0.5 (09/11/18@05:59)
AST (Vit)	37 (09/11/18@05:59)
ALT (Vit)	44 (09/11/18@05:59)

EHR HANDOUT GIVES YOU INFO. YOU NEED TO CHOSE APPROPRIATE PAIN MEDICATION:

1. ALLERGIES / ADVERSE RXNS
2. LABS
3. DIAGNOSES
4. MEDICATIONS
5. PREGNANCY STATUS / BREAST FEEDING STATUS
6. BLOOD PRESSURE (HISTORIC)
7. COAGULATION STATUS (INR)
8. PRIMARY CARE PROVIDER

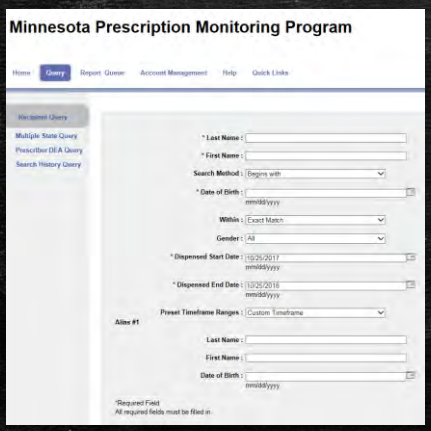
Again, this only works if the patient also gets their medical care and prescriptions at your facility. Make sure to ask if the patient <u>also</u> gets care elsewhere! Maybe they see a cardiologist, etc. elsewhere….

OPPORTUNITIES

Establish working relationships with your pharmacy staff and don't be afraid to ask them for help with prescribing. They have more training & experience in medication contraindications, interactions, etc. They want to be asked BEFORE you send the patient down to the pharmacy to pick up a medication that is not appropriate. They don't want to be the person that says "NO" after-the-fact.

OPPORTUNITIES

Utilize your state's PDMP / PMP



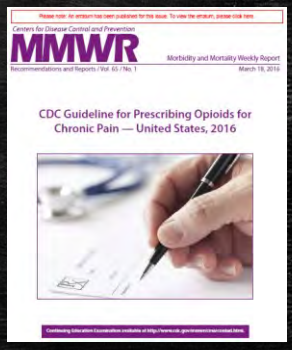
- You may be able to designate this to auxiliary staff or ask pharmacy to check it for you.
- Check for current / history of opioid prescriptions BEFORE you tell the patient what you are going to prescribe and BEFORE you send the patient down to the pharmacy to pick up their prescription.
- Strongly recommend this is documented in clinical notes.

CDC 2016 GUIDELINES ON OPIOID PRESCRIBING

CDC GUIDELINES FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN, 2016

- 42 page guideline re: prescribing opioids **chronically**
- most of the guidelines don't exactly apply to dentists, as we are **acute** prescribers

➢ For example, DDS/DMD don't generally prescribe opioids for more than 7 days, so they technically don't have to utilize the PDMP.



CDC SPECIFIC GUIDELINES ON ACUTE PRESCRIBING

1. Chronic opioid therapy often stems from the use of opioids for acute pain.
2. Clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
3. Don't prescribe additional day(s) supply "just in case".
4. Referred DDS to Pennsylvania Guidelines on the Use of Opioids in Dental Practice *(no official ADA guidelines available in 2016)*

RECOMMENDATIONS FOR MANAGEMENT OF ACUTE DENTAL PAIN

A COLLABORATION BETWEEN THE INDIAN HEALTH SERVICE DIVISION OF ORAL HEALTH (DOH) AND INDIAN HEALTH SERVICE HEROIN, OPIOID AND PAIN EFFORTS (HOPE) COMMITTEE

HOPE & DOH COLLABORATION ON DENTAL GUIDELINES

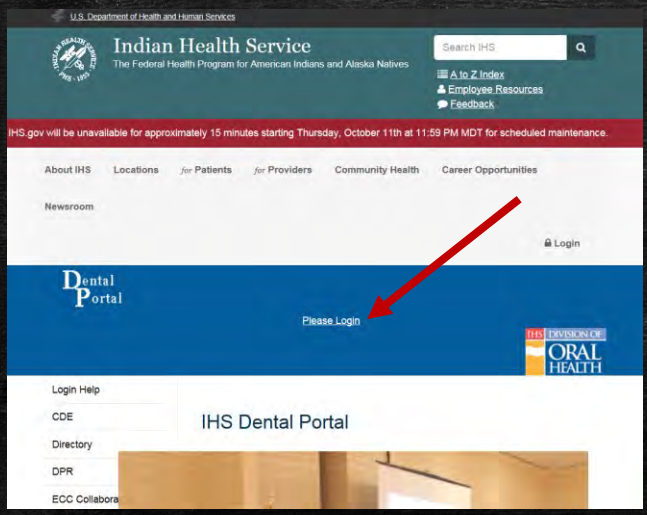
- Created by a workgroup composed of IHS dentists and pharmacists. Reviewed and approved by IHS oral surgeons, ADOs, DOH, and HOPE committee.
- Evidence based
- Developed utilizing literature review, ADA & state recommendations, Dental Management of the Medically Compromised Patient Textbook, and Drug Information Handbook for Dentistry.

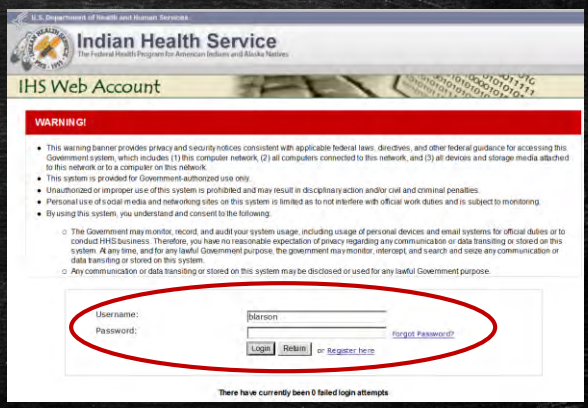
- Discusses how dental prescribing of opioids impacts opioid epidemic
- References research on pain relief of opioids vs. NSAIDs + APAP
- Outlines guidance for dental acute pain prescribing for adults – general population
- Outlines guidance for dental acute pain prescribing for adults – medically compromised & special populations
- Outlines guidance for pre-op pain control and non-Rx methods of pain control
- Includes pain management decision tree & info. on specific opioids and NSAIDs
- Recommends additional dental-specific resources on dental pain prescribing

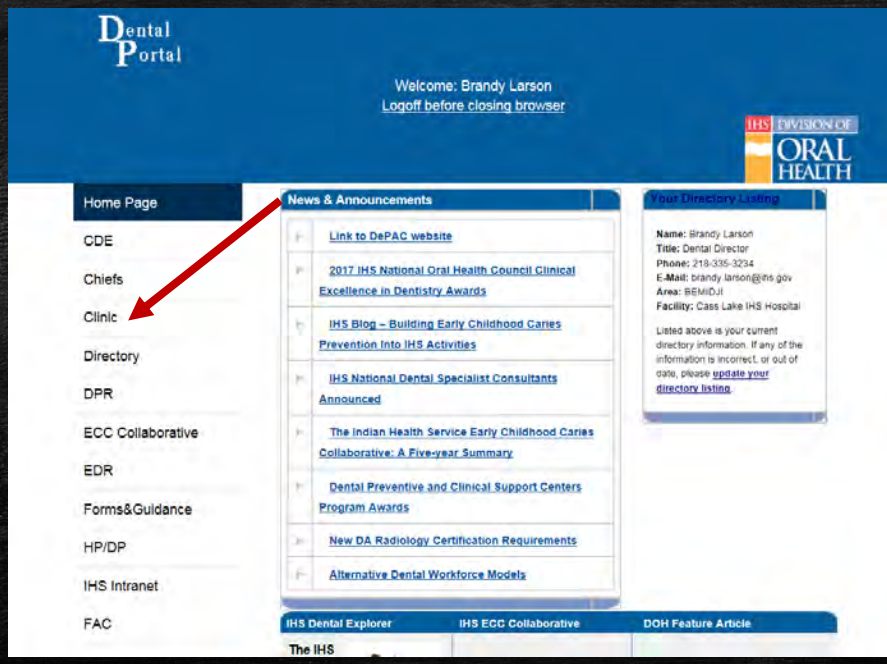
WHY DID IHS CREATE THEIR OWN GUIDELINES?

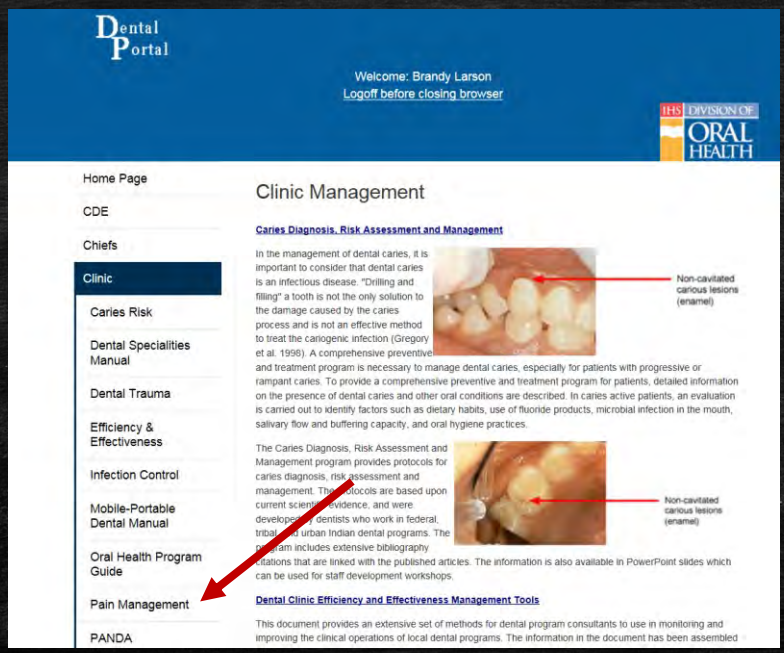
- Other guidelines are vague and address philosophy of prescribing rather that assisting DDS with selecting appropriate individualized pain medications / strategies
- Tailored to IHS because it references medications / dosages on IHS formulary
- Gives **general** guidelines to prevent ruling out NSAIDs simply due to a blanket diagnosis (lab value references like CrCl, etc.)
- Recommends strategies (like utilizing UDS) that aren't usually available in private practice

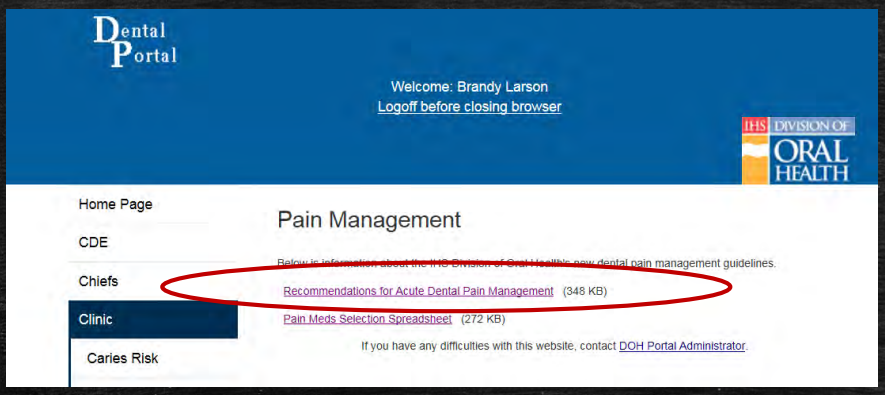
IHS Dental Portal: www.ihs.gov/DOH






Dental Portal
Welcome: Brandy Larson
Logoff before closing browser
IHS DIVISION OF ORAL HEALTH
Home Page
CDE
Chiefs
Clinic
Directory
DPR
ECC Collaborative
EDR
Forms&Guidance
HP/DP
IHS Intranet
FAC
News & Announcements
Link to DePAC website
2017 IHS National Oral Health Council Clinical Excellence in Dentistry Awards
IHS Blog – Building Early Childhood Caries Prevention Into IHS Activities
IHS National Dental Specialist Consultants Announced
The Indian Health Service Early Childhood Caries Collaborative: A Five-year Summary
Dental Preventive and Clinical Support Centers Program Awards
New DA Radiology Certification Requirements
Alternative Dental Workforce Models
Your Directory Listing
Name: Brandy Larson
Title: Dental Director
Phone: 218-335-3234
E-Mail: brandy.larson@ihs.gov
Area: BEMIDJI
Facility: Cass Lake IHS Hospital
Listed above is your current directory information. If any of the information is incorrect, or out of date, please update your directory listing.
IHS Dental Explorer
IHS ECC Collaborative
DOH Feature Article
The IHS


Dental Portal
Welcome: Brandy Larson
Logoff before closing browser
IHS DIVISION OF ORAL HEALTH
Home Page
CDE
Chiefs
Clinic
Caries Risk
Dental Specialities Manual
Dental Trauma
Efficiency & Effectiveness
Infection Control
Mobile-Portable Dental Manual
Oral Health Program Guide
Pain Management
PANDA
Clinic Management
Caries Diagnosis, Risk Assessment and Management
In the management of dental caries, it is important to consider that dental caries is an infectious disease. "Drilling and filling" a tooth is not the only solution to the damage caused by the caries process and is not an effective method to treat the cariogenic infection (Gregory et al. 1998). A comprehensive preventive and treatment program is necessary to manage dental caries, especially for patients with progressive or rampant caries. To provide a comprehensive preventive and treatment program for patients, detailed information on the presence of dental caries and other oral conditions are described. In caries active patients, an evaluation is carried out to identify factors such as dietary habits, use of fluoride products, microbial infection in the mouth, salivary flow and buffering capacity, and oral hygiene practices.
Non-cavitated carious lesions (enamel)
The Caries Diagnosis, Risk Assessment and Management program provides protocols for caries diagnosis, risk assessment and management. The protocols are based upon current scientific evidence, and were developed by dentists who work in federal, tribal and urban Indian dental programs. The program includes extensive bibliography citations that are linked with the published articles. The information is also available in PowerPoint slides which can be used for staff development workshops.
Non-cavitated carious lesions (enamel)
Dental Clinic Efficiency and Effectiveness Management Tools
This document provides an extensive set of methods for dental program consultants to use in monitoring and improving the clinical operations of local dental programs. The information in the document has been assembled



https://www.ihs.gov/generalweb/webapps/webprofile/indexpop.cfm?ihs_component=weblogin&newquery=1&rs=http://www.ihs.gov/DOH/

1. **Recommendations for Acute Dental Pain Management** – Reviewed & Approved by DOH & HOPE
2. **Pain Meds Selection Spreadsheet** – Meant to be a template that needs to be adapted and updated locally

Recommendations for Management of Acute Dental Pain

A collaboration between the Indian Health Service Division of Oral Health (DOH) & Indian Health Service National Committee on Heroin, Opioid and Pain Efforts (HOPE)

Content:

21 page document:
- 6 sections
- 2 decision trees → pre- & post- pain management (general population)
- 3 appendix (resources)
- references

Intended uses:
- general reference
- training document for new dentists
- establishing a local policy

Purpose

The purpose of this document is to provide evidence-based guidance on prescribing for acute dental pain. This guidance seeks to reduce unnecessary opioid prescribing and assist dentists in selecting the most appropriate, effective, and safest pain medication based on patients' individual medical status. This document does not consider every medical condition but rather addresses the most common systemic medical conditions that affect acute pain medicine prescribing. This document is intended for general dentists and does not address pain management for the more complex and extensive surgeries performed by oral surgeons.

Clinical Summary of Common Dental Pain Medications

ACETAMINOPHEN (APAP) - Acetaminophen has been shown to have a synergistic effect when administered with NSAIDs for the treatment of acute dental pain, with efficacy similar or superior to opioid therapy[11,12,15,16,19,20,24]. The total acetaminophen dose from ALL sources (including opioid fixed dose combinations) should not exceed 3,000 mg daily (4,000 mg daily if monitored). Patients should be counseled not to combine acetaminophen prescriptions with other over the counter medications containing acetaminophen.

Recommendations for Prescribing & Administering in the General Population:

- Pre-operative pain management:
  - Using a single dose oral NSAID *(see figure 1)* 30-60 minutes prior to dental procedures may delay onset and reduce intensity of post-procedural pain, though contraindications and perioperative bleeding risks must be considered[21-23,28,29]. The use of a pre-operative NSAID is not recommended in procedures anticipated to introduce significant trauma or bleeding.
  - Consider the use of an antiseptic mouthrinse, such as chlorhexidine gluconate, to promote healing, prevent post-operative infection, and reduce post-operative pain.

Recommendations for Prescribing & Administering for Special Populations:

- Pre-operative pain management:
  - Pre-operative NSAIDs should be used with extreme caution in patients with clotting disorders or taking anticoagulants. Standard precautions and contraindications regarding NSAIDs, as outlined below, should also be followed.
  - Consider the use of an antiseptic mouthrinse without alcohol in patients with a history of substance use disorder to prevent relapse.

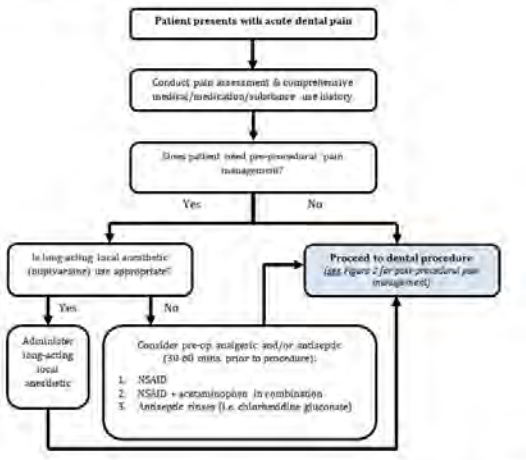
- Recommendations for Prescribing for Special Populations
  - Allergy & Drug Intolerance
  - Anticoagulant Use
  - Benzodiazepine Use
  - Gastro-Intestinal Conditions
    - Gastric Bypass
    - Gastritis, Gastrointestinal Bleeding / Ulcer, Hiatal Hernia, Irritable Bowel Syndrome / Disease, Peptic Ulcer Disease, & Ulcerative Colitis
  - Hepatic Conditions
    - Alcohol Abuse
    - Liver Impairment
  - Opioid Use
    - Abstinence-Based Treatment for Opioid Use Disorder
    - Chronic Pain Patients
    - Medication-Assisted Treatment for Opioid Use Disorder
    - Substance Use Disorders
  - Pregnancy
  - Renal impairment
  - Ventilation Impairment

Recommendations for only the most common or significant medical conditions, is not all-inclusive

Renal impairment

- Codeine should be avoided for all patients with renal impairment.
- NSAIDs should be avoided if:
  - Creatinine Clearance [CrCl] <30 mL/min.
  - Estimated Glomerular Filtration Rate [eGFR] <30 mL/min.
  - Estimated Glomerular Filtration Rate [eGFR] 30 - 60 mL/min. when there is concurrent disease, such as diabetes.
- Acetaminophen and acetaminophen/opioid combinations require prolonged dosing intervals in patients with significant renal impairment:
  - Glomerular Filtration Rate [GFR] 10-50 mL/min/1.73m², limit dosing to q6h.
  - Glomerular Filtration Rate [GFR] <10 mL/min/1.73m², limit dosing to q8h.
  - For kids with intermittent dialysis, limit dosing to q8h.
- If an opioid is required, tramadol is the opioid of choice. It should, however, be reduced to 100 mg q12h if Creatinine Clearance [CrCl] <30mL/min.

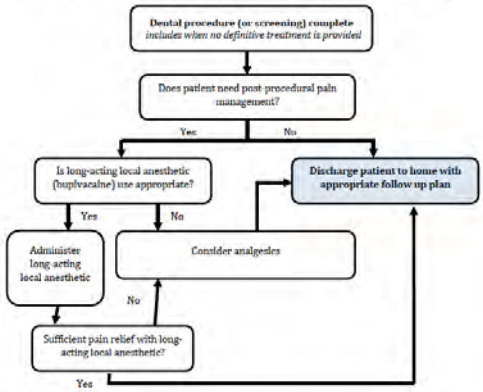
Figure 1. Recommendations for Pre-Procedural Acute Dental Pain Management (general population)



PRE-OPERATIVE NSAIDs*

Preoperative Medications	Recommended Dose	Timing
Ibuprofen	400 mg	30 mins. prior to procedure
Naproxen Sodium	550 mg	1 hr. prior to procedure**
Naproxen	500 mg	1 hr. prior to procedure

Figure 2. Recommendations for Post-Procedural Acute Dental Pain Management



POST-OPERATIVE NSAIDs*

NSAID	Recommended Dose	Max Daily Dose	Tp** (hours)	t 1/2 (hours)	Analgesic Onset (hours)	Analgesic Duration (hours)
PROPIONIC ACIDS						
Ibuprofen	400-800 mg q6h	3,200 mg	1-2	1.8-2	0.5	4-6
Naproxen (base)	500 mg q12h or 250 mg q6h	1,000 mg	2-4	12-15	1	up to 7
Naproxen Sodium	550 mg q12h or 275 mg q6h	1,100 mg	1-2	12-13	1	up to 7
ACETIC ACIDS						
Diclofenac Sodium	50 mg q8h	150 mg	2-3	1-2	1	4-6
Diclofenac	(can do 100 mg loading dose)		1-2	1-2	0.5	4-6
Etodolac	400 mg q8h or 200 mg q6h	1,200 mg	1-2	7.3	0.5	4-12

** Tp = Time to peak response*

NSAID SAFETY COMPARISIONS

DRUG	COX-2 Selectivity *(in vitro)*	GI Risk	Cardiovascular Risk
ACETIC ACID - NSAIDS			
Diclofenac Na	High	Moderate	High
Etodolac	High	Low	Moderate
PROPIONIC ACID - NSAIDS			
Ibuprofen	Moderate	Low	Moderate - High
Naproxen	Low	Moderate – High	Low

**From Pharmacist's Letter / Prescriber's Letter November 2011 (PL Detail-Document #271106)*

Figure 1. Recommendations for Pre-Procedural Acute Dental Pain Management (general population)

Figure 2. Recommendations for Post-Procedural Acute Dental Pain Management

POST-OPERATIVE OPIOIDS*

Opioid	Recommended Dose	Morphine Equiv. Dose
Codeine/ Acetaminophen	30/300mg q6h	4.5 mg per dose
Hydrocodone/ Acetaminophen	5mg/325mg q6h	5 mg per dose
Tramadol**	50mg q6h	5 mg per dose

***Opioids and NSAIDs lists are not all-inclusive; selection should be guided by patient-specific factors, individual facility protocols, and medication formulary.**

***Tramadol (utilized without NSAID or APAP) is usually dosed at 100mg q8h or q6h for moderate - severe dental pain.*

POST-OPERATIVE PAIN MEDICATION DOSING RECOMMENDATIONS FOR THE GENERAL POPULATION

Expected Pain →	Mild to Moderate Pain (i.e. mild trauma / inflammation)	Moderate to Severe Pain (i.e. moderate trauma / inflammation)	Severe Pain (i.e. significant trauma / inflammation)
1st line therapy	Ibuprofen 400-600 mg q6h or alternative NSAID[5,6,7,11] **or** Acetaminophen 325-650 mg q6h[7] ---------- *2 day supply – scheduled dosing interval*	Ibuprofen 400-800 mg q6h or alternative NSAID[5,6,7,11] **and** Acetaminophen 500-650 mg q6h[7] ---------- *3 day supply – scheduled dosing interval*	Ibuprofen 400-800 mg q6h or alternative NSAID[5,6,7,11] **and** Acetaminophen 500-650 mg q6h[7] **and** Hydrocodone/APAP 5/325 mg q6h or alternative opioid[1,4,7,9] ---------- *2-3 day PRN opioid supply with scheduled NSAID/APAP dosing interval*
If inadequate pain control	Take both NSAID **and** Acetaminophen	Add PRN Hydrocodone/ APAP 5/325 mg q6h **or** alternative opioid[1,4,7,9] *(1 day supply)*	For pain extending past 72 hours, use Ibuprofen 400-800 mg q6h prn[7]

NOTE: Acetaminophen dosage from all sources should not exceed 3,000 mg daily if patient unmonitored / 4,000 mg if monitored.[37]

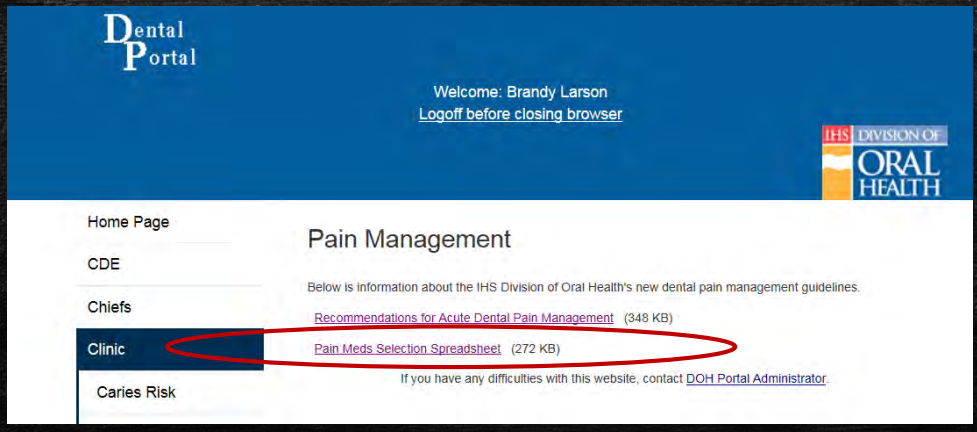
NOTE: Some NSAID & APAP dosage recommendations have been adjusted to accommodate what formulations are available at IHS facilities.

Appendix A: ADA Statement on the Use of Opioids in the Treatment of Dental Pain

Appendix B: Dental Specific Resources -- Acute Dental Pain Management

Appendix C: Benzodiazepines, Sedative-Hypnotics, and Anxiolytics

References



CL FORMULARY PAIN MEDS	OK for kids?	Breast Feeding OK?	Pregnancy OK?	Maximum Dosing	Renal Considerations	Hepatic Considerations	Cardiac Considerations	Drug Interactions	Contra-indications	Adverse Effects	Misc.
ALL NSAIDs											
ALL NSAIDs			N		**Avoid if:** Creatinine Clearance [CrCl] <30 mL/min. **Avoid if:** Estimated Glomerular Filtration Rate [eGFR] <30 mL/min. **Avoid if:** Estimated Glomerular Filtration Rate [eGFR] 30 - 60 mL/min. and concurrent disease *(like diabetes)*	**Dosing adjustments:** None for mild-moderate disease **Severe Hepatic Impairment:** -Avoid in severe impairment or active hepatic disease -Avoid in patients with Cirrhosis *(due to increased risk of esophageal hemorrhages)* **Alcoholism:** consider Rx Proton Pump Inhibitor (PPI)	**Contraindicated:** -CHF -Cardiac Edema -Recent Acute MI -Unstable Angina -Perioperative period of Bypass Surgery **Aspirin:** Take NSAID Rx 8 hrs. prior to Aspirin and take Aspirin 2 hrs. prior to NSAID Rx *--> NSAIDs lower effectiveness of Aspirin in prevention of stroke / MI because they have to bind to same receptors and can prevent the irreversible*	**Avoid Concomitant Use:** increases toxicity due to potential renal dysfunction: -Lithium -Digoxin -Methotrexate *(high-dose)* Medications causing Myelosuppression or Thrombocytopenia: -Omacetaxine -Synribo **Moderate:** -Aspirin -*anticoagulants* -*antiplatlets* *--> avoid if possible or Rx PPI w/ NSAIDs to minimize GI bleeds* **Mild:** -*Corticosteroids* -Alcohol -Tobacco -*SSRIs* -*SNRIs* -*tricyclic antidepressants*	**Allergy:** -History of Aspirin Triad Rxns -NSAID Allergy -NSAID induced Asthma **GI [avoid]:** -GI ulcer/bleeding -IBS / IBD **GI [caution]:** - Gastric Bypass -Gastritis - Hiatal Hernia - Peptic Ulcer Disease *--> consider Rx PPI* **Bleeding Disorders:** -Intracranial Hemorrhage, -Thrombocytopenia, -Agranulocytosis, -Aplastic Anemia, -Coagulation Defects, -C-V Bleeding, -Hemorrhagic Diathesis, -Incomplete Hemostasis	**Bleeding:** Prolonged bleeding *(less than Aspirin)* **Cardiac:** -Increased risk of MI / Stroke *(due to increased risk of blood clots)* - Increased Blood Pressure & Edema *(due to Sodium Retention)* --> no demonstrated long-term CV risks with short duration of use --> Lowering dosages of Ibuprofen and Naproxen lower risk of death for cardiac patients	Synergistic if combined w/ Acetaminophen Low risk of constipation and no centrally mediated vomiting / nausea, or respiratory suppression *(like seen in opioids)* Must Rx PPI if prescribing NSAID to Gastric Bypass patient. Rx M&M sized pills or liquid. Recommend taking with food to minimize GI adverse effects

Pain Meds Ref. | Interaction Meds

Dental Pain Meds Selection Spreadsheet

- Promotes safe and effective prescribing

- What we use at Cass Lake to help select best pain med for medically compromised patients → **very specific**

- 7 pages

CL FORMULARY PAIN MEDS	OK for kids?	Breast Feeding OK?	Pregnancy OK?	Maximum Dosing	Renal Considerations	Hepatic Considerations	Cardiac Considerations	Drug Interactions	Contra-indications	Adverse Effects	Misc.
PROPIONIC ACID NSAIDs											
Ibuprofen **200mg** **400mg** **800mg tabs** *(Advil, Motrin)*	Y	Y	N	PATIENTS (45+ lbs.) - **200 mg** (45 lbs.) - **400 mg** (88 lbs.) -**600 mg** (120 lbs.) -**800 mg** (175 lbs.) **QID** Max daily dose (175+ lbs.) = **8 tabs** (400 mg tab) *Consult a pediatric dosing chart for kids < 88 lbs.* **Onset** = 0.5 hr. **Peak** = 1-2 hrs. **Duration** = 4-6 hrs. **t-1/2** = 1.8-2 hrs.	**Dosing Adjustments:** No dosing adjustments for mild - moderate renal disease		Higher risk of blood clots than other NSAIDS --> caution in pts. w/ peripheral artery disease / atherosclerosis **Cardiovascular Risk:** Moderate - High		**GI Risk:** Low	**CNS:** Dizziness (3-9%) **GI Disturbances:** (<10%)	Some Ibuprofen formulations may contain phenylalanine *(CL formulation does not)*
Naproxen [Base] **500mg tabs** *(Naprosyn)*	Y	N	N	PATIENTS (12-64 yrs. & 110+ lbs.) **500 mg BID** Max daily dose = **2 tabs** (500 mg tab) **Onset** = 1 hr.	**Dosing Adjustments:** No dosing adjustments for mild - moderate renal disease		Less risk of blood clots than Ibuprofen --> safer in pts. w/ peripheral artery disease / atherosclerosis Less likely to interfere with antiplatelet activity of Aspirin than Ibuprofen **Cardiovascular Risk:** Low		**Elders > 65 yrs.** Due to long half-life **GI Risk:** Moderate - High	**CNS:** Dizziness (9%) Drowsiness (3-9%) Headache (9-15%) **Dermatologic:** Pruritus (3-9%) Rash/Ecchymoses (3-9%) **Endocrine:** Fluid retention (3-9%) **GI Disturbances:** (<14%) **Hematologic:** Hemolysis (3-9%)	Similar adverse effects to Ibuprofen, but more of them and more significant effects Pediatric doses not available at CL pharmacy Naproxen Na has faster onsent but is not on formulary Max daily dose of

CL FORMULARY PAIN MEDS	OK for kids?	Breast Feeding OK?	Pregnancy OK?	Maximum Dosing	Renal Considerations	Hepatic Considerations	Cardiac Considerations	Drug Interactions	Contra-indications	Adverse Effects	Misc.
OPIOIDS											
ALL OPIOIDS	N	N	*Consult PCP / OBGYN*					**Avoid Concomitant Use:** *-mixed agonist / antagonist opioids* *-opioid antagonists* *-CNS depressants* -Metoclopramide (Reglan, Metozolv)	**Addiction:** Opioid dependence	**CNS:** CNS Depression Respiratory Depression Sedation Dizziness	Not a good anti-inflammatory
									Intoxication w/: -alcohol -centrally-acting analgesics -hypnotics -opioids -psychotropics		
								Significantly Increased Sedation: -Cyclobenzaprine (Amrix, Fexmid, Flexeril, Tabradol)	**Respiratory:** Caution w/ impaired ventilation *Including*: -Asthma -COPD -Emphysema -Bronchitis -Sleep Apnea	**GI:** Constipation Nausea Vomiting	Do not significantly affect bleeding or platelet aggregation *(but may interact w/ Warfarin)*
								Black Box Warning: *benzodiazepines* + opioids = increased sedation, respiratory suppression, & death			Nausea is centrally mediated and taking w/ food will not decrease nausea.
								FDA Warning: Can interact w/ *antidepressants* & *migraine meds* to cause Serotonin Syndrome (Serotonin build up causing toxicity)	**CNS:** ↑ intracranial pressure / head injury		
									Adrenal Impairment: Can cause reduced Cortisol production if significant adrenal impairment present		Use caution in Sleep Apnea patients.

CL FORMULARY PAIN MEDS	OK for kids?	Breast Feeding OK?	Pregnancy OK?	Maximum Dosing	Renal Considerations	Hepatic Considerations	Cardiac Considerations	Drug Interactions	Contra-indications	Adverse Effects	Misc.
OPIOIDS, cont.											
Codeine + Acetaminophen **30/300mg tabs** *(Tylenol #3)*	N	N	Y	PATIENTS (12+ yrs.) **-30/300 mg** (48-110 lbs.) **-60/600 mg** (110+ lbs.) **QID** *(can dose q 4 hrs. if necessary)* Max daily dose (48-110 lbs.) = **6 tabs** (30/300 mg tab) Max daily dose (110+ lbs.) = **12 tabs** (30/300 mg tab)	**Dosing Adjustments:** if GFR 10-50 mL/min/1.73m2, limit to QID	**Dosing Adjustments:** -Mild - mod. impairment -Active liver disease -Alcoholism * 30/300mg QID	**Caution:** CV disease *Including*: *-Acute MI* *-Post-MI* *-Unstable Angina*	**Avoid Concomitant Use:** -Azelastine -Eluxadoline -Orphenadrine -Paraldehyde -Thalidomide *CYP2D6 inhibitors* --> - Amiodarone -Cimetidine -Desipramine -Duloxetine (Cymbalta) -Fluoxetine (Prozac) -Paroxetine (Paxil) -Propafenone -Quinidine -Ritonavir	**CYP2D6 "Ultrarapid Metabolizers"**	**GI:** 10% -Abdominal pain -Constipation --> More emotogenic than other opioids	No studies showing that Tylenol #3 interacts w/ Warfarin, but studies do show Acetaminophen can if taken > 1 week
					Dosing Adjustments: if GFR < 10 mL/min/1.73m2, limit to TID	**Dosing Adjustments:** - Cirrhosis * 30/300mg TID			**Allergy:** Metabisulfite **Alcoholism** **CNS depression** **Caution with:** -Morbid obesity -Hypovolemia -Adrenal Insufficiency -Impaired Biliary Tract -Thyroid Disorder -Prostatic Hyperplasia -Seizure Disorder	**Hepatic:** Acute liver failure if recommended doses exceeded	**2017 FDA Contraindication**: should not be used to treat pain in kids <12 years
					Caution: Severe renal impairment	**Avoid if:** Severe hepatic impairment / disease				**Psuedoallergy:** Codeine is most likely opioid to trigger pseudoallergy (can also occur with NSAIDs and other opioids)	**2017 FDA Warning:** recommend against use in kids ages 12-18 who are obese or have breathing conditions (e.g. sleep apnea, severe lung disease)
				Onset = 0.5-1 hrs. **Peak** = 1.5-2 hrs. **Duration** = 4-6 hrs. **t-1/2** = 2-3 hrs.	*Dosing adjustments based on Acetaminophen*					
Hydrocodone + Acetaminophen **5/325mg tabs** *(Lortab, Norco, Zydone, **Vicodin)*	N	N	Y	PATIENTS (110+ lbs.) **10/650 mg QID** *(can dose q 4 hrs. if necessary)* Max daily dose = **12 tabs** (5/325 mg tab)	**Dosing Adjustments:** if GFR 10-50 mL/min/1.73m2, limit to QID	**Dosing Adjustments:** -Mild - mod. impairment -Active liver disease -Alcoholism *5/325mg QID	**Caution:** CV disease *Including*: *-Acute MI* *-Post-MI* *-Unstable Angina*	**Avoid Concomitant Use:** -Alcohol -Conivaptan -Eluxadoline -Fusidic Acid -Idelalisib -Orphenadrine -Thalidomide	**Alcoholism** **CNS depression** **GI:** Caution w/ acute abdominal conditions	**GI:** *Most Common* --> Constipation *Less Common* --> Dyspepsia Peptic Ulcer	No studies showing that Vicodin interacts w/ Warfarin, but studies do show Acetaminophen can if taken > 1 week
					Dosing Adjustments: if GFR < 10 mL/min/1.73m2, limit to TID						
				ELDERS (>65 yrs.) & PATIENTS (48-110 lbs.) **5/325 mg QID** *(can dose q 4 hrs. if needed)*	**Caution:** renal impairment	**Caution:** hepatic impairment	**Cardiac AE's:** *Frequency Unknown* --> -Bradycardia -Cardiac Arrest		**Caution with:** -Morbid Obesity -Adrenal Insufficiency -Impaired Biliary Tract -Thyroid Disorder	**Hepatic:** Acute liver failure if recommended doses exceeded	**Vicodin is

Common Meds that Interact with Pain Meds

ADDICTION MEDS.	ANTI-CLOTTING	ANTIDEPRESSANTS, MOOD STABILIZERS, & SEROTONIN AFFECTING MEDS				ANTIPSYCHOTICS & PSYCHOTROPICS		SEDATIVES, HYPNOTICS, & ANXIOLYTICS	
Mixed Agonist / Antagonist Opioids	Anticoagulants	Tricyclic Antidepressants (TCAs)	Monoamine Oxidase Inhibitors (MAOIs)	Selective Serotonin Reuptake Inhibitors (SSRIs)	Other "Serotonin Syndrome" Causing Meds	Antipsychotics	Psychotropics	Benzodiazepines	Sedatives, Hypnotics, & Anxiolytics
Bunavail	Apixaban	Amitriptyline	Eldepryl	Brintellix	Amerge	Abilify	Anafranil	Alprazolam	Ambien
Buprenex	Coumadin	Amoxapine	Emsam	Celexa	Axert	Adasuve	Atenolol	Ativan	Ataraх
Buprenorphine	Dabigatran	Anafranil	Isocarboxazid	Citalopram	Bupropion	Aripiprazole	Atomoxetine	Chlordiazepoxide	Belsomra
Depade	Edoxaban	Asendin	Linezolid	Escitalopram	Carbamazepine	Aristada	Catapres	Clonazepam	Benadryl
Dolophine	Eliquis	Aventyl Hydrochloride	Marplan	Fluoxetine	Depakene	Asenapine	Clomipramine	Clorazepate	Busodium
Methadone	Jantoven	Clomipramine	Nardil	Fluvoxamine	Imitrex	Brexpiprazole	Clonidine	Dalmane	Buspar
Methadose	Pradaxa	Desipramine	Parnate	Lexapro	Lithium	Cariprazine	Corgard	Diazepam	Buspirone
Probuphine	Rivaroxaban	Doxepin	Phenelzine	*Olanzapine / Fluoxetine*	Lithobid	Chlorpromazine	Fluvoxamine	Doral	Butabarbital
Suboxone	Savaysa	Elavil	Selegiline		Maxalt	Clozapine	Gabapentin	Estazolam	Butalbital
Zubsolv	Warfarin	Imipramine	Tranylcypromine	Paroxetine	Rizatriptan	Clozaril	Guanfacine	Flurazepam	Butisol Sodium
	Xarelto	Norpramin	Zelapar	Paxil	Sumatriptan	Decanoate	Inderal	Halcion	Carisoprodol
Opioid Antagonists		Nortriptyline		Prozac	Tegretol	Discmelt	Intuniv	Klonopin	Chloral Hydrate
	Antiplatelets	Pamelor	**Mood Stabilizers**	Sarafem	Valproic Acid	Droperidol	Kapvay	Libritabs	Diphenhydramine
Naloxone		Protriptyline		Sertraline	Wellbutrin	Fanapt	Lopressor	Librium	Edluar
Naltrexone	Aspirin	Silenor	Carbatrol	Vortioxetine	Zyban	Fazaclo	Luvox	Lorazepam	Equanil
Narcan	Brilinta	Sinequan	Depakote	Zoloft		Fluphenazine	Metoprolol	Midazolam	Eszopiclone
Contrave	Clopidogrel	Surmontil	Divalproex Sodium		*OTC meds w/ Dextromethorphan*	Geodon	Minipress	Mitran	Fiorinal
Vivitrol	Effient	Tofranil	Equetro	**Serotonin & Norepinephrine Reuptake Inhibitors (SNRIs)**		Haldol	Nadolol	Niravam	Hydroxyzine
	Plavix	Trimipramine	Eskalith			Haloperidol	Naltrexone	Oxazepam	Intermezzo
	Prasugrel	Vanatrip	Lamictal		Droperidol	Iloperidone	Neurontin	Poxi	Luminal
	Ticagrelor	Vivactil	Lamotrigine		Granisetron	Inapsine	Pindolol	Prosom	Lunesta
			Oxcarbazepine	Cymbalta	Inapsine	Invega	Prazosin	Quazepam	Mebaral
		Misc. Antidepressants		Desvenlafaxine	Linezolid	Latuda	Propranolol	Restoril	Mephobarbital
		Desyrel		Duloxetine	Metoclopramide	Lauroxil	Reserpine	Serax	Meprobamate
		Ludiomil		Effexor	Norvir	Loxapine	Revia	Temazepam	Miltown
		Maprotiline		Fetzima	Ondansetron	Loxitane	Serpasil	Tranxene	Nembutal
		Mirtazapine		Khedezla	Reglan	Lurasidone	Strattera	Triazolam	Pentobarbital
		Nefazodone		Levomilnacipran	Ritonavir	Maintena	Symbyax	Valium	Ramelteon
		Remeron		Milnacipran	Zofran	Mellaril	Tenex	Versed	Rozerem
		Serzone		Pristiq	Zyvox	Molindone	Tenormin	Xanax	Secobarbital
		Soltab		Trazodone		Navane	Visken		Seconal Sodium
		Trazodone		Venlafaxine		Olanzapine			Solfoton
		Viibryd				Orap			Soma
		Vilazodone				Paliperidone			Somnote
						Perphenazine			Sonata
						Pimozide			Suvorexant

Pain Meds Ref. | **Interaction Meds** | Pediatric Dosing

2nd tab

Acetaminophen Pediatric Dosing

Dosing = 10 – 15 mg/kg/dose every 4 – 6 hours (Max 5 doses in 24 hours)

	Children's Mapap Suspension	Children's Chewable Mapap	Mapap Tablets (Adult)
Concentration	**160 mg/5 ml**	**80 mg**	**325 mg**
Weight lbs.			
6 – 11 lbs.	1.3 mL	½ tablet	
12 – 17 lbs.	2.5 mL	1 tablet	
18 – 23 lbs.	3.8 mL	1 ½ tablet	
24 – 35 lbs.	5 mL	2 tablets	
36 – 47 lbs.	7.5 mL	3 tablets	
48 – 59 lbs.	10 mL	4 tablets	
60 – 71 lbs.	12.5 mL	5 tablets	
72 – 95 lbs.	15 mL	6 tablets	
48 - 95 lbs.			1 tablet
96+ lbs.	20 mL	8 tablets	2 tablets

Ibuprofen Pediatric Dosing

Dosing = 5 – 10 mg/kg/dose every 6 to 8 hours (Max of 4 doses in 24 hours)

	Children's Ibuprofen Suspension	Ibuprofen Tablet	Ibuprofen Tablet
Concentration	**100 mg/5 ml**	**400 mg**	**800 mg**
Weight lbs.			
12 – 17 lbs.	2.5 mL		
18 – 23 lbs.	3.8 mL		
24 – 35 lbs.	5 mL		
36 – 47 lbs.	7.5 mL		
48 – 59 lbs.	10 mL		
60 – 71 lbs.	12.5 mL		
72 – 95 lbs.	15 mL		
88 – 175 lbs.	20 mL	1 tablet	
176+ lbs.	40 mL	2 tablets	1 tablet

3rd tab

This document is a bit of a monster for DOH to manage and keep updated. Therefore, this document is meant to be used as a template for what programs can develop locally and MUST be updated locally. It should reflect only medications that is on your formulary.

LOCAL EFFORTS AND IMPLEMENTING CHANGE

HOW DO I GAIN SUPPORT FROM ADMINISTRATION?

- Make the IHS Recommendations document into a local policy and get the blessing of QAPI & administration
- Ask them to support you when patients complain / address how to handle pain-control questions in patient surveys
- Ask them to include dental prescribing if announcing overall opioid prescribing campaign to the community
- Remind them that dentistry is NOT pain free - patient expectation should be a goal of 30% - 50% pain reduction, not 100%

HOW DO I ENGAGE OTHER DENTISTS IN OPIOID REDUCTION EFFORTS?

- Encourage DDS to complete IHS trainings on prescribing via the IHS Division of Oral Health Web Portal & ADA CDE
- Encourage collaboration between DDS & pharmacists to address special population needs *(kidney disease, alcoholism, etc.)*
- Address patient expectations with a goal of 30% - 50% pain reduction, not 100%
- Educate all dental staff about local and regional substance abuse programs / resources and referral processes *(SIBRT, etc.)*

- Empower DDS to have enough time in their schedule to definitively treat emergency patients rather than prescribing pain meds and rescheduling
- Consider asking pharmacy to monitor dental opioid prescribing by PDMP monthly reports or request independent review if you suspect opioid prescribing should be evaluated
- Consider asking ER/UC to send dental pain patients to dental department for definitive care rather than prescribing opioids (whenever feasible and after a medical screening)
- Implement the IHS Guidelines as a local policy and review the policy when onboarding new DDS

OTHER DENTAL-SPECIFIC GUIDELINES

From the ADA's website (ADVOCACY tab)

- Lists ADA Policies, Guidelines, and Statements re: Opioid Prescribing

Policies and Recommendations on Substance Use Disorders

Below are the ADA's official policies, statements, and guidelines on alcoholism, drug addiction, and other substance use disorders, as adopted by the ADA House of Delegates.

Interim Board Policy on Opioid Prescribing
(B-37-2018)

Statement on the Use of Opioids in the Treatment of Dental Pain
(Trans. 2005:328; 2016:286)

Statement on Alcoholism and Other Substance Use Disorders
(Trans. 2005:328)

Statement on Provision of Dental Treatment for Patients with Substance Use Disorders
(Trans. 2005:329)

Statement on Alcohol and Other Substance Use by Pregnant and Postpartum Patients
(Trans. 2005:330)

Guidelines Related to Alcohol, Nicotine, and Drug Use by Child or Adolescent Patients
(Trans. 2005:330)

Insurance Coverage for Chemical Dependency Treatment
(Trans. 1986:519; 2012:442)

ADA Statement on the Use of Opioids in the Treatment of Dental Pain

1. When considering prescribing opioids, dentists should conduct a medical and dental history to determine current medications, potential drug interactions and history of substance abuse.
2. Dentists should follow and continually review Centers for Disease Control and State Licensing Boards recommendations for safe opioid prescribing.
3. Dentists should register with and utilize prescription drug monitoring programs (PDMP) to promote the appropriate use of controlled substances for legitimate medical purposes, while deterring the misuse, abuse and diversion of these substances.
4. Dentists should have a discussion with patients regarding their responsibilities for preventing misuse, abuse, storage and disposal of prescription opioids.
5. Dentists should consider treatment options that utilize best practices to prevent exacerbation of or relapse of opioid misuse.

ADA Statement on the Use of Opioids in the Treatment of Dental Pain

6. Dentists should consider nonsteroidal anti-inflammatory analgesics as the first-line therapy for acute pain management.
7. Dentists should recognize multimodal pain strategies for management for acute postoperative pain as a means for sparing the need for opioid analgesics.
8. Dentists should consider coordination with other treating doctors, including pain specialists when prescribing opioids for management of chronic orofacial pain.
9. Dentists who are practicing in good faith and who use professional judgment regarding the prescription of opioids for the treatment of pain should not be held responsible for the willful and deceptive behavior of patients who successfully obtain opioids for non-dental purposes.
10. Dental students, residents and practicing dentists are encouraged to seek continuing education in addictive disease and pain management as related to opioid prescribing.

ADA House of Delegates Adopted: October 2016

Interim Board Policy on Opioid Prescribing (B-37-2018)

Continuing Education

B-37-2018. Resolved, that the ADA supports mandatory continuing education (CE) in prescribing opioids and other controlled substances, with an emphasis on preventing drug overdoses, chemical dependency, and diversion. Any such mandatory CE requirements should:

1. Provide for continuing education credit that will be acceptable for both DEA registration and state dental board requirements,
2. Provide for coursework tailored to the specific needs of dentists and dental practice,
3. Include a phase-in period to allow affected dentists a reasonable period of time to reach compliance

Dosage and Duration

Resolved, that the ADA supports statutory limits on opioid dosage and duration of no more than seven days for the treatment of acute pain, consistent with Centers for Disease Control and Prevention (CDC) evidence-based guidelines

Prescription and Drug Monitoring

Resolved, that the ADA supports dentists registering with and utilizing Prescription Drug Monitoring Programs (PDMPs) to promote the appropriate use of controlled substances for legitimate medical purposes and deter the misuse, abuse and diversion of these substances

Resolved, that the ADA supports improving the quality, integrity, and interoperability of state prescription drug monitoring programs.

ADA Board of Trustees
March 2018

Journal of the American Dental Association

Select opioid-related articles from the Journal of the American Dental Association (JADA).

- Benefits and Harms Associated with Analgesic Medications Used in the Management of Acute Dental Pain: An Overview of Systematic Reviews (JADA April 2018)
- Opioid Prescribing Practices From 2010 Through 2015 Among Dentists in the United States: What Do Claims Data Tell Us? (JADA April 2018)
- Prescription Monitoring Program Data: What It Can Tell You (JADA April 2018)
- Opioid prescribing and risk mitigation implementation in the management of acute pain: Results from The National Dental Practice-Based Research Network (JADA April 2018)
- Sex and Race or Ethnicity Disparities in Opioid Prescriptions for Dental Diagnoses Among Patients Receiving Medicaid (JADA April 2018)
- Why do we prescribe Vicodin? (JADA July 2016)
- Dental opioid prescribing and multiple opioid prescriptions among dental patients (JADA July 2016)
- Addressing after-hours requests for prescription drugs (JADA April 2014)
- Combining ibuprofen and acetaminophen for acute pain management after third-molar extractions (JADA August 2013)
- Substance-use screening and interventions in dental practices: Survey of practice-based research network dentists regarding current practices, policies and barriers (JADA June 2013)
- Prevention of prescription opioid abuse: The role of the dentist (JADA July 2011)
- What Should I do When I Suspect a Patient May be Abusing Prescription Drugs? (JADA May 2008)
- What are my ethical responsibilities when I suspect an employee of substance abuse? (JADA February 2007)

From the ADA's website (ADVOCACY tab)

- List of free JADA articles on dental pain prescribing and opioids
- 5 of the 13 articles are in April 2018!
- 8 of the 13 articles span from 2007-2016!

Journal of the American Dental Association, April 2018

Mississippi State Board of Dental Examiners

Board Officers:

Roy L. Irons, D.D.S., President
Frank L. Conaway, Jr., D.M.D., Vice-President
Robert Michael Harkins, D.M.D., Secretary

Board Members:

William Mark Donald, D.M.D.
T. Delton Moore, Jr., D.D.S.
Steven Mark Porter, D.D.S.
Robert L. Smith, Jr., D.D.S.
Laura C. Richoux, R.D.H.

Leah Diane Howell, Executive Director

Telephone: 601-944-9622
Facsimile: 601-944-9624

Suite 100, 600 East Amite Street
Jackson, Mississippi 39201-2861

Internet: www.dentalboard.ms.gov
E-Mail: dentist@dentalboard.ms.gov

IMMEDIATE ATTENTION FOR ALL CURRENTLY LICENSED MISSISSIPPI DENTISTS

As each of you are aware, there is an opioid epidemic in our country right now. In 2009, opioid overdoses became the **NUMBER 1** leading cause of accidental deaths in the United States. In 2015, Mississippi was number FIVE in the country for the number of opioid pain reliever medications written per 100 persons! Governor Phil Bryant was concerned enough to create an Opioid Task Force in an effort to seek input in combating this terrible scourge plaguing our Mississippi families and communities. The Governor's Task Force drafted recommendations affecting all prescribers and pharmacies in our State, as well as law enforcement and other entities. Several of those recommendations are directed toward our State's dentists.

The Mississippi State Board of Dental Examiners was requested to implement the Task Force's recommendations to assist in reducing the use of opioids and their adverse effects. The following summarizes the Board's amendments to Regulations 35 (Prescribing, Dispensing, Maintenance, Records, and Inventory of Controlled Substances) and 41 (Continuing Education) to effect the Task Force's recommendations.

- First and foremost, a dentist who prescribes a Schedule II or Benzodiazepine to his/her patients in greater than a **THREE DAY** supply is **REQUIRED** to access the Mississippi Prescription Monitoring Program (PMP) and query the patient's prescription history **PRIOR TO PRESCRIBING** these medications. This one step, alone, could dramatically reduce overuse of opioids and their concomitant abuse. Although the Board cannot monitor every such prescription, dentists are advised that whenever a complaint of any kind is filed with the Board regarding a dentist, the Board's investigative staff shall query the PMP to ensure that the dentist in question has checked the PMP to verify a patient's prescription history prior to prescribing the aforementioned medications. The PMP maintains a history of all controlled substances prescriptions; as such, the Board can quite easily and effectively check the PMP to ensure a dentist's compliance. In other words, there must be a history of a dentist checking the PMP. Additionally, once a dentist has queried the PMP **PRIOR TO** prescribing the noted medications, a reference **MUST** be placed in the patient's chart sufficiently noting that the dentist performed the required PMP check as to the patient's prescription history.
- Second, every dentist who prescribes, administers, or dispenses any controlled substance within the State of Mississippi, or who proposes to engage in the prescribing, administering, or dispensing of any controlled substance within the State of Mississippi, **SHALL** be required to obtain three (3) hours of continuing education every two (2) years regarding the prescription of opioids. The Governor's Task Force actually recommended five (5) hours of continuing education every two (2) years; however, the Board determined that three (3) hours was more than appropriate and sufficient to comply with the Task Force's recommendation along these lines. To enable dentists greater flexibility in fulfilling the new mandate, this continuing education shall be considered clinical continuing education and shall be exempt from the personal attendance requirement required for clinical continuing education courses. In other words, as an alternative to personally attending courses regarding the prescription of opioids, dentists also may obtain this required clinical continuing education through Internet webinars and computer-based, video, audio, reading and/or correspondence/home study courses, and dentists must ensure compliance with the post-study examination requirements for such coursework set forth in Section 7 of Board Regulation 41.
- Third, the Board has endeavored to limit the amount of opioids given per prescription. Three (3) days' coverage of an opioid is recommended by the Centers for Disease Control and Prevention (CDC). According to the CDC, a three (3) day course typically is adequate in a dental setting. Furthermore, the Board has mandated that no Schedule II medications are to be prescribed or dispensed for acute non-cancer pain for more than seven (7) days.
- Fourth, and in addition to the Governor's Task Force, the Board recommends that all dentists rethink their prescribing habits. It is easy to get into a routine, and, quite frankly, the Board feels this very well may be the case with many dentists. Dentists who routinely prescribe or dispense opioids should be aware that patients can be quite aggressive and creative in their efforts to obtain opioids. Rather than prescribing an opioid as the first line of defense for pain, dentists should consider using a non-opioid pain reliever. Many studies have shown that the combination of Ibuprofen 200 mg with Acetaminophen 500 mg every four (4) hours actually is more effective than an opioid. The Board understands many dentists feel they are not part of the opioid crisis because they do not prescribe controlled substances to the same level as prescribed by physicians; however, dentists need to be aware that a majority of relapses by addicts are fueled by prescriptions from dentists who may, or may not, be aware of their patients' prescription/drug histories. The current opioid epidemic does not rest solely on the shoulders of physicians. Rather, the current opioid epidemic rests on the shoulders of **ALL HEALTHCARE PROVIDERS** who routinely prescribe controlled substances to their patients!
- Finally, the Board's new opioid requirements do **NOT** include opioids or Benzodiazepines administered through intravenous sedation.

All dentists should visit the Laws and Codes section of the Board's web site (http://www.dentalboard.ms.gov) and review Board Regulations 35 and 41.

The direct link to Board Regulation 35 is:

http://www.dentalboard.ms.gov/msbde/msbde.nsf/webpageedit/Laws_RegsAdopted_reg35/$FILE/regulation35.pdf?OpenElement

The direct link to Board Regulation 41 is:

http://www.dentalboard.ms.gov/msbde/msbde.nsf/webpageedit/Laws_RegsAdopted_reg41/$FILE/regulation41.pdf?OpenElement

If you have questions or require additional information, please feel free to contact the Board.

THANK YOU—

MISSISSIPPI STATE BOARD OF DENTAL EXAMINERS

Minnesota Board of Dentistry
University Park Plaza, 2829 University Ave SE, Suite 450
Minneapolis, MN 55414-3249
Website mn.gov/boards/dentistry
Phone 612.617.2250 - Toll Free 888.240.4762 - Fax 612.617.2260
MN Relay Service for Hearing Impaired 800.627.3529

STATEMENT ON SAFE PRESCRIBING AND THE USE OF OPIOIDS IN DENTAL SETTINGS

Model policies across the country have been updated to address changes in prescribing practices with emphasis on appropriate prescribing. Current policies consider multi-modalities, informed consent, and a balanced approach for managing pain and improving patient functionality. The Board considered the relevant literature, model policies, and other local and national resources when preparing the statement.

The statement is meant to offer guidance to dental providers in the management of pain and is not intended to set a standard of care or replace state and federal statutes. The Board promotes appropriate prescribing, dispensing, and administration of controlled substance medications and encourage dental providers to work cooperatively and effectively to manage the dimensions of pain and minimize prescription drug abuse and diversion. Towards that end, and in the interest of public protection, the Minnesota Board of Dentistry issues the following guidance statement.

To effectively assist dental patients in the management of acute dental pain, dental professionals should consider the following:

1. Before initiating pain therapy- conduct and document medical and dental history, including documentation of current medications and appropriate diagnostic imaging and testing. If opioids are to be prescribed, providers should include information gathered from patient interview, physician documentation, and/or any screening tools used regarding the patient's psychiatric status and substance use history and record in the dental record.

2. Dental providers should administer non-steroidal, anti- inflammatory drugs (NSAIDs) as first-line analgesic therapy, unless contraindicated. NSAIDs have been demonstrated to be very effective for the treatment of dental pain, and can be more effective than opioids.

3. Considerations should be given to initiating NSAID therapy, unless contraindicated, immediately before the procedure, then continue dosing on a schedule basis immediately following the procedure. If patient is taking anticoagulant or has a history of hepatic or renal impairment, cautions must be taken and provider must assess risks and consult with treating physician when indicated.

4. Acetaminophen has been shown to be synergistic with NSAIDs, with the efficacy of low dose opioids. When providers administer acetaminophen, it should be on a scheduled basis, unless contraindicated.

5. Providers should consider the use of local anesthetic techniques, including local infiltration of dental local anesthetics and regional nerve blocks whenever possible to assist in pain management.

6. If an opioid is to be administered, the dose and duration of therapy should be for a short period of time, and for conditions that typically are expected to be associated with more severe pain. Do not prescribe doses or amounts that are in excess to the expected need or requirement for effective pain management.

- When opioids are indicated, the provider should choose the lowest potency opioid necessary to manage patient's pain. Preferably, no more than a three day supply for acute dental pain.
- Long-acting opioids or extended-release preparations are contraindicated for the treatment of acute procedural pain.
- Providers should be aware of patient's concurrent medications and the potential for drug interactions. Assess the patient's risk for drug interactions. Involve the patient, physician and pharmacist when indicated. Use of anti-depressants, concurrent use of other opioids, or benzodiazepines can increase the risk of adverse events and even result in death.
- Care should be used when prescribing opioid combination product medications (eg. Vicodin), to ensure that the total does of Acetaminophen does not exceed 3,000 mg daily in adult patients.
- Care should be used when administering opioids to patients with obstructive sleep apnea, as these patients are at an increased risk for opioid- induced adverse events.
- Query the Minnesota Prescription Monitoring Program for patient history of all Schedules II, III, IV and V controlled substances, butalbital and gabapentin dispensed to your patient in the last 12 months.
- Extreme caution should be exercised when responding to requests for opioid analgesics, especially from patients who are new to the practice or who have not been recently seen or evaluated. In general, prescribing opioids absent a face-to-face evaluation is not indicated.

MINNESOTA BOARD OF DENTISTRY

Anesthesia and Pain Management

Special Edition Newsletter

May 2018

ATTENTION

DENTISTS, if you hold an active DEA license, have the ability to prescribe controlled substances, and you DO NOT have an active Prescription Monitoring Account, you are now in **non-compliance** with the law that took effect July 1, 2017. Going forward, this will become subject to formal complaint with the Board. Register here today.

Announcing Minnesota's Opioid Prescribing Guidelines

Recently released guidelines will help Minnesota communities reduce opioid prescriptions; encourage safe, consistent standards when opioids are called for; and deliver compassionate support to people who need ongoing opioid therapy. Built on the understanding that opioids are not the best option for treating chronic pain and may actually worsen it, Minnesota's guidelines focus on post-acute care — the first 45 days after an injury or surgery — as a critical time for preventing long-term use.

Background

Governor Dayton and the Minnesota Legislature established the Opioid Prescribing Improvement Program in 2015 to reduce opioid dependency and substance use by Minnesotans due to the prescribing of opioids by health care providers. The Opioid Prescribing Work Group was convened to advance the program's work, which includes developing statewide guidelines on appropriate opioid prescribing. The opioid prescribing guidelines are a joint effort of the medical community and the Minnesota Department of Health and Department of Human Services.

Learn More

Visit the opioid prescribing guidelines website to read about the framework for Minnesota's guidelines.

Last year, the Minnesota Board of Dentistry also adopted a guidance statement on the use of opioids specific to *dental pain management.*

- As a reminder, in Minnesota it is illegal is a person procures, attempts to procure, possesses, or has control over a controlled substance by any of the following means:
  - (i) fraud, deceit, misrepresentation, or subterfuge;
  - (ii) using a false name or giving false credit; or
  - (iii) falsely assuming the title of, or falsely representing any person to be, a manufacturer, wholesaler, pharmacist, physician, doctor of osteopathic medicine licensed to practice medicine, dentist, podiatrist, veterinarian, or other authorized person for the purpose of obtaining a controlled substance.

See Minnesota Statutes 152.025 CONTROLLED SUBSTANCE CRIME IN THE FIFTH DEGREE.

8. Providers should provide patients with instructions on safe storage and disposal of unused medications, including opioids, to ensure these medications are not available for possible misuse or diversion.

9. Providers should understand and comply with any current federal and state laws, regulatory guidelines and policies that govern the prescribing of controlled substances.

10. Providers who prescribe opioids for pain management should seek appropriate training and educational resources for themselves, clinical staff and patients to help address the growing opioid epidemic that has affected both Minnesota and the United States.

Resources for Prescribing

Evidence for Efficacy of Pain Medication

NSAIDs are Stronger Pain Medications

Ibuprofen and Acetaminophen Step-Wise Guidelines for Pain Management

MDA Protocol for Assessment and Non-Opioid Management of Oral/Facial Pain

Chronic Pain Considerations:

- Unless the provider has training and experience in the use of opioids for the treatment of non- cancer pain or chronic facial pain, long-acting or extended release opioids should not be prescribed.
- Patients reporting unexpectedly prolonged pain, especially patients who do not have clear evidence of ongoing pathology, should not be prescribed opioids. The provider should consider referral to appropriate dental, orofacial pain or chronic pain specialist in patients who request continuation of opioid medications beyond the normal, expected recovery period.
- A patient whose behavior raises the providers concern for the presence of a substance use disorder should be encouraged to seek evaluation and possible treatment for the condition through primary care provider, substance treatment programs, or other appropriate referral sources.
- Provider should coordinate pain therapy with other providers before the procedure whenever possible in patients who are receiving chronic opioids, who have a history of substance use disorder, or who are at high risk for aberrant drug-related behavior. The use of a written agreement with the patient may be indicated and appropriate.

References

American Dental Association Statement on the Use of Opioids in the Treatment of Dental Pain 2016

Centers for Medicare and Medicaid Services What Is a Prescriber's Role in Preventing Prescription Drug Diversion?

Institute for Clinical Systems Improvement Pain: Assessment, Non-Opioid Treatment Approaches and Opioid Management 2016

Minnesota Boards of Nursing, Medical Practice and Pharmacy Joint Statement on Pain Management 2015

Minnesota Opioid Prescribing Work Group DRAFT Acute Pain Prescribing Recommendations 2017

State of Pennsylvania Guidelines on Opioids in Dental Practice 2015 Content modified

OPIOID QUALITY IMPROVEMENT PLEDGE

Cigna is committed to helping reduce opioid use among Cigna members by 25 percent within three years. Cigna currently has many initiatives underway to identify and help drive solutions to further address the opioid epidemic.

One initiative is the Opioid Quality Improvement Pledge. We ask that you take this pledge, and thereby commit to:

• Encouraging prescribers to individually sign the Surgeon General's "Turn the Tide" pledge (Turnthetiderx.org):

• Taking steps to improve the quality and coordination of care for patients receiving opioids.

• Reducing potentially avoidable opioid prescriptions when alternative therapies are available.

Please make a pledge selection below:

Yes : This office, and its associated providers, takes the Opioid Quality Improvement Pledge.

No : This office, and its associated providers, does not take the Opioid Quality Improvement Pledge.

Thank you for your support in addressing this epidemic and driving change within your community.

Email to Dentists from Cigna Dental Insurance

Other Resources on Acute Dental Pain Prescribing

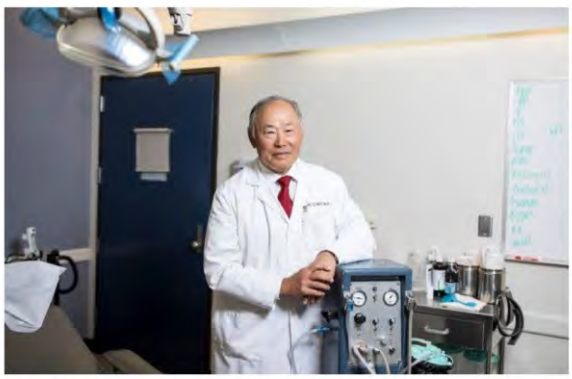
- **Pennsylvania Guidelines on the Use of Opioids in Dental Practice, 2015**. This document was recommended in the 2016 Guideline for Prescribing Opioids for Chronic Pain. http://www.health.pa.gov/My%20Health/Diseases%20and%20Conditions/A-D/Documents/opioid%20dental%20prescribing%20guidelines%20-final.pdf
- **Dental Guideline on Prescribing Opioids for Acute Pain Management, 2016.** Developed by the Dr. Robert Bree Collaborative and Washington State Agency Medical Directors' Group with actively practicing dentists and public stakeholders. http://www.breecollaborative.org/wp-content/uploads/2017-10-26-FINAL-Dental-Opioid-Recommendations_Web.pdf
- **American Association of Oral and Maxillofacial Surgeons White Paper, 2017. Opioid Prescribing: Acute and Postoperative Pain Management.** https://www.aaoms.org/docs/govt_affairs/advocacy_white_papers/opioid_prescribing.pdf

Other Resources on Acute Dental Pain Prescribing

- **American Dental Association free CDE courses on opioid prescribing and combating opioid abuse**. Approximately 4 free CDE courses specific to opioids each year. https://www.ada.org/en/advocacy/advocacy-issues/prescription-opioid-abuse
- **Safe Opioid Prescribing for Acute Dental Pain CDE Course.** Two-hour CDE class from Boston University https://www.opioidprescribing.com/dental_landing
- **Substance Abuse and Mental Health Services Administration (SAMHSA)'s Providers' Clinical Support System for Opioids (PCSS - O) and Medication Assisted Treatment (PCSS - MAT).** Expert mentors are available to assist with questions or concerns about opioids and treatment of substance use disorders and free CDE specific to dentistry. https://pcss-o.org/ and https://pcssmat.org/
- **Prevention of Prescription Opioid Abuse: The role of the dentist.** JADA article, 2011. http://jada.ada.org/article/S0002-8177(14)62264-9/pdf

The New York Times July 10, 2017

Breaking the Opioid Habit in Dentists' Offices



Dr. Harold Tu, the director of the division of oral and maxillofacial surgery at the University of

npr September, 2017

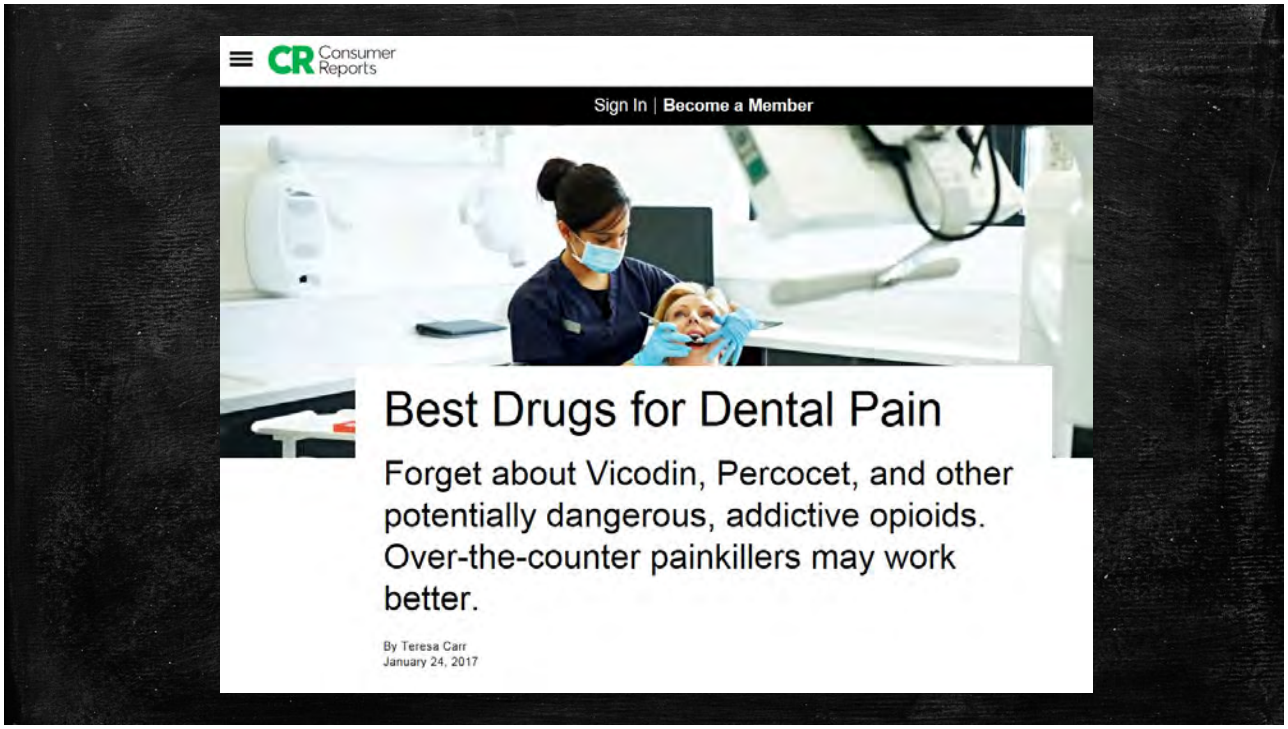
PUBLIC HEALTH

Dental Schools Add An Urgent Lesson: Think Twice About Prescribing Opioids

September 8, 2017 · 3:46 PM ET
Heard on All Things Considered

ROBERT SIEGEL JESSICA CHEUNG

→ Patients may also be hearing about this in the news


CR Consumer Reports
Sign In | Become a Member
Best Drugs for Dental Pain
Forget about Vicodin, Percocet, and other potentially dangerous, addictive opioids. Over-the-counter painkillers may work better.
By Teresa Carr
January 24, 2017