Care for People with Pain during COVID-19:

Real-World Implications for Person-Centered Policy, Practice, and Education

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INNOVATION IN PAIN MANAGEMENT DELIVERY AS A RESPONSE TO OPIOID MISUSE AND OVERDOSE AND COVID-19

Bob Twillman, Ph.D., FACLP

Pain Management Psychologist
Saint Luke's Health System
Kansas City, Missouri

Pain Management in the Context of COVID-19: The Good, The Bad, and The Ugly

- Caring for people with pain has changed dramatically in the context of COVID-19
- The nature of the COVID-19's effects varies widely, depending on a number of factors
- Some changes present significant opportunities to improve pain care
- Others represent threats to people with pain and their clinicians
- The long-term impact of COVID-19 on pain care is unknown, but very worthy of our attention

The Good

- Increased access to some types of care through telehealth applications, with improved payment
- Innovation in complementary and integrative treatments so telehealth delivery is possible
- Lowered barriers to prescribing for pain and opioid use disorder treatment

The Bad

- People without technical savvy and/or up-to-date technology are limited in using telehealth
- Some treatments—even self-management—are unavailable, disrupting continuity of care
- Increased access for people with pain does not mean more clinicians are available
- Increased baseline stress increases anxiety and depression, which, in turn, increases pain
- Exacerbation of some social determinants

The Ugly

People with pain often have conditions, or treatments, that make them more vulnerable to catching the virus and dying as a result

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CONSEQUENCES FOR PATIENTS IN PAIN

KATE NICHOLSON, JD

THE LAY OF THE LAND

- **Existing Crisis in which Pain is Inadequately Treated Relative to its Prevalence and Disabling Consequences.**

- **Overlay of the Opioid/Overdose Crisis on access to medication and care before COVID-19** (Pendulum swing on prescribing has created barriers to access to care; these barriers compound w/ intersection with race).

- **New problems and disparities from COVID-19, and from our actions to allay the spread of SARS-CoV-2.**

CHRONIC PAIN: A VULNERABLE POPULATION

- **People with chronic pain may be more vulnerable to COVID-19.**
  - Many of the diseases that cause chronic pain may leave patients immune compromised.
  - Many people with chronic pain have multiple co-morbidities.
  - Many of the treatments for pain-generating conditions may leave people immune compromised as well (chemo, steroids, opioids).
  - Pain intersects with race, age, disability (those already most susceptible to COVID-19 and poor outcomes from it).

ACCESS TO MEDICATION

- **Hoarding of Hydroxychloroquine.** A study published in *JAMA Intern Med.*, showed spikes in sales of the drug tripled after well-known public figures lauded it.
- **Concerns with shortages for people with Lupus and Rheumatoid Arthritis.** (Opinion piece in *Washington Post* by Kayla Behbahani, a psychiatrist at Brigham and Women's).


PostEverything • Perspective

I have lupus. Stop hoarding the drug I need to survive.

Coronavirus anxiety is causing a run on drugs that may or may not prevent or treat it.

[Visual Description: photo of headline from Washington Post on hoarding medication.]

ACCESS TO MEDICATION (CONT.)

- **Supply Issues: Shortage of Opioids for Ventilator Patients.**

Painkillers, sedatives in short supply during COVID-19 pandemic

Hospital groups push for increased supply of drugs to ease patient struggles

- FDA/DEA are working to shore up supply.
- DEA raised its ceiling by 15%. (But these shortages due to blanket cuts were foreseeable (seen prev. in parenteral opioid shortage/2018)).

[Visual Description: Photo of EMT workers taking someone from an ambulance}

ACCESS TO MEDICATION (CONT.)

- **DEA Changes in Prescribing of Controlled Substances.**
- Positive changes in which the DEA authorized an exception to the Ryan Hatch Act permitting providers to prescribe controlled substances based on a telemedicine visit without a prior in-person visit (or telemed. in a DEA-registered facility).
- Impact: I've heard from patients who have found that this works swimmingly. I have also heard from patients in states where this is not permitted under state law.
- Concern recently expressed by authors Villars, Widera, & Kollas in Health Affairs that palliative care patients, especially the elderly, may not have audio-visual access.
- I still hear from patients who are being denied fills (one recently whose doctor was sick, w/ suspected COVID19, and the on-call physician refused to prescribe the opioid medication).

ACCESS TO SERVICES AND CARE

- **Expanded telehealth has been valuable** for mental health services, addiction treatment, and in many other areas.
- **But a lot of maintenance care for pain, including many integrative treatments we address, are hand-on** and have been closed. There can be real consequences in terms of flare ups when these are stopped.
- **Screening and routine blood work may also be postponed.** From a rheumatoid arthritis patient on twitter: "I was supposed to see a rheumatologist last month. We were making progress figuring out why I'm in constant pain and now it's just eternal limbo. Labs need to be done. Telehealth is no use here. I was so close."
- **Interventional and non-emergency surgical techniques** have also been postponed.

PATIENT HYPO

Coronavirus has created a crisis for primary care doctors and their patients

How the coronavirus is making America's health care access problems even worse.

Apr 27, 2020, 7:50am EDT

Dania Palanker with her daughter and husband in the front yard of her Washington, DC, home.

Dania Palanker, an assistant research professor for the Center on Health Insurance Reforms at Georgetown's Health Policy Institute.

[Visual description: photo of a mother with brown hair and glasses and her young brunette daughter seated on front steps outside of a white brick house while husband/father looks on.]

DANIA'S WORDS

- The article follows Dania as she drives to Philadelphia from the Washington, DC, area to get a nerve block treatment because her regular clinic in DC stopped all outpatient services.
- Dania ponders: "Is maintaining your health … urgent care? Not something we usually put in the box of 'urgent,' but if we don't take care of it, it's going to get urgent or emergent."
- On the consequences for someone with CP: "I feel very intense pain pretty much everywhere in my body," she says. "Yeah, it's not life or death, but it's not just quality of life. There's pain that impedes on your quality of life and there's pain that impedes your life." She goes on to talk about how she can't care for or play with her daughter.

CONSEQUENCES OF ISOLATION

- **Psychological consequences** of isolation for people in chronic pain who are already at higher risk for depression, anxiety & suicidal ideation. (I've given a lot of talks on resilience and social and cultural supports are a big part of maintaining mental fortitude).

- **Practical consequences for people with pain who have disabilities that require the assistance of caregivers**. One of the primary problems people with disabilities are experiencing is abandonment by direct care workers with inadequate PPEs or who fear exposure.

- **For some, this may mean relocation to an institutional care setting** – which, given the exposure rates in group homes, is the last place most any of us would want to be right now.

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May 14, 2020

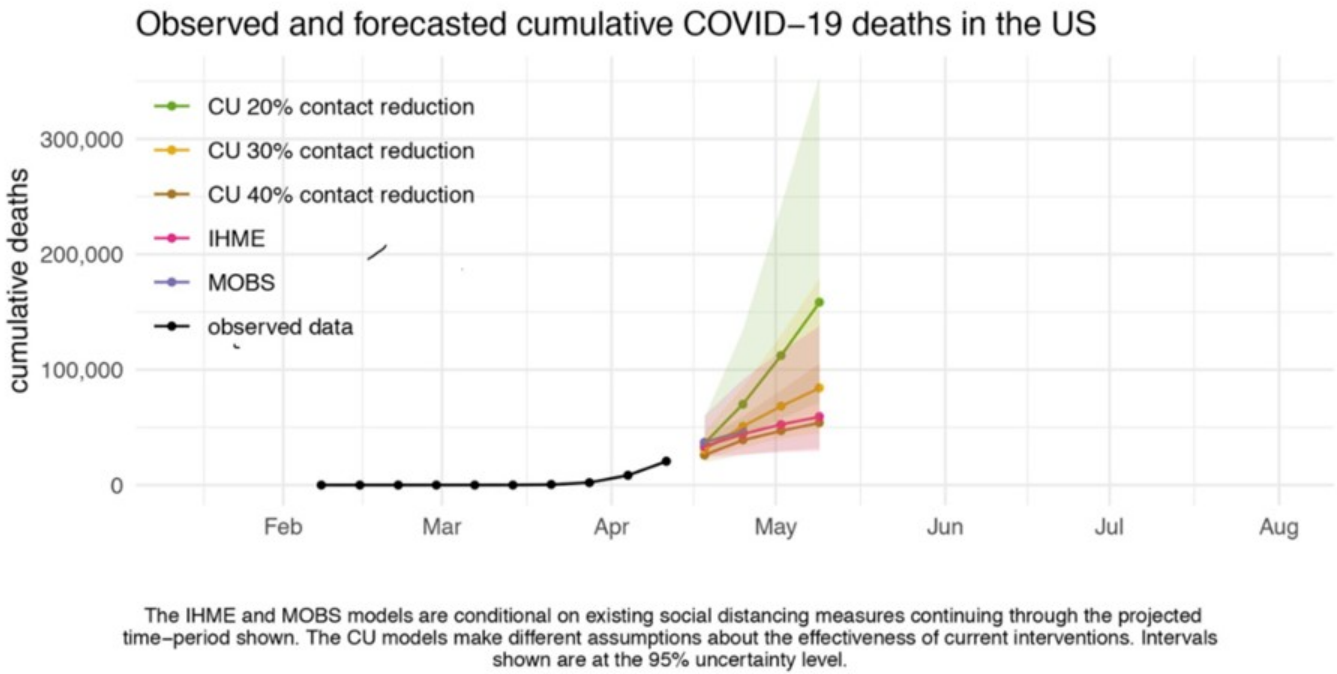
Andrey Ostrovsky, MD | Managing Partner | Social Innovation Ventures | @andreyostrovsky

Disclosures

- I reference portfolio companies of Social Innovation Ventures

Social Innovation Ventures

COVID19: 41,758 US deaths (as of 4/22/20)



The IHME and MOBS models are conditional on existing social distancing measures continuing through the projected time−period shown. The CU models make different assumptions about the effectiveness of current interventions. Intervals shown are at the 95% uncertainty level.

Source: https://www.cdc.gov/coronavirus/2019-ncov/covid-data/forecasting-us.html

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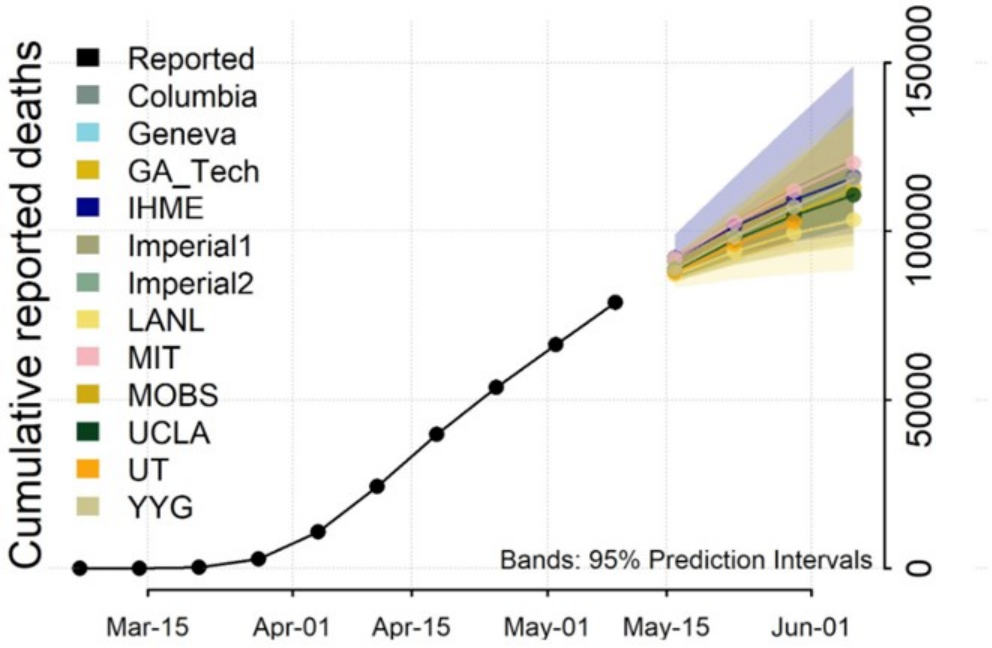
COVID19: 82,246 US deaths (as of today)



Source: https://www.cdc.gov/coronavirus/2019-ncov/covid-data/forecasting-us.html

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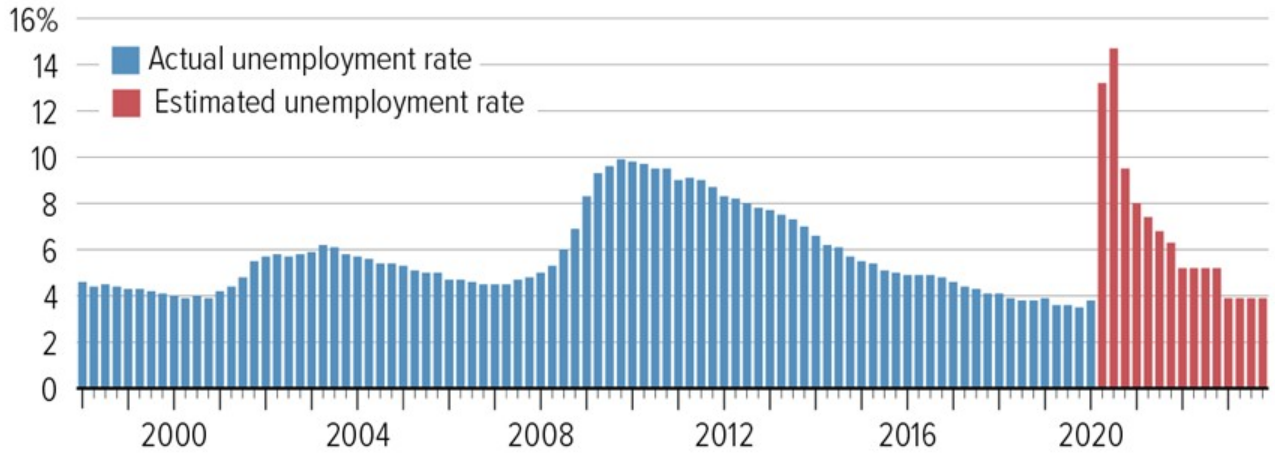
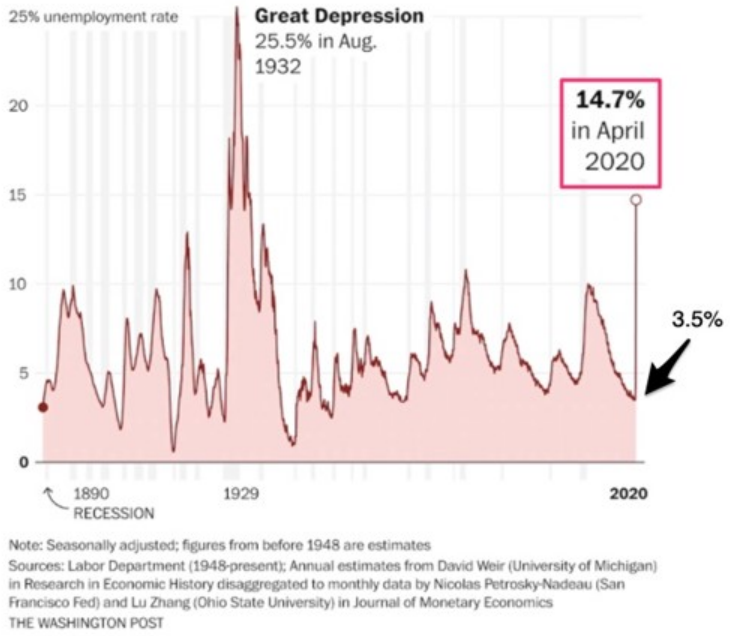
US unemployment rate jumped to 13.5% (22M) as of 4/22/20



Source: Actual: Bureau of Labor Statistics; Estimated: Goldman Sachs quarterly estimates from 2020 and 2021 and annual estimates for 2022 and 2023, (April 1 2020)

Source: https://www.cbpp.org/research/state-budget-and-tax/states-need-significantly-more-fiscal-relief-to-slow-the-emerging-deep; https://www.washingtonpost.com/business/2020/04/16/unemployment-claims-coronavirus/

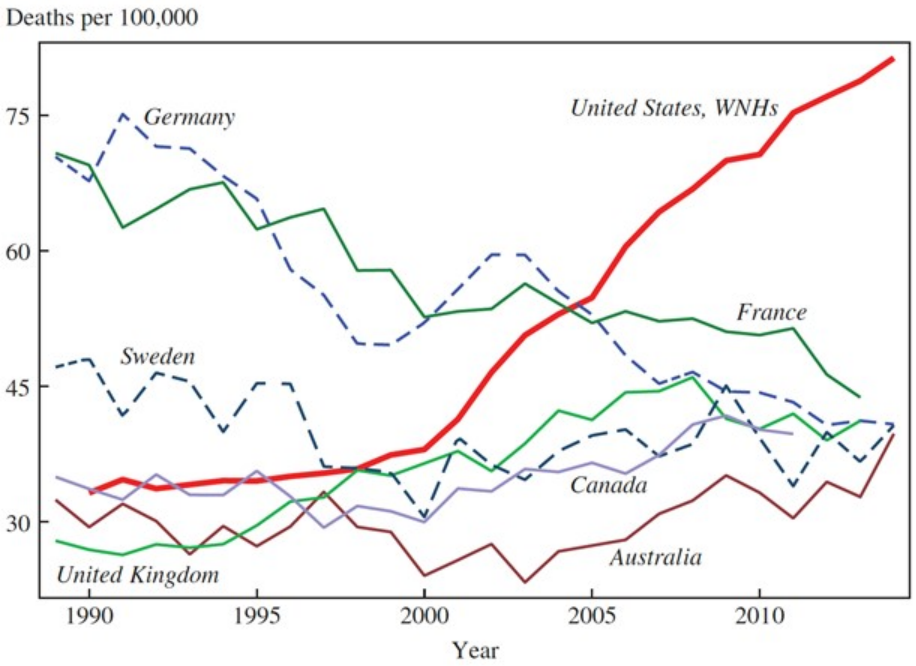
US unemployment rate jumped to 14.7% (36M) and rising



Source: Washington Post

Link between SES and Deaths of Despair (OD, EtOH, Suicide)

Figure 5. Deaths of Despair by Country for Age 50–54, 1989–2014[a]



Source: A. Case, A. Deaton. Mortality and morbidity in the 21st century. Brookings Pap. Econ. Act. 2017, 397–476 (2017)

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What needs to happen: Policy

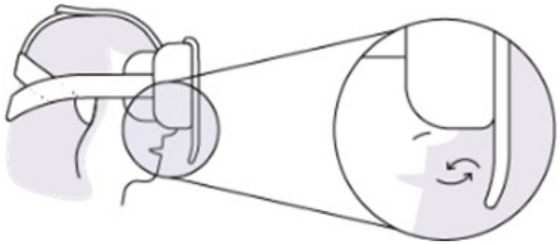
- Increase Medicaid FMAP to 12% (in addition to 6.2% increase from Families First Coronavirus Response Act to full)
- Increase payment to Medicaid providers
- Expand Medicaid

Manage pain non-pharmacologically in your home: AppliedVR

Technology that aims to deliver safe and effective prescription virtual reality (VRx) therapeutics to improve clinical outcomes for patients with serious health conditions

Source: https://appliedvr.io/

Building the First FDA-Approved Portfolio of Prescription VR Therapeutics (VRx)



Dynamic Breathing

Guided Relaxation

Interactive Games

Source: https://appliedvr.io/

Evidence

- Published Studies: 5 about 500 patients
  - 49% reduction in acute pain (n=120)*
- Completed Studies (not yet published): 7 with about 500 patients
  - Chronic pain study (n=109)
    - 34% reduction in pain intensity
    - 41% reduction in pain related insomnia
    - 49% reduction in pain related stress
    - 48% less pain intrusion with mood
- Active Studies: 9 with about 500 patients
- In Planning or IRB Review: 12 > 1,000 patients

*Source: Speigel B et al. Virtual reality for management of pain in hospitalized patients: A randomized comparative effectiveness trial. Virtual reality for management of pain in hospitalized patients: A randomized comparative effectiveness trial. PLoS ONE 14(8): e0219115. 2019.

FDA pipeline

PARTNERS	PRODUCT	INDICATION	DISCOVERY	PRE-CLINICAL	PHASE 1	PHASE 2	PHASE 3
NIH National Institute on Drug Abuse · Cleveland Clinic · Geisinger	ReliefVRx™	Acute pain					
NIH National Institute on Drug Abuse · Geisinger	EaseVRx™	Chronic pain					
National Anxiety Institute	AnxietyVRx™	Acute anxiety					

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Avoid isolation through virtual peers: Inquisit Health

Platform to support an empathetic workforce of peer mentors that serve as a remote team of “digital community health workers (dCHWs)”

Source: https://www.inquisithealth.com/

Evidence

Evidence
Randomized clinical

UCSF Penn

NIH

$2.4M +
5 years

Technology
What we built

1. Mentor Training Program
2. Mentoring Platform
3. Management System

Turnkey Solutions
Peer support →

PEER MENTOR
UNIVERSITY

Montefiore Study
Patient population: HbA1c>9%

Enrollment: 794 patients

Intervention: 42 mentors worked with each patient 1-on-1 for up to 12 mo. Average Engagement Per Patient: 20 phone calls, 278 phone minutes

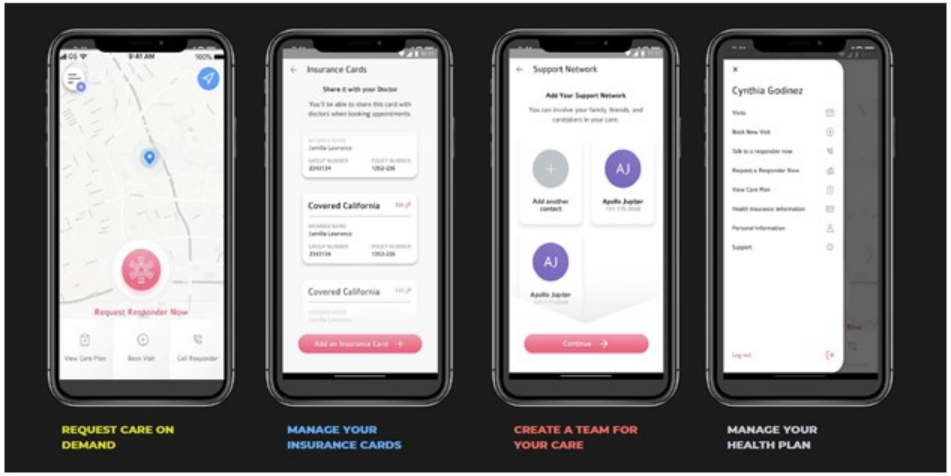
Methods: Pre-/post- HbA1c lab data was analyzed

Results: -1.7 point change in HbA1c [pre-/post- analysis] vs -0.4 in nurse CDE intervention control

Sources: Study unpublished, in preparation for peer-review

Bring urgent care into the home: Ready Responders

EMTs sent to patient's homes with telemedicine support from physician to help prevent avoidable emergency room use



Source: https://readyresponders.com/

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Evidence (*preliminary*)

- 97% satisfaction
- ED utilization: 50% compared to control group
- Per-patient annualized net savings of $3,100
- Note: Not peer-reviewed

Source: https://readyresponders.com/

Reduce Stigma: Shatterproof

- Non-profit working to eliminate overdose deaths
- Developed Stigma program for Opioid Use Disorder

Source: https://www.shatterproof.org/shattering-stigma

Any questions?

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Thank you!

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Patients with pain haven't gone away during COVID-19

Daniel Blaney-Koen, JD
May 2020

Learning objectives

- Identify pre-COVID state and national policies to mitigate opioid-related harms with drug overdose morbidity and mortality data
- Discuss COVID-specific policies designed to help patients with pain and what is needed to implement them
- Suggest post-COVID next steps for COVID-specific policies, including the role of organized medicine and patient advocates

Pre-COVID policies and data affecting patients with pain

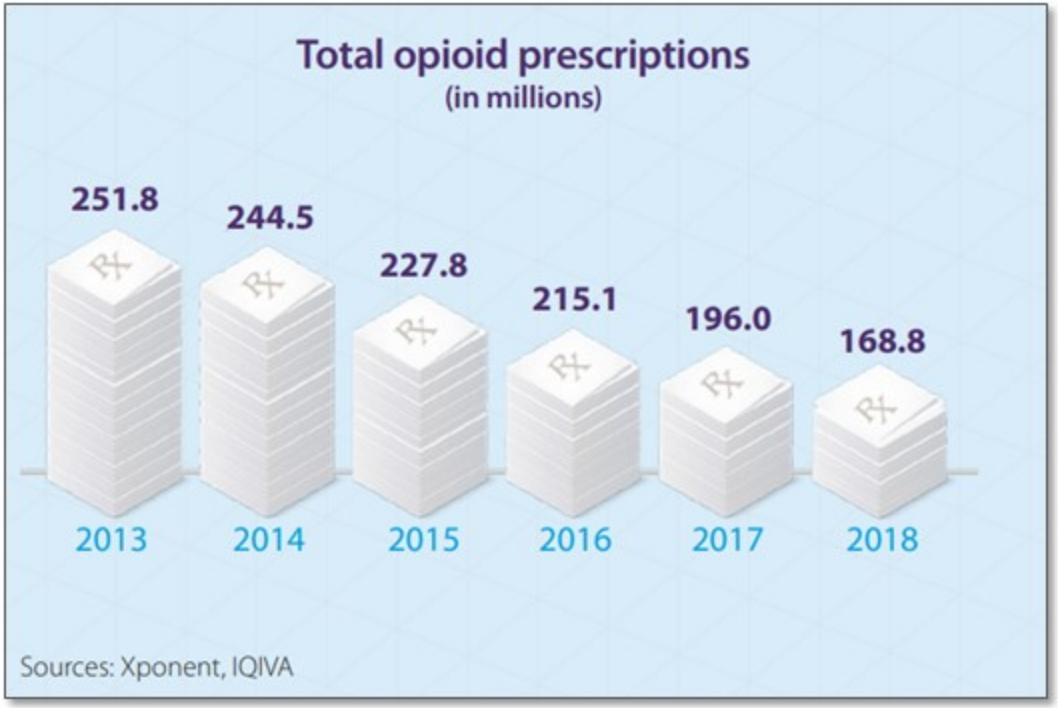
Lase Ajayi, MD
Member since 2013

Patient care starts with the patient-physician relationship

- The nation's opioid epidemic did not begin with patients who had chronic pain, cancer, in hospice or needed palliative care
- The nation's response to the opioid epidemic began as a state-by-state effort
- While exceptions to opioid prescribing exempted chronic pain in statute, implementation has been arbitrary at best

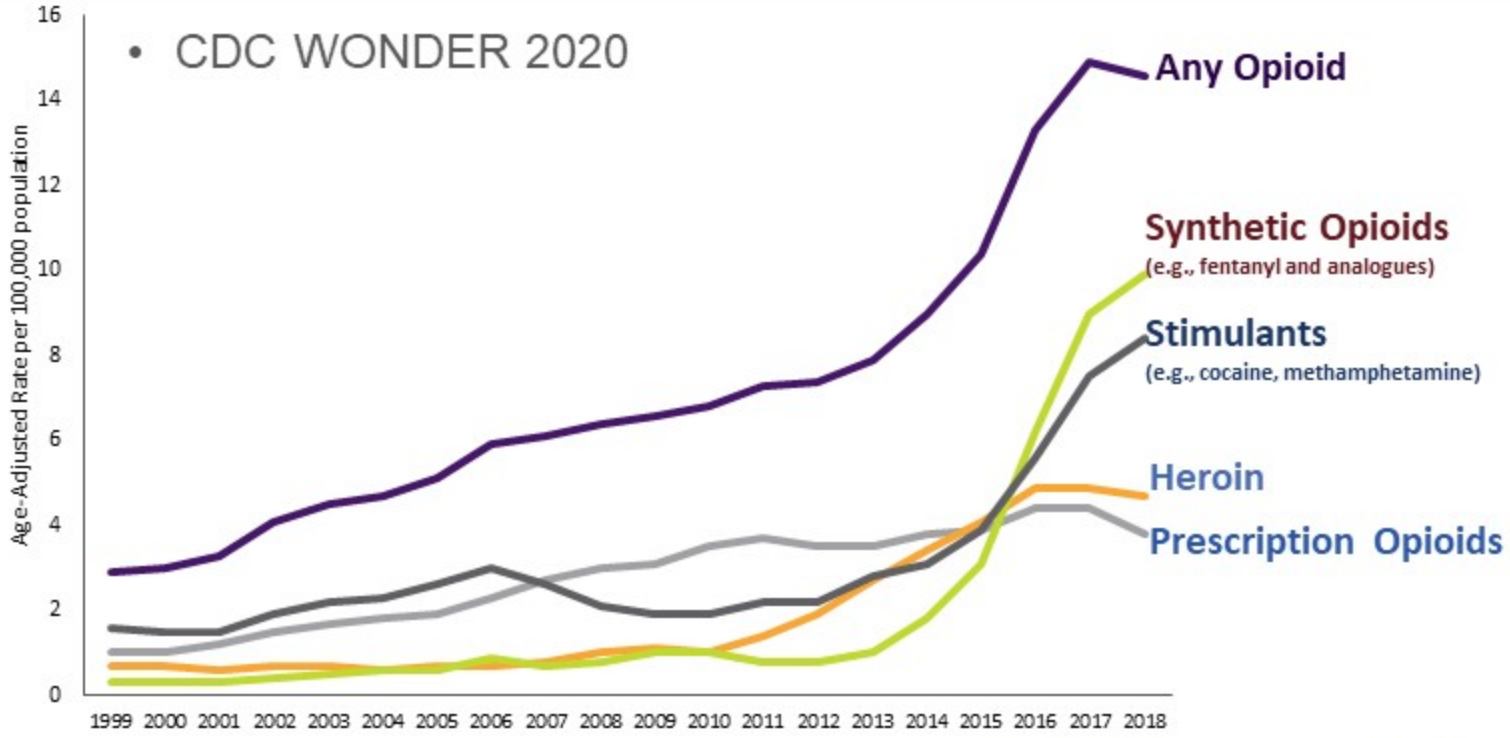
Opioid Prescribing Down 33 Percent

- Between 2013 and 2018, the number of opioid prescriptions decreased by more than 80 million — a 33 percent decrease nationally.
- Every state has seen a decrease in opioid prescriptions over the last five years; state-based restrictions pursued 2016-2018.
- Pharmacy chain, payer, PBM restrictions began largely 2017-2018.



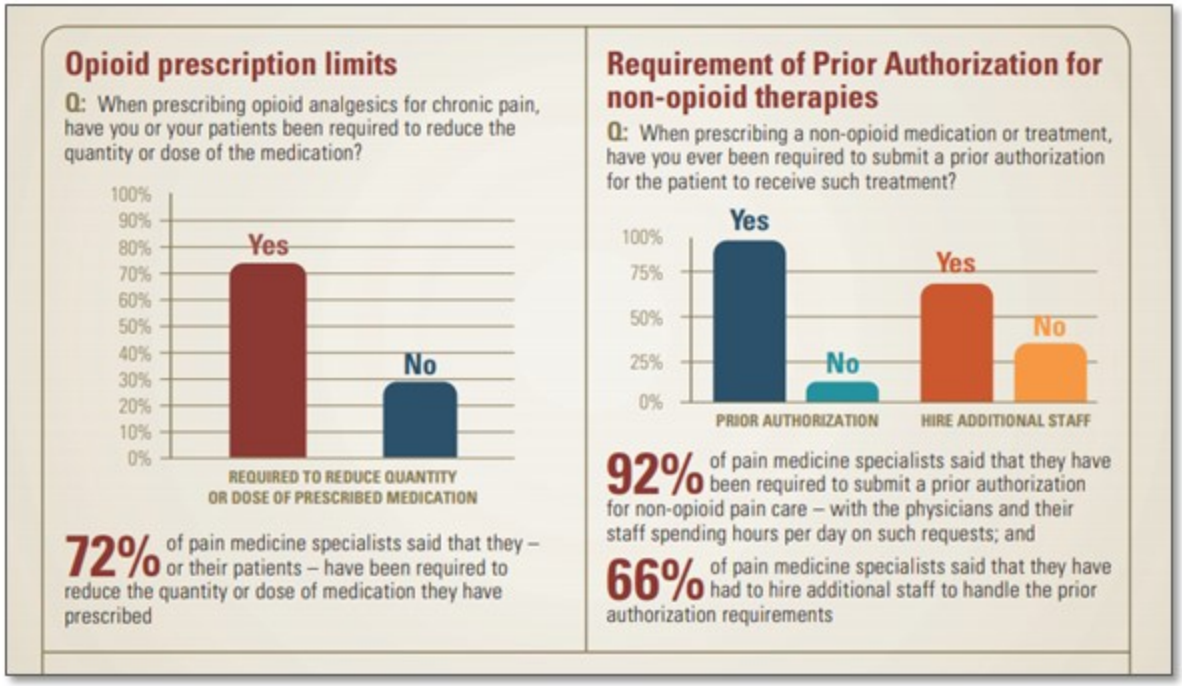
AMA | Physicians' powerful ally in patient care

Trajectories of the epidemic: Patients Continue to Die



AMA | Physicians' powerful ally in patient care

Second Annual Survey of Pain Medicine Specialists Highlights Continued Plight of Patients with Pain, And Barriers To Providing Multidisciplinary, Non-Opioid Care

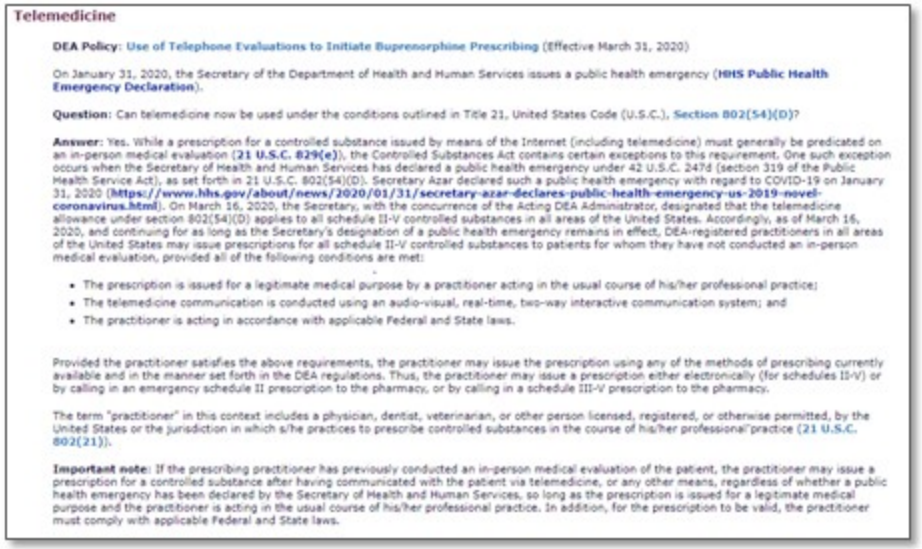


http://abpm.org/uploads/files/abpm%20survey%202019-v3.pdf

COVID-related policies designed to help patients with pain

AMA recommendation to states:

Adopt DEA guidance authorizing physicians to prescribe opioid medications to existing patients without an in-person evaluation; authorize the prescription to be sent to the pharmacy via telephone.



Telemedicine

DEA Policy: Use of Telephone Evaluations to Initiate Buprenorphine Prescribing (Effective March 31, 2020)

On January 31, 2020, the Secretary of the Department of Health and Human Services issues a public health emergency (**HHS Public Health Emergency Declaration**).

Question: Can telemedicine now be used under the conditions outlined in Title 21, United States Code (U.S.C.), Section 802(54)(D)?

Answer: Yes. While a prescription for a controlled substance issued by means of the Internet (including telemedicine) must generally be predicated on an in-person medical evaluation (**21 U.S.C. 829(e)**), the Controlled Substances Act contains certain exceptions to this requirement. One such exception occurs when the Secretary of Health and Human Services has declared a public health emergency under 42 U.S.C. 247d (section 319 of the Public Health Service Act), as set forth in 21 U.S.C. 802(54)(D). Secretary Azar declared such a public health emergency with regard to COVID-19 on January 31, 2020 (**https://www.hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html**). On March 16, 2020, the Secretary, with the concurrence of the Acting DEA Administrator, designated that the telemedicine allowance under section 802(54)(D) applies to all schedule II-V controlled substances in all areas of the United States. Accordingly, as of March 16, 2020, and continuing for as long as the Secretary's designation of a public health emergency remains in effect, DEA-registered practitioners in all areas of the United States may issue prescriptions for all schedule II-V controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:

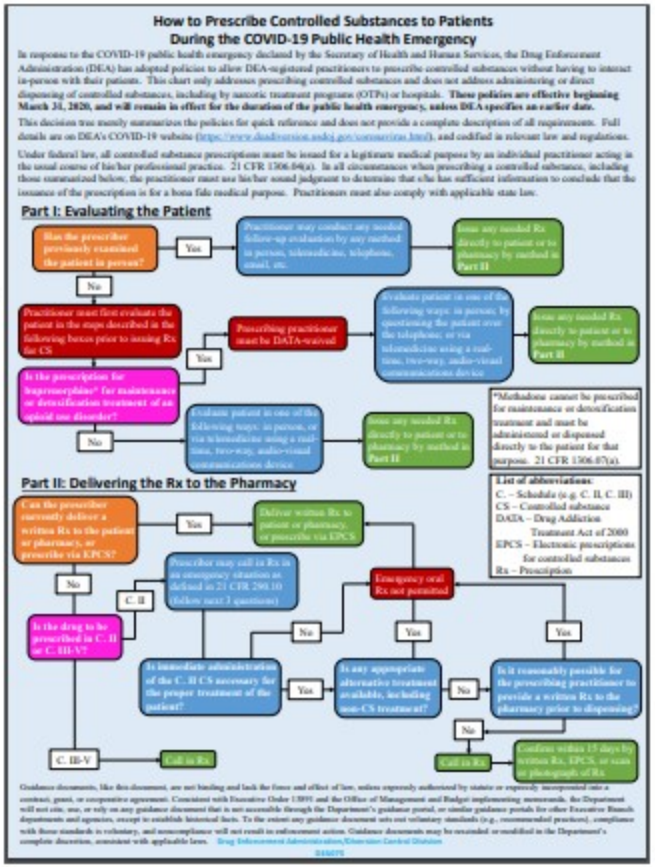
- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice;
- The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system; and
- The practitioner is acting in accordance with applicable Federal and State laws.

Provided the practitioner satisfies the above requirements, the practitioner may issue the prescription using any of the methods of prescribing currently available and in the manner set forth in the DEA regulations. Thus, the practitioner may issue a prescription either electronically (for schedules II-V) or by calling in an emergency schedule II prescription to the pharmacy, or by calling in a schedule III-V prescription to the pharmacy.

The term "practitioner" in this context includes a physician, dentist, veterinarian, or other person licensed, registered, or otherwise permitted, by the United States or the jurisdiction in which s/he practices to prescribe controlled substances in the course of his/her professional practice (**21 U.S.C. 802(21)**).

Important note: If the prescribing practitioner has previously conducted an in-person medical evaluation of the patient, the practitioner may issue a prescription for a controlled substance after having communicated with the patient via telemedicine, or any other means, regardless of whether a public health emergency has been declared by the Secretary of Health and Human Services, so long as the prescription is issued for a legitimate medical purpose and the practitioner is acting in the usual course of his/her professional practice. In addition, for the prescription to be valid, the practitioner must comply with applicable Federal and State laws.

https://www.deadiversion.usdoj.gov/coronavirus.html



How to Prescribe Controlled Substances to Patients During the COVID-19 Public Health Emergency

In response to the COVID-19 public health emergency declared by the Secretary of Health and Human Services, the Drug Enforcement Administration (DEA) has adopted policies to allow DEA-registered practitioners to prescribe controlled substances without having to interact in-person with their patients. This chart only addresses prescribing controlled substances and does not address administering or direct dispensing of controlled substances, including by narcotic treatment programs (OTPs) or hospitals. **These policies are effective beginning March 31, 2020, and will remain in effect for the duration of the public health emergency, unless DEA specifies an earlier date.**

This decision tree merely summarizes the policies for quick reference and does not provide a complete description of all requirements. Full details are on DEA's COVID-19 website (https://www.deadiversion.usdoj.gov/coronavirus.html), and codified in relevant law and regulations.

Under federal law, all controlled substance prescriptions must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his/her professional practice. 21 CFR 1306.04(a). In all circumstances when prescribing a controlled substance, including those summarized below, the practitioner must use his/her sound judgment to determine that s/he has sufficient information to conclude that the issuance of the prescription is for a bona fide medical purpose. Practitioners must also comply with applicable state law.

Part I: Evaluating the Patient

Has the prescriber previously examined the patient in person? — Yes → Practitioner may conduct any needed follow-up evaluation by any method: in person, telemedicine, telephone, email, etc. → Issue any needed Rx directly to patient or to pharmacy by method in Part II

No → Practitioner must first evaluate the patient in the steps described in the following boxes prior to issuing Rx for CS

Prescribing practitioner must be DATA-waived → Yes → Evaluate patient in one of the following ways: in person, by questioning the patient over the telephone, or via telemedicine using a real-time, two-way, audio-visual communications device → Issue any needed Rx directly to patient or to pharmacy by method in Part II

Is the prescription for buprenorphine* for maintenance or detoxification treatment of an opioid use disorder?

No → Evaluate patient in one of the following ways: in person, or via telemedicine using a real-time, two-way, audio-visual communications device → Issue any needed Rx directly to patient or to pharmacy by method in Part II

*Methadone cannot be prescribed for maintenance or detoxification treatment and must be administered or dispensed directly to the patient for that purpose. 21 CFR 1306.07(a).

Part II: Delivering the Rx to the Pharmacy

Can the prescriber currently deliver a written Rx to the patient or pharmacy, or prescribe via EPCS? — Yes → Deliver written Rx to patient or pharmacy, or prescribe via EPCS

No → Prescriber may call in Rx in an emergency situation as defined in 21 CFR 290.10 (follow next 3 questions)

Is the drug to be prescribed in C. II or C. III-V?

C. II → Emergency oral Rx not permitted

Is immediate administration of the C. II CS necessary for the proper treatment of the patient? — Yes → Call in Rx

No → Is any appropriate alternative treatment available, including non-CS treatment? — Yes → Call in Rx

No → Is it reasonably possible for the prescribing practitioner to provide a written Rx to the pharmacy prior to dispensing? — Yes → Call in Rx

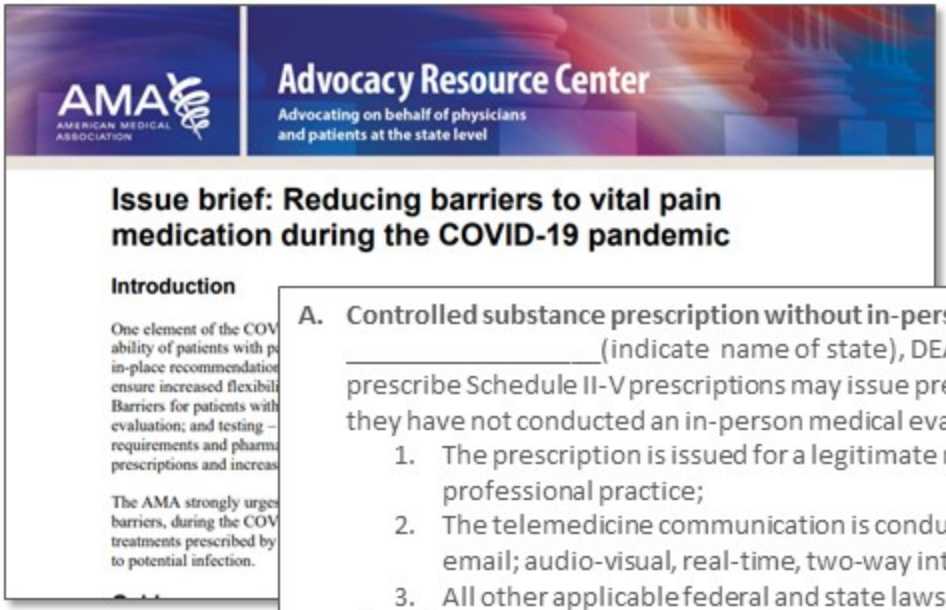
No → Confirm within 72 hours by written Rx, EPCS, or scan or photograph of Rx

C. III-V → Call in Rx

List of abbreviations:
C. – Schedule (e.g. C. II, C. III)
CS – Controlled substance
DATA – Drug Addiction Treatment Act of 2000
EPCS – Electronic prescriptions for controlled substances
Rx – Prescription

Guidance documents, like this document, are not binding and lack the force and effect of law, unless expressly authorized by statute or expressly incorporated into a contract, grant, or cooperative agreement. Consistent with Executive Order 13891 and the Office of Management and Budget implementing memoranda, the Department will not cite, use, or rely on any guidance document that is not accessible through the Department's guidance portal, or similar guidance portals for other Executive Branch departments and agencies, except to establish historical facts. To the extent any guidance document sets out voluntary standards (e.g., recommended practices), compliance with those standards is voluntary, and noncompliance will not result in enforcement action. Guidance documents may be rescinded or modified in the Department's complete discretion, consistent with applicable laws. Drug Enforcement Administration/Diversion Control Division

https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-023)(DEA075)Decision_Tree_(Final)_33120_2007.pdf



A. **Controlled substance prescription without in-person evaluation.** During the COVID-19 public health emergency in _____(indicate name of state), DEA-registered physicians and other health care practitioners authorized to prescribe Schedule II-V prescriptions may issue prescriptions for controlled substances (Schedules II-V) to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:
    1. The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice;
    2. The telemedicine communication is conducted by any needed follow-up method, including: in-person; telephone; email; audio-visual, real-time, two-way interactive communication system; and
    3. All other applicable federal and state laws are followed.
B. **Direct issuance to pharmacy or patient permitted.** The physician or practitioner may issue a prescription for controlled substances (Schedules II-IV), directly to the patient or to the pharmacy by calling in the prescription to the pharmacy or by providing the patient with a written prescription.
C. **Multiple prescriptions allowed.** A DEA-registered physician or practitioner may issue a prescription providing a patient with up to a 90-day supply for a controlled substance (Schedules II-V), subject to the following:
    1. The prescribing physician or practitioner must sign and date the multiple prescriptions as of the date issued; and
    2. The prescribing physician or practitioner must write on each separate prescription the earliest date on which the prescription can be filled.

https://www.ama-assn.org/system/files/2020-05/issue-brief-reducing-barriers-vital-pain-medication.pdf

Post-COVID next steps

AMA Opioid Task Force

2015 Recommendations: Actions Physicians Can Take

PDMPs
Register for and use your state PDMP to make more informed prescribing decisions

TAKE ACTION ›

Education
Ensure you have the education and training on effective, evidence-based treatment

TAKE ACTION ›

Treatment
Support and advocate for comprehensive care for patients in pain and those with a substance use disorder

TAKE ACTION ›

Stigma
Removing stigma is essential to ending the nation's opioid epidemic

TAKE ACTION ›

Naloxone
Expand access to naloxone in the community and through co-prescribing

TAKE ACTION ›

Safe Storage and Disposal
Work with your patients to promote safe storage and disposal of opioids and all medications

TAKE ACTION ›

2019 Recommendations: Actions Policymakers Can Take

Access to MAT
Remove prior authorization, step therapy and other inappropriate administrative burdens or barriers that delay or deny care for FDA-approved medications used as part of medication-assisted treatment (MAT) for opioid use disorder (OUD).

TAKE ACTION ›

Mental health
Support assessment, referral and treatment for co-occurring mental health disorders as well as enforce meaningful oversight and enforcement of state and federal mental health and substance use disorder parity laws.

TAKE ACTION ›

Comprehensive pain care and rehabilitation access
Remove administrative and other barriers to comprehensive, multimodal, multidisciplinary pain care and rehabilitation programs.

TAKE ACTION ›

Maternal and child health
Support maternal and child health by increasing access to evidence-based treatment, preserving families, and ensuring that policies are non-punitive.

TAKE ACTION ›

Civil and criminal justice reforms
Support reforms in the civil and criminal justice system that help ensure access to high quality, evidence-based care for OUD, including MAT.

TAKE ACTION ›

2015 Recommendations
AMA Opioid Task Force Recommendations for Physicians

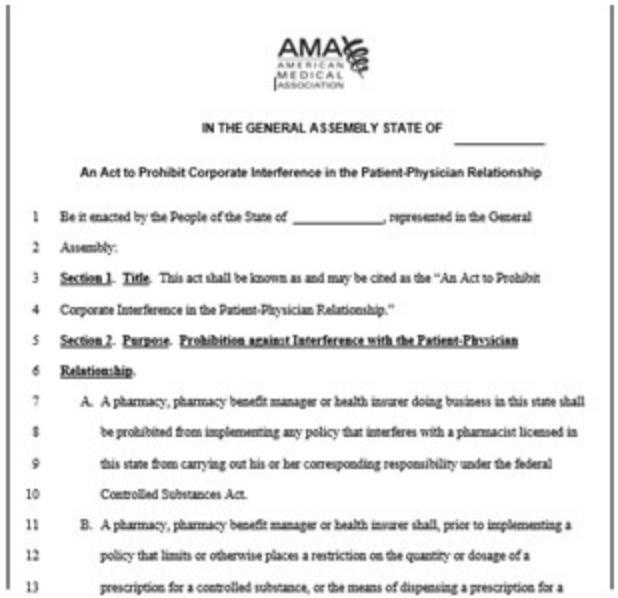
TAKE ACTION ›

www.end-opioid-epidemic.org

AMA | Physicians' powerful ally in patient care

Opportunities to help patients with pain

- 2020 state legislative sessions will resume
- 2021 state rate and form filing June-August



AMA AMERICAN MEDICAL ASSOCIATION

IN THE GENERAL ASSEMBLY STATE OF _____

An Act to Prohibit Corporate Interference in the Patient-Physician Relationship

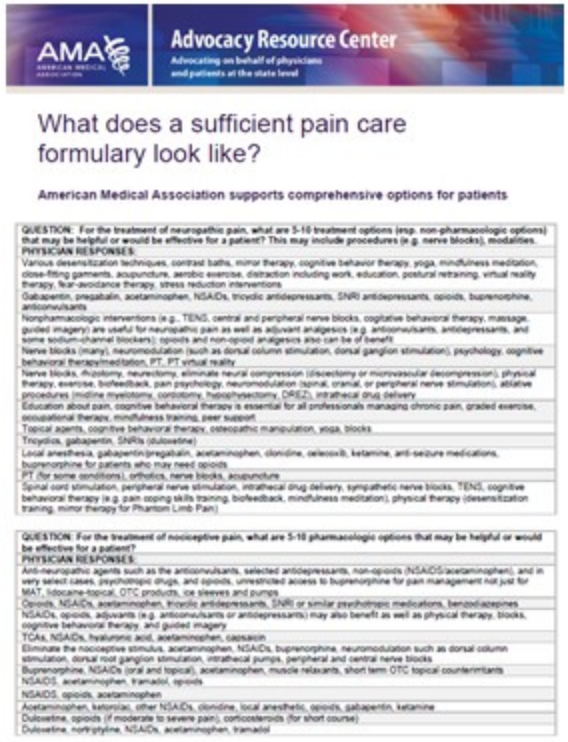
Be it enacted by the People of the State of _____, represented in the General Assembly:

Section 1. Title. This act shall be known as and may be cited as the "An Act to Prohibit Corporate Interference in the Patient-Physician Relationship."

Section 2. Purpose. Prohibition against Interference with the Patient-Physician Relationship.

A. A pharmacy, pharmacy benefit manager or health insurer doing business in this state shall be prohibited from implementing any policy that interferes with a pharmacist licensed in this state from carrying out his or her corresponding responsibility under the federal Controlled Substances Act.

B. A pharmacy, pharmacy benefit manager or health insurer shall, prior to implementing a policy that limits or otherwise places a restriction on the quantity or dosage of a prescription for a controlled substance, or the means of dispensing a prescription for a controlled substance, shall be required to submit said policy to the state medical board, state pharmacy board and any other appropriate regulatory board charged with regulating health care professionals for review prior to implementation.



AMA | Advocacy Resource Center
Advocating on behalf of physicians and patients at the state level

What does a sufficient pain care formulary look like?

American Medical Association supports comprehensive options for patients

QUESTION: For the treatment of neuropathic pain, what are 5-10 treatment options (esp. non-pharmacologic options) that may be helpful or would be effective for a patient? This may include procedures (e.g. nerve blocks), modalities.
PHYSICIAN RESPONSES:
Various desensitization techniques, contrast baths, mirror therapy, cognitive behavior therapy, yoga, mindfulness meditation, close-fitting garments, acupuncture, aerobic exercise, distraction including work, education, postural retraining, virtual reality therapy, fear-avoidance therapy, stress reduction interventions
Gabapentin, pregabalin, acetaminophen, NSAIDs, tricyclic antidepressants, SNRI antidepressants, opioids, buprenorphine, anticonvulsants
Nonpharmacologic interventions (e.g., TENS, central and peripheral nerve blocks, cogitative behavioral therapy, massage, guided imagery) are useful for neuropathic pain as well as adjuvant analgesics (e.g. anticonvulsants, antidepressants, and some sodium-channel blockers); opioids and non-opioid analgesics also can be of benefit
Nerve blocks (many), neuromodulation (such as dorsal column stimulation, dorsal ganglion stimulation); psychology, cognitive behavioral therapy/meditation, PT, PT virtual reality
Nerve blocks, rhizotomy, neurectomy, eliminate neural compression (discectomy or microvascular decompression), physical therapy, exercise, biofeedback, pain psychology, neuromodulation (spinal, cranial, or peripheral nerve stimulation), ablative procedures (midline myelotomy, cordotomy, hypophysectomy, DREZ), intrathecal drug delivery
Education about pain, cognitive behavioral therapy is essential for all professionals managing chronic pain, graded exercise, occupational therapy, mindfulness training, peer support
Topical agents, cognitive behavioral therapy, osteopathic manipulation, yoga, blocks
Tricyclics, gabapentin, SNRIs (duloxetine)
Local anesthesia, gabapentin/pregabalin, acetaminophen, clonidine, celecoxib, ketamine, anti-seizure medications, buprenorphine for patients who may need opioids
PT (for some conditions), orthotics, nerve blocks, acupuncture
Spinal cord stimulation, peripheral nerve stimulation, intrathecal drug delivery, sympathetic nerve blocks, TENS, cognitive behavioral therapy (e.g. pain coping skills training, biofeedback, mindfulness meditation); physical therapy (desensitization training, mirror therapy for Phantom Limb Pain)

QUESTION: For the treatment of nociceptive pain, what are 5-10 pharmacologic options that may be helpful or would be effective for a patient?
PHYSICIAN RESPONSES:
Anti-neuropathic agents such as the anticonvulsants, selected antidepressants, non-opioids (NSAIDS/acetaminophen), and in very select cases, psychotropic drugs, and opioids, unrestricted access to buprenorphine for pain management not just for MAT, lidocaine-topical, OTC products, ice sleeves and pumps
Opioids, NSAIDs, acetaminophen, tricyclic antidepressants, SNRI or similar psychotropic medications, benzodiazepines
NSAIDs, opioids, adjuvants (e.g. anticonvulsants or antidepressants) may also benefit as well as physical therapy, blocks, cognitive behavioral therapy, and guided imagery
TCAs, NSAIDs, hyaluronic acid, acetaminophen, capsaicin
Eliminate the nociceptive stimulus, acetaminophen, NSAIDs, buprenorphine, neuromodulation such as dorsal column stimulation, dorsal root ganglion stimulation, intrathecal pumps, peripheral and central nerve blocks
Buprenorphine, NSAIDs (oral and topical), acetaminophen, muscle relaxants, short term OTC topical counterirritants
NSAIDS, acetaminophen, tramadol, opioids
NSAIDS, opioids, acetaminophen
Acetaminophen, ketorolac, other NSAIDs, clonidine, local anesthetic, opioids, gabapentin, ketamine
Duloxetine, opioids (if moderate to severe pain), corticosteroids (for short course)
Duloxetine, nortriptyline, NSAIDs, acetaminophen, tramadol

Thank you