CHART REVIEW GUIDELINE

STANDARD OF PRACTICE FOR PRESCRIBING OPIOIDS

Attached for your use is a checklist which you may use as a support document if you are concerned about prescribing issues encountered while performing the chart review for a physician colleague.

This checklist has been developed using the information outlined in the CPSM Standards of Practice of Medicine – **Schedule L – Prescribing Opioids**

The checklist is divided into sections as follows:

- **Part I** – Acute pain or post-operative analgesia
- **Part II** – Initial trial for non-acute non-cancer pain in opioid naïve patients prescribed amount up to 50 milligrams morphine equivalents per day
- **Part III** – Patients currently prescribed between 50 and 90 milligrams morphine equivalents per day (Mid-Level Risk)
- **Part IV** – Patients prescribed more than 90 milligrams morphine equivalents per day (High-Level Risk)
- **Part V** – Patients new to a member's practice and already taking opioids for a significant period of time
- **Part VI** – Adolescent patients
- **Part VII** – Continued prescribing of opioids for patients with non-cancer pain

STANDARD OF PRACTICE FOR PRESCRIBING OPIOIDS

PART I – ACUTE PAIN OR POST-OPERATIVE ANALGESIA

For patients with acute pain or who require post-operative analgesia, review of the chart demonstrates that the member

1. Prescribed the lowest effective dose of immediate release preparations limited to what the patient will need before community follow-up will be resumed: ☐Three days or less ☐Seven days ☐Up to one month	☐Yes ☐No
2. When discharging patients from acute-care settings, or post-operatively, prescribed only the quantities of opioids that the patient would need before community follow-up would be resumed, or in accordance with the expected course of the illness where follow-up was not anticipated.	☐Yes ☐No
3. Obtained a second opinion (by teleconference is permitted) from a member or authorized prescriber prior to prescribing opioids after thirty days from the time of the onset of the acute pain or surgery.	☐Yes ☐No
4. Had regard to the patient's risk of opioid misuse and substance abuse history, optimizing non-opioid treatment options if appropriate.	☐Yes ☐No
5. Discussed the risks of opioids with the patient, including side effects and long term medical complication; physical dependence and the risks of addiction, overdose and death; risks of failure to store opioids safely, including diversion, death and the risks of crime (being targeted for their medication); risks of consuming alcohol and/or other sedating substances with opioids simultaneously; risks of operating a motor vehicle or heavy machinery; safety-sensitive occupational risks; child and elder care responsibilities. If any of the risks mentioned above are not discussed, the reason for such omission is clear from reviewing the rest of the medical record (for instance it is documented that the patient does not hold a valid driver's license and does not drive).	☐Yes ☐No ☐Yes ☐No

COMMENTS:

STANDARD OF PRACTICE FOR PRESCRIBING OPIOIDS

PART II - INITIAL TRIAL FOR NON-ACUTE NON-CANCER PAIN IN OPIOID NAIVE PATIENTS PRESCRIBED AMOUNT UP TO 50 MILLIGRAMS MORPHINE EQUIVALENTS PER DAY

A member must determine if a trial of opioids is clinically appropriate for treatment of non-cancer pain for an opioid naïve patient. Review of the chart demonstrates that, prior to prescribing opioids, the member

1. Conducted and documented a comprehensive history and physical examination, including	
a. pain condition	☐Yes ☐No
b. general medical condition	☐Yes ☐No
c. current medication	☐Yes ☐No
d. opioid use history	☐Yes ☐No
e. psychiatric status	☐Yes ☐No
f. substance abuse history	☐Yes ☐No
g. trauma history	☐Yes ☐No
h. psychosocial history	☐Yes ☐No
i. previous non-pharmacological treatments and therapies	☐Yes ☐No
j. assessed the patient's risk for opioid misuse, abuse, or diversion and consider appropriate screening tools to determine the patient's risk for addiction to opioids	☐Yes ☐No
k. obtained applicable medical records	☐Yes ☐No
l. obtained (photo)identification from patient, unless well known to the member or the patient's social circumstances appear to be such that (photo)identification is unavailable.	☐Yes ☐No
COMMENTS:	

STANDARD OF PRACTICE FOR PRESCRIBING OPIOIDS	
2. Optimized available non-opioid treatment options, including non-opioid pharmacotherapy and non-pharmacological treatment modalities, including considering psychology, psychiatry, sports medicine, physiotherapy, occupational therapy, kinesiology, chiropractic, and dietary.	☐Yes ☐No
3. Reviewed the patient's current and past medications utilizing DPIN or eChart. (If DPIN or eChart access is unavailable, consult with a pharmacist to obtain DPIN. If no access to DPIN, eChart, or pharmacist, then a maximum three-day prescription can be written to permit such access.).	☐Yes ☐No
4. Started with a trial of opioids as a therapeutic trial of less than three months. If therapeutic goals were not met or the harms outweighed the benefits, then discontinued as a slow taper.	☐Yes ☐No
5. Used caution and prescribed the lowest effective dosage of opioid medication. Titrated the dosage gradually, with frequent tolerability checks and clinical reassessments. Monitored opioid effectiveness until optimal dosage was attained, subject to, and documenting, the following: a. Prescriptions written for a maximum of up to three months, but never authorized the dispensing of more than a one-month supply of any opioid. (For patients in remote communities or travelling, the dispensing may be for up to three months) b. All dosages recorded clearly in the medical record.	☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No
6. Patient was reassessed, including for pain and function, and benefits and risks, at least twice in the first month, monthly for the next two months; thereafter at least every three months. (For patients in remote communities reassess as frequently as possible if not able to achieve the above.)	☐Yes ☐No
7. Benzodiazepine(s) were tapered slowly to the lowest functional dose, or if possible zero, if a patient on existing long-term prescribed benzodiazepine(s) required an opioid trial (either prior to or concurrently). Excluding acute and time-limited indications, did not initiate treatment with benzodiazepines in combination with long-term opioid therapy, except in limited and exceptional circumstances which were documented.	☐Yes ☐No ☐Yes ☐No
COMMENTS:	

STANDARD OF PRACTICE FOR PRESCRIBING OPIOIDS	
8. Documented in the chart discussion of the following topics with the patient: a. Treatment goals including specific and realistic goals of reduced pain severity (not elimination of pain), and improved physical, psychological, social and functional states.	☐Yes ☐No
b. Non-pharmacological therapy and non-opioid analgesics are preferred for chronic non-cancer pain.	☐Yes ☐No
c. Potential benefit of long term opioid treatment is modest.	☐Yes ☐No
d. Discussed the risks of opioids with the patient, including side effects and long term medical complication; physical dependence and the risks of addiction, overdose and death; risks of failure to store opioids safely, including diversion, death and the risks of crime (being targeted for their medication); risks of consuming alcohol and/or other sedating substances with opioids simultaneously; risks of operating a motor vehicle or heavy machinery; safety-sensitive occupational risks; child and elder care responsibilities.	☐Yes ☐No
If any of the risks mentioned above are not discussed, the reason for such omission is clear from reviewing the rest of the medical record (for instance it is documented that the patient does not hold a valid driver's license and does not drive).	☐Yes ☐No
e. Circumstances under which to seek help and where to obtain help if required.	☐Yes ☐No
f. The end of treatment, including decreasing dosages and returning unused opioids to a pharmacy for safe disposal.	☐Yes ☐No
g. Which health care provider(s) will be providing refill prescription for the patient and which health care provider(s) will be following up and prescribing refill prescriptions if the usual health care provider(s) is not available.	☐Yes ☐No
9. Required baseline urine drug testing prior to initiating an opioid trial, and require random and/or periodic urine drug testing on an annual basis, or more frequently if there are concerns.	☐Yes ☐No
10. Did not prescribe opioids for patients with an active substance use disorder (excluding nicotine) without considering first obtaining guidance (by telephone is permitted) from a physician specializing in addiction.	☐Yes ☐No
COMMENTS:	

STANDARD OF PRACTICE FOR PRESCRIBING OPIOIDS

PART III - PATIENTS CURRENTLY PRESCRIBED BETWEEN 50 AND 90 MILLIGRAMS MORPHINE EQUIVALENTS PER DAY (MID-LEVEL RISK)

For the member's patients that the member is considering prescribing, or are currently prescribed, between **50 and 90 milligrams** morphine equivalents per day, review of the chart demonstrates that the member

1. Maintained vigilance for potential diversion and other substances of concern by:	
a. Verifying the patient's current and past medications utilizing DPIN or eChart at least every three months. (If DPIN or eChart access is unavailable, consult with a pharmacist to obtain DPIN (or contact the prescribing doctor if opioids are prescribed by another doctor). If no access to DPIN, eChart, or pharmacist, then a maximum three-day prescription can be written to permit such access.)	☐Yes ☐No
b. Ordered an initial urine drug screen if not done in the past year, and at least yearly thereafter.	☐Yes ☐No
2. If not already done, documented a comprehensive history and physical examination, including	
a. pain condition	☐Yes ☐No
b. general medical condition	☐Yes ☐No
c. current medication	☐Yes ☐No
d. opioid use history	☐Yes ☐No
e. psychiatric status	☐Yes ☐No
f. substance abuse history	☐Yes ☐No
g. trauma history	☐Yes ☐No
h. psychosocial history	☐Yes ☐No
i. previous non-pharmacological treatments and therapies	☐Yes ☐No
j. assessed the patient's risk for opioid misuse, abuse, or diversion and consider appropriate screening tools to determine the patient's risk for addiction to opioids	☐Yes ☐No
k. Comprehensive reassessment of the above must occur at least yearly.	☐Yes ☐No

COMMENTS:

STANDARD OF PRACTICE FOR PRESCRIBING OPIOIDS	
3. Used caution and prescribed the lowest effective dosage of opioid medication. Titrated the dosage gradually, with frequent tolerance checks and clinical reassessment. Monitored opioid effectiveness until optimal dosage was attained, subject to, and documenting, the following: a. A careful reassessment of the dose is recorded including discussion and documentation of specific and realistic goals of reduced pain severity (not elimination of pain), and improved physical, psychological, and social functioning b. Carefully reassessment of evidence of individual benefits and risks considered when increasing dosage to more than **50 milligrams** morphine equivalents per day c. Prescriptions written for a maximum of up to three months, but never authorized the dispensing of more than a one-month supply of any opioid. (For patients in remote communities, the dispensing may be for up to three months. For patients travelling, the dispensing may be for up to three months, if the patient has been on a stable long-term prescription.) d. All dosages recorded clearly in the medical record.	☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No
4. Benzodiazepine(s) were tapered slowly to the lowest functional dose, or zero if possible, if a patient on existing long-term prescribed benzodiazepine(s) was concurrently taking long-term opioids. Excluding acute and time-limited indications, did not initiate treatment with benzodiazepines in combination with long-term opioid therapy, except in limited and exceptional circumstances which were documented.	☐Yes ☐No ☐Yes ☐No
5. Considered optimizing available non-opioid treatment options, including nonopioid pharmacotherapy and non-pharmacological treatment modalities, including considering psychology, psychiatry, sports medicine, physiotherapy, occupational therapy, kinesiology, chiropractic, and dietary.	☐Yes ☐No
COMMENTS:	

STANDARD OF PRACTICE FOR PRESCRIBING OPIOIDS

PART IV - PATIENTS PRESCRIBED MORE THAN 90 MILLIGRAMS MORPHINE EQUIVALENTS PER DAY (HIGH-LEVEL RISK)

For the member's patients that the member is considering prescribing, or are currently prescribed, more than **90 milligrams** morphine equivalents per day, review of the chart demonstrates that the member

1.	Performed each element in Part III.	☐Yes ☐No
2.	Did not abruptly discontinue medications – "bridging" prescriptions during assessment of the patient is entirely acceptable to avoid dangers of withdrawal.	☐Yes ☐No
3.	Determined the lowest effective dose of opioid needed to achieve and/or maintain the goals of reduced pain severity (not elimination of pain), and improved physical, psychological, and social functioning, and considered a trial of slow tapering of the opioids. When tapering, if the patient had a substantial increase in pain and decrease in function that persisted more than one month after a dose reduction, tapering may be undertaken more slowly, paused or potentially abandoned in such patients.	☐Yes ☐No ☐Yes ☐No
4.	Consulted with an appropriate specialist and/or multidisciplinary program (including these possibilities: practice colleague, pain clinic, psychiatry, psychology, addiction specialist, sports medicine, pharmacist, physiotherapist, kinesiologist, chiropractor, occupational therapist, dietitian, if available) when the patient received a **90 milligrams morphine equivalents dose daily for longer than 90 days** or the patient experienced serious challenges in tapering off opioids, or if opioid use disorder was suspected.	☐Yes ☐No
5.	If the patient was on **90 milligrams** morphine equivalents per day or less, and there was documented benefit to the patient, then the treatment was continued. (See Part VII)	☐Yes ☐No
6.	Except in circumstances of exceptional need and clearly documented benefit, restricted prescription to no more than **90 milligrams** morphine equivalents per day. A second opinion of another member was sought if considering escalating doses in excess of 90 milligrams morphine equivalents per day.	☐Yes ☐No

COMMENTS:

STANDARD OF PRACTICE FOR PRESCRIBING OPIOIDS

PART V - PATIENTS NEW TO A MEMBER'S PRACTICE AND ALREADY TAKING OPIOIDS FOR A SIGNIFICANT PERIOD OF TIME

For patients who are new to a member's practice and who have already been taking opioids for a significant period of time (approximately six weeks), review of the chart demonstrates that the member

1. Maintained vigilance for potential diversion and other substances of concern by verifying the current opioid prescription by:	
a. Obtaining collateral information from both the previous prescriber(s) and dispensing pharmacy(ies) confirming the clinical indication and then-current opioid dosage	☐Yes ☐No
b. Reviewing the patient's current and past medications utilizing DPIN or eChart. If DPIN or eChart access is unavailable, consult with a pharmacist to obtain DPIN, (or contact the prescribing doctor). (If no access to DPIN, eChart, or a pharmacist, then a maximum three-day prescription may be written to permit such access.)	☐Yes ☐No
c. Ordering an initial urine drug screen.	☐Yes ☐No
2. Conducted and documented a comprehensive history and physical examination including	
a. pain condition	☐Yes ☐No
b. general medical condition	☐Yes ☐No
c. current medication	☐Yes ☐No
d. opioid use history	☐Yes ☐No
e. psychiatric status	☐Yes ☐No
f. substance abuse history	☐Yes ☐No
g. trauma history	☐Yes ☐No
h. psychosocial history	☐Yes ☐No
i. previous non-pharmacological treatments and therapies	☐Yes ☐No
j. assessed the patient's risk for opioid misuse, abuse, or diversion and consider appropriate screening tools to determine the patient's risk for addiction to opioids	☐Yes ☐No
k. obtained applicable medical records	☐Yes ☐No
l. obtained (photo)identification from patient, unless well known to the member or the patient's social circumstances appear to be such that (photo)identification was unavailable.	☐Yes ☐No

COMMENTS:

STANDARD OF PRACTICE FOR PRESCRIBING OPIOIDS	
3. Used caution and prescribed the lowest effective dosage of opioid medication.	☐Yes ☐No
Titrated the dosage gradually, with frequent tolerance checks and clinical reassessment.	☐Yes ☐No
Monitored opioid effectiveness until optimal dosage was attained, subject to, and documenting, the following:	
a. Carefully reassessed evidence of individual benefits and risks when considering increasing dosage to more than **50 milligrams** morphine equivalents per day.	☐Yes ☐No
b. If the patient was on more than **90 milligrams** morphine equivalents per day, careful reassessment of the dose was required including discussion and documentation of specific and realistic goals of reduced pain severity (not elimination of pain), and improved physical, psychological, and social functioning.	☐Yes ☐No
To determine the lowest effective dose of opioid needed to achieve and/or maintain these goals, a trial of slow tapering of the opioids was considered. When tapering, if the patient had a substantial increase in pain and decrease in function that persisted more than one month after a dose reduction, then tapering may be undertaken more slowly, paused, or potentially abandoned in such patients.	☐Yes ☐No
c. In those rare circumstances where tapering was not appropriate, if the patient was on **90 milligrams** morphine equivalents per day or more, and there was documented benefit to the patient, then the treatment was continued. See Part VII	☐Yes ☐No
d. Did not abruptly discontinue medications – "bridging" prescriptions during assessment of the patient is entirely acceptable to avoid dangers of withdrawal.	☐Yes ☐No
e. Prescriptions written for a maximum of up to three months, but never authorized the dispensing of more than a one-month supply of any opioid. (For patients in remote communities, the dispensing may be for up to three months. For patients travelling, the dispensing may be up to three months, if the patient has been on a stable long-term prescription.)	☐Yes ☐No
f. All dosages recorded clearly in the medical record.	☐Yes ☐No
COMMENTS:	

STANDARD OF PRACTICE FOR PRESCRIBING OPIOIDS	
4. Used caution and prescribed the lowest effective dosage of opioid medication.	☐Yes ☐No
Titrated the dosage gradually, with frequent tolerance checks and clinical reassessment.	☐Yes ☐No
Monitored opioid effectiveness until optimal dosage was attained, subject to, and documenting, the following:	
a. Carefully reassessed evidence of individual benefits and risks when considering increasing dosage to more than **50 milligrams** morphine equivalents per day.	☐Yes ☐No
b. If the patient was on more than **90 milligrams** morphine equivalents per day, careful reassessment of the dose was required including discussion and documentation of specific and realistic goals of reduced pain severity (not elimination of pain), and improved physical, psychological, and social functioning.	☐Yes ☐No
To determine the lowest effective dose of opioid needed to achieve and/or maintain these goals, a trial of slow tapering of the opioids was considered. When tapering, if the patient had a substantial increase in pain and decrease in function that persisted more than one month after a dose reduction, then tapering may be undertaken more slowly, paused, or potentially abandoned in such patients.	☐Yes ☐No
c. In those rare circumstances where tapering was not appropriate, if the patient was on **90 milligrams** morphine equivalents per day or more, and there was documented benefit to the patient, then the treatment was continued. See Part VII	☐Yes ☐No
d. Did not abruptly discontinue medications – "bridging" prescriptions during assessment of the patient is entirely acceptable to avoid dangers of withdrawal.	☐Yes ☐No
e. Prescriptions written for a maximum of up to three months, but never authorized the dispensing of more than a one-month supply of any opioid. (For patients in remote communities, the dispensing may be for up to three months. For patients travelling, the dispensing may be up to three months, if the patient has been on a stable long-term prescription.)	☐Yes ☐No
f. All dosages recorded clearly in the medical record.	☐Yes ☐No

STANDARD OF PRACTICE FOR PRESCRIBING OPIOIDS	
5. Consulted with an appropriate specialist and/or multidisciplinary program (including these possibilities: practice colleague, pain clinic, psychiatry, psychology, addiction specialist, sports medicine, pharmacist, physiotherapist, kinesiologist, chiropractor, occupational therapist, dietitian, if available) when the patient received a **90 milligrams** morphine equivalents dose daily for longer than 90 days or the patient experienced serious challenges in tapering off opioids or if opioid use disorder is suspected.	☐Yes ☐No
COMMENTS:	

STANDARD OF PRACTICE FOR PRESCRIBING OPIOIDS

PART VI – ADOLESCENT PATIENTS

The concern of opioid use in adolescents parallels the cautious approach in Parts I – V. There are additional vulnerabilities (including concern that dependency develops more quickly in adolescents) which add to the need for considering alternate treatments to opioids.

For the member's adolescent patients with acute pain or post-operative analgesia, review of the chart demonstrated that the member:	
1. Attempted, with caution, to adapt Part I to prescribing for adolescents.	☐Yes ☐No
2. Prescribed dosages of opioid that are reduced in proportion to the body mass and development stage of the adolescent.	☐Yes ☐No
For the member's adolescent patients for whom opioids are being prescribed (excluding cancer, palliative, and end-of-life care, and excluding with acute pain or post-operative analgesia) review of the chart demonstrated that the member:	
1. Attempted, with caution, to adapt Parts II - V to prescribing for adolescents.	☐Yes ☐No
2. Utilized non-steroidal anti-inflammatory medication and acetaminophen, or other alternate medication, unless otherwise contraindicated, prior to prescribing opioids.	☐Yes ☐No
3. Prior to prescribing opioids, documented the consent of the adolescent if developmentally mature enough to provide consent. If the adolescent was not developmentally mature enough to provide consent, documented consent of the parent(s) or legal guardian(s) prior to prescribing opioids.	☐Yes ☐No
4. Prescribed dosages of opioids that are reduced in proportion to the body mass and development stage of the adolescent.	☐Yes ☐No

COMMENTS:

STANDARD OF PRACTICE FOR PRESCRIBING OPIOIDS

PART VII - CONTINUED PRESCRIBING OF OPIOIDS FOR PATIENTS WITH NON-CANCER PAIN

Continued prescribing of opioids for patients with non-cancer pain under Parts II-VI must only occur under specific circumstances. Review of the chart showed documentation of:	
1. Measurable clinical improvement in pain, function, and quality of life evaluations	☐Yes ☐No
AND	
2. Maintenance of a satisfactory level of improvements in these parameters which outweighed the risks of continued opioid treatment.	☐Yes ☐No
Continuing to prescribe opioids, or even the same dose of opioids, solely on the basis that they have been prescribed previously is not acceptable.	

COMMENTS:

Overall assessment of opioid prescribing based on this chart review

☐Satisfactory

☐Unsatisfactory

COMMENTS: