AFFIDAVIT OF NATHANIEL E FRANK-WHITE

1. I am a Records Request Processor at the Internet Archive, located in San Francisco, California. I make this declaration of my own personal knowledge.

2. The Internet Archive is a website that provides access to a digital library of Internet sites and other cultural artifacts in digital form. Like a paper library, we provide free access to researchers, historians, scholars, and the general public. The Internet Archive has partnered with and receives support from various institutions, including the Library of Congress.

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5. The Internet Archive assigns a URL on its site to the archived files in the format http://web.archive.org/web/[Year in yyyy][Month in mm][Day in dd][Time code in hh:mm:ss]/[Archived URL] aka an "extended URL". Thus, the extended URL http://web.archive.org/web/19970126045828/http://www.archive.org/ would be the URL for the record of the Internet Archive home page HTML file (http://www.archive.org/) archived on January 26, 1997 at 4:58 a.m. and 28 seconds (1997/01/26 at 04:58:28). The date indicated by an extended URL applies to a preserved instance of a file for a given URL, but not necessarily to any other files linked therein. Thus, in the case of a page constituted by a primary HTML file and other separate files (e.g., files with images, audio, multimedia, design elements, or other embedded content) linked within that primary HTML file, the primary HTML file and the other files will each have their own respective extended URLs and may not have been archived on the same dates.

6. Attached hereto as Exhibit A are true and accurate copies of screenshots of the Internet Archive's records of the archived files for the URLs and the dates specified in the attached coversheet of each printout.

7. Attached hereto as Exhibit B are true and accurate copies of the Internet Archive's records of the archived files for the URLs and the dates specified in the attached coversheet of each file.

8. I declare under penalty of perjury that the foregoing is true and correct.

DATE: 03/24/2022

Nathaniel E Frank-White

JURAT

State/Commonwealth of TEXAS)
)
☐ City ☑ County of Brazoria)

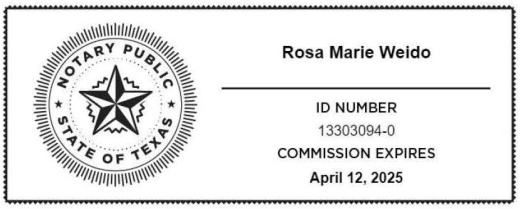
On 03/24/2022 (Date), before me, Rosa Marie Weido (Notary Name),
the foregoing instrument was subscribed and sworn (or affirmed) before me by:

Nathaniel E Frank-White.
Name of Affiant(s)

❑ Personally known to me **-- OR --**

❑ Proved to me on the basis of the oath of _____ **-- OR --**
Name of Credible Witness

☑ Proved to me on the basis of satisfactory evidence: driver_license
Type of ID Presented



WITNESS my hand and official seal.

Notary Public Signature: Rosa Marie Weido

Notary Name: Rosa Marie Weido
Notary Commission Number: 13303094-0
Notary Commission Expires: 04/12/2025
Notarized online using audio-video communication

Notary Public, State of Texas

DESCRIPTION OF ATTACHED DOCUMENT

Title or Type of Document: _____

Document Date: 03/24/2022

Number of Pages (including notarial certificate): 3

EXHIBIT A

https://web.archive.org/web/20160307184724/http://www.allergan.com/products/key-products/product-prescribing

WHAT WE TREAT
KEY PRODUCTS
Specialty Products
Generic Products
Product Search
Product Prescribing
Labeling
RESEARCH & DEVELOPMENT
DRUG SAFETY
QUALITY
PATENT NOTICES
MEDICAL INFORMATION

Product Prescribing

Allergan Product Prescribing and Labeling Information

Product name	Patient Information
ATELVIA® (risedronate sodium) delayed-release tablets	PDF
ACAMPROSATE CALCIUM Delayed-Release Tablets	PDF
ACTONEL® (risedronate sodium) tablets	PDF
ACULAR LS® (ketorolac tromethamine ophthalmic solution) 0.4%	PDF
ACULAR® (ketorolac tromethamine ophthalmic solution) 0.5%	PDF
ACUVAIL® (ketorolac tromethamine ophthalmic solution) 0.45%	PDF
ACZONE® (dapsone) Gel 5%	PDF
ACZONE® (dapsone) Gel, 7.5%	PDF
AeroChamber Plus® Flow-Vu® Anti-Static Valved Holding Chamber	PDF
AeroChamber Plus® Flow-Vu® aVHC Small Mask/Medium Mask	PDF
ALOCRIL® (nedocromil sodium ophthalmic solution) 2%	PDF
Alora (Estradiol Transdermal System, USP)	PDF
ALPHAGAN® P (brimonidine tartrate ophthalmic solution) 0.1% and 0.15%	PDF
AMETHIA Lo tablets for oral use	PDF
Amethia™ Levonorgestrel/ethinyl estradiol tablets and ethinyl estradiol tablets for oral use	PDF
ANDRODERM® (testosterone transdermal system), for topical use CIII	PDF
AquADEKs® Chewable Tablets (aqua-dex') Multivitamin and Mineral Supplement	PDF
Armour® Thyroid (thyroid tablets, USP)	PDF
ASACOL (mesalamine) delayed-release tablets, for oral use	PDF
ASACOL® HD (mesalamine) delayed-release tablets, for oral use	PDF
AVAGE® (tazarotene) Cream 0.1%	PDF
AVYCAZ (ceftazidime and avibactam) for injection, for intravenous use	PDF
AZELEX® (azelaic acid cream) 20%	PDF
BENTYL (dicyclomine hydrochloride) capsules, for oral use, BENTYL (dicyclomine hydrochloride) tablets, for oral use, BENTYL (dicyclomine hydrochloride) injection, for intramuscular use	PDF
BETAGAN® (levobunolol hydrochloride ophthalmic solution, USP) 0.5%	PDF

U.S. PRODUCTS

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SEARCH DATABASE >

LABELING AND SAFETY INFORMATION

Allergan Natrelle® Collection and Breast Aesthetics Product Labeling and Safety Information

More

BLEPH®-10 (sulfacetamide sodium ophthalmic solution, USP) 10%	PDF
BLEPHAMIDE® (sulfacetamide sodium – prednisolone acetate ophthalmic suspension, USP) 10%/0.2%	PDF
BLEPHAMIDE® (sulfacetamide sodium and prednisolone acetate ophthalmic ointment, USP) 10%/0.2%	PDF
BOTOX® (onabotulinumtoxinA)	PDF
BOTOX® (onabotulinumtoxinA) Injection Needle	PDF
BOTOX® and BOTOX® Cosmetic Med Guide	PDF
BOTOX® Cosmetic (onabotulinumtoxinA)	PDF
Brevicon® (Norethindrone and Ethinyl Estradiol Tablets USP, 0.5 mg/0.035 mg)	PDF
BYSTOLIC® (nebivolol) tablets, for oral use	PDF
CAMPRAL® (acamprosate calcium) Delayed-Release Tablets	PDF
CANASA® (mesalamine) rectal suppository	PDF
CARAFATE® (sucralfate) Suspension	PDF
Celexa® (citalopram hydrobromide) Tablets	PDF
CERVIDIL (dinoprostone, 10 mg)	PDF
COMBIGAN® (brimonidine tartrate/timolol maleate ophthalmic solution) 0.2%/0.5%	PDF
Crinone® (progesterone gel)	PDF
DALIRESP® (roflumilast) tablets	PDF
DALVANCE (dalbavancin) for injection, for intravenous use	PDF
DELZICOL (mesalamine) delayed-release capsules, for oral use	PDF
Diltiazem hydrochloride, extended-release capsules, USP	PDF
DORYX® (doxycycline hyclate delayed-release tablets)	PDF
ELESTAT® (epinastine HCl ophthalmic solution) 0.05%	PDF
ENABLEX ® (darifenacin) extended-release tablets	PDF
ESTRACE® (estradiol vaginal cream, USP, 0.01%)	PDF
Femcon Fe	PDF
Femcon Fe	PDF
femhrt® (norethindrone acetate/ethinyl estradiol tablets)	PDF
Femring® (estradiol acetate vaginal ring)	PDF
FETZIMA® (levomilnacipran) extended-release capsules, for oral use	PDF
Fioricet (butalbital, acetaminophen, and caffeine capsules, USP)	PDF
Fioricet with Codeine CIII (butalbital, acetaminophen, caffeine, and codeine phosphate) Capsules	PDF
Fiorinal® with Codeine C-III (Butalbital, Aspirin, Caffeine, and Codeine Phosphate Capsules, USP)	PDF
FLUOROPLEX® (fluorouracil) 1% Topical Cream	PDF
FLUTTER® Mucus Clearance Device	PDF
FML FORTE® (fluorometholone ophthalmic suspension) 0.25%	PDF
FML® (fluorometholone ophthalmic ointment) 0.1%	PDF
FML® (fluorometholone ophthalmic suspension, USP) 0.1%	PDF
GELNIQUE 3% (oxybutynin) gel 3%, for topical use	PDF
GENERESS Fe (norethindrone and ethinyl estradiol chewable tablets and ferrous fumarate chewable tablets)	PDF
INFeD (Iron Dextran Injection USP)	PDF
JUVÉDERM VOLUMA® XC	PDF
JUVÉDERM® Ultra	PDF
JUVÉDERM® Ultra Plus	PDF
JUVÉDERM® Ultra Plus XC	PDF
JUVÉDERM® Ultra XC	PDF
KADIAN® (morphine sulfate) extended-release capsules, for oral use, CII	PDF
KYBELLA (deoxycholic acid) injection, for subcutaneous use	PDF

LASTACAFT® (alcaftadine ophthalmic solution) 0.25%	PDF
LATISSE® (bimatoprost ophthalmic solution) 0.03%	PDF
LEVOTHROID® (levothyroxine sodium tablets, USP)	PDF
Lexapro® (escitalopram oxalate) Tablets, Lexapro® (escitalopram oxalate) Oral Solution	PDF
LILETTA (levonorgestrel-releasing intrauterine system)	PDF
LINZESS (linaclotide) capsules, for oral use	PDF
Lo Loestrin® Fe	PDF
Lo Loestrin® Fe (norethindrone acetate and ethinyl estradiol tablets, ethinyl estradiol tablets and ferrous fumarate tablets)	PDF
LUMIGAN® 0.01% (bimatoprost ophthalmic solution)	PDF
Minastrin®24 Fe	PDF
MONUROL (fosfomycin tromethamine) sachet	PDF
NAMENDA (memantine HCl) tablets, for oral use, NAMENDA (memantine HCl) solution, for oral use	PDF
NAMENDA XR (memantine hydrochloride) extended release capsules, for oral use	PDF
NAMZARIC (memantine hydrochloride extended-release and donepezil hydrochloride) capsules, for oral use	PDF
NUVESSA TM (metronidazole vaginal gel 1.3%)	PDF
OCUFEN® (flurbiprofen sodium ophthalmic solution, USP) 0.03%	PDF
OCUFLOX® (ofloxacin ophthalmic solution) 0.3%	PDF
OZURDEX® (dexamethasone intravitreal implant) 0.7 mg	PDF
POLYTRIM® (polymyxin B sulfate and trimethoprim ophthalmic solution, USP)	PDF
PRED FORTE® (prednisolone acetate ophthalmic suspension, USP) 1%	PDF
PRED MILD® (prednisolone acetate ophthalmic suspension, USP) 0.12%	PDF
PRED-G® (gentamicin and prednisolone acetate ophthalmic ointment, USP) 0.3%/0.6%	PDF
PRED-G® (gentamicin and prednisolone acetate ophthalmic suspension, USP) 0.3%/1%	PDF
PreQue 10®	PDF
PREVAGE® MD	PDF
PYLERA® (bismuth subcitrate potassium, metronidazole, tetracycline hydrochloride) capsules	PDF
RAPAFLO® (silodosin) capsules	PDF
RECTIV (nitroglycerin) Ointment 0.4%, for intra-anal use	PDF
REFRESH CONTACTS® Contact Lens Comfort Drops	PDF
RESTASIS® (cyclosporine ophthalmic emulsion) 0.05%	PDF
SANCTURA XR® (trospium chloride extended release capsules)	PDF
SANCTURA® (trospium chloride)	PDF
SAPHRIS® (asenapine) sublingual tablets	PDF
Savella® (milnacipran HCl) Tablets	PDF
TAZORAC® (tazarotene) Cream 0.05% and 0.1%	PDF
TAZORAC® (tazarotene) Gel 0.05% and 0.1%	PDF
TEFLARO® (ceftaroline fosamil) for injection, for intravenous use	PDF
Thyrolar Tablets (Liotrix Tablets, USP)	PDF
Tiazac® (diltiazem hydrochloride)	PDF
TRELSTAR® (triptorelin pamoate for injectible suspension)	PDF
TUDORZA® PRESSAIR® (aclidinium bromide inhalation powder)	PDF
ULTRESA (pancrelipase) delayed-release capsules, for oral use	PDF
URSO 250® (ursodiol) tablets, for oral use,URSO Forte® (ursodiol) tablets, for oral use	PDF
VANIQA® (eflornithine hydrochloride) Cream, 13.9%	PDF
VIBERZI (eluxadoline) tablets, for oral use, CIV	PDF

VIIBRYD (vilazodone hydrochloride) tablets, for oral use	PDF
VIOKACE (pancrelipase) tablets, for oral use	PDF
VRAYLAR (cariprazine) capsules, for oral use	PDF
ZENPEP® (pancrelipase) delayed release capsules	PDF
ZYMAXID® (gatifloxacin ophthalmic solution) 0.5%	PDF

To access a full list of Actavis U.S. products and related resources, please visit the Product Search page.

https://web.archive.org/web/19970413022818/http://www.pain.com/

Welcome to the
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About Dannemiller

Straight From The Top: A chronic pain sufferer shares some of her survival secrets in this weekly column.	Do you need to find a **Pain Specialist or Pain Clinic** in your area? Click here to begin your search!	**Ask The Pain Doctor**: Specially trained pain physicians respond to your requests.

/orldwide Congress on Pain!

The **Dannemiller Memorial Educational Foundation** , a leader in pain management education since 1984, has designed this web site to provide both the professional and the consumer with current information on pain and pain management.

Through the use of simple navigational buttons, you will be able to access a growing **LIBRARY** of informational articles on pain and pain management; and a list of **EDUCATIONAL RESOURCES** you can use for continuing medical education in the field of pain and pain management; visit the **PAIN EXPO** which is a "virtual trade show" of exhibits from commercial companies whose products serve the pain management professional; **PAIN RESOURCES** includes a comprehensive listing of professional pain management associations, pain publications, and hyperlinks to resources for pain; **CONSUMER INFO** is a special site for consumers to find information about pain through informational articles, links to other consumer health sites and a special forum for consumers to communicate with each other.

Using the **PAIN FORUM** professionals can communicate to share their thoughts and experiences with their peers.

This page will change continually. New information will be added to provide you with an ever expanding database of information so that each time you log on, you'll find new and interesting information on pain.

Register: Please register in our Guest Book and let us know what you think of the Worldwide Congress on Pain. **Click here to register** . This information will not be released by the Dannemiller Foundation.

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http://web.archive.org/web/20190129201700/http://www.prescriberesponsibly.com/risk-assessment-resources

Risk Assessment Resources

The initial evaluation of the patient in pain should include a risk assessment to identify those patients who may be at risk to misuse, abuse, or divert opioid analgesics. These resources can be used in conjunction with the patient's personal and family history to individualize the level of patient monitoring required in the treatment plan. After the initial assessment, the clinician should continue to monitor the patient carefully for treatment efficacy and possible evidence of opioid misuse.[66]

CAGE Questionnaire Adapted to Include Drugs (CAGE–AID)[67]

- Four-question screener to be administered by healthcare provider
- Assesses for potential drug and alcohol problems
- Evaluates risk based on the following 4 behaviors associated with substance abuse: feelings that one should "**C**ut down on substance use," becoming **A**nnoyed by criticism of substance use habits, feeling
- **G**uilty about one's use of substances, having an "**E**ye opener" in the morning to alleviate discomfort
- Affirmative answers to 2 out of 4 questions warrant further investigation[68]

Opioid Risk Tool (ORT)[69]

- Provider-administered survey consisting of 5 questions[66]
- Analyzes patient and family history to determine a risk category for the patient

Initiating Opioid Therapy

An **opioid agreement** should be considered to document and clarify treatment goals and expectations. It should help facilitate compliance and educate patients on responsible participation in their pain care. Opioid agreements are best used practice-wide to avoid bias. See table 2 for important points of an opioid agreemtent.

Sample Opioid Agreement

A sample agreement includes risk/benefit information and a list of potential opioid side effects.

- Washington State Department of Labor and Industries[70]

Clinical Opiate Withdrawal Scale[71]

- Widely used, healthcare professional–administered questionnaire[72]
- Asks provider to rate 11 signs and symptoms of opioid withdrawal as observed on a numerical scale

References Used in the Section:

66 Agency Medical Directors Group. Interagency guideline on opioid dosing for chronic non-cancer pain: an educational aid to improve care and safety with opioid therapy. http://www.agencymeddirectors.wa.gov/opioiddosing.asp. Accessed June 5, 2011.

67 Brown RL, Rounds LA. Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. *Wis Med J*. 1995; 94(3):135-140.

68 National Institute on Drug Abuse. Diagnosis and treatment of drug abuse in family practice. http://archives.drugabuse.gov/diagnosis-treatment/diagnosis5.html. Accessed December 17, 2010.

69 Community Anti-Drug Coalitions of America. Opioid Risk Tool (ORT). http://www.preventrxabuse.org. Accessed June 5, 2011.

70 The Office of the Medical Director, Washington State Department of Labor and Industries. Opioid progress report. http://www.LNI.wa.gov/Forms/pdf/F245-359-000.pdf. Accessed June 5, 2011.

71 California Society of Addiction Medicine. Guideline for Physicians Working in California Opioid Treatment Programs. Table 6. Clinical Opiate Withdrawal Scale (COWS). www.csam-

Pain Assessment Resources

- BPI
- PADT
- NRS
- Wong-Baker FACES® Pain Rating Scale

read more

Risk Assessment Resources

- CAGE -AID
- ORT
- Clinical Opiate Withdrawal Scale.

read more

Hospital Resources

- Make the Case
- Measure and Define
- Analyze and Improve
- Launch and Control
- Appendix/Toolkit

read more

AAPM – State Legislation & Regulation Tracking.

read more

asam.org/files/CSAMOTPGuideline21Apr09.pdf. Accessed June 5, 2011.

72 Tompkins DA, Bigelow GE, Harrison JA, Johnson RE, Fudala PJ, Strain EC. Concurrent validation of the Clinical Opiate Withdrawal Scale (COWS) and single-item indices against the Clinical Institute Narcotic Assessment (CINA) Opioid Withdrawal Instrument. *Drug Alcohol Depend*. 2009;105(1-2):154-159.

https://web.archive.org/web/20120322234928/http://www.letstalkpain.org/real_story/addictions.html

Let's Talk PAIN
Talk • Listen • Act

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Resources for Pain Management: Understanding Tolerance, Physical Dependence and Addiction

LISTEN

The use of strong pain medication, particularly opioids, often carries the stigma of drug addiction and abuse. As a result, many healthcare professionals prescribe opioids conservatively for pain management and many patients and their families are just as cautious about starting opioid medications. In many ways, this harmful stigma can be attributed to a lack of understanding about addiction and its related areas, such as pharmacologic tolerance and physical dependence - none of which are the same. By understanding the key differences between these terms, people affected by pain and their healthcare professionals can feel and communicate better about the pain management treatment choices they make.

- *Tolerance* is a biological state of adaptation in which exposure to a drug induces changes that result in a reduction of one or more of the drug's effects over time.
- *Physical dependence* is a biological state of adaptation that is manifested by a drug class-specific syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.
- *Addiction* is a primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestation. It is characterized by behaviors that include one or more of the following: impaired control over drug use, continued use despite harm, and craving.

The American Academy of Pain Medicine, American Pain Society and American Society of Addiction Medicine explain the differences between tolerance, dependence and addiction as follows:

Tolerance refers to the situation in which a drug becomes less effective over time and an increased dosage of the medication is required to maintain the same pain relief. This isn't always the case. Some people with persistent pain can stay on the same dose of opioid for a long time and not develop a tolerance. Many times, if a person needs a larger dose of a drug, it's because their pain is worse or the problem causing their pain has changed.

Physical dependence means that a person will develop symptoms and signs of withdrawal (e.g., sweating, rapid heart rate, nausea, diarrhea, goosebumps, anxiety) if the drug is suddenly stopped or the dose is lowered too quickly. This does NOT mean you are addicted. In fact, many non-addictive drugs can produce physical dependence. Physical dependence is considered a normal response for those patients who are being treated over several days or on a regular basis with opioids.

To prevent withdrawal, the dose of medication must be decreased slowly and your physician may choose to do this through a process known as titration. If you believe that you no longer need to take the opioid medication or want to reduce the dose, it is essential to speak to your healthcare professional. They will guide you on how to decrease your dose over time to prevent the experience of withdrawal.

Addiction to a medication means a person has lost control over the use of the drug and they continue to use it despite harmful consequences. The term addiction now refers to a medical diagnosis and is defined as a primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and expression. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.

A related term is *pseudoaddiction*, which refers to patient behaviors that may occur when pain is under-treated. This includes an increased focus on obtaining medications ("drug seeking" or "clock watching") and even illicit drug use or deception. Pseudoaddiction is different from true addiction because such behaviors can be resolved with effective pain management.

How can an individual tell if they are becoming addicted? How can a healthcare professional determine if their patient is developing an addiction? Here are some warning signs:

- Taking more pain medication than prescribed
- Requesting prescriptions from multiple doctors
- Using alcohol or other medications to increase the effects of the pain medication
- Taking pain medication to deal with other problems, such as anxiety or stress
- Friends or loved ones expressing concern about use of pain medication

It is important to become more familiar with the relationships between pain management and addiction, tolerance and physical dependence. Knowing the difference between these terms can prevent misunderstandings about pain management. With a better understanding, individuals with pain, their families, friends, and healthcare professionals can improve how they **talk**, **listen** and **act** about pain.

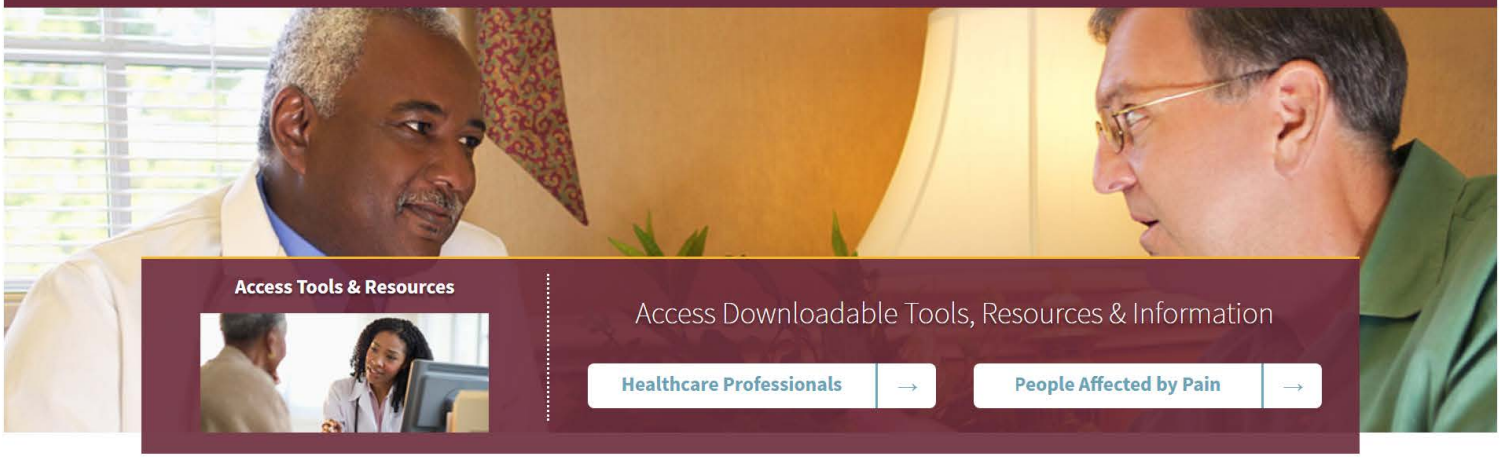
A Doctor's Point of View

You need Adobe Flash Player to view the videos on this site. Download the Flash plug-in at http://www.adobe.com/products/flashplayer/

My Pain Journal
Keep track of your meds...your pain levels... what days are good... which are bad
> download your journal

For more information on the safe use of pain therapies, visit PainSAFE™.

http://web.archive.org/web/20151011111918/http://painmatters.com:80/



Access Tools & Resources

Access Downloadable Tools, Resources & Information

Healthcare Professionals →

People Affected by Pain →

BE THE VOICE THAT INSPIRES CHANGE

DESIGN FOR DIALOGUE

Join Pain Matters and the pain community as we reimagine the exam room experience to foster a more open dialogue between healthcare professionals and people affected by pain.

Learn More →

PAIN MATTERS DOCUMENTARY

Watch Film →

Produced by the Discovery Channel, the film chronicles the lives of people living with pain.

View Stories →

Short video stories from people and families affected by chronic pain.

PAIN PERSPECTIVES

Hear from the Community →

New Survey Results Address Rx Abuse, presented by Bob Twillman, PhD

Check back for regular updates from the pain community.

Financial support, clinical input, and other expertise for the Pain Matters film were provided by Teva Pharmaceuticals.

"Chronic pain continues to be a serious issue for millions of Americans, and Teva is committed to supporting responsible pain management that meets the needs of people living with pain and healthcare professionals."[1]

— Michael Hayden, MD, PhD, President of Global R&D and Chief Scientific Officer at Teva Pharmaceuticals

More About Teva Pharmaceuticals →

https://web.archive.org/web/20010605165846/http://www.partnersagainstpain.com/html/profed/pmc/pe_pmc4.htm#barriers

Professional Education

Information, Tools, and Services for Medical Professionals Only

Pain Management Center

Undertreatment of Pain (30)

- Chronic pain: A new disease? NEW!
- Physicians' attitudes toward pain and the use of opioid analgesics: Results of a survey from the Texas Cancer Pain Initiative (2000)
- A drug use evaluation of selected opioid and nonopioid analgesics in the nursing facility setting (2000)
- Opioids and pain management: What do nurses know? (1999)
- Pain and pain treatment in AIDS patients: A longitudinal study (2000)
- Cancer pain management by radiotherapists: A survey of radiation oncology group physicians (2000)
- Pain is an epidemic, undertreated disease, experts say (2000)
- Ethnicity and analgesic practice (2000)
- Analysis of pain content in nursing textbooks (2000)
- Should Pain Management Services Be Denied If There Are No Objective Signs of Injury? (2000)
- "We Don't Carry That" - Failure of Pharmacies in Predominantly Nonwhite Neighborhoods to Stock Opioid Analgesics (2000)
- Four Perspectives on the Concept of 50% Pain Relief from *Pain Forum*
- Dispelling the Myths & Misconceptions of Pain Management (2000)
- Palliative Care and Hospice Programs (2000)
- Barriers to Effective Cancer Pain Management: A Review of the Literature (1999)
- Controlling Cancer Pain: Missed Opportunities (2000)
- Dismantling the Barriers: Providing Palliative and Pain Care (2000)
- Opioids for Managing Patients with Chronic Pain: Community Pharmacists' Perspectives and Concerns (1999)
- The Art and Science of Relieving Pain (1999)
- Correlates and Management of Nonmalignant Pain in the Nursing Home (1999)

- Lower Body Osteoarticular Pain and Dose of Analgesic Medications in Older Disabled Women: The Women's Health and Aging Study (1999)
- Chronic pain-associated behaviors in the nursing home: resident versus caregiver perceptions (1999)
- In the system: the lived experience of chronic back pain from the perspectives of those seeking help from pain clinics (1999)
- Organizational factors hinder more effective use of opioids to relieve pain (1997)
- Physicians surveyed on managing cancer pain (1997)
- Minority patients' cancer pain inadequately treated (1997)
- Elderly burn victims are shortchanged on pain medication (1997)
- One of Five Adults in Chronic Pain (1997)
- Pain at End of Life Inadequately Treated (1997)

Chronic pain: A new disease?

Nearly one-third of the American population experiences chronic pain at some point in life. This figure, disturbing on its own, becomes more problematic in light of recent studies which demonstrate that chronic pain is a destructive disease process that creates pathologic changes in the central and peripheral nervous systems. This means a paradigm shift for physicians who must begin to understand chronic pain not as a simple disorder, but as a serious medical disease that demands early and aggressive treatment.

Chronic pain is being understood more clearly today as far more — and far more pernicious — than a protracted version of acute pain. The repeatedly generated neural signals characteristic of chronic pain can become embedded in the spinal cord like a memory, creating physiochemical changes in the neural pathways and creating hypersensitivity to those same pain signals. Patients who have suffered from uncontrolled pain for months or years often develop pain in areas well beyond the organ or dermatone originally affected.

Physicians unfamiliar with this concept of neural plasticity may deem their patient's chronic pain psychogenic because it fails to conform to their pre-conceived map of the nervous system. Instead, physicians need to realize that failure to treat chronic pain can result in physical, psychological, and behavioral consequences. The changes wrought by chronic pain on neural pathways may also require new treatment approaches. Author Daniel Brookoff, M.D., says the clinical implications of such neural phenomena are "clear but underappreciated — inadequately treated pain is a much more important cause of opioid tolerance than the use of opioids themselves."

Brookoff concludes by suggesting that opioid analgesics can be the mainstay of safe, effective treatment for chronic pain disease, and so, prevent the damage of untreated chronic pain. (Brookoff D. *Hosp Pract*. 2000;35(7):45-52,59.)

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Physicians' attitudes toward pain and the use of opioid analgesics: Results of a survey from the Texas Cancer Pain Initiative

"Serious mismanagement and undermedication in treating acute and chronic pain" continue to plague both patients and the physicians who treat them. The clinical scenario seems to endure despite significant advances in knowledge of human pain mechanisms. Clinicians lack knowledge of opioid pharmacology and use; have difficulty making equianalgesic conversions among opioids; have a negative view of patients with chronic pain, and remain reluctant to prescribe opioids (some are inhibited by multicopy prescription programs and fear of regulatory reprisal). Using a 59-item survey, researchers studied the practices, beliefs, and attitudes about pain among 386 physicians in Texas. The intent of the survey was to identify barriers to adequate pain management and to assess the impact community size and medical discipline might have on those barriers.

Many physicians were, in critical clinical instances, reluctant to use opioids, i.e., often reserving them until patients' pain is severe and intractable. Ten percent would "withhold opioids from a patient with severe pain until prognosis is < 1 year, or terminal." (See Table.) Fear of iatrogenic addiction was widespread. Prescribing habits were greatly affected by fear of government scrutiny. The majority thought there should be limits on the number of opioid tablets prescribed and 25% believed adherence to this practice would minimize potential for regulatory scrutiny. One-third believed that tolerance, rather than unrelieved pain, underlies an increase in requests for opioids. Physicians also displayed inadequate knowledge of the prevalence of pain in cancer, and the value of opioids in cancer pain. Half of physicians surveyed said they did not enjoy treating patients with intractable conditions

intractable conditions.

Physicians in large communities feared creating addiction; physicians in small communities also feared creating addiction, knew less about pain management, and were less accepting toward treating chronic pain with opioids. Psychiatrists had the least negative attitudes toward pain and its treatment, were less reluctant to prescribe opioids, and less fearful of addiction risk than physicians in other disciplines including internal medicine and surgery/anesthesia. (Weinstein SM, Laux LF, Thornby JI, et al. *South Med J*. 2000;93:479-487.)

Selected responses to survey of 386 Texas physicians
Agreement shows misconception about pain management

Survey Question	Agree (%)	Disagree (%)
Narcotics should be restricted to treatment of severe intractable pain	30.5	64.4
Using narcotics to relieve the pain of benign conditions is ill-advised	31.5	57.5
There are limits to the number of narcotics tablets a patient should be prescribed	67.1	21.7
I give patients a limited supply of pain medications to avoid being investigated	23.8	53.6
Increasing requests for analgesics indicate tolerance to the analgesic	62.4	24.7

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A drug use evaluation of selected opioid and nonopioid analgesics in the nursing facility setting

Results of this multicenter, 3-month retrospective drug use evaluation among nursing facility (NF) residents found that analgesic prescribing for most residents was inconsistent with recommended pain therapy for older persons (e.g., high use of propoxyphene, low use of long-acting opioids, and frequent prn prescribing). The authors state that the current approach to pain management in NF settings is substandard and conclude that education is urgently needed for NF practitioners. (Cramer GW, Galer BS, Mendelson MA, Thompson GD. *J Am Geriatr Soc*. 2000;48:398-404.)

The 2065 NF residents, of whom 76.8% reported chronic pain, received at least one selected analgesic for pain. The following data on this group was also reported:

40.6% of residents received no pain assessment during the 3-month study period

- 41.8% of patients were assessed for pain by observation only
- 16.6% of patients were assessed by objective measures (i.e., numeric pain scales)

69.4% of patients received no nonpharmacologic therapy for pain

55.8% of all opioid prescriptions were for drugs containing propoxyphene

35.6% of all analgesic prescriptions were for propoxyphene with acetaminophen

- Propoxyphene is specifically not recommended for older patients due to lack of proven superiority to acetaminophen, renal toxicity, long half life, and toxic metabolite accumulation.

63.2% of analgesics prescribed were short-acting drugs prescribed prn, rather than the long-acting agents recommended for the elderly population

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Opioids and pain management: What do nurses know?

Since 1998, researchers McCaffery and Ferrell have surveyed 8000 nurses to assess their knowledge of pain management. In comparing results of two earlier surveys (1988-1990, 1995), it was clear that nurses have become more informed about pain assessment and relief during the elapsed time. However, they also discovered that too many nurses still lack "basic knowledge necessary to manage pain properly."

Between 1990 and 1995, nurses became more adept at assessing pain on the basis of patient self report (the accepted method) rather than on the basis of behavior (i.e., if the patient's verbal report was of severe pain, but the individual, for whatever reason, was also smiling or laughing, the nurse was less likely to record and take steps to relieve the pain). This suggested that the most difficult concept for nurses to accept is that they must act on *reports* of severe pain, *regardless of patient's behavior*. They also improved in their willingness to increase a safe but ineffective dose of morphine by 50% to relieve pain. Nevertheless, in 1995, more than half (53.2%) still failed to grasp basic principles of pain assessment and titration of safe but ineffective opioid doses. Overall, patient's behavior was still the factor most likely to lead nurses to undertreat pain. Many nurses also harbor the fear of creating addiction among pain patients. A significant educational effort is required to help nurses fully understand — and differentiate among — the concepts of addiction, tolerance, and physical dependence. (McCaffery M, Ferrell BR. *Nursing*. March, 1999:48-52.)

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Pain and pain treatment in AIDS patients: A longitudinal study

Among AIDS patients, there is a high incidence of disturbing pain, which is often inadequately treated. In 95 AIDS patients enrolled in a 2-year study, incidence of pain was 88%. In 69% of patients, pain was constant and interfered with daily living to a degree described as moderate or severe.

Pain conditions were related to infections, malignancy, or neuropathy, and pain localizations increased as death approached. Survival rate for patients without pain at study entry was higher than for those with pain. At the start of the study, 77% of patients had inadequate pain control, as indicated by negative scores on the Pain Management Index (PMI) a measure of patient-reported pain relief from analgesic therapy.

Patients received a variety of pain treatments during the study. Adequate analgesic treatment, as assessed using World Health Organization guidelines, increased during the study from 23% to 64%, as did PMI.

Although the great majority of patients said they were satisfied with their analgesic treatment, many felt that pain was not taken seriously by physicians and were often reluctant to take analgesics (See below). (Frich LM, Borgbjerg FM. *J Pain Symptom Manage*. 2000;19:339-347.)

Commonly expressed attitudes and beliefs among AIDS patients

Issue	Attitude/belief
Pain treatment	• Belief that physician is authority and responsible for pain treatment • Belief that pain not taken seriously by physicians • Preference for contact with the same physician or nurse during treatment • Belief that treatment received is optimal, so that they must accept living with pain
Reluctance to take analgesics	• Patient "taught not to take it" • Patient "wants to save it for later" • Patient fears "using up the possibility if pain gets unbearable" • Patient "afraid of addiction" • Patient fears side effects of sedation, dizziness, constipation, nausea, if doses are increased

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Cancer pain management by radiotherapists: A survey of radiation therapy oncology group physicians

According to a recent survey, most radiotherapists may believe that cancer pain is inadequately controlled. Results of this survey, conducted among 92 physicians at a 1997 meeting of Radiation Therapy Oncology Group (RTOG), revealed that 83% felt pain in most cancer patients is undermedicated.

Forty percent rated pain control as fair or poor in their own practices, which may be explained in part by prescribing habits. Almost half (47%) would only prescribe a "weak" opioid (e.g., codeine) rather than a "strong" opioid (e.g., morphine) for severe bone-cancer pain of long duration.

In addition, 23% would wait to prescribe maximal analgesia until a patient's prognosis was less than 6 months; 25% would not choose the oral route. In contrast, physicians who would treat pain earlier were also more likely to use oral medications. A full 95% of the physicians surveyed did not prescribe laxatives or antiemetics to manage opioid side effects. Radiotherapy physicians cited many familiar barriers to effective pain management (see below).

Forty-four percent rated their medical school training in pain management as poor — a finding similar to that obtained in a 1993 survey conducted among oncologists by the Eastern Cooperative Oncology Group (ECOG). In that survey, radiotherapists and surgeons were less likely to treat pain aggressively with medications than were medical oncologists. Authors of the current survey suggest that "Radiation oncologists are more liable to see radiation as a way to treat pain, and may be more concerned with opioid side effects than medical oncologists." (Cleeland CS, Janjan NA, Scott CB, et al. *Int J Radiation Oncol Biol Phys.* 2000;47:203-208.)

Most frequently cited barriers to cancer pain management: 1997 RTOG* survey

Barrier	% physicians citing
Inadequate pain assessment	77

Patient reluctance to report pain	60
Patient reluctance to take opioids	72
Staff reluctance to prescribe opioids	41
Inadequate staff knowledge of pain management	40
Patient inability to pay	23
Excessive state regulation of analgesics	22
Staff reluctance to administer opioids	20
Lack of specialists	17

*Radiation Therapy Oncology Group

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Pain is an epidemic, undertreated disease, experts say

With chronic pain affecting over 40 million Americans, experts are now recommending that it be "considered a disease state of the nervous system, not merely a prolonged acute symptom." Left untreated or undertreated chronic pain can consume a patient's life, making even the most basic activities difficult to perform. Compounding the problem is physicians' reluctance to prescribe opioids for fear they will lose their license or face criminal action. Fortunately, state and federal legislation, as well as professional society guidelines, are in the works and/or being adopted which will make it easier for physicians to prescribe pain medication to those who need it most.

But conquering this new epidemic will take more than legislation. Effective treatment of chronic pain is going to require widespread education to dispel providers' misconceptions and to teach proper diagnosis. Chronic pain can manifest as headache, myofascial pain, fibromyalgia, neuropathic pain, phantom limb pain — syndromes best diagnosed on the basis of *clinical* criteria. Unfortunately, physicians too often rely on results of MRIs or CT scans; and these imaging tests won't pick up nerve damage or other problems that can contribute to pain. As a result, physicians end up describing the patient's problem rather than providing a diagnosis — or they may dismiss the pain as psychogenic. The author suggests that physicians can learn to treat chronic pain more effectively if they begin to trust their own clinical judgment rather than rely solely on routine tests or "mechanical" evaluations. Pain medicine specialists interviewed for the article conclude that, while diagnostic tools and treatment options continue to be refined, most pain today can be managed using the tools we have available. (Sipkoff M. *The Quality Indicator*. May, 2000;1-8)

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Ethnicity and analgesic practice

A study of admissions to an Atlanta, Georgia emergency department found that black patients were less likely to receive analgesia than white patients with similar injuries. Records were reviewed for a 40-month period and included 217 patients (127 black, 90 white) who were managed by 37 different physicians. All patients included in the study were admitted to the emergency room with new, isolated long-bone fractures.

The presence of pain was noted in similar proportion for both black and white patients. However, only 57% of black patients received analgesics compared to 74% of white patients. The authors state that this finding suggests "...patient ethnicity affects decision-making, independent of objective clinical criteria."

The authors found that physicians were not failing to properly assess pain, rather they failed to administer appropriate analgesia in a consistent way. The authors go on to suggest that since the only factor affecting the disparity in prescribing analgesics was the physician's decision to administer medication, those prescribing decisions may be affected by patient ethnicity. To correct this problem, the authors suggest that pain management guidelines be refined so that existing, standardized pain assessment scales are paired with clear analgesic guidelines. (Todd KH, Deaton C, D'Adamo AP, Goe L. *Ann Emerg Med.* 2000;35[1]:11-16.)

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Analysis of pain content in nursing textbooks

Nurses are essential professionals in pain management, yet their textbooks have only limited content on pain. According to a new study by Ferrell and colleagues, pain content accounted for only 0.5% of the total text content in 50 textbooks used in nursing education; end-of-life (EOL) care accounted for only 2% of the content. An analysis of texts also showed that most had no information about many key topics, such as the principles of addiction, tolerance, and dependence, as well as barriers to pain management. These results are shown in the table below. The authors concluded that there are significant deficits in nursing texts when it comes to pain management. They urged publishers and editors to fill the "void" and enhance pain content in books used by nurses. (Ferrell B, Virani R, Grant M, et al. *J Pain Symptom Manage*. 2000;19:216-228.)

Ratings of Pain Content by Category for Nursing Texts (N=46)

Pain Content Category	Absent/No mention	Present	Content helpful, commendable
Definition	52%	15%	33%

Definition	52%	15%	33%
Assessment - Physical	43%	20%	37%
Assessment - Scales	57%	13%	30%
Pharmacologic management of pain at EOL	57%	17%	26%
Use of invasive techniques	65%	2%	33%
Principles of addiction, tolerance, dependence	60%	20%	20%
Nonpharmacologic management of pain at EOL	48%	9%	43%
Physical pain vs. suffering	83%	11%	6%
Side effects of opioids	68%	15%	17%
Barriers to pain management	76%	11%	13%
Fear of opioids hastening death/opioids near death	76%	15%	9%
Equianalagesic	72%	17%	11%
Recognition of nurses' own burden in pain management	80%	13%	7%
Summary score of pain content	64.4%	13.7%	21.9%

Adapted from Ferrell B, Virani R, 2000.

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Should Pain Management Services Be Denied If There Are No Objective Signs of Injury?

Measurable physiologic changes are associated with chronic pain but may be undetectable on imaging studies. Why? In patient terminology, it's because pain is essentially a "software" problem, whereas imaging studies show only the "hardware," telling us nothing about changes in receptor fields, neurotransmitters, metabolism of neuron pools or altered thresholds of pain signal propagation - the software.

Patients with chronic neuropathic pain may appear perfectly normal on the outside - and on imaging studies as well - yet may truly be suffering severe and often debilitating pain. Likewise, a patient with a small injury can be debilitated by pain that is organic and very real, yet be denied services by an insurance carrier because the extent of the pain cannot be explained by an identified anatomic change. Such patients can be abandoned by their insurance carriers and left as malingerers.

Science teaches that the size of injury does not correlate with the extent of pain. Yet physicians often ignore this fact in their actual clinical practices. Since pain is largely a software problem, analysis during a clinical situation is basically only a cursory look at the hardware.

The author suggests that physicians be persistent in teaching and advocating for their patients, that they support and perform research, and that they take an active role in medical societies and political lobbies that strive to improve patient care and health care delivery. In his opinion, passive behavior will not help the field of pain medicine. (Saberski LR. *The Pain Clinic*. 2000;Feb:10,12.)

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"We Don't Carry That" - Failure of Pharmacies in Predominantly Nonwhite Neighborhoods to Stock Opioid Analgesics

Fewer than 50% of New York City pharmacies have, in stock, an adequate supply of first-line opioid medications to treat a person suffering from severe pain. Pharmacies in predominantly nonwhite neighborhoods are significantly less likely to stock opioids than are pharmacies in predominantly white neighborhoods. Two thirds of the pharmacies that carried ***no*** opioids were in predominantly nonwhite neighborhoods.

Pharmacists give three chief reasons for having inadequate supplies of opioids: (1) regulations with regard to disposal, illicit use, and fraud; (2) low demand (which is consistent with other reports that nonwhite patients are significantly less likely than white patients to receive prescriptions for opioid and other analgesics); and (3) fear of theft.

These findings suggest that members of racial and ethnic minority groups are at even greater risk for undertreatment of pain than reported in the clinical literature. (Morrison RS, Wallenstein S, Natale DK, et al. *N Engl J Med*. 2000;342:1023-1026.)

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Four Perspectives on the Concept of 50% Pain Relief from *Pain Forum*

The Fallacy of 50% Pain Relief as Standard for Satisfactory Treatment Outcome

"The 50% pain threshold has too little real meaning for so many people that it should be eliminated as the most important of measures. How different would our literature appear if we chose pain

as the most important of measures. How different would our literature appear if we chose pain relief at the 90% level and required that outcomes correlated the meaning of that pain reduction with the other factors that better describe our patients? The threshold for satisfactory relief we have accepted is so low that it makes our work acceptable, at least to us, without really describing what happens to our patients." *J. L. Seres*

How did medicine get here? The concept of the 50% relief threshold originated in publications by the Johns Hopkins pain group in 1991. The effort to report outcomes in a standardized fashion was a major contribution and the 50% standard offered an objective goal with some statistical meaning. It is still true that outcome measures in the treatment of chronic pain are difficult to standardize. Pain levels and improvement in pain often don't correlate with functional ability, need for medication or suffering behaviors. The 50% threshold became the standard for minimally adequate pain relief despite the fact that very little literature supports this outcome as valid. It is easy to use and so has in effect become the "gold standard" of outcome, a term author Seres challenges as confusing, misleading and one that should be discontinued. The review looks at composite outcome measures that potentially have greater meaning.

Richard B. North, M.D., is professor of neurosurgery, anesthesiology and critical care medicine at Johns Hopkins University School of Medicine, i.e., part of the Hopkins Pain Group. In his responsive commentary, "The Glass is Half Full," Dr. North points out that the "modern" criterion of 50% pain relief was preceded by numerous publications, spanning two decades, on spinal cord stimulation and failed back surgery syndrome that used this criterion explicitly. North does agree with Seres that other outcome measures should be reported as well. He also states that the Johns Hopkins pain group routinely includes standard pain rating methods, but considers the following as additional measures of outcome: patient satisfaction, need for additional treatment, medication requirements, activities of daily living and return to work. Patients and physicians should not place undue reliance on any single outcome criterion. Nor should there be excessive reliance on outcome measures that only indirectly reflect relief of pain. *R. B. North, MD*

Also in response to Dr. Seres, John D. Loeser, MD, writes, in "Seres' Fallacies," that decent outcome measures are needed, outcomes that reflect the use of valid and relevant instruments to assess the many aspects of pain, suffering and pain behaviors. Statistical issues and appropriate measures to determine outcomes for patients with chronic pain are two components of poor outcome reports that Seres did not identify, says Loeser. He also believes that work is important in an adult's life and the treatment of pain must use return to work or, in the elderly, return to retirement activities as a primary outcome measure.

Loeser comments that although measures of treatment efficacy are important, he believes the approach is an inadequate measure of medicine. Physicians, and particularly surgeons, should not think of themselves as only providing technology; they play many additional roles and should also be providing guidance, information, reassurance, prognosis, comfort, and support. To the degree the physician perceives his/her work as unidimensional, concepts such as patient report of pain level as a primary measure of efficacy take hold. The "good" physician who embodies both technical skill and compassion looks beyond the single-measure report for other indicators — both subtle and apparent — of success. *J. D. Loeser, MD*

Kenneth A. Follett, MD, in the third response to Dr. Seres, "The Fallacy of Using a Solitary Outcome Measure as the Standard for Satisfactory Pain Treatment Outcome" says that "percent of pain relief" is a solitary measure that, used alone, minimizes the multidimensional nature of pain, pain management and outcomes. If it is agreed that pain intensity ratings are a measure of therapeutic outcome, who should provide the rating? Patients may not accurately describe their responses to treatment. Patients, significant others and physicians all rate treatment outcomes differently, with significant others typically reporting the lowest. Ratings of pain intensity are subjective giving rise to the need for more objective measurements of pain and outcomes of treatment. In different capacities, family members, healthcare providers, employers, payors, and society all share the burden of pain. Since each of these parties has a different goal for treatment of the individual's pain disorder, their measures of success will be different.

The Uniform Outcome Measures project of the American Academy of Pain Medicine is developing an outcome measure that incorporates standardized assessment tools and functional testing. The purpose is to reduce the subjectivity and inconsistency in the assessment of responses to pain therapy. Success or failure of therapy will depend on whether the goals established for each patient have been met, although the determination of success will remain as varied as the individuals seeking relief. *K. A. Follett, MD*

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Dispelling the Myths & Misconceptions of Pain Management

Patients in the long-term-care setting may believe that chronic pain is an inevitable sign of aging, that nothing can be done, that it is a punishment for past actions, or a sign of serious illness or impending death. They may hesitate to acknowledge pain, fearing that this would be a sign of personal weakness, lead to painful tests, or result in a loss of independence. Caregivers may perceive elderly patients (particularly the cognitively impaired) as having a higher tolerance for pain, using pain as an attention-seeking behavior, or being prone to opioid addiction.

These myths and misconceptions, many of which are imbedded firmly in sociocultural beliefs, pose significant barriers to pain relief for the elderly. These are best corrected through education of patient and family, and through ongoing in-service programs for healthcare staff.

The International Narcotics Control Board and the World Health Organization are urging governments to identify – and work to remove – "barriers to opioid access." The medical use of opioids for pain relief restores patients' comfort and dignity and improves quality of remaining life; results which far outweigh the sociocultural fears that have grown up around them. (Kaldy J. *Caring for the Ages*. 2000; 1(1):27.)

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Palliative Care and Hospice Programs

Palliative care and hospice programs are points on a continuum of comprehensive patient care, with hospice care being the final chapter. Although palliative medicine has become a subspecialty within American medicine, all physicians must become more skilled at meeting the palliative-care needs of their patients.

The American Medical Association has developed a new training module that provides physicians with fundamental skills in communications, ethical decision making, and palliative care. The American Society of Clinical Oncology recently adopted recommendations about end-of-life care. The World Health Organization has reiterated its "ladder approach" to pharmacologic pain management, which progresses from nonopioids (e.g., nonsteroidal anti-inflammatory drugs) to "weak" opioids (e.g., codeine, oxycodone) to "strong" opioids (i.e., morphine and morphine-like drugs) and advocates the formulation of a pain regimen tailored to the needs of each patient.

Many physicians fear creating opioid addiction and abuse because they do not understand the mechanisms and principles of pain management or the need for high doses of analgesics to relieve severe pain. (Kaur JS. *Mayo Clin Proc*. 2000;75:181-184.)

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Barriers to Effective Cancer Pain Management: A Review of the Literature

It is estimated that up to 90% of cancer pain can be treated through available means. Yet many patients continue to suffer needlessly: pain is experienced by as many as 45% of patients with early-stage cancer and 75% of patients with advanced-stage cancer.

According to clinical practice guidelines developed by the World Health Organization (WHO) and the U.S. Agency for Health Care Policy and Research (AHCPR), opioids are the drugs of choice for the management of moderate to severe pain. Despite the wide availability of these guidelines, however, both healthcare providers and patients continue to hold misconceptions about opioids and other drugs used to treat cancer pain. Other barriers to effective relief include poor communication between patients and healthcare providers and the lack of formal assessment procedures.

The majority of physicians and nurses agree that most cancer patients who experience pain are undermedicated, yet they believe that patients' requests for increased analgesic doses are the result of drug tolerance rather than disease progression or increased pain. Many of these professionals do not accept the fact that cancer pain is not inevitable. They fear that opioid use will result in addiction, drug tolerance, and uncontrollable side effects, especially respiratory depression. They fail to differentiate between addiction and physical dependence and to recognize that a) the risk for addiction is low in patients with no history of substance abuse and b) that there is little or no tolerance to the analgesic effects of opioids. They often base opioid doses on the severity of disease or their own fear of drug tolerance rather than on the intensity and level of the patient's pain. Many do not acknowledge the efficacy of opioids administered orally or antidepressants prescribed as adjuvants.

Physicians acknowledge that insufficient knowledge and inadequate education contribute to the problem of undertreated pain. Cancer specialists, family practitioners, and other providers have different levels of knowledge regarding the management of cancer pain. Not all physicians are familiar with the WHO principles of pain management, and even those who are may not necessarily use this knowledge in clinical practice. A European study of 306 physicians who treat cancer patients found that only 25% of physicians were familiar with the WHO principles. And, while 86% were willing to prescribe "strong" opioids for cancer pain, 44% undermedicated. The majority (97%) of physicians in this study expressed concerns related to cancer pain management including difficulty in managing side effects to inadequate pain relief. They also responded that their education in cancer pain management was inadequate.

Physicians seldom use standardized assessment procedures to measure pain intensity, despite the fact that the patient is the best source of information for the treatment of pain. Moreover, they do not separately evaluate different types of pain, even though these could reflect different etiologies.

Patients and caregivers present additional barriers to effective pain management. These barriers include the belief that cancer pain is inevitable and cannot be alleviated; concern that pain is indicative of disease progression; reluctance to report pain which would "bother the doctor," or distract the physician from dealing with the cancer itself; and fear that the medication will be addictive, be "bad" for their bodies, or produce unpleasant side effects.

Interventions have been designed to educate healthcare providers, patients, and family members regarding the treatment of cancer pain and to overcome the frequent lack of communication between providers and patients regarding pain. Yet much remains to be done to address this problem. (Pargeon KL, Hailey BJ. *J Pain Symptom Manage*. 1999;18:358-368.)

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Controlling Cancer Pain: Missed Opportunities

Healthcare professionals miss opportunities every day to help relieve the pain and distress experienced by cancer patients and those with other serious illness.

During an office visit, a time, theoretically, devoted to physician-patient communication, a physician will frequently fail to treat, or even discuss a patient's pain. The reasons are many. Communication often requires that the patient speak up voluntarily, to "complain" about pain. Emotional barriers to this proactive behavior include 1) wanting to be a good (noncomplaining) patient; 2) concern about

having to take "strong pain killers;" and 3) worry that talking about pain will take time from dealing with the disease. "Assessment can overcome this reluctance, especially if it is part of the visit routine." Patients with aggressive disease must be asked about pain severity at every visit (minimum) and told to call the office between visits if pain becomes a problem.

On the physician side, the barriers that impede inquiry about pain are rooted deeply in the medical education process. Studies show that poor physician training, particularly in pain assessment but also in pain management significantly impedes adequate pain treatment. Little or no time is devoted to teaching pain assessment and management to medical students and postgraduate training is not much better. This is true even among cancer specialists, who, in two studies, delayed giving morphine to a dying patient until the prognosis narrowed to < 6 months. This pain management "strategy" was practiced despite the physicians' knowledge that morphine is required to treat severe cancer pain. Concern over analgesic adverse effects was the barrier in these cases to earlier use of morphine. In both studies, inadequate assessment was named the major barrier to effective pain control.

Patients need to expect that contact with their physician will result in good pain management; in pain reduced to a level where function is enhanced. When patients can expect this, they can be trained to report pain, take appropriate medication and, most importantly, to collaborate in assessment and management of their pain. Communication means fewer missed opportunities. (Cleeland CS. [Report]. *MSJAMA*. January 5, 2000)

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Dismantling the Barriers: Providing Palliative and Pain Care

In 1997, the Institute of Medicine (IOM) called for the need to improve care of patients at the end of life in its report "Approaching Death." Noting that the United States suffers from severe deficiencies in the delivery of palliative care, the IOM requested that healthcare professionals commit themselves to use existing knowledge to reduce pain and manage symptoms in patients nearing death. Perhaps most important, the IOM recommended that medical training programs educate practitioners in the care of dying patients.

Many barriers prevent healthcare professionals from delivering - and patients from receiving - humane and compassionate treatment at the end of life. These barriers include clinicians' fears of inducing physical or psychological addiction to pain medications, their misconceptions about pain tolerance, and assessment biases. Fear of regulatory scrutiny affects physicians' willingness to even prescribe pain medication. Medical and nursing textbooks devote only a few pages to current pain and symptom control guidelines. This professional ignorance of proper use of opioids has been most glaring in the care of dying patients who have spent their final days or hours in needless suffering.

Increased attention to pain and palliative care education at all medical schools is essential. Education, clinical experience, and role modeling, all elements of medical training, can help reduce undertreatment of pain, at the end of life, and across the continuum of care. (Foley K. *MSJAMA*. 2000;283:115.)

While pain is one of the most common nonspecific complaints of patients seeking medical attention, the fear of pain is especially heightened when thoughts turn to the end of life. The following statistics - on human fear and on the prevalence of pain - support the concept that pain has become a serious public health problem.

- 72% of people in the general population fear dying in pain
- 57% of cancer patients agreed with the statement that a painful death can be expected with cancer
- 69% of the same cancer patients said they would consider suicide if their pain could not be managed
- 56% of 1308 oncology patients reported moderate to severe pain while 72% of physicians (same study) expressed lack of knowledge concerning pain management
- 50% of seriously ill patients (noncancer diagnoses) who were conscious during the last 3 days of life reported moderate to severe pain
- 4.5 million patients from developing and industrialized countries die in pain each year

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Opioids for Managing Patients with Chronic Pain: Community Pharmacists' Perspectives and Concerns

A survey of retail pharmacists in New Jersey was conducted in order to assess knowledge and attitudes regarding the use of opioids in chronic cancer and noncancer patients. Since previous studies have shown that pharmacists often have concerns about stocking and dispensing opioids as a result of a fear of robbery and federal investigation, this study also attempted to quantify these fears.

The most enlightening discovery of this study was the many misconceptions that pharmacists have about tolerance, physical dependence and addiction. Physicians often carry the same misconceptions and often underprescribe necessary pain medications. The Drug Enforcement Agency has emphasized that physicians should prescribe controlled substances when appropriate

without fear of investigation. In the same vein, pharmacists should not fear dispensing for legitimate medical purposes. The authors suggest that communication between the prescriber and the dispenser can enhance legitimate medical practice. (Greenwald BD, Narcessian EJ. *Journal of Pain and Symptom Management.* 1999;17[5]:369-375)

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The Art and Science of Relieving Pain

The goal of ideal pain management is to relieve both acute and chronic pain with appropriate medications while minimizing side effects of those medications. This type of treatment often does not happen for many different reasons. One of the primary reasons that patients frequently do not receive adequate pain relief is that pain levels are not properly assessed. One way to reduce this problem is by allowing the patient to communicate his pain through the use of pain assessment tools. Once pain has been assessed, there are several measures that health care professionals can take to minimize other factors that contribute to a patient's suffering. The author suggests premedicating a patient before procedures that are likely to induce increased pain as a method of avoiding needless suffering. Additionally, increasing early evening doses should assist the patient in achieving a restful sleep as sleep deprivation can increase suffering. (O'Brien ME. *Home Health Care Consultant.* 1999;6[10]:26-33)

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Correlates and Management of Nonmalignant Pain in the Nursing Home

Nonmalignant pain is common among nursing home residents. Approximately 26% of the 50,000 residents studied experience pain on a daily basis. As a result of this pain, many residents experience severe impairment of daily activities, impaired sleep, depression and anxiety. The investigators found evidence that one-quarter of residents reporting pain receive no analgesics. Furthermore, men, racial minorities, and cognitively impaired residents were less likely to receive analgesics than residents who were cognitively intact.

The authors conclude that it is likely that many more nursing home residents may experience daily pain but do not report it. In fact, 56% of day-to-day health symptoms are not reported to health professionals. Older patients often feel that their symptoms cannot be treated or they believe that pain is a natural part of aging. In order to prevent nursing home residents from having to live with daily pain, the authors suggest that adopting a multidisciplinary approach including research and education for professionals and patients will lead to optimal pain management. (Won A, Lapane K, Gambassi G, Bernabei R, Mor V, Lipsitz L. *J Am Geriatr Soc.* 1999;47:936-942)

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Lower Body Osteoarticular Pain and Dose of Analgesic Medications in Older Disabled Women: The Women's Health and Aging Study

Older women are frequently afflicted with osteoarticular pain that affects the lower back, hips, knees or feet and often produces physical disability, depression and disturbed sleep. An article, which appeared in the *American Journal of Public Health*, reveals the findings of a study designed to determine the doses of analgesic medications in relation to the severity of osteoarticular pain.

The study revealed that almost 50% of participants experienced severe pain most frequently in the knees or hips. Based on data collected on dose, the authors concluded that many women experiencing severe pain use either extremely high or extremely low analgesic doses that may not be effective in relieving pain. The cost of the drugs and lack of contact with a physician may be reasons why participants used very low doses of medication. One of the reasons participants may have used exceedingly high doses is a result of a lack of drug efficacy at recommended dosage. The authors conclude that severe osteoarticular pain may lead to the worsening of disability. As a result, older women must be treated with more effective and safer pain controlling agents. (Pahor M, et al. *Am J Public Health.* 1999;89:930-934)

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Chronic pain-associated behaviors in the nursing home: resident versus caregiver perceptions

Pain assessment in nursing home residents has been poor. These older adults are often hesitant to complain and seek treatment and often view the pain that they are experiencing as a result of the aging process. Additionally, nursing home staff frequently overlook chronic pain when residents do not manifest physical symptoms of pain when residents do report it. Furthermore, there is a wide range of reactions that residents with varied levels of cognitive function have to the pain that they experience which makes it difficult to find an appropriate method of assessment. The authors suggest that nursing home staff use more objective measures such as caloric intake and sleep efficiency to aid in the diagnosis of chronic pain. (Weiner D, Peterson B, Keefe F. *Pain.* 1999;80:577-588)

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In the system: the lived experience of chronic back pain from the perspectives of those seeking help from pain clinics

Twenty back pain patients in the UK describe their lived experiences in dealing with "the system." For these patients in pain, the systems which caused them grief were the medical, social security and legal systems – systems that are designed to treat and support them. Participants in the study

and legal systems -- systems that are designed to treat and support them. Participants in the study described the irrevocable changes that their pain had made to all aspects of their lives.

The authors concluded that suppressed anger is a common experience of chronic pain sufferers. They suggest that this study will offer clinicians a better understanding of negative attitudes of back pain patients. It is hoped that gaining awareness of this problem will prompt further research in the development of more effective and humane approaches to the management of people who have acute and chronic pain. (Walker J, Holloway I, Sofaer B. *Pain.* 1999;80:621-628)

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Organizational factors hinder more effective use of opioids to relieve pain

Although effective relief for most forms of pain are obtainable through medical prescription, too many cancer patients still suffer with unrelieved pain.

The numerous stumbling blocks to managing pain effectively that exist within the medical profession, as well as governmental regulations that inhibit use of some important pain medications in many countries throughout the world are discussed in an article from *Support Care in Cancer*. Lack of sufficient knowledge of modern pain medications among doctors and nurses have been manifested in poor decision-making in treating patients' pain as well as the spread of unfounded beliefs against the use of opioids.

The article also mentions the lack of continuity that exists when a patient moves from the hospital into community care, and how a single patient can often have several physicians addressing his or her case at the same time, with no single clinician overseeing the patient's pain.

Ways in which these and similar barriers can be surmounted are discussed at the article's conclusion. (Redmond K. *Support Care Cancer.* 1997;5:451-456)

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Physicians surveyed on managing cancer pain

Physicians in Canada were recently surveyed on their knowledge and practices in managing cancer pain. Of the 2,686 who responded, 39% were medical or radiation oncologists and 18% were classified as family physicians. The extent of professional education received in the area of palliative care and management of cancer pain was rated as "fair" or "poor" by two-thirds of the responding physicians.

The authors concluded that Canadian medical training programs need to place greater emphasis on pain management. The authors further suggested that surveys of this type, when given periodically, can act as a check on physicians' adherence to official pain management guidelines. (MacDonald N, Findlay HP, Bruera E, Dudgeon D, Kramer J. *J Pain Symptom Manage.* 1997;14:332-342)

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Minority patients' cancer pain inadequately treated

Pain can be a prominent symptom in any person with cancer. Sadly, it has been found that cancer patients who are members of ethnic minorities often receive less adequate treatment for their pain than their nonminority counterparts.

In a recent study of 281 minority patients with cancer, 77% suffered from pain related to their cancer or took pain medication. Forty-one percent of the patients who suffered from pain reported severe pain. Only 35% of minority patients with cancer pain received prescription medications at guideline-recommended dosage strengths, compared with 50% of Caucasian patients. Less adequate pain relief was reported by Hispanic cancer patients in particular.

It is hoped that gaining awareness of this problem will prompt health professionals to improve their attention to controlling pain in minority patients. (Cleeland CS, Gonin R, Baez L, Loehrer P, Pandya KJ. *Ann Intern Med.* 1997;127:813-816)

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Elderly burn victims are shortchanged on pain medication

In a recent study, patients with burns covering an average of 17.2% of their body were divided into three age categories: age 55-65, age 66-75, and age 76-92.

Investigation showed a difference between the amount of opioid prescribed and the amount actually administered. Patients in the youngest group were given significantly more opioid medication during treatment procedures than the minimum prescribed, and patients in the oldest group were given significantly less opioid medication on an as-needed basis than the minimum prescribed. (Honari S, Patterson DR, Gibbons J, Martin-Herz SP, Mann R, Gibran NS, Heimbach DM. *J Burn Care Rehabil.* 1997;18:500-504)

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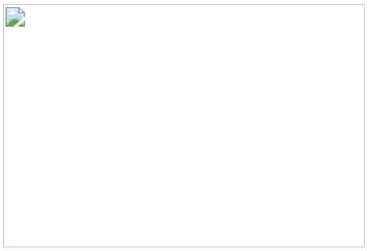
One of Five Adults in Chronic Pain

A recent pain survey confirms what health professionals know: lots of Americans are missing work and missing out on life because of pain.

and missing out on life because of pain.

The "Michigan Pain Study" polled a sample of 1,500 adults in Michigan about the severity of their pain, its treatment, and its impact on their lives.The poll was conducted by the public opinion firm EPIC/MRA and sponsored by the Pain Education Fund of Chelsea (Michigan) Community Hospital.

By generalizing from the sample, the poll estimated that 1.2 million residents of Michigan suffer from chronic pain--about one in five adults.



Of this group, 42% reported that their pain has affected personal and work relationships. Thirty-five percent missed more than 20 days of work and 21% went to the emergency room for pain in the past year. A full 70% said they are still experiencing pain despite treatment.

These results show that chronic pain has far-reaching effects on family and economic life. Says EPIC/MCA pollster Ed Sarpolus:

> "Pain is a major health problem, not only for those who directly suffer from it, but for everyone in Michigan.The costs to society are real, in the form of lost productivity, repeat hospital visits, and ineffective treatment. In addition, the situation is denying people and their families basic quality of life."

Michigan Pain Study Results At-A-Glance

Design Polled sample of 1500 adults, generalized statewide

Extent of Chronic Pain

- 1.2 million adults in Michigan (one out of five) suffer some form of chronic pain

Nature of Chronic Pain

- 40% of people with chronic pain reported that pain is constant and has a major impact on their lives

Workplace Impact

- 35% of people with chronic pain missed more than 20 days of work during the past year
- 28% reported pain severe enough to impair job performance for more than 20 days during the past year

Personal Impact

- 42% of people with chronic pain reported that pain affects relationships with family, spouse, co-workers
- 48% said they "get depressed" about their pain
- 0% said they have thought about committing suicide

Treatment

- 21% of people with chronic pain visited a hospital emergency room an average of four times during the past year
- 70% said they still experience pain despite treatment
- 22% reported that treatment makes pain worse
- 13% reported being denied pain medications, medical devices and/or referrals to other professionals/pain centers
- 22% feel uncomfortable discussing pain with their physicians

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Pain at End of Life Inadequately Treated

Washington, DC--A special panel of the Institute of Medicine has concluded that too many Americans are dying without skillful palliative care and pain control.

According to panel chair Christine Cassel, MD, head of geriatrics at Mt. Sinai-New York, the result is that Americans have come to fear that they will die alone, and that they will die in distress and pain. (Source: *The New York Times,* 6/4/97)

- American emphasis on high-tech cures has caused us to neglect pain management and palliative care for the dying. In trying so hard to save lives, we have become less skilled at helping people as they approach death.
- More medical training in palliative care is necessary
- Changes are needed in laws regulating prescription narcotics and in our attitudes toward narcotic use for pain control. One attitude that especially needs changing is our unreasonable fear about addiction at life's end. As noted by panelist Robert Burt, a professor at Yale Law School, "There is a tension between the need to control illegal drugs and the need for palliative care to control pain...Controls are more rigid than they need to be." (Source: *The New York Times*, 6/4/97)

The panel's report, *Approaching Death: Improving Care at the End of Life,* is available from National Academy Press, 1-800-624-6242.

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https://web.archive.org/web/20040603003006/http://partnersagainstpain.com/index-mp.aspx?sid=7

Key Definitions

pain management

Pain management is the systematic study of clinical and basic science and its application for the reduction of pain and suffering. This newly emerging discipline emphasizes an interdisciplinary approach to treatment, blending tools, techniques and principles taken from a variety of the healing arts to create a holistic paradigm for the reduction of pain and suffering.[1]

acute pain

Also known as warning pain, this pain is the discomfort or signal that alerts you something is wrong in your body. Pain results from any condition that stimulates the body's sensors, such as infections, injuries, hemorrhages, tumors, and metabolic and endocrine problems. Acute pain usually abates as the underlying problem is treated. Early management of acute pain may hasten the recovery of the causative problem and reduce the length of treatment, therefore reducing health care costs.[2]

chronic pain

A pain state which is persistent and in which the underlying cause of the pain cannot be removed or otherwise treated. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease.[3]

addiction

Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.[4]

physical dependence

Physical dependence is a state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood levels of the drug, and/or administration of an antagonist.[4]

tolerance

Tolerance is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time.[4]

pseudoaddiction

Pseudoaddiction is a term which has been used to describe patient behaviors that may occur when pain is undertreated. Patients with unrelieved pain may become focused on obtaining medications, may clock watch, and may otherwise seem inappropriately drug seeking. Even such behaviors as illicit drug use and deception can occur in the patient's efforts to obtain relief. Pseudoaddiction can be distinguished from true addiction in that the behaviors resolve when the pain is effectively treated.[4] Misunderstanding of this phenomenon may lead the clinician to inappropriately stigmatize the patient with the label 'addict'. In the setting of unrelieved pain, the request for increases in drug dose requires careful assessment, renewed efforts to manage pain, and avoidance of stigmatizing labels.[5]

pseudotolerance

Pseudotolerance is the need to increase dosage that is not due to tolerance, but due to other factors such as: disease progression, new disease, increased physical activity, lack of compliance, change in medication, drug interaction, addiction, and deviant behavior. When a once-fixed opioid dose is no longer effective, the above conditions should be reviewed to exclude pseudotolerance.[5]

References:

1. *What is pain management?* Page from American Academy of Pain Management Web site. Available at http://www.aapainmanage.org. Accessed on 1/8/02. **2.** A Brief Guide to Pain Medicine. American Academy of Pain Medicine; Glenview, Illinois, 1996. **3.** *Model Guidelines for the Use of Controlled Substances for the Treatment of Pain.* Federation of State Medical Boards of the United States, Inc. May, 2 1998, Euless, Texas. **4.** *Definitions related to the Use of Opioids for the Treatment of Pain.* A consensus document from the American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine. The American Academy of Pain

Online CE Resources

Pain Management, Lawful Prescribing, and Anti-Diversion Skills and Strategies for Physicians and Pharmacists

More

New Feature

Is It Something Other Than Pain?

Information to help identify patients with opioid abuse problems

More

Resources for Your Patients

- Patient Comfort Assessment Guide
- Home Care of the Hospice Patient
- Managing Cancer Pain

the American Society of Addiction Medicine. The American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine, February 2001. **5.** Cherny NI . Opioid analgesics: Comparative features and prescribing guidelines. *Drugs*. 1996 May;51(5):713-37.

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JCAHO Standards

JCAHO Pain Standards: Accreditation and Pain Management

The pain management guidelines implemented by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in January 2001 mandate the regular assessment of pain and the establishment of policies and procedures that support the appropriate use of pain medication.

In this section you will find educational materials developed by Purdue Pharma to help you comply with the JCAHO pain standards, as well as a listing of comprehensive pain support services.

Below is a brief summary of the issues addressed by the JCAHO pain guidelines, with links to materials to help with compliance:

A. Involve patients in their care:

- Provide statement of patient's rights
- Provide information about pain and pain relief measures

View a sample of materials here

B. Appropriate assessment and management of pain in all patients:

- Plan, support and coordinate assessment and management activities and resources
- Educate staff in proper assessment and management of pain

View a sample of materials here

C. Identification of patients in pain, reassessment and follow-up:

- Educate staff in:
  - Proper pain assessment
  - Barriers to reporting pain
  - Proper use of analgesics

View a sample of materials here

D. Hospital monitoring of patients post-procedure:

- Assess pain when making decisions about discharge in terms of
  - Changes in quality of pain
  - Changes in intensity of pain
  - Response to treatment

View a sample of materials here

E. Teach patients that pain management is part of treatment:

- Offer patients and families instructional material about pain management to meet their ongoing needs
- Provide educational materials that are easy to understand

View a sample of materials here

F. Provide for a continuum of care upon discharge:

- Consider patient's needs upon discharge
- Provide services to help meet those needs

View a sample of materials here

Did you find this information helpful?
Not Helpful ○ 1 ○ 2 ○ 3 ○ 4 ◉ 5 Very Helpful
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Pain Management

Chronic pain sufferers advocate against stigma of prescription pain meds

For chronic pain sufferers, there is a real problem with the abuse of painkillers in the United States. While the number of patients who have a legitimate need for prescription painkillers — 100 million plus — is vastly more than the number of people addicted to painkillers — 11 million — there is a stigma attached to the prescribing, dispensing and utilization of pain medicines.

Advocating for pain patients

Ensuring access to chronic pain medications

Pain therapy and advocacy

The Office of National Drug Control Policy releases the 2014 National Drug Control Strategy

Jul 10, 2014 | By Michael Johnsen

The Office of National Drug Control Policy released the 2014 National Drug Control Strategy, the Obama Administration's primary blueprint for drug policy in the United States.

Purdue Pharma granted priority review designation for abuse-deterrent hydrocodone tablet

Jul 08, 2014 | By Michael Johnsen

Purdue Pharma on Tuesday announced that the Food and Drug Administration has granted priority review designation for the company's once-daily, single-entity hydrocodone bitartrate tablet.

CDC: Opioid prescribing varies widely by state

Jul 02, 2014 | By Michael Johnsen

Health care providers wrote 259 million prescriptions for opioid painkillers in 2012 — many more in some states than in others — according to a Vital Signs report released Tuesday by the Centers for Disease Control and Prevention that highlights the danger of overdose.

PUTTING A FACE ON PAIN MANAGEMENT

Chronic pain sufferer Dennis Kinch pens book to encourage pain community
Dennis Kinch lives by the motto, "Do what you can, when you can." These seven words have carried him through hardships and triumphs. In 2005-2006, they even spearheaded his crusade to walk the entire Route 66 to raise awareness about chronic pain.

Ehlers-Danlos Syndrome patient Ellen Smith serves as advocate for pain relief
Ellen Smith has Ehlers-Danlos Syndrome, a progressive degenerative connective tissue disorder characterized by joint hypermobility, skin extensibility and tissue fragility. Ellen knew from childhood she was unusually flexible and highly mobile, but thought nothing of it.

Gina Libby strives to improve pain medication legislation
At the age of 42, Gina Libby has lived with chronic pain for more than 20 years. Yet it hasn't stopped her from making an impact; she's on the front lines of pain advocacy, using her experience to influence healthcare policy and teach others. As a young girl, Gina was diagnosed with severe scoliosis, or curvature of the spine,

Former radio personality Radene Marie Cook rues 'fail first' treatment plans
For decades, Radene Marie Cook had two complimentary careers: she was a professional actress, dancer and singer, and she enjoyed a 16-year run as an on-air radio personality. But on March 16, 2000, all that changed. While working, her aircraft was hit by a "microburst."

New England regional summit held to address opioid abuse

Jun 20, 2014 | By Antoinette Alexander

In an effort to address opioid drug abuse, governors of five New England states convened for a summit on Monday, the National Association of Boards of Pharmacy stated.

Industry-supported bill on prescription drug diversion passes House committee

Jun 12, 2014 | By Michael Johnsen

The House Energy and Commerce Committee on Tuesday advanced bipartisan legislation sponsored by full committee vice chair Marsha Blackburn to address the nation's growing prescription drug abuse epidemic.

Carex Health Brands launches AccuRelief TENS devices

Jun 12, 2014 | By Michael Johnsen

Carex Health Brands on Thursday introduced AccuRelief Pain Relief Systems, a line of transcutaneous electrical nerve stimulation (TENS) therapy FDA–approved for full-body, over–the–counter use.

Study: Almost half of all narcotic prescriptions written by 5% of opioid prescribers

Jun 10, 2014 | By Michael Johnsen

As many as 40% of U.S. narcotic prescriptions in 2011-2012 were written by only 5% of opioid prescribers, according to a study Express Scripts presented Monday at AcademyHealth's annual research meeting.

FDA approves BDSI's NDA for Bunavail

Jun 09, 2014 | By Ryan Chavis

BioDelivery Sciences International on Monday announced that the Food and Drug Administration approved its new drug application for Bunavail (buprenorphine and naloxone) buccal film (CIII).

FDA accepts NDA for investigational extended-release oral formulation of hydrocodone/APAP

May 29, 2014 | By Michael Johnsen

Depomed on Wednesday announced that the Food and Drug Administration has accepted for filing a new drug application from Mallinckrodt for MNK-155.

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Target bolsters exec team with new hires as it continues to focus on digital efforts
Rite Aid enters fifth Health Alliance partnership

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Poll

Should closely held companies have the right to refuse to provide certain kinds of health care to their employees?

- Yes
- No

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SPECIAL REPORTS

"Otherhood": Women without kids hold buying power

Women today play a dynamic role in society, and brands and marketers including those within the retail pharmacy space are tirelessly working to earn her trust and loyalty, as she often makes most of the healthcare decisions for her family. While reaching "moms" is no doubt important, new research suggests that brands and marketers may be missing a tremendous opportunity among those women who are rewriting the fairy tale. Enter "Otherhood." more ...

IN THIS ISSUE

DSN 6/23/14

DSN takes a closer look at some of the trends playing out within the key beauty categories and sheds some light on the "other" women that brands are neglecting.

New Products

Lake Consumer Products to launch vH essentials PMS Relief Formula
Lake Consumer Products, a subsidiary of Wisconsin Pharmacal Co., on Thursday...

Breg launches brace for sufferers of patella mal-tracking
Breg on Thursday announced the launch of the FreeRunner knee brace with new...

FDA approves Anacor's antifungal solution
Anacor Pharmaceuticals announced that the Food and Drug Administration has...

Kiss Products to launch imPRESS Press-On Manicure collection for back to school
Kiss Products' Broadway Nails brand has created the new impress Press-On...

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FloraTummys is a new probiotic especially made for kids rather than a line extension of the adult probiotic. more ...

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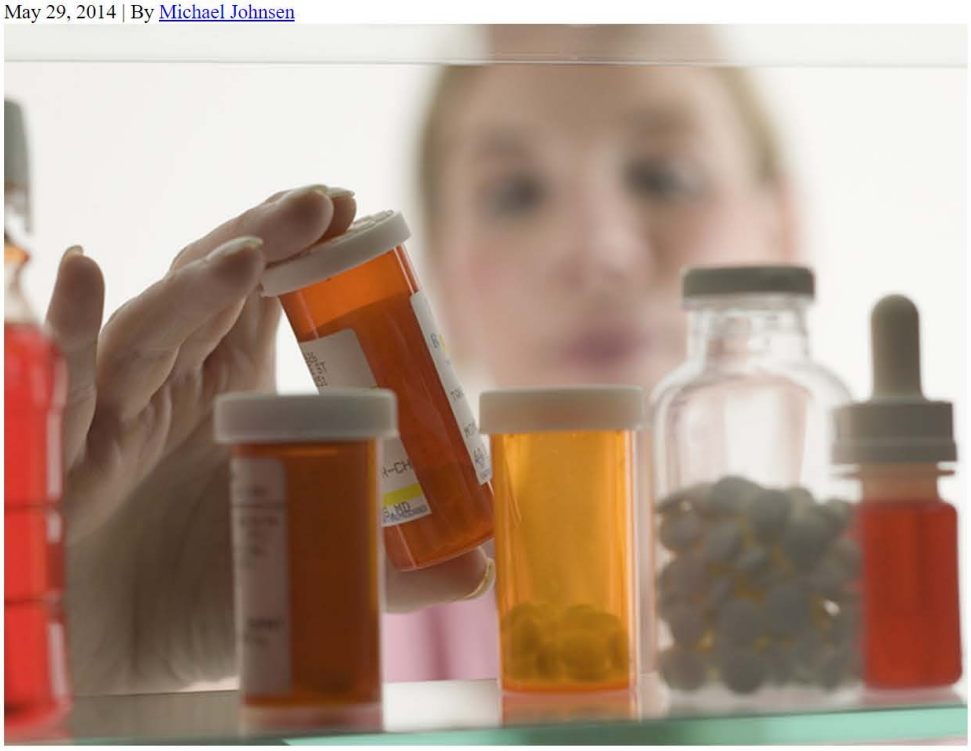
Chronic pain sufferers advocate against stigma of prescription pain meds

May 29, 2014 | By Michael Johnsen



MIDDLETOWN, Conn. — For chronic pain sufferers, there is a real problem with the abuse of painkillers in the United States. While the number of patients who have a legitima need for prescription painkillers — 100 million plus — is vastly more than the number of people addicted to painkillers — 11 million — there is a stigma attached to the prescribi dispensing and utilization of pain medicines. And that stigma has created an, at times, insurmountable hurdle that leaves legitimate patients suffering in silence.

"The person seeking relief from pain is not [suffering] from the same disease as a person who is an addict," said Paul Gileno, president of the U.S. Pain Foundation. "Two separat diseases … [But] it's hard to decipher because right away [people associate] pain patients with that group of addicts."
According to a 2011 report from the Institutes of Medicine, more than 100 million Americans suffer from chronic pain. Of those, 25.8 million suffer chronic pain from diabetes, 2 million suffer chronic pain from a cardiovascular event, and 11.9 million suffer chronic pain from cancer.

Conversely, the number of abusers totals 11 million, according to a May 2014 report in *JAMA Internal Medicine*. Of those, 55.5% are men, 32.1% are between the ages of 18 and 25, and 58.5% make less than $50,000 each year. Only 12% of Americans older than the age of 50 — an age group arguably more closely associated with diabetes, cardiovascular disease

and cancer — abuse painkillers for nonmedical purposes.

“Out of those 11 million who are abusing pain medications, we don’t know that they’re coming out of the 100 million Americans [with chronic pain], because we don’t know if they’re legitimate pain patients at the start,” Gileno said. While there is certain to be some overlap, the 11 million may simply represent addicts who have chosen pain medicines as their conduit to get high.

But the media focus has historically been on the addicts and how to curtail their access to the pain medicines they crave. That creates a real stigma that inhibits access for legitimate patients from doctors to pharmacists to the patients themselves.

“Doctors are limiting prescribing because of the stigma,” Gileno said. “[And] pharmacies are either not carrying products or questioning patients on their prescriptions even though they have a legitimate [need].” The stigma associated with pain medicines even extends to patients, with many patients worried that they may become an addict because they’ve been prescribed an opioid to address their chronic pain. “They listen to the media instead of their doctor,” he said, and forego the appropriate care.

"Out of those 11 million who are abusing pain medications, we don’t know that they’re coming out of the 100 million Americans [with chronic pain].”

According to a recent analysis from the Centers for Disease Control and Prevention, only 27% of the highest risk painkiller users get opioids through their own prescriptions. They are about four times more likely than the average user to buy the drugs from a dealer.

Researchers analyzed data for the years 2008 through 2011 from the Substance Abuse and Mental Health Services Administration’s National Survey on Drug Use and Health. Other major sources of opioids for frequent nonmedical users include obtaining drugs from friends or relatives for free (26%), buying from friends or relatives (23%) or buying from a drug dealer (15%).

In an effort to abate the stigma associated with legitimate use of pain medicines, the U.S. Pain Foundation fields some 200 “Pain Ambassadors” who make up a grassroots education campaign — first, that chronic pain sufferers have both legitimate needs for and significant hurdles in acquiring their pain remedies, and second, that there are market-driven options available, such as abuse-deterrent medicines. “For us, as a patient advocacy group, that’s what we need to do,” Gileno said. “An educated patient is an empowered patient. An empowered patient is a better patient for a doctor because the doctor can actually help them on their journey to get them the answers they need.”

Recommended stories

- Ensuring access to chronic pain medications
- Survey shines spotlight on treatment of pain sufferers by healthcare providers
- DSN shines spotlight on the chronic pain patient

New York's online database of drug prescriptions curtailing 'doctor shopping'

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Rite Aid reports 2.7% lift in Q1 sales; Wellness Stores now make up 29% of chain
CVS Caremark comments on role of Rx, retail clinics in Health Affairs blog

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Over the next 12 months which social media platform will best help grow your business?

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- ○ Pinterest
- ○ YouTube
- ○ Vine
- ○ Instagram
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SPECIAL REPORTS

"Otherhood": Women without kids hold buying power

Women today play a dynamic role in society, and brands and marketers — including those within the retail pharmacy space — are tirelessly working to earn her trust and loyalty, as she often makes most of the healthcare decisions for her family. While reaching “moms” is no doubt important, new research suggests that brands and marketers may be missing a tremendous opportunity among those women who are rewriting the fairy tale. Enter “Otherhood.” more ...

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New Products

Upsher-Smith Laboratories launches Testosterone Gel (1%)
Upsher-Smith Laboratories on Wednesday announced the launch of Testosterone Gel...

BOOM! By Cindy Joseph! launches Boomstick Minis
BOOM! By Cindy Joseph!, which was founded by model and makeup artist Cindy...

Larabar introduces granola line
The makers of Larabar have announced the debut of Renola, a new type of granola...

Murad launches Skin Smoothing Polish
Skin care brand Murad has announced the launch of its new Skin Smoothing Polish...

Featured Product

FLORATUMMYS

FloraTummys is a new probiotic especially made for kids rather than a line extension of the adult probiotic. more ...

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http://web.archive.org/web/20161006094858/http://partnersagainstpain.com/

Click here for selected Important Safety Information regarding extended-release/long-acting opioid products.

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Patients & Caregivers | Healthcare Professionals

- Patients & Caregivers Home
- Measuring Pain
- Tracking Pain
- Caregiver Corner
- Integrative Medicine

Pain. It's not something you need to manage alone. **You have a Partner.**

Caregiver Corner
Pain creates many challenges, not only for the people who suffer from it, but also for those who care for them. Find valuable resources in the Caregiver Cornerstone Program, created especially for family caregivers.

TOOLS & RESOURCES

Use these tools to track your pain and other symptoms for discussion with your healthcare professional.

GO NOW >

COMMUNICATION GUIDE

The Conversation Starts Here

Effective communication is the key to managing pain. Download your free "road map" for productive two-way conversations with your doctor.

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- Tracking Pain
- Caregiver Corner
- Integrative Medicine
- Ask Partners Against Pain®

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- Products Overview
- Pain Management Education Tools
- Health Links
- Contact

Pain management education tools for patient and physician communication.

Our Pain Assessment brochure, with a pain rating scale, can help patients and physicians to evaluate patient pain. Download our Pain Assessment brochure PDF

Our Lidoderm® Information brochure describes how Lidoderm® works to help relieve the pain of Postherpetic Neuralgia. Download our Lidoderm® Information brochure PDF

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Patients - Pain Management Education Tools

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American Pain Society

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Patients - Pain Management Education Tools

Pain management education tools for patient and physician communication.


Understanding Your Pain: Pain Assessment


Understanding Your Pain: Taking Oral Opioid Analgesics


Things You Should Know about the Neuropathic Pain of Postherpetic Neuralgia


Brief Pain Inventory Short Form

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FOR CAREGIVERS

A caregiver is anyone who helps someone with the things they cannot do alone.

You don't have to be a trained professional to be called a caregiver. People who are living with moderate to severe chronic pain often need a caregiver. The type of pain and how serious it is may determine how much help they need.

Understanding moderate to severe chronic pain

It can be hard for someone who does not have moderate to severe chronic pain to understand the effect it can have on a person's life. Familiar activities take much more effort. Tasks that used to be simple become difficult chores. Leisure activities may become impossible. Depending on the type of chronic pain, it can affect:

- Walking
- Driving
- Doing errands like shopping and cleaning
- The ability to work
- Taking part in sports activities

A person with chronic pain may need help with the simplest tasks or may not be able to do them at all. They often rely on a caregiver, like you, for help. They may feel frustrated and dependent when they can't do the things they need or want to do.

The caregiver's role

Everyone's chronic pain has a different effect on their life. Your role as a caregiver will depend on how the person you know is affected and what they want help with. Let the person tell you what help they need. In this way, they can feel as independent as possible while feeling supported by you at the same time.

To learn more about helping someone who is living with moderate to severe chronic pain, please **download our caregiver's guide**.

Download the Brochure
Caregiver's Guide

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OPANA® ER Indication

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PATIENT PROFILE: BILL

Bill has to find a pain medication that allows him to keep working

Hello, my name is Bill and I am a 40 year old construction worker who developed low back pain. I have been on pain treatment for several months for my severe, chronic low back pain, my doctor keeps increasing my current medication but the pain still remains.

It is important that whatever types of pain medication my doctor suggests that I am still able to continue work to support my family.

Are you like Bill? Talk to your doctor to find out if OPANA ER is an appropriate choice for your moderate to severe chronic pain.

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Wanda
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Mike
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Stella
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PATIENT PROFILE: WANDA

Wanda needs to control her pain while feeling comfortable with her medication

Hello, my name is Wanda and I am a 46 year old teacher who has been diagnosed with non-Hodgkin's lymphoma. I had been taking morphine but stopped after talking with my doctor because the side effects were intolerable.

I soon learned that there were other kinds of pain medication beside morphine and that I may respond differently to them. The doctor decided to switch me from morphine to OPANA® ER and within a few days, I started to feel pain relief. I guess one size does not fit all.

The most important thing I learned is that everyone reacts differently to medication. If you find the side effects of your medication to be intolerable, it's up to you to talk to your doctor.

Are you like Wanda? Talk to your doctor to find out if OPANA ER is an appropriate choice for your moderate to severe chronic pain.

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http://web.archive.org/web/20100411062936/http://www.opana.com/patient/opana/profile-stella.aspx

Stella needs improved pain control while managing the risk of interactions with her other medications

Hello, my name is Stella and I am a 68 year old school secretary. Several years ago, I was diagnosed with osteoarthritis in the hip and spine. Although my doctor has prescribed a pain medication, my pain remains severe enough that I may have to retire if I am unable to continue doing my job.

As I have gotten older, my doctor has added different medications to my daily routine, including a pill for high blood pressure, a blood thinner, and an opioid to help manage my pain. When he recently prescribed an anti-depressant for me, he explained something called "drug interactions". Basically, each medication affects my body in a different way. Taking more than one at a time means it is important to consider how one medication might affect another.

Along with the anti-depressant, my doctor switched me to a different opioid for my pain. He said it may help reduce my pain without interfering with the other drugs I am taking.

I appreciate that my doctor explained how everything works. I feel more comfortable taking several medications knowing that I can call my doctor at any time if I have any questions or concerns. That open line of communication is very important to me.

Are you like Stella? Talk to your doctor to find out if OPANA ER is an appropriate choice for your moderate to severe chronic pain.

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Wanda VIEW PROFILE

Mike VIEW PROFILE

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PATIENT PROFILE: MIKE

Mike needs prescription medication to control his moderate to severe chronic pain

Hello, my name is Mike and I am a 53 year old accountant who developed degenerative disc disease from playing football during my younger days. I have been taking over the counter drugs but the pain has progressed. I do physical therapy twice a week to maintain my flexibility and range of motion, but the pain still remains.

Since ibuprofen and physical therapy are not enough, my doctor suggested that he may want to put me on an opioid treatment to help reduce my pain score.

Are you like Mike? Talk to your doctor to find out if OPANA ER is an appropriate choice for your moderate to severe chronic pain.

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Wanda
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Stella
VIEW PROFILE

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Oxymorphone can be abused in a manner similar to other opioid agonists, legal or illicit. This should be considered when prescribing or dispensing OPANA ER in situations where the physician or pharmacist is concerned about an increased risk of misuse, abuse, or diversion.

OPANA ER is an extended-release oral formulation of oxymorphone indicated for the management of moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time.

OPANA ER is NOT intended for use as an as needed analgesic.

OPANA ER TABLETS are to be swallowed whole and are not to be broken, chewed, dissolved, or crushed. Taking broken, chewed, dissolved, or crushed OPANA ER TABLETS leads to rapid release and absorption of a potentially fatal dose of oxymorphone.

Patients must not consume alcoholic beverages, or prescription or nonprescription medications containing alcohol, while on OPANA ER therapy. The co-ingestion of alcohol with OPANA ER may result in increased plasma levels and a potentially fatal overdose of oxymorphone.

- **OPANA ER contains oxymorphone, an opioid agonist and Schedule II controlled substance with an abuse liability similar to morphine and can be abused in a manner similar to other opioid agonists, legal or illicit**
- OPANA ER is **contraindicated** in patients with a known hypersensitivity to oxymorphone hydrochloride, morphine analogs such as codeine, or any of the other ingredients of OPANA ER; in patients with moderate or severe hepatic impairment or in any situation where opioids are **contraindicated** such as: patients with respiratory depression (in the absence of resuscitative equipment or in unmonitored settings), acute or severe bronchial asthma, hypercarbia, and in any patient who has or is suspected of having paralytic ileus
- OPANA ER is not indicated for pain in the immediate post-operative period (the first 12–24 hours following surgery), or if the pain is mild, or not expected to persist for an extended period of time. OPANA ER is only indicated for post-operative use if the patient is already receiving the drug prior to surgery or if the post-operative pain is expected to be moderate or severe and persist for an extended period of time. Physicians should individualize treatment, moving from parenteral to oral analgesics as appropriate (see American Pain Society guidelines)

- Respiratory depression is the chief hazard of OPANA ER, particularly in elderly or debilitated patients. OPANA ER should be administered with extreme caution to patients with conditions accompanied by hypoxia, hypercapnia, or decreased respiratory reserve such as: asthma, chronic obstructive pulmonary disease or cor pulmonale, severe obesity, sleep apnea syndrome, myxedema, kyphoscoliosis, central nervous system (CNS) depression, or coma
- Patients receiving other opioid analgesics, general anesthetics, phenothiazines or other tranquilizers, sedatives, hypnotics, or other CNS depressants (including alcohol) may experience additive effects resulting in respiratory depression, hypotension, profound sedation, or coma
- OPANA ER should be used with caution in elderly and debilitated patients and in patients who are known to be sensitive to CNS depressants, such as those with cardiovascular, pulmonary, renal, or hepatic disease. OPANA ER should be used with caution in patients with mild hepatic impairment and in patients with moderate to severe renal impairment. These patients should be started cautiously with lower doses of OPANA ER while carefully monitoring for side effects
- OPANA ER is not indicated for preemptive analgesia (administration preoperatively for the management of postoperative pain)
- The most common adverse drug reactions (≥10%) in clinical trials for OPANA ER were nausea, constipation, dizziness (excluding vertigo), vomiting, pruritus, somnolence, headache, increased sweating, and sedation
- Patients and their families should be instructed to flush any OPANA ER tablets that are no longer needed

- **Please see full Prescribing Information, including boxed WARNING for OPANA ER**

- Oxymorphone is also available in injectable form. For more information, please see the full prescribing information for **OPANA Injection**
- Vermont prescribers, please see additional information for **OPANA ER**

ENDO PHARMACEUTICALS
CHADDS FORD, PENNSYLVANIA 19317
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To obtain formulary information for OPANA ER and OPANA, **click here**

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Visit www.endopromise.com for more information.

http://web.archive.org/web/20091217010215/http://www.opana.com:80/patient/about-opioids.aspx

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Opioids are one treatment option for moderate to severe pain

Opioids are a type of medicine that are generally prescribed to manage pain, either by themselves or in combination with other treatments. The information contained in this web site does not replace talking with your healthcare provider about your pain treament options including medication.

What is a long-acting opioid?

Long-acting opioids are a type of pain medicine used for moderate to severe chronic pain that lasts most of the day. They are sometimes called "controlled-release" or "extended-release" because the medicine is gradually released into the body over an 8-24 hour period or longer. Long-acting opioids are usually taken at regularly scheduled times, such as every 12 hours. OPANA® ER is an example of a long-acting opioid.

How do long-acting opioids differ from short-acting opioids?

Compared to long-acting opioids, short-acting opioids are primarily used to treat acute pain and are taken as needed. Short-acting opioids may be used alone or combined with opioid or non-opioid analgesics. OPANA® is an example of a short-acting opioid.

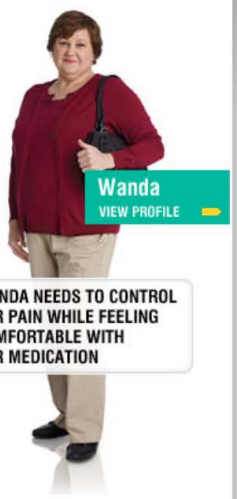
What is the risk of becoming addicted to a long-acting opioid?

Addiction is defined as compulsive drug seeking that is beyond a person's voluntary control even it if may cause harm. Most doctors who treat patients with pain agree that patients treated with prolonged opioid medicines usually do not become addicted. Physical dependence, which is different from addiction, may develop when taking opioids for pain relief for a long time. This means that your body adapts to the drug and you will have withdrawal symptoms if the medicine is stopped or decreased suddenly. Taking opioids for pain relief is NOT addiction.

To learn more about opioids, please download our brochure, **Information on Taking a Long-Acting Opioid**.

Download the Brochure
Taking Long-Acting Opioids

English
Русский
Español
中文



OPANA® and OPANA® ER Indications

OPANA

- OPANA is indicated for the relief of moderate to severe acute pain where the use of an opioid is appropriate

OPANA ER

- OPANA ER is indicated for the relief of moderate to severe pain in patients requiring continuous, around-the-clock opioid treatment for an extended period of time
- OPANA ER is NOT intended for use as an as needed analgesic
- OPANA ER is not indicated for pain in the immediate post-operative period (12-24 hours following surgery) for patients not previously taking opioids because of the risk of oversedation and respiratory depression requiring reversal with opioid antagonists
- OPANA ER is not indicated for pain in the post-operative period if the pain is mild or not expected to persist for an extended period of time

OPANA and OPANA ER Important Safety Information

OPANA ER has a boxed warning as follows:

WARNING: OPANA ER contains oxymorphone, which is a morphine-like opioid agonist and a Schedule II controlled substance, with an abuse liability similar to other opioid analgesics.

Oxymorphone can be abused in a manner similar to other opioid agonists, legal or illicit. This should be considered when prescribing or dispensing OPANA ER in situations where the physician or pharmacist is concerned about an increased risk of misuse, abuse, or diversion.

OPANA ER is an extended-release oral formulation of oxymorphone indicated for the management of moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time.

OPANA ER is NOT intended for use as an as needed analgesic.

OPANA ER TABLETS are to be swallowed whole and are not to be broken, chewed, dissolved, or crushed. Taking broken, chewed, dissolved, or crushed OPANA ER TABLETS leads to rapid release and absorption of a potentially fatal dose of oxymorphone.

Patients must not consume alcoholic beverages, or prescription or nonprescription medications containing alcohol, while on OPANA ER therapy. The co-ingestion of alcohol with OPANA ER may result in increased plasma levels and a potentially fatal overdose of oxymorphone.

- **OPANA, like OPANA ER, contains oxymorphone, an opioid agonist and Schedule II controlled substance with an abuse liability similar to morphine and can be abused in a manner similar to other opioid agonists, legal or illicit**
- OPANA and OPANA ER are **contraindicated** in patients with a known hypersensitivity to oxymorphone hydrochloride, morphine analogs such as codeine, or any of the other ingredients of OPANA and OPANA ER; in patients with moderate or severe hepatic impairment or in any situation where opioids are **contraindicated** such as: patients with respiratory depression (in the absence of resuscitative equipment or in unmonitored settings), acute or severe bronchial asthma, hypercarbia, and in any patient who has or is suspected of having paralytic ileus
- OPANA ER is not indicated for pain in the immediate post-operative period (the first 12–24 hours following surgery), or if the pain is mild, or not expected to persist for an extended period of time. OPANA ER is only indicated for post-operative use if the patient is already receiving the drug prior to surgery or if the post-operative pain is expected to be moderate or severe and persist for an extended period of time. Physicians should individualize treatment, moving from parenteral to oral analgesics as appropriate (see American Pain Society guidelines)
- Respiratory depression is the chief hazard of OPANA and OPANA ER, particularly in elderly or debilitated patients. OPANA and OPANA ER should be administered with extreme caution to patients with conditions accompanied by hypoxia, hypercapnia, or decreased respiratory reserve such as: asthma, chronic obstructive pulmonary disease or cor pulmonale, severe obesity, sleep apnea syndrome, myxedema, kyphoscoliosis, central nervous system (CNS) depression, or coma
- Patients receiving other opioid analgesics, general anesthetics, phenothiazines or other tranquilizers, sedatives, hypnotics, or other CNS depressants (including alcohol) may experience additive effects resulting in respiratory depression, hypotension, profound sedation, or coma
- OPANA and OPANA ER should be used with caution in elderly and debilitated patients and in patients who are known to be sensitive to CNS depressants, such as those with cardiovascular, pulmonary, renal, or hepatic disease. OPANA and OPANA ER should be used with caution in patients with mild hepatic impairment and in patients with moderate to severe renal impairment. These patients should be started cautiously with lower doses of OPANA or OPANA ER while carefully monitoring for side effects
- OPANA ER is not indicated for preemptive analgesia (administration preoperatively for the management of postoperative pain)
- The most common adverse drug reactions (≥10%) reported at least once by patients treated with OPANA in the clinical trials were nausea and pyrexia
- The most common adverse drug reactions (≥10%) in clinical trials for OPANA ER were nausea, constipation, dizziness (excluding vertigo), vomiting, pruritus, somnolence, headache, increased sweating, and sedation
- Patients and their families should be instructed to flush any OPANA and OPANA ER tablets that are no longer needed

- **Please see full Prescribing Information for OPANA**

- **Please see full Prescribing Information, including boxed WARNING for OPANA ER**

- Oxymorphone is also available in injectable form. For more information, please see the full prescribing information for **OPANA Injection**
- Vermont prescribers, please see additional information for **OPANA** and **OPANA ER**

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The Partnership for Responsible Opioid Management through Information, Support, and Education

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The PROMISE™ initiative consists of practical clinical information, educational resources, and patient support tools—all focused on ensuring the appropriate use of opioid analgesics and minimizing the inherent risks of misuse, abuse, and diversion of these medications.

As a leader in the development and distribution of schedule II opioid analgesic medications, Endo Pharmaceuticals is:

Committed to providing safe and effective opioid analgesic treatment options for patients suffering from moderate-to-severe pain.

Dedicated to improving patient care and the appropriate clinical use of opioid analgesics through access to treatment and a proactive approach to managing the potential risks inherent in opioid therapy.

Responsive with programs designed to promote appropriate and responsible use of opioid analgesic medications and minimize the risks of misuse, abuse, and diversion.

PROMISE™ is one more example of Endo's ongoing collaboration with patients, caregivers, health care professionals and government agencies to ensure patients have appropriate medical access to opioid analgesics for pain relief while also having the means to minimize the potential inherent risks of these medications.

For more information about PROMISE™, please call Bill Newbould, VP of Corporate Communications, at Endo at 1-800-892-6131

http://web.archive.org/web/20120110124347/http://www.endopromise.com:80/

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Strengthening Patient Care With Educational Resources and Support

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http://web.archive.org/web/20081209003305/http://www.endopromise.com/education.aspx

PROMISE™ Initiative
Strengthening Patient Care With Educational Resources and Support

ENDO PHARMACEUTICALS
Leading the Way to Appropriate and Responsible Use of Opioid Analgesics

PROMISE™

Educational Support

PROMISE™ offers clinicians, pharmacists, and patients a wide range of valuable information and continuing education (CE) opportunities through numerous forums and venues:

- **National Initiative on Pain Control,** supported by an educational grant from Endo, provides accredited continuing education via multiple learning modalities including:
  - Interactive case-based workshops
  - Live audioconferences
  - Live Webcasts and on-demand Web-based programs
  - Regional symposia
  - CE-accredited newsletters
- **Endo supports educational initiatives** through professional societies, including:
  - Academy of Managed Care Pharmacy
  - American Academy of Family Physicians
  - American Academy of Pain Management
  - American Academy of Pain Medicine
  - American College of Physicians
  - American Pain Society
  - American Society of Pain Management Nurses
  - Multinational Association for Supportive Care in Cancer
  - Oncology Nursing Society
- **Department of Health and Human Services Office of Women's Health Initiative** offers accredited CE materials addressing the responsible use of opioids for chronic pain
- **Endo supports innovative independent educational Web sites,** including:
  - PainEDU.org—an award-winning educational Web site for healthcare professionals who treat patients with pain
  - PainKnowledge.org—an online resource for healthcare professionals that supports optimizing the management of patients with pain
  - painACTION.com—a consumer and provider Web site that informs and supports the care of patients with chronic pain
- **Endo provides ongoing support** to two innovative national traineeships designed for physicians, nurses, and pharmacists in training:
  - American Pain Society Residents' Course—a two-day course for medical, nursing, and pharmacy residents that focuses on the principles of pain assessment and management
  - American Society of Health System Pharmacists Traineeship—an intensive self-study and experiential traineeship for pharmacists who provide specialized services for patients in pain

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http://web.archive.org/web/20081208081959/http://www.endopromise.com/painmanage.aspx

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Pain Management Resource Kit

PROMISE™ provides access to practical tools for the healthcare professional and the patient designed to support the appropriate and responsible use of opioid analgesic medications.

- **Pain Assessment Inventory**—provides assessment of severity and quality of a patient's pain
- **SOAPP®**—Screener and Opioid Assessment for Patient's with Pain
  - — Patient self-report tool supported by the National Institute on Drug Abuse (NIDA) and an educational grant from Endo that helps clinicians assess the relative risk of medication misuse so patients can be managed appropriately
- **Tamper-evident prescription pads** that help guard against alteration, forgery, and counterfeiting
- **Patient/Physician Treatment Agreement** which can be used by clinicians to document the conditions under which a patient will be treated with opiods
- ***A Clinical Guide to Opioid Analgesia* handbook**
- **Patient and Caregiver Educational Materials:**
  - — Understanding Your Pain: Taking Oral Opioid Analgesics
  - — Understanding Your Pain: Using a Pain Rating Scale

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PROMISE™

Risk Minimization Action Plan (RiskMAP) Overview

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The Endo risk minimization action plan was developed to reduce and control the potential risks of misuse, abuse, and diversion associated with opioid analgesics. It focuses on appropriate drug labeling and promotion, controls on distribution, proactive pharmacovigilance, extensive education of healthcare professionals, patients and sales personnel, and support of clinically meaningful research. Key elements include:

- **FDA-approved product labelling and responsible promotion:** All informational and promotional materials associated with our product(s) undergo stringent reviews to ensure that they meet the guidelines identified by the FDA.
- **Diversion control in the supply chain:** Endo's extensive opioid analgesic experience and established procedures help ensure control of distribution.
- **Surveillance:** To identify and track regional misuse and abuse trends, Endo utilizes proactive pharmacovigilance and a variety of sources for data gathering, including the new **National Addictions Vigilance Intervention and Prevention Program (NAVIPPRO)** monitoring system. This system, developed by Inflexxion, provides real-time data to serve as an early warning system for misuse and abuse across the country.
- **Education Intervention:** Educational intervention initiatives help healthcare professionals attempt to reach the highest-risk age groups, including teens and young adults. Support from Endo will help myStudentBody.com provide key drug education, helping to prevent abuse and misuse of prescription medications among college students.
- **Employee and sales force training:** All relevant company employees, especially professional sales personnel, are trained in the medical issues associated with opioid analgesics, the relevant regulations and laws, the appropriate use of opioid medications, and risk management principles and responsibilities.

For more information about PROMISE™, please call Bill Newbould, VP of Corporate Communications, at Endo at 1-800-892-6131

http://web.archive.org/web/20080509121859/http://www.endopromise.com/relatedlinks.aspx

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Related Links

The following links will direct you away from the PROMISE™ website. Endo Pharmaceuticals is not responsible for the content on these sites and assumes no liability for the information they provide. Please report any broken links to webmaster@endo.com.

Pain Management Organizations

- Academy of Managed Care Pharmacy
- American Pain Society
- American Society of Health System Pharmacists
- American Academy of Family Physicians
- American Academy of Pain Management
- American Academy of Pain Medicine
- American College of Physicians
- American Medical Association
- American Society for Pain Management Nursing
- American Society of Pain Educators
- Department of Health and Human Services Office of Women's Health Initiative
- Multinational Association for Supportive Care in Cancer
- Oncology Nursing Society

Pain Management Websites

- painACTION.com
- PainEDU.org
- StopPain.org

Resource Tools

- Database of State Laws, Regulations, and Other Official Governmental Policies
- Pain Assessment Inventory
- Patient/Physician Treatment Agreement
- SOAPP®
- PainKnowledge.org

Other Related Websites

- Inflexxion.org
- myStudentBody.com

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http://web.archive.org/web/20141008052725/http://www.opana.com/patient/about-opioids/about-opioids.aspx

PRINT

About opioids

Opioids are a type of medicine that is generally prescribed to manage pain, either by itself or in combination with other treatments. The information contained in this website does not replace talking with your healthcare provider about your pain treatment options, including medication. **For information specific to OPANA® ER, click here.**

- What is a long-acting opioid?
- How do long-acting opioids differ from short-acting opioids?
- Are long-acting opioids addictive?
- How should I take my long-acting pain relief medicine to get the best pain relief?
- What should I do if I miss a dose?
- What happens if I take too much medicine?
- What are the common symptoms seen following an overdose?
- Can I drink wine or other alcoholic beverages while taking long-acting opioids?
- What side effects will I have during treatment with a long-acting opioid?
- Will I be able to drive and/or operate heavy machinery?
- I take several other medicines to treat other conditions. Is there a risk of an interaction between my pain medicine and these other drugs?

INDICATION

OPANA® ER is an opioid agonist indicated for the relief of moderate to severe pain in patients requiring continuous around-the-clock opioid treatment for an extended period of time.

IMPORTANT SAFETY INFORMATION

WARNING: ABUSE POTENTIAL, LIFE-THREATENING RESPIRATORY DEPRESSION, ACCIDENTAL EXPOSURE, and INTERACTION WITH ALCOHOL

Abuse Potential

OPANA® ER contains oxymorphone, an opioid agonist and Schedule II controlled substance with an abuse liability similar to other opioid agonists, legal or illicit. Assess each patient's risk for opioid abuse or addiction prior to prescribing OPANA® ER. The risk for opioid abuse is increased in patients with a personal or family history of substance abuse (including drug or alcohol abuse or addiction) or mental illness (e.g., major depressive disorder). Routinely monitor all patients receiving OPANA® ER for signs of misuse, abuse, and addiction during treatment.

Life-threatening Respiratory Depression

Respiratory depression, including fatal cases, may occur with use of OPANA® ER,

MORE SAFETY INFO

IMPORTANT SAFETY INFORMATION

WARNING: ABUSE POTENTIAL, LIFE-THREATENING RESPIRATORY DEPRESSION, ACCIDENTAL EXPOSURE, and INTERACTION WITH ALCOHOL

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OPANA® ER contains oxymorphone, an opioid agonist and Schedule II controlled substance with an abuse liability similar to other opioid agonists, legal or illicit. Assess each patient's risk for opioid abuse or addiction prior to prescribing OPANA® ER. The risk for opioid abuse is increased in patients with a personal or family history of substance abuse (including drug or alcohol abuse or addiction) or mental illness (e.g., major depressive disorder). Routinely monitor all patients receiving OPANA® ER for signs of misuse, abuse, and addiction during treatment.

Life-threatening Respiratory Depression

Respiratory depression, including fatal cases, may occur with use of OPANA® ER, even when the drug has been used as recommended and not misused or abused. Proper dosing and titration are essential and OPANA® ER should only be prescribed by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain. Monitor for respiratory depression, especially during initiation of OPANA® ER or following a dose increase. Instruct patients to swallow OPANA® ER tablets whole. Crushing, dissolving, or chewing OPANA® ER can cause rapid release and absorption of a potentially fatal dose of oxymorphone.

Accidental Exposure

Accidental ingestion of OPANA® ER, especially in children, can result in a fatal overdose of oxymorphone.

Interaction with Alcohol

The co-ingestion of alcohol with OPANA® ER may result in an increase of plasma levels and potentially fatal overdose of oxymorphone. Instruct patients not to consume alcoholic beverages or use prescription or non-prescription products that contain alcohol while on OPANA® ER.

LIMITATIONS OF USAGE

OPANA® ER is not intended for use as an as-needed (PRN) analgesic; for pain that is mild or not expected to persist for an extended period of time; for acute pain; for postoperative pain unless the patient is already receiving chronic opioid therapy prior to surgery or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time.

CONTRAINDICATIONS

OPANA ER is contraindicated in patients with significant respiratory depression; acute or severe bronchial asthma or hypercarbia; known or suspected paralytic ileus; moderate and severe hepatic impairment; hypersensitivity (e.g. anaphylaxis) to oxymorphone, any other ingredients in OPANA ER, or to morphine analogs such as codeine; and conditions that increase the risk of life-threatening respiratory depression.

WARNINGS AND PRECAUTIONS

- Respiratory depression is the primary risk of OPANA ER. Respiratory depression, if not immediately recognized and treated, may lead to respiratory arrest and death. Management of respiratory depression may include close observation, supportive measures, and use of opioid antagonists, depending on the patient's clinical status.
- While serious, life-threatening, or fatal respiratory depression can occur at any time during the use of OPANA ER, the risk is greatest during the initiation of therapy or following a dose increase. Closely monitor patients for respiratory depression when initiating therapy with OPANA ER, following dose increases, and when OPANA ER is given concomitantly with other drugs that depress respiration. Respiratory depression is more likely to occur in elderly, cachectic, or debilitated patients as they may have altered pharmacokinetics due to poor fat stores, muscle wasting, or altered clearance compared to younger, healthier patients.
- Monitor patients for respiratory depression who have significant chronic obstructive pulmonary disease or cor pulmonale, and patients having a substantially decreased respiratory reserve, hypoxia, hypercapnia, or pre-existing respiratory depression, particularly when initiating therapy and titrating with OPANA ER, as in these patients, even usual therapeutic doses of OPANA ER may decrease respiratory drive to the point of apnea. Consider the use of alternative non-opioid analgesics in these patients if possible.
- Hypotension, profound sedation, coma, or respiratory depression may result if OPANA ER is used concomitantly with other CNS depressants (e.g., sedatives, anxiolytics, hypnotics, neuroleptics, other opioids). Additionally, consider the patient's use, if any, of alcohol or illicit drugs that cause CNS depression. If OPANA ER therapy is to be initiated in a patient taking a CNS depressant, start with a lower OPANA ER dose than usual and monitor patients for signs of hypotension, sedation and respiratory depression and consider using a lower dose of the concomitant CNS depressant.
- There is an increased risk in patients whose ability to maintain blood pressure has already been compromised by a reduced blood volume or concurrent administration of certain CNS depressant drugs (e.g. phenothiazines or general anesthetics). Monitor these patients for signs of hypotension after initiating or titrating the dose of OPANA ER.
- Monitor patients taking OPANA ER who may be susceptible to the intracranial effects of CO_2 retention (e.g., those with evidence of increased intracranial pressure or brain tumors) for signs of sedation and respiratory depression, particularly when initiating therapy with OPANA ER. Opioids may obscure the clinical course in a patient with a head injury.
- Avoid the use of OPANA ER in patients with circulatory shock; with impaired consciousness or coma; or with GI obstruction.
- The oxymorphone in OPANA ER may cause spasm of the sphincter of Oddi. Monitor patients with biliary tract disease, including acute pancreatitis, for worsening symptoms.
- The oxymorphone in OPANA ER may aggravate convulsions in patients with convulsive disorders, and may induce or aggravate seizures in some clinical settings. Monitor patients with a history of seizure disorders for worsened seizure control during OPANA ER therapy.
- Do not abruptly discontinue OPANA ER. If OPANA ER is abruptly discontinued in a physically-dependent patient, an abstinence syndrome may occur. Use a gradual downward titration of the dose every two to four days to prevent signs and symptoms of withdrawal.
- Infants born to mothers physically dependent on opioids will also be physically dependent and may exhibit respiratory difficulties and withdrawal symptoms.
- Chronic maternal use of oxymorphone during pregnancy can affect the fetus with subsequent withdrawal signs. Neonatal opioid withdrawal syndrome, unlike opioid withdrawal syndrome in adults, may be life-threatening and should be treated according to protocols developed by neonatology experts.
- OPANA ER is not recommended during labor and delivery, pregnancy, or nursing.
- OPANA ER may impair the mental or physical abilities needed to perform potentially hazardous activities such as driving a car or operating machinery. Warn patients not to drive or operate dangerous machinery unless they are tolerant to the effects of OPANA ER and know how they will react to the medication.
- Patients 65 years of age or older, patients with mild hepatic impairment, and patients with moderate to severe renal impairment have an increase in oxymorphone bioavailability. For these patients on prior opioid therapy, start at 50% of the starting dose for a younger patient or a patient with normal hepatic or renal function and titrate slowly and monitor closely for respiratory and central nervous system depression.
- In opioid-naïve patients initiate OPANA ER using the 5 mg dose and monitor closely for respiratory and central nervous system depression.
- OPANA ER can be abused and is subject to criminal diversion. The high drug content in extended release formulations adds to the risk of adverse outcomes from abuse and misuse. Proper assessment of the patient, proper prescribing practices, periodic re-evaluation of therapy, and proper dispensing and storage are appropriate measures that help to reduce abuse of opioid drugs. Careful record-keeping of prescribing information, including quantity, frequency, and renewal requests as required by state law, is strongly advised.
- OPANA ER is administered at a frequency of twice daily (every 12 hours). Administer on an empty stomach, at least 1 hour prior to or 2 hours after eating.

Risks Specific to Abuse of OPANA ER

- OPANA ER is for oral use only. Abuse of OPANA ER poses a risk of overdose and death. This risk is increased with concurrent abuse of OPANA ER with alcohol and other substances. OPANA ER tablets must be taken whole, one tablet at a time, with enough water to ensure complete swallowing immediately after placing in the mouth. Taking cut, broken, chewed, crushed, or dissolved OPANA ER enhances drug release and increases the risk of overdose and death.

ADVERSE REACTIONS

- Adverse reactions reported at (≥2%) in placebo-controlled trials were: nausea, constipation, dizziness, somnolence, vomiting, pruritus, headache, sweating increased, dry mouth, sedation, diarrhea, insomnia, fatigue, appetite decreased, and abdominal pain.
- In clinical trials there were several adverse events that were more frequently observed in subjects 65 and over compared to younger subjects. These adverse events included dizziness, somnolence, confusion, and nausea.
- Post-marketing Experience - The following adverse reactions have been identified during post approval use of OPANA ER. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure. Nervous system disorder: amnesia, convulsion, memory impairment.

DRUG INTERACTIONS

- Concurrent use of OPANA ER and other CNS depressants including sedatives, hypnotics, tranquilizers, general anesthetics, phenothiazines, other opioids, and alcohol can increase the risk of respiratory depression, hypotension, profound sedation, or coma. Monitor patients receiving CNS depressants and OPANA ER for signs of respiratory depression and hypotension. When such combined therapy is contemplated, reduce the initial dose of one or both agents.
- Mixed agonist/antagonist analgesics (i.e., pentazocine, nalbuphine, butorphanol, or buprenorphine) may reduce the analgesic effect of OPANA ER or may precipitate withdrawal symptoms in these patients. Avoid the use of mixed agonist/antagonist analgesics in patients receiving OPANA ER.
- Cimetidine can potentiate opioid-induced respiratory depression. Monitor patients for respiratory depression when OPANA ER and cimetidine are used concurrently.
- Anticholinergics or other medications with anticholinergic activity when used concurrently with opioid analgesics may result in increased risk of urinary retention and/or severe constipation, which may lead to paralytic ileus. Monitor patients for signs of respiratory and central nervous system depression when OPANA ER is used concurrently with anticholinergic drugs.

Please see full Prescribing Information, including boxed WARNING and Medication Guide for OPANA® ER.

Oxymorphone is also available in immediate release tablets and injectable form. For more information, please see full Prescribing Information for **OPANA® Tablets** and **OPANA® Injection**.

Vermont prescribers, please see additional information for **OPANA® ER**.

Rx Only

http://web.archive.org/web/20141008052720/http://www.opana.com/patient/about-opana-er/about-opana-er.aspx

About OPANA® ER

A treatment option for moderate to severe chronic pain

The challenges of treating chronic pain are complex. OPANA® ER has been developed to help manage many of those challenges. **We recommend you read the following important information before you start taking OPANA® ER.** This information does not take the place of talking with your healthcare provider about your medical condition or your treatment. Be sure to share this important information with members of your household or other caregivers.

For a complete list of questions and precautions for OPANA ER, please review the full Prescribing Information, including its boxed WARNING and Medication Guide.

IMPORTANT: Keep OPANA® ER in a safe place away from children. Accidental use by a child is a medical emergency and can result in death. If a child accidentally takes OPANA ER, get emergency help right away.

- What is the most important information I should know about OPANA® ER?
- What is OPANA® ER?
- Who should not take OPANA® ER?
- What should I tell my healthcare provider before starting OPANA® ER?
- How should I take OPANA® ER?
- What should I avoid while taking OPANA® ER?
- What are the possible side effects of OPANA® ER?
- How should I store OPANA® ER?
- General information about OPANA® ER
- What are the ingredients in OPANA® ER?

INDICATION

OPANA® ER is an opioid agonist indicated for the relief of moderate to severe pain in patients requiring continuous around-the-clock opioid treatment for an extended period of time.

IMPORTANT SAFETY INFORMATION

WARNING: ABUSE POTENTIAL, LIFE-THREATENING RESPIRATORY DEPRESSION, ACCIDENTAL EXPOSURE, and INTERACTION WITH ALCOHOL

Abuse Potential

OPANA® ER contains oxymorphone, an opioid agonist and Schedule II controlled substance with an abuse liability similar to other opioid agonists, legal or illicit. Assess each patient's risk for opioid abuse or addiction prior to prescribing OPANA® ER. The risk for opioid abuse is increased in patients with a personal or family history of substance abuse (including drug or alcohol abuse or addiction) or mental illness (e.g., major depressive disorder). Routinely monitor all patients receiving OPANA® ER for signs of misuse, abuse, and addiction during treatment.

Life-threatening Respiratory Depression

Respiratory depression, including fatal cases, may occur with use of OPANA®

MORE SAFETY INFO

IMPORTANT SAFETY INFORMATION

WARNING: ABUSE POTENTIAL, LIFE-THREATENING RESPIRATORY DEPRESSION, ACCIDENTAL EXPOSURE, and INTERACTION WITH ALCOHOL

Abuse Potential

OPANA® ER contains oxymorphone, an opioid agonist and Schedule II controlled substance with an abuse liability similar to other opioid agonists, legal or illicit. Assess each patient's risk for opioid abuse or addiction prior to prescribing OPANA® ER. The risk for opioid abuse is increased in patients with a personal or family history of substance abuse (including drug or alcohol abuse or addiction) or mental illness (e.g., major depressive disorder). Routinely monitor all patients receiving OPANA® ER for signs of misuse, abuse, and addiction during treatment.

Life-threatening Respiratory Depression

Respiratory depression, including fatal cases, may occur with use of OPANA® ER, even when the drug has been used as recommended and not misused or abused. Proper dosing and titration are essential and OPANA® ER should only be prescribed by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain. Monitor for respiratory depression, especially during initiation of OPANA® ER or following a dose increase. Instruct patients to swallow OPANA® ER tablets whole. Crushing, dissolving, or chewing OPANA® ER can cause rapid release and absorption of a potentially fatal dose of oxymorphone.

Accidental Exposure

Accidental ingestion of OPANA® ER, especially in children, can result in a fatal overdose of oxymorphone.

Interaction with Alcohol

The co-ingestion of alcohol with OPANA® ER may result in an increase of plasma levels and potentially fatal overdose of oxymorphone. Instruct patients not to consume alcoholic beverages or use prescription or non-prescription products that contain alcohol while on OPANA® ER.

LIMITATIONS OF USAGE

OPANA® ER is not intended for use as an as-needed (PRN) analgesic; for pain that is mild or not expected to persist for an extended period of time; for acute pain; for postoperative pain unless the patient is already receiving chronic opioid therapy prior to surgery or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time.

CONTRAINDICATIONS

OPANA ER is contraindicated in patients with significant respiratory depression; acute or severe bronchial asthma or hypercarbia; known or suspected paralytic ileus; moderate and severe hepatic impairment; hypersensitivity (e.g. anaphylaxis) to oxymorphone, any other ingredients in OPANA ER, or to morphine analogs such as codeine; and conditions that increase the risk of life-threatening respiratory depression.

WARNINGS AND PRECAUTIONS

- Respiratory depression is the primary risk of OPANA ER. Respiratory depression, if not immediately recognized and treated, may lead to respiratory arrest and death. Management of respiratory depression may include close observation, supportive measures, and use of opioid antagonists, depending on the patient's clinical status.
- While serious, life-threatening, or fatal respiratory depression can occur at any time during the use of OPANA ER, the risk is greatest during the initiation of therapy or following a dose increase. Closely monitor patients for respiratory depression when initiating therapy with OPANA ER, following dose increases, and when OPANA ER is given concomitantly with other drugs that depress respiration. Respiratory depression is more likely to occur in elderly, cachectic, or debilitated patients as they may have altered pharmacokinetics due to poor fat stores, muscle wasting, or altered clearance compared to younger, healthier patients.
- Monitor patients for respiratory depression who have significant chronic obstructive pulmonary disease or cor pulmonale, and patients having a substantially decreased respiratory reserve, hypoxia, hypercapnia, or pre-existing respiratory depression, particularly when initiating therapy and titrating with OPANA ER, as in these patients, even usual therapeutic doses of OPANA ER may decrease respiratory drive to the point of apnea. Consider the use of alternative non-opioid analgesics in these patients if possible.
- Hypotension, profound sedation, coma, or respiratory depression may result if OPANA ER is used concomitantly with other CNS depressants (e.g., sedatives, anxiolytics, hypnotics, neuroleptics, other opioids). Additionally, consider the patient's use, if any, of alcohol or illicit drugs that cause CNS depression. If OPANA ER therapy is to be initiated in a patient taking a CNS depressant, start with a lower OPANA ER dose than usual and monitor patients for signs of hypotension, sedation and respiratory depression and consider using a lower dose of the concomitant CNS depressant.
- There is an increased risk in patients whose ability to maintain blood pressure has already been compromised by a reduced blood volume or concurrent administration of certain CNS depressant drugs (e.g. phenothiazines or general anesthetics). Monitor these patients for signs of hypotension after initiating or titrating the dose of OPANA ER.
- Monitor patients taking OPANA ER who may be susceptible to the intracranial effects of CO_2 retention (e.g., those with evidence of increased intracranial pressure or brain tumors) for signs of sedation and respiratory depression, particularly when initiating therapy with OPANA ER. Opioids may obscure the clinical course in a patient with a head injury.
- Avoid the use of OPANA ER in patients with circulatory shock; with impaired consciousness or coma; or with GI obstruction.
- The oxymorphone in OPANA ER may cause spasm of the sphincter of Oddi. Monitor patients with biliary tract disease, including acute pancreatitis, for worsening symptoms.
- The oxymorphone in OPANA ER may aggravate convulsions in patients with convulsive disorders, and may induce or aggravate seizures in some clinical settings. Monitor patients with a history of seizure disorders for worsened seizure control during OPANA ER therapy.
- Do not abruptly discontinue OPANA ER. If OPANA ER is abruptly discontinued in a physically-dependent patient, an abstinence syndrome may occur. Use a gradual downward titration of the dose every two to four days to prevent signs and symptoms of withdrawal.
- Infants born to mothers physically dependent on opioids will also be physically dependent and may exhibit respiratory difficulties and withdrawal symptoms.
- Chronic maternal use of oxymorphone during pregnancy can affect the fetus with subsequent withdrawal signs. Neonatal opioid withdrawal syndrome, unlike opioid withdrawal syndrome in adults, may be life-threatening and should be treated according to protocols developed by neonatology experts.
- OPANA ER is not recommended during labor and delivery, pregnancy, or nursing.
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- In opioid-naïve patients initiate OPANA ER using the 5 mg dose and monitor closely for respiratory and central nervous system depression.
- OPANA ER can be abused and is subject to criminal diversion. The high drug content in extended release formulations adds to the risk of adverse outcomes from abuse and misuse. Proper assessment of the patient, proper prescribing practices, periodic re-evaluation of therapy, and proper dispensing and storage are appropriate measures that help to reduce abuse of opioid drugs. Careful record-keeping of prescribing information, including quantity, frequency, and renewal requests as required by state law, is strongly advised.
- OPANA ER is administered at a frequency of twice daily (every 12 hours). Administer on an empty stomach, at least 1 hour prior to or 2 hours after eating.

Risks Specific to Abuse of OPANA ER

- OPANA ER is for oral use only. Abuse of OPANA ER poses a risk of overdose and death. This risk is increased with concurrent abuse of OPANA ER with alcohol and other substances. OPANA ER tablets must be taken whole, one tablet at a time, with enough water to ensure complete swallowing immediately after placing in the mouth. Taking cut, broken, chewed, crushed, or dissolved OPANA ER enhances drug release and increases the risk of overdose and death.

ADVERSE REACTIONS

- Adverse reactions reported at (≥2%) in placebo-controlled trials were: nausea, constipation, dizziness, somnolence, vomiting, pruritus, headache, sweating increased, dry mouth, sedation, diarrhea, insomnia, fatigue, appetite decreased, and abdominal pain.
- In clinical trials there were several adverse events that were more frequently observed in subjects 65 and over compared to younger subjects. These adverse events included dizziness, somnolence, confusion, and nausea.
- Post-marketing Experience - The following adverse reactions have been identified during post approval use of OPANA ER. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure. Nervous system disorder: amnesia, convulsion, memory impairment.

DRUG INTERACTIONS

- Concurrent use of OPANA ER and other CNS depressants including sedatives, hypnotics, tranquilizers, general anesthetics, phenothiazines, other opioids, and alcohol can increase the risk of respiratory depression, hypotension, profound sedation, or coma. Monitor patients receiving CNS depressants and OPANA ER for signs of respiratory depression and hypotension. When such combined therapy is contemplated, reduce the initial dose of one or both agents.
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OPANA ER is used concurrently with anticholinergic drugs.

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Vermont prescribers, please see additional information for **OPANA® ER**.

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https://web.archive.org/web/20160320215150/http://vetsinpain.org/?page_id=408#.Vu8bfer7QXJ

Resources

When you've been trained to tough it out no matter what, looking for help doesn't always feel like the right thing to do. But now you don't have to go it alone. We're here for you because we care.

And, because we want to help, we've collected a wide range of information that you might find useful. If you can't find what you need, please let us know. We'll do our best to get you an answer. For now, please take a look at these resources:

American Chronic Pain Association

Our Mission

- To facilitate peer support and education for individuals with chronic pain and their families so that these individuals may live more fully in spite of their pain..
- To raise awareness among the health care community, policy makers, and the public at large about issues of living with chronic pain.
- Visit the ACPA Pain Management Tools to find out how the ACPA can help you on your path to wellness.

Our VetsInPain Program

Mission

- To assist U.S. veterans who live with pain.
- As a project of the American Chronic Pain Association, we recognize the specific needs of U.S. veterans and military personnel.
- In response, the VIP program provides education in pain management and a selection of other veteran-oriented resources, including online access to ACPA peer support groups.
- Our virtual peer support groups are intended for veterans with transportation issues. Remember that virtual meetings are not a substitute for face-to-face peer support group meetings.

Emergency Hotline for Veterans, 24 / 7 Call Center: 1-877-4aid-vet

VA Pain Management facilitate effective pain management by providing convenient, centralized access to resources for the provision of pain services within the VA healthcare system.

Jobs

Build the attitude, knowledge, and skills you need to find a secure position, even when chronic pain threatens to challenge your confidence in a rough job market.

- Feds Hire Vets – Information about the benefits available to you as a veteran seeking work
- VA Careers – VA.gov website of job postings within the VA System
- VA For Vets – Facilitates the reintegration, retention and hiring of Veteran employees at the Department of Veterans Affairs (VA).

American Chronic Pain Association

Search
Search

Contact Us

Phone: 800.533.3231
Fax: 916.652.8190
Email: vip@theacpa.org

Combined Federal Campaign #10549

Angel Flight- Rest In Peace Brothers and Sisters

Veterans In Pain Facebook Badge-Try It On!

- VA Internship Programs – Information on VA Internship programs
- VetsJobs – America's Premier Job Board
- VetSuccess – VetSuccess connects employers to Veterans and puts jobs geared toward Vets in an easily accessible place on the web.

Housing

Get the word about shelter, whether your concern is homelessness, accessible housing, mortgage or rent payments, VA home loans, preventing foreclosure, or a related problem.

- Homeless Veterans – VA Information for Homeless Veterans
- Local Homeless Veterans Coordinator – Find your local Homeless veteran coordinator (PDF Download)

Service Records & Awards

Nothing gets done without the right paperwork. Here's a library of links for finding your records, navigating the proper channels, or rounding up hard-earned medals, decorations, citations.

- Service Records – Information to obtain your service records
- Awards/Replacement Medals

https://web.archive.org/web/20160320215807/http://vetsinpain.org/?page_id=12#.Vu8c-Or7QXJ

Events

Vets in Pain

Presented by the American Chronic Pain Association

With so many of our veterans returning home, many with injuries, there is an increased need to help them to return to a full life. One of the major obstacles for so many of them is their injuries that, for many lead to chronic pain problems. Our focus is to validate the impact of chronic pain among veterans and their families as we increase knowledge about pain management among veterans so that they can improve the quality of their life and reduce their sense of suffering. There are 14 events in select VA facilities in 2014, which will focus on pain management, starting and maintaining peer lead groups for people with pain as well as how to maintain wellness. All veterans and staff members are welcome to attend. There is no cost to attend these events.

Objectives

- Explore the impact that pain has on the person with pain, their family, health care professionals and the public, and what the ACPA provides.
- Learn about the American Chronic Pain Association *Ten Steps from Patient to Person*. Understand what the steps, what they mean and how to apply them to daily life.
- Identify what it takes to establish a peer lead group for people with pain. Discuss what the ACPA provides to potential facilitators and the basics of starting and maintaining a group.

VA Events 2014

For more information click on an event below. The events are open to all veterans, family members and health care staff. You must register for the event by calling 800-533-3231.

- February 24 ~ Atlanta, GA
- March 21 ~ Puerto Rico
- April 4 ~ San Francisco
- April 10 ~ Wichita, KS
- May 9 ~ Chillicothe, OH
- May 16 ~ August, ME
- May 29 ~ Iowa City, IA
- June 4 ~ Orange, NJ
- June 13 ~ Little Rock, AR
- June 16 ~ Lexington, KY
- June 27 ~ Prescott, AZ
- July 22 ~ Fargo, ND
- October 2 ~ New York, NY
- October 10 ~ White City, OR

If there is not a VIP event scheduled in your area, contact the ACPA to recieve a copy of the Veterans in Pain DVD. Call 1-800-533-3231 or Email acpa@theacpa.org

American Chronic Pain Association

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Angel Flight- Rest In Peace Brothers and Sisters

Veterans In Pain Facebook Badge-Try It On!

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Welcome.

Vets in Pain
Presented by the American Chronic Pain Association

With so many of our veterans returning home, many with injuries, there is an increased need to help them to return to a full life. One of the major obstacles for so many of them is their injuries that, for many lead to chronic pain problems. Our focus is to validate the impact of chronic pain among veterans and their families as we increase knowledge about pain management among veterans so that they can improve the quality of their life and reduce their sense of suffering. We are in the process of scheduling these events in select VA facilities in 2016 (PART OF THE SCHEDULE IS BELOW), which will focus on pain management, starting and maintaining peer lead groups for people with pain as well as how to maintain wellness. All veterans and staff members are welcome to attend. There is no cost to attend these events.

Objectives:

Explore the impact that pain has on the person with pain, their family, health care professionals and the public, and what the ACPA provides.

Learn about the American Chronic Pain Association *Ten Steps from Patient to Person*. Understand what the steps, what they mean and how to apply them to daily life.

Identify what it takes to establish a peer lead group for people with pain. Discuss what the ACPA provides to potential facilitators and the basics of starting and maintaining a group.

VA Events 2016

The events are open to all veterans, family members and health care staff. You must register for the event by calling 800.533.3231

March 30, 2016, Mather, CA

April 28, 2016, Salisbury, NC

May 2, 2016, Reno, NV

May 18, 2016, Topeka, KS

May 25, 2016, Tampa Bay, FI

June 1, 2016, Cincinnati, OH

August 2, 2016, Detroit, MI

We'd like to thank you for your service, and for your sacrifices. In return, we hope that in these pages you'll find information you can use as you make your journey to a fuller, more rewarding life. We're glad you're here.

ACPA – Living with Pain Video Series

American Chronic Pain Association

Search
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Contact Us

Phone: 800.533.3231
Fax: 916.652.8190
Email: vip@theacpa.org

Combined Federal Campaign #10549

Angel Flight- Rest In Peace Brothers and Sisters

Veterans In Pain Facebook Badge-Try It On!

Veterans, check out the video we have made for you! Veterans In Pain Video

Please contact the American Chronic Pain Association at 1-800- 533-3231 to receive your free copy.

Pathways to Safer Opioid Use

PATHWAYS TO Safer Opioid Use

Pathways to Safer Opioid Use is an immersive, interactive training tool that was designed using the opioid-related recommendations outlined in the National Action Plan for Adverse Drug Event Prevention (ADE Action Plan). The training uses the principles of health literacy and a multimodal, team-based approach to promote the appropriate, safe, and effective use of opioids to manage chronic pain.

This web-based training allows you to assume the role of 4 playable characters who make decisions – controlled by you – about preventing opioid-related adverse drug events (ADEs). The characters represent the following roles: primary care physician, nurse, pharmacist, andpatient.

In this behavior-based training using interactive video, you will learn how to:

- Apply health literacy strategies to help patients understand and act on information to prevent opioid-related ADEs
- Identify individual risk factors, opioid medications, and interactions that place individuals with chronic pain at increased risk for opioid-related ADEs
- Recognize the importance of a multidisciplinary, team-based approach to treating patients with chronic pain
- Demonstrate the ability to combine the principles of the Health Literate Care Model and the biopsychosocial model of chronic pain management through case study examples

Please, take a minute to complete our survey-we want to hear from you! ACPA Pharmacist Relationships
Combined Federal Campaign #10549

Site made possible by: endo

CONTACT US PRIVACY POLICY TERMS AND CONDITIONS

American Chronic Pain Association

http://web.archive.org/web/20070107154306/http://www.painknowledge.org:80/aboutus/AboutUs.aspx

Search PainKnowledge.org
GO

Meet the Faculty

Perry G. Fine, MD

Chairman

View all faculty

About the NIPC

More than half of all Americans suffer from chronic or recurrent pain. Daily, physicians are faced with finding safe and effective methods and treatments to provide optimal pain relief for their patients.

NIPC NATIONAL INITIATIVE ON PAIN CONTROL®

The National Initiative on Pain Control® (NIPC®), through numerous educational venues, offers innovative, interactive, and practical activities that support the Initiative's goals.

NIPC educational activities highlight the magnitude of the problem, providing guidance in pain assessment, and offer proven strategies for pain management, all with the aim of improving patient outcomes.

All NIPC programs are developed and continuously evaluated by the NIPC Education Council, an expert multidisciplinary team of specialists, researchers, and practicing physicians in pain management. The NIPC Faculty includes nationally respected experts in the pain management field.

Examples of NIPC activity formats are:

- DINNER DIALOGUES®
- CONFERENCE LINE® Seminars
- Saturday Seminars
- Webcasts
- Newsletters
- CD-ROMs

Examples of NIPC content areas include:

- Persistent Pain
- Postoperative Pain
- Opioid Analgesia
- Neuropathic Pain

Educational Goals of the NIPC

Elevate the importance of managing the patient with pain by heightening physician and healthcare provider awareness of the impact of pain on the patient's daily living and societal burdens.

Empower physicians to differentiate types of pain, resulting in improved precision in diagnosis and therapeutic decisions.

Provide physicians with the latest advances and strategies in pain management and translate clinical data into clinical practice utility.

Emphasize importance of tolerability, safety, and nontoxicity in selecting effective pain therapies.

Address barriers to achieving pain control and common misconceptions regarding use of pain therapies.

Here's what past attendees had to say about NIPC activities:

"Best CME activity that I have participated in and I have been in practice for over 30 years."

"Timely presentation on one of the most critical issues facing practitioners today. The subject matter was well presented as to the advantages for the physician and patient."

"I recently received your CD-ROM containing the Opioid Analgesia Tool Kit. I found it to be extremely well done and very informative. Would it be possible to obtain more copies of it to distribute to our pain physicians?"

"How do we get more of our colleagues to attend these meetings? There is so much information out there regarding the treatment of pain, and they really need to hear these programs. I've been to the last two and I plan on attending more that are offered."

http://web.archive.org/web/20110226012549/http://painedu.org/

PainEDU.org
IMPROVING PAIN TREATMENT THROUGH EDUCATION

E-MAIL ADDRESS PASSWORD Login

FORGOT YOUR PASSWORD? NOT REGISTERED?

CEU · SPOTLIGHT · ROUNDTABLE · ARTICLES · TOOLS · PUBLICATIONS · OPIOID RISK MANAGEMENT · RESOURCES

You need to upgrade your Flash Player. This is an educational website for clinicians, teaching about pain management and the assessment of chronic pain patients for opioid and pain killer addiction. It is a comprehensive resource and is based on the latest scientific information about pain management and treatment. The topics were developed with input from pain management professionals. The information included at this site was chosen based on clinician interests, best practices in the field and a desire to deliver health education in an interactive manner. We seek to provide ideas and strategies that help educate clinicians and improve the overall treatment and care of chronic pain while preventing opioid and pain killer addiction. The Current *Opioid* Misuse Measure (COMM) will help clinicians identify whether a patient, currently on long-term opioid therapy, may be exhibiting aberrant behaviors associated with misuse of opioid medications, also known as pain killer addiction. In contrast, the Screener and Opioid Assessment for Patients with Pain (SOAPP) is intended to predict which *chronic pain* patients, being considered for long-term opioid therapy, may exhibit behaviors indicating future opioid or *pain killer addiction*. Since the COMM examines concurrent misuse, it is ideal for helping clinicians monitor patients' aberrant medication-related behaviors over the course of treatment.

NEW ON PAINEDU.ORG

- PainEDU PAINWeek® 2011 Scholarship
- Massage Therapy for Pain Conditions
- Update on Postherpetic Neuralgia

PAIN EDU COURSE

Online Interactive Course

This interactive, **online** pain management course is designed for:

- Physicians
- Nurses
- Pharmacists
- Psychologists

Earn NO COST continuing education credits right now!

OPIOID RISK MANAGEMENT

Concerned about prescribing opioids for chronic pain?

Screener and Opioid Assessment for Patients with Pain (SOAPP®)

The Screener and Opioid Assessment for Patients with Pain (SOAPP) is a brief paper and pencil tool to facilitate assessment and planning for chronic pain patients being considered for long-term opioid treatment.

Current Opioid Misuse Measure(COMM)®

The Current Opioid Misuse Measure (COMM) will help clinicians identify whether a patient, currently on long-term opioid therapy, may be exhibiting aberrant behaviors associated with misuse of opioid medications.

PUBLICATIONS

Request your copy of the Inflexxion Health Series publications.

The PainEDU.org Manual
A Pocket Guide to Pain Management, 3rd Ed.
Updated on line quarterly

NEW!
Managing Chronic Pain with Opioids in Primary Care, 2nd Edition

Cross-Cultural Pain Management
Effective Treatment of Pain in the Hispanic Population

Your Guide to Pain Management
A Road Map for painACTION.com

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Inflexxion Health Series

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A Pocket Guide to Pain Management

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Effective Treatment of Pain in the Hispanic Population

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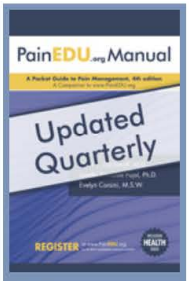
The PainEDU Manual
A Pocket Guide to Pain Management

This is the 4th edition of a comprehensive pain resource for health care providers. Expanded with new up-to-date content, the manual provides an overview of pain epidemiology, pathophysiology, types of pain, assessment, measurement tools, diagnostic testing and treatment.
Published: 2010
Authors: Kevin L. Zacharoff, M.D., Lynette A. Menefee Pujol, Ph.D., and Evelyn Corsini, M.S.W.



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Authors: Kevin L. Zacharoff, M.D., Lynette A. Menefee Pujol, Ph.D., and Evelyn Corsini, M.S.W.

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Electronic Format: PDF

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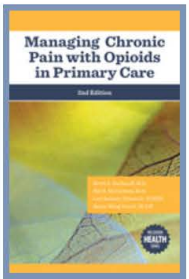
Managing Chronic Pain with Opioids in Primary Care, 2nd Edition

This user-friendly guide provides easily accessible information to practicing clinicians that addresses their concerns about prescribing opioids, while at the same time providing for the safe and effective treatment of their patients with chronic, moderate to severe pain.This provides clinicians suggestions to preparing a practice, guidelines to assess risk, and practical tips on the long-term management of patients with opioids. This new edition adds a significant amount of new content, including a summary of recent guidelines and important regulatory issues that will likely affect all health care providers that utilized opioids for chronic pain management in the primary care setting.
Published: 2010
Authors: Kevin L. Zacharoff, MD, Bill H. McCarberg, MD and Lori Reisner, PharmD, FCSHP, Synne Wing Venuti, MSW



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Authors: Kevin L. Zacharoff, MD, Bill H. McCarberg, MD and Lori Reisner, PharmD, FCSHP, Synne Wing Venuti, MSW

Physical Format: Paperback

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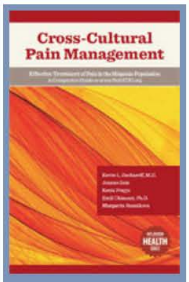
Cross-Cultural Pain Management

Effective Treatment of Pain in the Hispanic Population

This addition to the Inflexxion Health Series provides guidance to clinicians affected by the cultural transformation that is taking place in the United States. While this book offers details about some of the issues that may separate Hispanic patients from others, its primary purpose is to minimize these differences to reach common ground. The focus of the text is to help establish mutual understanding and communication between healthcare providers and Hispanic patients, which is critical to quality care.
Published: 2009
Authors: Kevin L. Zacharoff, M.D, Joanne Zeis, Kezia Frayjo, Emil Chiauzzi, Ph.D., Margarita Reznikova



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Your Guide to Pain Management

A Road Map for painACTION.com

This Guide is a useful adjunct to the PainACTION.com website for patients with chronic pain. It gives them access to detailed information about building productive partnerships with healthcare providers, and ways to develop effective skills for self-management, communication, and coping. Specific topics cover important aspects of the chronic pain ?journey?, including safe use of prescription pain medications, managing back pain, migraine pain, and cancer-related pain. Much of the information is useful for patients dealing with any type of chronic pain.
Published: 2009
Authors: Kevin L. Zacharoff, M.D., Emil Chiauzzi, Ph.D., Evelyn Corsini, M.S.W. Pravin Pant, Synne Wing Venuti, M.S.W., Roanne Weisman

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Opioids911-Safety

Help for Safely Using Opioid Pain Relievers from PAIN TREATMENT TOPICS

Healthcare Provider?
- Click here for how to use Opioids911 with patients.

Quick Reference
- Signs of an Opioid Emergency
- Emergency Rescue Steps
- Common Opioid Pain Relievers
- Side Effects of Opioids
- Opioid Withdrawal Symptoms
- Personal Information MedCard

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American Association for the Treatment of Opioid Dependence

American Chronic Pain Association

American College of Apothecaries

American Pain Foundation

American Society for Pain Management Nursing

National Association of Drug Diversion Investigators

National Family Partnership

5. Frequently Asked Questions about opioid safety.

FAQs

Q Should I stop using all other pain relievers when taking opioids?

A Opioid pain relievers may be all that you need to take; however, this should be decided between you and the healthcare provider who prescribes opioids for you. Be certain to tell the prescriber and your pharmacist about all medicines and other substances you have been taking, whether or not for pain. This includes over-the-counter products, herbs, and vitamins. Also, it is very important for your safety that the healthcare provider know the amount of alcohol you drink and if you have been using marijuana or "street drugs."

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Q Is it best to take as little of the opioid medicine as possible?

A The best amount of opioid medicine to take is exactly what was prescribed for you. Skipping regularly scheduled doses when your pain is weaker, or sometimes taking less medicine than prescribed to make it last longer and save money, could result in your pain getting out of control. If this happens, taking more than the prescribed amount to relieve the pain could be dangerous. Always take opioids that were precribed for use "as needed" or for breakthough pain according to the prescriber's instructions. If your opioid medicine is not working for you the way you would like it to, or its cost is straining your budget, talk to your healthcare provider about your concerns.

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Q Do I really need to avoid all alcohol while taking opioids?

A Drinking any alcohol — whether beer, wine, or hard liquor — while using opioid medicines can be very dangerous. Even small amounts

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of alcohol can increase opioid sedative effects, making you feel drowsy, confused, or dizzy. You could easily fall and hurt yourself. Too much alcohol combined with opioids can cause drug overdose and possibly kill you. And, it is impossible to know in advance how much is "too much" alcohol. At the least, if you still want to have an occasional drink while taking opioids, discuss it first with your healthcare provider.

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Q Can I drive a car while taking opioid pain relievers?

A When first starting an opioid medicine, or after a dose increase, you should avoid driving a car or operating any potentially dangerous equipment, such as a lawnmower or power tools. This is for your own safety as well as to protect other persons. Until your body becomes accustomed to the opioids you may feel sleepy, less alert, and have slower reaction times, which can result in serious accidents. After awhile, you will probably be able to drive again and operate equipment, but you should ask your healthcare provider about this whenever opioids are being prescribed or the dose is being changed. It is important to remember that you may have poorer ability to drive or perform other tasks that require attention and skill even if you do not feel sleepy or otherwise different.

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Q I have no place to lock up my opioid medicines — what can I do?

A While it may seem inconvenient to keep medicines locked up, you need to safeguard your opioids as you would your jewelry or money. Other persons who you least suspect — visitors or workers coming into your home, friends, or even close family — may look for opioids that they can use for their own pain, or abuse to get "high," or sell to others. Children or pets may innocently get into opioids that are not locked away and poison themselves. You could be a source of drugs that seriously harm others, and you will not have the medicine you need for pain.

Look around your home; perhaps, there is a locking drawer or file cabinet where you can store your opioids. If not, many hardware and office supply stores sell locking metal boxes (sometimes called "cash boxes"). You also can purchase special locking containers for medicines on the Internet <click here for sources>. Be certain to share an extra key or the lock combination with someone you trust.

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Q What is wrong with sharing a small amount of opioids with a friend or relative?

A There are at least four reasons for never sharing opioids with others, whether it is for their pain or other reasons:

(1) A single opioid capsule, tablet, or patch could kill someone who is not used to taking the drug;

(2) Even if the person has their own prescription for an opioid pain reliever, your particular opioid and the dose may not be the same and could make them very sick;

(3) By sharing, you may run out of your opioid medicine sooner and not be able to get a refill to treat your pain;

(4) It is against the law to share opioids with others, whether for free or for money — it is considered illegal drug diversion and you could be arrested.

Many people believe, correctly, that the police are not peeking in their windows to see if they are sharing opioids with others. However, if a person is harmed from the "borrowed" opioid and ends up in the emergency room or dead, the police will be asking where they got the drug — and you are the offender. So, you are not doing the other person, or yourself, a favor by sharing even a small amount of your opioid medicine, and you could accidentally do them great harm.

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Q Why is it unsafe to open capsules or crush tablets to make taking opioids easier?

A If you have trouble swallowing solid medicines discuss this with your opioid prescriber. Most opioid medicines are made to deliver a

specific amount of the drug during a specific period of time. Opening capsules or crushing tablets of opioids may give you too much opioid in too short a time, which can make you sick or cause harmful overdose. There are liquid formulations of many opioids, and there are certain opioids that can be opened, cut, or crushed, but you need to *check first* with your opioid prescriber or pharmacist for directions. Also, if you have been prescribed opioid patches, they should never be cut — applying only part of a patch could release too much of the medicine too quickly into your body and be very harmful.

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Q Could I eventually become addicted to opioid pain relievers?

A 

Many persons who must take opioid medicines for some time are afraid that they will become drug addicts. However, this very rarely happens *IF* the opioids are taken for pain relief and exactly as instructed by the opioid prescriber. Addiction is actually a physical and mental disease that may develop if a person wrongly uses opioids to feel "high" or to change their mood rather than for pain relief. After awhile, the person loses control and cannot stop abusing opioids, even though it is not helping their pain and is ruining their work or school, social, and family lives.

Addiction is not a natural side effect of taking opioid pain relievers. It is more likely to occur in a person who has had substance abuse or addiction problems in the past (including alcoholism). Or, since it can be hereditary, you may be more likely to develop addiction if close family members have had problems with drugs or alcohol. You should tell your opioid prescriber if you or a family member has had such problems. You can still be prescribed opioids for pain, but certain precautions can be taken to help protect you from becoming addicted to the medicine. Opioid addiction is often confused with tolerance to the medicine or physical dependence on it, and these conditions are discussed in the next two questions. Also, you can <click here> for more information on addiction.

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Q What if the opioid medicine stops helping my pain after awhile?

A Over time, as your body gets used to the opioid medicine, it may not seem to provide the same amount of pain relief. It is possible that your pain condition has gotten worse, or you may have developed ***tolerance*** to opioid pain-relieving effects. That is, it seems to take more opioid to provide the same amount of pain relief. This does not always happen and it does *NOT* mean that you have become addicted to the medicine. Your healthcare provider may instruct you to take more of the opioid or take it more often. However, never change the dosing on your own, as this could be dangerous. In some cases, the prescriber may switch you to a different opioid medicine — fortunately, there are many different types of opioids available.

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Q What causes opioid withdrawal?

A As your body gets used to a steady amount of opioid medicine each day, you may become ***physically dependent*** on it. In that case, suddenly reducing the amount or stopping the medicine entirely can cause "withdrawal." This also can occur if you start taking another medicine that reduces effects of the opioid — called a "drug interaction." Opioid withdrawal typically is not harmful, but it can feel quite unpleasant and even painful — somewhat like having a very bad case of the flu. Physical dependence and withdrawal can naturally occur after opioids are taken for some time and, by themselves, are *NOT* signs of addiction. Uncomfortable withdrawal can be avoided if the opioid dose is very gradually reduced over time, as directed by your opioid prescriber. For more information on what withdrawal is like <click here>, and be sure to tell your healthcare provider if you start having withdrawal signs or symptoms.

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Q What if I am running out of opioids before my next appointment?

A 

The important question you will be asked is, "Why are you running out early?" There are at least four situations to consider:

(1) Did your pain get worse and you took more opioid medicine than was prescribed? You should call your opioid prescriber *before* changing the dose on your own.

(2) Was your opioid medicine lost or ruined for some reason? You should call the prescriber right away if that happens.

(3) Was your opioid medicine stolen? You should file a police report, get a copy of the report, and then call the opioid prescriber.

(4) Did you share part of your opioid medicine with someone else? You should never do this as it might harm or even kill the other person, and it is against the law.

Remember, you are responsible for taking your opioid medicine only as prescribed and keeping it safe. So, depending on what happened, your prescriber may be concerned that you are not following directions or protecting the opioids as you should. You might not receive a refill before your next scheduled appointment. For advice on how to deal with running out of opioid medicine before your prescription can be refilled or if you cannot get prescription refills after a disaster — for example, a hurricane, flood, earthquake, or fire — or for some other reason <click here>.

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Q When can I stop taking the opioid medicines?

A As long as opioids are helping to control your pain, and you have a better quality of life because of it, you may need to continue taking the medicines for an indefinite period of time. Taken as directed, along with proper medical care, opioids have a good safety record. On the other hand, persistent pain without any relief can be harmful physically and mentally. At some point, you may want to reduce or stop the opioid to see if your pain is still there or bearable without the medicine; however, talk to your healthcare provider about this first. If you stop taking opioids on your own you may suffer uncomfortable withdrawal.

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Q I hear that opioids cause constipation — what can be done?

A Constipation — having irregular or difficult bowel movements — is a common problem with all opioid medicines. Opioids naturally slow the movement of food through the intestine and bowel; although, some people are more bothered by this than others. You should ask your healthcare provider about constipation whenever opioids are being prescribed, and be sure to mention if you already have constipation. Diet and exercise can help ease constipation and there are prescription medicines that can help. You can also ask your pharmacist about an over-the-counter product to ease constipation due to opioids. *Do not* select a product on your own without getting professional advice, since some products can make opioid-related constipation worse.

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Q What if I become pregnant while taking opioid medicines?

A Tell your opioid prescriber if you are planning to get pregnant or as soon as you think you may be pregnant. Some studies suggest there is a very small chance of a baby having certain birth defects if the mother takes opioids early in pregnancy. In most cases, opioids do not harm the developing baby if taken exactly as prescribed for pain, but the type of opioid or the dose may need to be changed so that the baby is not born dependent on opioids with uncomfortable withdrawal symptoms. In some cases, you and the prescriber may decide on another medicine or approach for relieving your pain.

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Q Why should I always use the same pharmacy to fill opioid prescriptions?

A Getting *all* of your prescriptions filled at the same pharmacy — or the same chain of pharmacies if they are linked by computer — is for your safety and convenience. That way the pharmacist will know of all medicines that you are taking and will notice if any of them may not work well together or be harmful when taken together. Also, once they know of your regular prescriptions, most pharmacies will be certain to keep the medicines that you need, including opioids, in stock and some will alert you before it is time for refills.

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Q There is a lot to remember about opioid safety — what should I do?

A Yes, there is a lot to remember. However, once you learn the basic "rules of the road" when it comes to opioid safety, you also should be able to use your other medicines more safely to help protect yourself and others. As a handy reminder, <click here> to download and print a one-page opioid safety information sheet. Be sure to also share it with family or friends who help to take care of you. And, regularly come back to this Opioids911-Safety program to refresh your memory.

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Q What if I cannot afford to buy the prescribed opioid medicines?

A 

Paying for medicines, including opioid pain relievers, can be difficult for many patients, whether or not they have some form of healthcare insurance. However, help is available for those who look for it. For one thing, there are Patient Assistance Programs, or PAPs, run by pharmaceutical companies, which provide free medicines to people who cannot afford to buy them. In the United States, there also are many federal, state, and local programs offering help with the costs of medicines for families and individuals needing assistance. At the least, there are organizations offering discount cards free of charge that provide large savings on medicines at participating pharmacies. Here are several websites based in the USA that are worth looking into:

- RxAssist.org — this website has an extensive list of PAPs, offers a prescription discount card, and has worthwhile articles and other information for healthcare professionals and patients. (USA Phone: 401-729-3284.)
- NeedyMeds.org — provides a free drug discount card and links to PAPs, government programs, and other helpful resources.
- Partnership for Prescription Assistance — provides a single point of free access to 475+ public and private assistance programs, including nearly 200 offered by pharmaceutical companies. (USA Phone: 888-477-2669.)
- RxHope.com — offers personalized assistance online for use by healthcare providers and their patients in applying to the various PAPs for aid. (USA Phone: 877-267-0517.)

Examine all 4 websites to see which might be best for your needs. Drug discount cards are available right away. However, applying for assistance programs will require you to fill out some paperwork, and you also may need the support of your opioid prescriber to qualify. It can take some weeks before assistance is provided, so you should seek help right away if you think you will be needing it.

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Help for Safely Using Opioid Pain Relievers from PAIN TREATMENT TOPICS

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3. How can I prevent problems with opioids?

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A. What opioid problems should I be prepared for?

Opioid pain relievers can be safe and effective *IF* you follow the directions from your healthcare providers and you take steps to avoid possible problems or risks. Here are some concerns to think about...

- Opioid medicines will not work as they should if you do not take them exactly as you are instructed by the prescriber.
- Opioids can be harmful if you take too much of the medicine or take it too often. This can lead to opioid *overmedication* or *overdose*.
- A serious risk of opioid medicines is called "respiratory depression," which is dangerously slow or weak breathing.
- Opioid medicines also can cause certain troublesome side effects, most commonly constipation, nausea, or sedation.
  - Constipation due to opioids may not go away, so you should ask your opioid prescriber about how to treat this.
  - Nausea may last about 3 to 4 days, and there is medicine that can help with this.
  - Sedation — feeling tired and groggy — may last 3 to 4 days after starting opioids or when the dose is increased.

  A complete list of opioid side effects is available <here>.
- Opioid medicines can be harmful to you if they are taken with alcohol or illegal drugs, or with certain other prescribed medicines.
- If others — adults, children, or pets — get hold of and swallow your opioid medicines it could injure them, possibly even causing death.
- Sharing your opioid medicine with anyone else is against the law and could do them great harm, possibly killing them.

- If you ruin your opioid medicine, lose it, or it is stolen you may not be able to get it replaced until it is time for the next refill.

Knowing about what can go wrong is a first step in avoiding the problems or risks. Below are helpful next steps.

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B. How can opioid problems be avoided?

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Opioid pain relievers, and many other medicines, can be dangerous if they are not used properly or are used by persons for whom they were not prescribed. Therefore, ***YOU*** are responsible for following certain safety steps to avoid problems. There are many things to remember but most of them are just good common sense.

Here are some special opioid safety tips to remember...

- Read and make sure you understand all information that comes with your opioid prescription. Check the label — are the medicine name, dose, and how often it is to be taken the same as your opioid prescriber talked to you about? Mistakes in filling prescriptions can happen.
- Take opioids only when and how you are instructed:
  - Never chew, cut, crush, or dissolve opioid tablets or open capsules, unless specifically told to do so by the prescriber or pharmacist.

  - Opioid patches must never be cut or folded, and they need to completely stick to the skin. Always take the old patch off before putting on a new one unless you are instructed otherwise. Never apply heat to a patch, such as in a hot bath, sauna, or hot tub, or with a heating pad, electric blanket, or heat lamp.
  - For opioid liquids, always ask your pharmacist for an accurate measuring device.

- Never take more opioid medicine or take it more often than has been prescribed for you. If you think that you need a higher dose, first ask your opioid prescriber.
- You (and your caregivers) should know the signs of opioid *overmedication* and opioid *overdose* to watch for.
  See a list of the signs <here>.
- If there are signs of overmedication, stop taking the opioids and call your opioid prescriber for instructions or, in the United States, you also can call the National Poison Hotline toll-free at 1-800-222-1222.
- If there are signs of overdose, call emergency medical services right away.
  Section 4 <*here*> provides advice for what to do in an emergency until help arrives. **Read it today**, so you are prepared **before** there is an emergency.

WARNING: If a child or pet ever swallows your opioid medicine, it is *always an emergency*. Call for help right away.

- A person just starting on opioids, or after a dose increase, should be watched closely, even during sleep, for several days or longer to see if there are signs of overmedication.
- Do not drink any alcohol (beer, wine, or hard liquor) or take other medicines (including over-the-counter products, herbs, or other drugs) while taking opioid medicines, unless your opioid prescriber says it is okay.

- Start taking a new opioid prescription, or any dose increase, during the daytime when you will be awake and other persons can watch to see how you react.
- Do not drive a car or operate dangerous equipment until you know how the opioids affect you and your opioid prescriber says it is okay.

- If you have had problems in the past with substance abuse or addiction, your opioid prescriber must know about it so opioid medicine can be properly prescribed for you.
- Always keep your opioid medicines stored in a safe place. A locked box, cabinet, or drawer would be best. *See below for suggestions on safe storage.*

WARNING: Never share your opioid medicine with anyone else. It could do them serious harm and it also is against the law — you could go to jail for doing this.

Here are general tips for avoiding problems with *any* medicines...

- Whenever you are given a prescription for a medicine,

always ask...

- What is the brand name and generic name of the medicine? What is the strength or dose?
- How often should I take it each day? What if I forget to take a dose?
- How will the medicine help me? What should I expect to happen? How will I feel?
- Exactly how and when should I take it? With or without food? For how many days?
- Do I need to avoid any foods, drinks, other medicines, over-the-counter products, or supplements (such as herbal products)?
- Are there any activities I need to avoid (such as driving)?
- Are there any side effects of the medicine? What should I do if they happen?
- Where can I learn more about this medicine?

- Keep your medicines in a separate place from those belonging to persons living with you, and clearly marked that they are yours. This way, you can avoid taking another person's medicine by mistake.
- Only take medicines in a well-lighted area, and wear your glasses if you need them for reading, so you can see clearly to take the right amount of the right medicine.
- Always open medicine containers over a countertop or other flat surface. Never open them over a sink or toilet where the contents can fall in and get ruined.
- If you have trouble keeping track of how to take medicines, have a helper sort them into containers for each day or several days at a time. *See below about medicine organizer trays.*
- When you are traveling...

  - Take along only the amount of medicine that you will need (plus a day or two extra). It is best not to mix all the medicines into a single container.
  - Keep your medicines with you at all times in a carrying bag or purse. Never pack medicines in your luggage or the trunk of a car, or leave them in your hotel/motel room.
  - For opioid medicines, you may be asked by security persons to prove that they were legitimately prescribed for you. You should...
    - Get a letter from your opioid prescriber stating the name of the opioid medicine, the dose, why you are taking it, and that it is needed during your trip.
    - If possible, have your pharmacist provide smaller travel containers for your opioids that are properly labeled with your name and other information about the medicine.
  - If you are traveling to a different time zone, ask your opioid prescriber about how to adjust the timing of when to take your medicine.
- Remember to take your medicines along if you must leave home in an emergency, such as during a flood, storm, fire, electrical failure, or other disaster.
- Be sure to have a list of your medicines with you at all times in your wallet or purse — you never know when a healthcare provider may need to know what you are taking. *See below for a handy way to make your list.*
- You must properly get rid of any unused or leftover medicines, or else they could be misused by others and do them harm.

  See government-approved instructions for disposing of opioids <here>.

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C. How can I keep track of my opioid medicines?

Keeping track of your medicines, and taking the right ones, in the right amounts, at the right times is necessary for safe and effective use. Plus, you do not want to be surprised by suddenly running out of medicine.

However, if you take more than one medicine, this can be difficult. So it is important to

keep an up-to-date list of your medicines for your healthcare providers. And, having a list handy in your wallet or purse in an emergency can be a life saver. *Here are some items that can be of help:*

Keep Your Medicines Organized

Counting out individual pills or tablets each day, or several times each day, can be a chore. It is easy to forget what medicine is to be taken and when. Also, it is unsafe to keep whole containers of opioids and other medicines in places where they might be found and used or stolen by others.

The solution is easy. Use an organizer tray that will allow you (or a helper) to count out medicines for several days or a week at a time and store them in separate compartments for each day. Some organizers also have compartments for different times during each day, such as morning, midday, evening, and bedtime.

Medicine organizer trays are available at any pharmacy. Ask the pharmacist to help you pick one out that is best for your needs.

EXTRA SAFETY TIPS:

1. **Always keep the organizer tray in a drawer or other out-of-the-way place where it will be safe.**
2. When you fill the organizer tray, take a count of your remaining medicine to see if any is missing and to check if it is time to ask for a refill.
3. If you take a liquid medicine or one that must be stored in the refrigerator, put a small reminder note in the proper compartment of the organizer for each day and time so you won't forget to take it.
4. Keep medicine you take only sometimes, such as for "breakthrough pain" (which is intense pain that comes and goes), stored-away separately and safely until you need it.

Medicine & Personal Information List - MedCard

The "MedCard" provides an easy way for you to keep a record of personal information and medical history that each of your healthcare providers will want to know about. It also has spaces to write-in the medicines you are taking, including the dose, when and why it is taken, and who prescribed it. Instructions are included for how to fill-in the information and fold this document down to a size that will fit in a wallet or purse.

MedCard PDF is available <here>.

Keep this MedCard with you at all times in your wallet or purse (put your insurance cards with it) and ask your healthcare providers to help you keep it updated. Show the MedCard to your pharmacist whenever you pick up a new medicine to make sure that it will not harmfully work against, or interact with, medicines or other products that you are already taking.

Emergency Medical ID Wallet Card

At a website called "MedIDs.com" you can type-in your personal information and print a small, 2-sided wallet-sized card from your computer. It can include your name, address, phone number, emergency contact information, healthcare provider's name/phone, your blood type, medical conditions, a list of medicine names, and allergies.

The cost is free for a basic card, or there is a small yearly fee* to store your information, update it as often as you want to, and print a new card.

To go to the MedIDs website <click here>.

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Medical Alert ID Bracelets & Tags

These personal identification items are important for persons who are taking opioid medicines on a long-term basis or have serious medical conditions. They can help medical workers to more quickly start lifesaving treatment in an emergency, even if you are

unconscious and cannot speak.

Different types of ID items are available, at different costs. Many of them can be engraved with several lines of vital information, such as the medicines you are taking, your medical conditions, and personal identification.

Here are a few websites offering items for purchase:*

- MedIDs.com <click here>.
- American Medical ID <click here>.
- MedicAlert Foundation <click here>.

(Medical Alert Foundation also offers a 24-hour emergency medical information and notification service by subscription.)

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D. What should I do to keep my opioids safe?

It is VERY important that you protect your opioid pain relievers (and other medicines) as you would your money, jewelry, or other valuables. Unfortunately, some persons coming into your home, who you may least suspect, might look for opioids to take for their own use or to sell. This includes, friends or family — especially teens and young persons — service people, or other visitors. Also, many medicines can be ruined if they are not safely kept in a proper place. *Here are some tips:*

- Always store medicines in a dry, cool place — not cabinets or shelves in the bathroom, which can get warm and humid. The bathroom is also the first place someone would look if they want to steal your medicines.
- Keep medicines out of the reach of children, other persons, or pets, and out of sight — never on counter tops, tables, or bedside stands.
- It is a good idea to keep a rough count of your opioid medicines — whether pills, tablets, capsules, or patches — at all times, so you will know if any are missing. On liquid containers, place a pen mark at the lowest level after taking a dose. Keep in mind that thieves can be clever and may replace medicines that they steal with something that looks similar.
- It is best to keep prescription medicines safe in a locking container, cabinet, file drawer, or desk drawer. Someone you trust should be told where the medicines are stored and given an extra key or told the combination-lock numbers.

Two websites that feature locking medicine containers are:*

- LockMed (metal boxes) <click here>.
- RxLocker (pictured) <click here>.

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CAUTION: It is always better to go to the extra trouble of keeping medicines safe and locked up, rather than being sorry later if they are stolen and cannot be replaced, and possibly do someone harm.

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E. How can I dispose of unused opioid medicine?

It is very important that you do not save leftover opioid medicines. When you are finished taking a prescription, or if you are prescribed a different opioid to take its place, the leftover medicine must be properly disposed of right away.

Why get rid of leftover opioids?

1. Leftover opioid medicine can spoil with time and not work well or even be harmful if used after it has become old.
2. You should not keep unused opioids in your house. You may even forget that you have them but other persons

may even forget that you have them but other persons, children, or pets may find the medicines, swallow them, and do themselves serious harm.

How should you get rid of unused opioid medicines?

Because opioid pain relievers can be harmful to others for whom they were not prescribed — whether children, adults, or pets — the recommendation at this time is that opioids should be removed from their containers and ***flushed down the toilet***.

However, other medicines are not disposed of by flushing because there have been concerns about the chemicals getting into local water supplies. These medicines may be taken out of their containers, mixed with garbage (such as coffee grounds, food scraps, kitty litter, or other waste), put into a sealed plastic bag, and thrown into the trash.

NOTE: In all cases, the labels on medicine containers should have your name and other identifying information torn off or scratched out before being thrown into the household trash.

Drug "take-back programs" can be another good way to get rid of unused or old medicines and reduce the chance that they may end up in the wrong hands. Contact your local police department to see if there is a take-back program in your area, and if there are any rules about when and which medicines can be taken back.

You also should read the information that comes with your prescription, which usually tells how to safely dispose of the particular medicine. ***If in doubt, you can always ask your pharmacist.***

The U.S. Food & Drug Administration has a special website that talks about safe medicine disposal, including a list of opioids that should be flushed down the toilet <here>.

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F. What should I do if my opioids are lost or missing?

If you believe that your opioid medicine has been ***stolen***, you should call the police to file a report right away. Then, tell the healthcare provider who prescribed the opioid for you about the theft and request a replacement refill. You should be prepared to provide a copy of the police report.

If you ***lose or ruin*** your opioid medicine, call your opioid prescriber and describe what happened. However, you may not be able to get a replacement refill and will need to wait until your next refill date — so, be prepared.

If you cannot get a replacement refill of opioid medicine, or you are running out of medicine early, see Section 4 <here> for how to deal with opioid withdrawal in an emergency.

CAUTION: Doing everything you can to prevent opioid medicine theft or loss in the first place is the best approach. If either happens, your healthcare provider may be concerned that you are not responsibly and safely handling the medicine and may not continue to prescribe opioids for you.

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Go to the next section:
4. What should be done in an emergency? <click here>

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Document Dates: First publication - September 2010
Researcher/Writer: Stewart B. Leavitt, MA, PhD
Medical Reviewers: Edward Hesterlee, BS, PharmD, FACA; Seth I. Kaufman, MD; Lee A. Kral, PharmD, BCPS; James D. Toombs, MD; Winnie Dawson, MA, RN, BSN
Research Sources: For reference citations of sources used in developing Opioids911-Safety <click here>.

This page was last updated on February 07, 2011.

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Newest Additions/Updates...

Latest Pain-Topics *News/Research UPDATES*

Mixed Results Found in Review of Botox for Headaches

Although botulinum toxin A (Botox®) injections are approved for the preventive treatment of severe headache conditions, a recent review and meta-analysis of clinical trials found only small benefits in patients with chronic migraine or daily headaches. At the same time, the injections were no better than placebo for preventing episodic migraine or tension-type headaches. Read more>

Treatments for Sciatica Pain Disappointing

Sciatica applies to lumbosacral radiculopathy due to the impingement of nerve roots as they emerge from the spinal canal. Up to half of all cases of such spinal pain may be neuropathic in origin. A pair of recent studies examined treatments for sciatica and found that very few are helpful and they confer only modest and temporarily relief. Learn more here>

Other Recent Pain-Topics *UPDATES* of Interest...

> Opium, Opioids & Death: Sophistry vs Science

> Cancer Patients Still Undertreated for Pain

> Lethal Cocktails: Alcohol, Sedatives, & Opioids

> Is Acupuncture Just a "Meaningful Placebo"?

> New Perspectives on Safer Opioid Rotation

> Do Antidepressants Help Osteoarthritis Pain?

See *Table of Contents* for ALL UPDATES>

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Latest Continuing Education (CME) Postings

Chronic Pain in Primary Care: Low Back Pain

From: PAINClinician.com, 2012.
Reviews pathophysiologic processes and potential "red flags" of serious spinal pathology. Discusses testing, physical maneuvers to identify symptom origins, and individualized multimodal therapy. See details>

Pain Management in Rheumatology

Program reviews pathophysiologic mechanisms of pain, and the significance of genetic background, environmental factors, neurohormonal influences, and neuroplasticity. See details>

NEW Pain Treatment GUIDELINES/REPORTS

2012 Update of ACR Guidelines on DMARDs for Rheumatoid Arthritis

From: American College of Rheumatology; 2012.
Five topic areas are covered. Recommendations for both

Bulletins

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American Academy of Pain Management
American Association for the Treatment of Opioid Dependence
American Chronic Pain Association
American College of Apothecaries
American Pain Foundation
American Society of Pain Educators
European Opiate Addiction Treatment Association
National Fibromyalgia & Chronic Pain Association
National Fibromyalgia Association
Reflex Sympathetic Dystrophy Syndrome Association

nonbiologic and biologic DMARDs are presented, based on disease duration and several specific disease entities. Advice in provided on screening patients at risk for latent TB infection and using vaccines in patients beginning or already receiving DMARDs. See details>

Guidelines on Therapies for OA of the Hand, Hip, and Knee

Update of evidence-based guidelines from the American College of Rheumatology (ACR) for efficacy and safety of pharmacologic and nonpharmacologic approaches to osteoarthritis (OA). See details>

NEW Resources for Patients

Patient Resource Guide: Reducing Your Pain

Reviews the challenges of managing chronic pain and offers useful definitions and tools. Pharmacologic and nonpharmacologic pain treatments are described, along with safety considerations. (Supported by an educational grant from Endo Pharmaceuticals.) See details>

Spotlight on Fibromyalgia

Articles and resources on fibromyalgia,including the need for an accurate diagnosis. See details>

Managing Opioid Risks

New Resources Feature Naloxone for At-Home Opioid Overdose Rescue

*A new **website** and a short **video** tell everything you -- and your patients -- need to know about the use of naloxone at home to reverse opioid overdose. There are instructions sheets for healthcare providers, including where to get naloxone and how to bill for related services, instructions for patients/caregivers, medicolegal information, and other helpful resources.* Access resources here>

NEW in Pain Disorders

Loosening the Grip of Migraine Attacks

By: Wenzel R, Aurora SK; *Pharmacy Today*; 2012.
Educational monograph addresses migraine assessment and educating patients on the best use of over-the-counter products, the importance of therapy timing, and drug dosing information. The authors stress that 'stratified care' is the recommend therapeutic approach to replace 'step care' in migraine treatment. See details>

Pain Management in Patients with Cancer: Focus on Opioid Analgesics

Reviews opioid drugs as monotherapy or with adjuvant analgesics. See details>

Opioid Rx & Safety

Drug-Drug Interactions: Focus on Opioid Use in the Elderly and Long Term Care

Reviews factors — like cardiovascular and renal function, and P450 enzyme variations — which can alter an elderly patient's opioid concentration and cause adverse effects or therapeutic failure. See details>

Management of Opioid Tolerability and Adverse Effects

Review discusses how opioid adverse effects may be classed as inhibitory or excitatory, or both. Counter strategies are presented. See details>

Pain & Disability Assessment Tools to Note

Pain Assessment in Nonverbal Patients

This paper updates an earlier version from 2006. It defines populations at risk and offers clinical recommendations for pain assessment in those unable to self-report, including children and adults with cognitive impairments or other conditions limiting verbal communication. See details>

Pain Disorders Section: Shingles/PHN

Shingles, or acute herpes zoster infection, is a complication of reactivated varicella zoster virus (chicken pox). In turn, this may foster development of postherpetic neuralgia (PHN). This section explore all aspects of shingles/PHN, including diagnosis and treatment strategies. See listings>

Making Sense of Pain Research [Series]

Improving pain practice requires better research. However, healthcare professionals, and certainly patients, usually have had little specific training in evaluating research. This UPDATES series on "Making Sense of Pain Research" helps to close the education gap, teaching readers how to understand and interpret the often mysterious and complex language of research to assess its quality and validity. See listings>

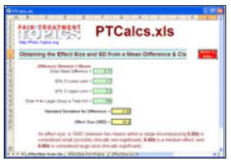
Opioids911-Safety!

Help for Safely Using Opioid Pain Relievers

Extensive, REMS-compliant, educational activity for patients and their caregivers focusing on the proper and safe use of opioid pain relievers. Pprovides an understanding of opioids and their risks. Vital instruction is provided on recognizing opioid problems and on being prepared for what to do during an emergency. Go to Opioids911.org>

SPECIAL ANNOUNCEMENTS

Be a Stats Wizard with *Free* PTCalcs



Knowing *effect sizes* of outcomes data is essential for understanding the clinical importance of pain research. **PTCalcs** from *Pain Treatment Topics* is a free, online MicroSoft® Excel® spreadsheet with 11 easy-to-use statistical calculators. Effect sizes and other vital parameters can be calculated by merely plugging-in data commonly found in published research reports. See details here>

UPDATED Opioid Analgesics Listing

Did you know that there is a complete and up-to-date listing of all FDA-approved opioid analgesics prescribed for at-home care available at Opioids911.org? Also included are direct links to the Medication Guides and REMS programs for applicable products. Click here>

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Stewart B. Leavitt, MA, PhD, Executive Director

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Opioid therapy is a cornerstone of severe acute and moderate-to-severe chronic pain management. Yet, resistance to opioid use can be a significant barrier to effective therapy.

Often, concerns about the perceived adverse effects and addictive properties of opioids, and/or regulatory scrutiny, cause these medications to be underused. Documents in this tab section address those concerns and help dispell the many misunderstandings.

- **OPIOID Rx & Safety** [General]
- **METHADONE Rx & Safety**
- **OXYCODONE Rx & Safety**
- **Opioid Risk Management**
- **Opioid Rx Regulatory & Legal Issues**
- **Addiction & Pain Treatment**

Also see the following sections for additional documents of interest:

- Opioid Clinical Guidelines: <Click Here>
- Opioid Systematic Reviews: <Click Here>
- Opioid Position/Policy/Consensus Statements: <Click Here>

Please register for e-Notifications to be alerted by e-mail of when this section is updated or there are announcements.

NEW = entry added or changed during the latest update.

P = ***Pain Treatment Topics*** exclusive document.

OPIOID Rx & Safety [General]

This section focuses on dispelling the myths surrounding opioid analgesics. Clinical guidance is provided for more effective application and prescribing of these vital pain medications, with a special emphasis on ***safety*** issues to prevent or manage adverse events.

View all details listings <Click Here> or select item below...

NEW **Drug-Drug Interactions: Focus on Opioid Use in the Elderly and Long Term Care**
By: Lynch T; from *American Journal of Managed Care*; 2011;17(Suppl 11):S293-S298 See details...>

Pharmacology of Opioids in the Treatment of Chronic Pain Syndromes
By: Ricardo Vallejo, MD, PhD; Robert L. Barkin, PharmD; and Victor C. Wang, PhD; from *Pain Physician*; 2011. See details...>

Management of Opioid Tolerability and Related Adverse Effects
By: Dmitry Arbuck, MD, et al. from *Journal of Medicine*, 2010. See details...>

Managing Chronic Pain with Opioids: A Call for Change
By: Paul Arnstein, PhD, RN; Barbara St. Marie, ANP. Nurse Practitioner Healthcare Foundation. 2010. See details...>

Opioids911-Safety
Help for Safely Using Opioids Pain Relievers from *Pain Treatment Topics*. See details...>

Patients Who Require Ultra-High Opioid Doses
By: Schneider J, Anderson A, Tennant F. *PPM*. 2009(Sep);9(7):10+. See details...>

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American Association for the Treatment of Opioid Dependence

American Chronic Pain Association

American College of Apothecaries

American Pain Foundation

American Society of Pain Educators

European Opiate Addiction Treatment Association

National Fibromyalgia & Chronic Pain Association

National Fibromyalgia Association

Reflex Sympathetic Dystrophy Syndrome Association

By: Howard S. Smith, MD. *Mayo Clinic Proceedings*. 2009(July).
See details...>

A Comparison of Long- and Short-Acting Opioids for Chronic Noncancer Pain

By: Charles E. Argoff, MD and Daniel I. Silvershein, MD. *Mayo Clinic Proceedings*. 2009(July). See details...>

Opioid Pharmacology

By: Andrea M. Trescot, MD, et al. *Pain Physician*. 2008(March);11: S133-S153. See details...>

Opioid Safety in Patients With Renal or Hepatic Dysfunction

From: ***Pain Treatment Topics*** - Sarah J. Johnson, PharmD, Updated November 2007. See details...>

Opioid Analgesics for Chronic Pain

By: Mary Lou Bossio, NP; from *Advance for Physician Assistants*; 2007.

See details...>

Managing Opioid-Induced Constipation

From: ***Pain Treatment Topics*** - Clyde R. Goodheart, MD, MBA, MS; Stewart B. Leavitt, MA, PhD, August 2006.
Also: Constipation... from *Consumer Reports Best-Buy-Drugs*, December 2008. See details of both articles...>

Overview of Oral Modified-Release Opioid Products for the Management of Chronic Pain

By: Calene M. Amabile, PharmD, BCPS, and Bill J. Bowman, BSPharm, PhD. Medscape, *Ann Pharmacother*; 2006;40(7). See details...>

Opioid Tapering: Safely Discontinuing Opioid Analgesics

From: ***Pain Treatment Topics*** - Lee A. Kral, PharmD, BCPS, March 2006. See details...>

Opioids for Chronic Nonterminal Pain

By: Jane C. Ballantyne, MD, FRCA; from Medscape; *South Med J*, 99(11); 2006. ***Also***: Use of Opioid Analgesics for the Treatment of Chronic Noncancer Pain; from Canadian Pain Society, 2003.

See details...>

VA/DoD Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain

From: Department of Veterans Affairs, Department of Defense; 2003.
Also available...
-- Opioid Assessment & Treatment Pocket Guide
-- Opioid Medications [Dosing] Pocket Guide

See details...>

Opioid/Medication Safety Information for Your Patients

-- How to Evaluate Health Information on the Internet
-- Proper Disposal of Prescription Drugs
-- Facts About Opioids, Methadone, Oxycodone, and Rx Drug Abuse
-- Buying Prescription Medicine Online: A Consumer Safety Guide

See details...>

See Opioid Therapy & Safety Guidelines <Click Here>

Also see the following in the *Current Comments* section...

- **The OIH Paradox: Can Opioids Make Pain Worse?** See Details...>
- **Using Objective Signs of Severe Pain to Guide Opioid Prescribing.** See Details...>
- **Opioid-Induced Sexual Dysfunction: Causes, Diagnosis, & Treatment.** See Details...>
- **Should Opioid Abusers Be Discharged From Opioid-Analgesic Therapy?** See Details...>
- **Maximizing Safety with Methadone & Other Opioids.** See Details...>
- **Overcoming Opiophobia & Doing Opioids Right.** See Details...>

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METHADONE Rx & Safety

The following evidence-based research reports focus on factors involved in safer prescribing of effective methadone analgesia.

Opioid Safety METHADONE

View all details listings <Click Here> or select item...

Methadone-Drug Interactions to Watch For

PCSS Guidance – Methadone and Drug Interactions

From: Physician Clinical Support System for Methadone (PCSS-M);

Elinore F. McCance-Katz, MD, PhD; updated July 2010.

Methadone-Drug* Interactions
(*Medications, illicit drugs, & other substances)
From: ***Pain Treatment Topics*** - Stewart B. Leavitt, PhD, 2006.
See details...>

Physician Clinical Support System – Methadone (PCSS-M)
From: SAMHSA/CSAT and ASAM; 2009. See details...>

Follow Directions: How to Use Methadone Safely [Public Outreach Campaign]
From: SAMHSA and FDA; 2009. See details...>

Oral Methadone Dosing for Chronic Pain:
A Practitioner's Guide
By: James D. Toombs, MD; from ***Pain Treatment Topics***, Updated March 2008. See details...>

Methadone Safety Handout for Patients (in English and Spanish)
By: Stewart B. Leavitt, MA, PhD; from ***Pain Treatment Topics***, Updated March 2008. See details...>

Keeping Patients Safe from Iatrogenic Methadone Overdoses
From: Institute for Safe Medication Practices (ISMP). February 14, 2008.
See details...>

FDA/DEA Public Health Advisories – Methadone Hydrochloride
From: US Food & Drug Administration and the Drug Enforcement Administration; various dates. See details...>

Revised Methadone Prescribing Information (PI) – October 2006
See details...>

Methadone-Associated Mortality – U.S. Government Reports
From: CSAT (Center for Substance Abuse Treatment), SAMHSA (Substance Abuse and Mental Health Services Administration), 2004

- A National Assessment of Methadone-Associated Mortality: Background Briefing Report
- Methadone-Associated Mortality: Report of a National Assessment

See details...>

Methadone Cardiac Concerns
From: *Addiction Treatment Forum* - Stewart B. Leavitt, MA, PhD; Mori J. Krantz, MD, FACC. October 2003. See details...>

"Zero Unintentional Deaths" — Methadone Safety
A special educational website under the direction of Lynn R. Webster, MD. See details...>

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OXYCODONE Rx & Safety

Oxycodone, alone and in combination with other analgesics, has been used for more than 80 years in the treatment of a variety of acute and chronic pain conditions. Compared with morphine, oxycodone has higher oral bioavailability and is considered twice as potent.

View all details listings <Click Here> or select item...

Commonsense Oxycodone Prescribing & Safety
From: ***Pain Treatment Topics*** - Lee A. Kral, PharmD, BCPS, June 2007. See details...>

Patient Instructions Handout: Safely Taking Oxycodone
From: ***Pain Treatment Topics*** - Lee A. Kral, PharmD, BCPS and Stewart B. Leavitt, MA, PhD; in English and Spanish, June 2007.
See details...>

Oxycodone: Pharmacological Profile and Clinical Data in Chronic Pain Management
By: F. Coluzzi and C. Mattia, in *Minerva Anesthesiologica*, 71(7-8), 2005.
See details...>

Oxycodone: Prescribing Information / Package Inserts (PIs)
See details...>

Criteria for Use of Controlled-release Oxycodone

By: Francine Goodman, PharmD, BCPS; William N. Jones, BSc, MSc; and Peter Glassman, MBBS, MSc.Washington, DC: Veterans Health Administration, Department of Veterans Affairs. Revised July 2003.

See details...>

Safety and Efficacy of Controlled-Release Oxycodone: A Systematic Literature Review

By: D. Gary Rischitelli, MD, JD, MPH, and Sean H. Karbowicz, PharmD. *Pharmacotherapy*. 2002;22(7):898-904. From Medscape Today.

See details...>

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Opioid Risk Management

Besides the potential for opioid analgesia adverse effects, which often can be controlled by safe prescribing practices, the risks of greatest concern have been opioid diversion, misuse, abuse, and addiction. Documents in this section offer guidance for better opioid risk management, including: patient risk assessment, risk minimization, and compliance monitoring.

View all details listings <Click Here> or select item below...

SECTION: Managing Opioid Emergencies

Managing An Opioid Crisis

What to know. What to do.

From: Opioids911-Safety; 2010. See details...>

Emergency Opioid Tapering During A Disaster

What to do when medication access is interrupted by disaster.

From: National Pain Foundation; undated. See details...>

Intranasal Naloxone for At-Home Opioid Rescue

By: Leavitt SB. *Practical Pain Management*. 2010(October);10(8):42-46.

See details...>

NEW Naloxone Prescribing Laws in the United States

From: Temple University, Beasley School of Law; Project on Harm Reduction in the Healthcare System. See details...>

Take-Home Naloxone (Website)

From: A consortium in the UK; updated continuously. See details...>

Naloxone – Drug Information (Labeling Info)

From: Merck Manual / Lexi-Comp. August 2008. See details...>

Using Naloxone – Fast Facts (Palliative Care)

By: von Gunten CF, Ferris F, and Weissman DE. Fast Fact and Concept #39: Using Naloxone, 2nd Ed. 2005(Jul). End-of-Life Palliative Education Resource Center. See details...>

Naloxone for the Reversal of Opioid Adverse Effects

By: Marcia L. Buck, PharmD in *Pediatr Pharm*. 2002;8(8). Reproduced on Medscape, 2002. See details...>

Intranasal Naloxone for Acute Opiate Overdose

From: Host source unspecified, undated. See details...>

SECTION: Clinical Tools for Assessing Opioid Risks

Clinical Tools for Assessing Opioid Risks

> **From PainEDU.org: SOAPP, COMM**
> **From EmergingSolutionsInPain.com: ORT, DAST, DIRE, CAGE-AID, SISAP, 5-Point Rx Opiate Abuse Checklist, POSIT**
> **From Health.Utah.gov: Checklist for Adverse Effects, Function, and Opioid Dependence**

See details for downloading tools....>

Monitoring Opioid Adherence in Chronic Pain Patients: Tools, Techniques, and Utility

By: Laxmaiah Manchikanti, MD, et al. *Pain Physician*. 2008(March);11: S155-S180. See details...>

SECTION: Urine Drug Screening/Testing

Urine Drug Testing in Chronic Pain

By: Christo PJ, PJ, Manchikanti L, Ruan X, et al. Pain Physician. 2011. See details...>

Urine Drug Testing in Clinical Practice:
The Art and Science of Patient Care
By: Douglas L. Gourlay, MD, FRCPC, FASAM; Howard A. Heit, MD, FACP, FASAM; Yale H. Caplan, PhD, D-ABFT. From: California Academy of Family Physicians. 2010. See details...>

A Clinical Guide to Urine Drug Testing:
Augmenting Pain Management and Enhancing Patient Care
By: Catherine A.Hammett-Stabler, PhD, DABCC, FACB and Lynn R.Webster,MD, FACPM, FASAM. From: University of Medicine & Dentistry of New Jersey, Center for Continuing & Outreach Education. 2008. See details...>

Urine Drug Screening: Practical Guide for Clinicians
By: Karen E. Moeller, PharmD, BCPP, et al. *Mayo Clinic Proceedings*. 2008;83(1):66-76. See details...>

SECTION: General Risk Minimization & Precautions

Use, Abuse, Misuse, and Disposal of Prescription Pain Medication Time Tool
From: American College of Preventive Medicine (ACPM), 2011.
See details...>

Commonsense Opioid-Risk Management in Chronic Noncancer Pain: *A Clinician's Perspective*
By: James D. Toombs, MD; from *Pain Treatment Topics*, August 2007.
See details...>

Avoiding Opioid Abuse While Managing Pain:
A Guide for Practitioners (Book)
By: Lynn R. Webster, MD, FACPM, FASAM, and Beth Dove; June 2007.
See review and ordering info...>

Patient Level Opioid Risk Management
By: Nathaniel P. Katz, MD, MS; from PainEDU.com, Inflexxion, Inc., 2007. See details...>

Assessing Obstructive Sleep Apnea Potential, Which May Affect Opioid Risk (*Snore Score*)
From: American Sleep Apnea Association. 2007. See details...>

Opioids for Pain: Risk Management
By: Steven Richeimer, MD; from California Society of Anesthesiologists; 2006. See details...>

Rapid-Onset Opioids: Recognizing and Preventing Abuse, Addiction, and Diversion
By: Lara K. Dhingra, PhD, and Steven D. Passik, PhD; from Medscape; 2006. See details...>

Universal Precautions in Pain Medicine:
The Treatment of Chronic Pain With or Without the Disease of Addiction
By: Douglas L. Gourlay, MD and Howard A. Heit, MD, in *Medscape Neurology & Neurosurgery*, 7(1), 2005. See details...>

Treating Pain and Preventing Abuse and Diversion
By: Brian Goldman, MD, MCFP, FACEP, from LearnSomething.com, 2005. See details...>

Opioid Risk Management - THCI Conference Presentations
From: Tufts Health Care Institute, 2005. See details...>

Also See: "Addiction & Pain Treatment " Section
Go to section below...>

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Opioid Rx Regulatory & Legal Issues

This section focuses on guidance and mandates coming from government agencies -- federal, state, or local -- or medical boards regarding the prescribing, dispensing, and administration of opioid medications.

View all details listings <Click Here> or select item...

U.S. FDA Opioid-REMS
From: U.S. Food and Drug Administration; 2011.
See details...>

DEA - Announcements

From: US Department of Justice, Drug Enforcement Administration. See details...>

DEA Office of Diversion Control - Bulletins

> **Don't Be Scammed By A Drug Abuser**
> **A Pharmacist's Guide to Prescription Fraud** See details...>

Achieving Balance in Federal and State Pain Policy

From: Pain & Policy Studies Group; University of Wisconsin Paul P. Carbone Comprehensive Cancer Center; Madison, Wisconsin; Updated July 2008. *Also available*: **Progress Report Card**. See details...>

Practitioner's Manual — An Informational Outline of the Controlled Substances Act

From: US Department of Justice, Drug Enforcement Administration, Office of Diversion Control, August 2006.
Also available: **Reference Lists of Controlled Substances**.
See details...>

Model Policy for the Use of Controlled Substances

From: Federation of State Medical Boards of the United States, Inc.; May 2004. See details...>

Prescription Monitoring Programs (PMPs)

From: Pain & Policies Study Group, University of Wisconsin and National Association for Model State Drug Laws. See details...>

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Addiction & Pain Treatment

The interface of addiction and pain treatment – particularly with opioid analgesics – is a common and vexing problem in clinical practice. This is complicated further by misunderstandings of distinctions between substance misuse, abuse, dependence, addiction, and pseudoaddiction.

This section of *Pain Treatment Topics* focuses on the clarification, identification, prevention, and treatment of addictive disorders within the context of pain and, conversely, on pain management with opioids in persons having a history of addiction.

View all details listings <Click Here> or select item below...

EUROPAD Journal on Addiction

Full editions available for free download as PDF documents. See journal listings...>
A *Pain Treatment Topics* affiliate organization.

Basics of Addiction: A Training Manual for Medical Practitioners on Opioid Dependence

From: Europad Journal on Addiction – June 2011. See details...>

SAMHSA Substance Abuse Treatment Facility Locator

From: U.S. Substance Abuse & Mental Health Services Administration (SAMHSA). Regularly updated. See details...>

NIDA*MED* Resources for Medical and Health Professionals [Drug Screening]

From: NIDA (National Institute on Drug Abuse); 2009. See details...>

Principles of Drug Addiction Treatment: A Research Based Guide (2nd Edition)

From: NIDA (National Institute on Drug Abuse); Revised April 2009.
See details...>

Best Biomarkers to Detect Underreported Alcohol Use

By: David R. Spiegel, MD; Neetu Dhadwal, MD; Frances Gill, MD. From *Current Psychiatry*; 2008 (September). See details...>

Challenges in Using Opioids to Treat Pain in Persons With Substance Use Disorders

By: Seddon R. Savage, MD, Kenneth L. Kirsh, PhD, and Steven D. Passik, PhD. From *Addiction Science & Clinical Practice* (a NIDA publication). 2008(June). See details...>

The Management of Breakthrough Pain With Rapid-Onset Opioids: Abuse, Addiction, and Diversion

By: Steven D. Passik, PhD and Kenneth L. Kirsh, PhD. From *Medscape Neurology & Neurosurgery*. 2008. See details...>

The New Science of Addiction

From: University of Utah, Genetics Science Learning Center. Updated 2008. See details...>

Safe Treatment of Pain in the Patient With a Substance Use Disorder

By: Penelope P. Ziegler, MD, FASAM; Psychiatric Times (CMP Medica), 24(1), 2007. See details...>

Pain Management Without Psychological Dependence: A Guide for Healthcare Providers

From: Substance Abuse and Mental Health Services Administration (SAMHSA). Substance Abuse in Brief Fact Sheet. 2006(Summer);4(1). See details...>

Pain in Opioid-Addicted Patients Entering Addiction Treatment

By: Stewart B. Leavitt, MA, PhD, revised July 2006. Adapted from *Addiction Treatment Forum*, 2004 (Winter);13(1). See details...>

Treatment of Acute Pain in Patients Receiving Buprenorphine/Naloxone for Addiction

By: David Fiellin, MD; from the Physician Clinical Support System (PCSS), 2005. See details...>

ASPMN Position Statement: Pain Management in Patients with Addictive Disease

From: American Society for Pain Management Nursing (ASPMN), September 2002. See details...>

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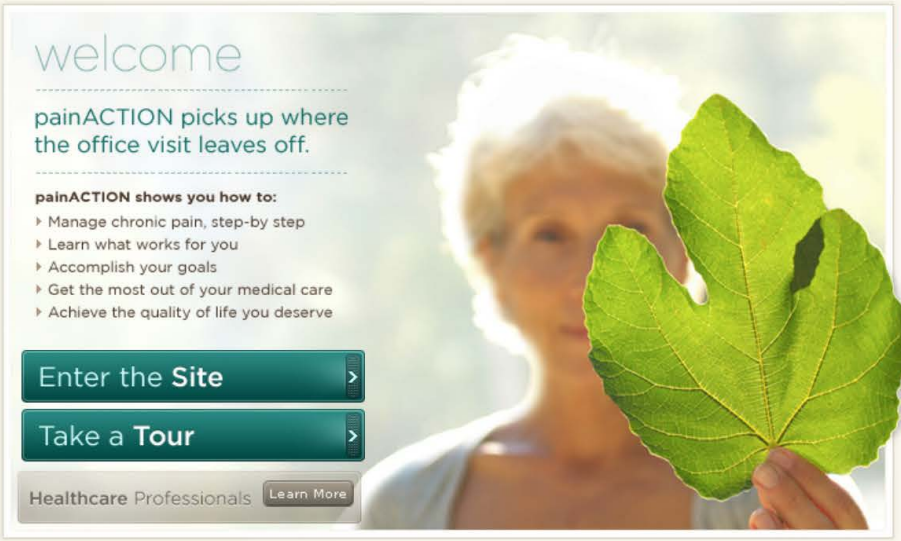

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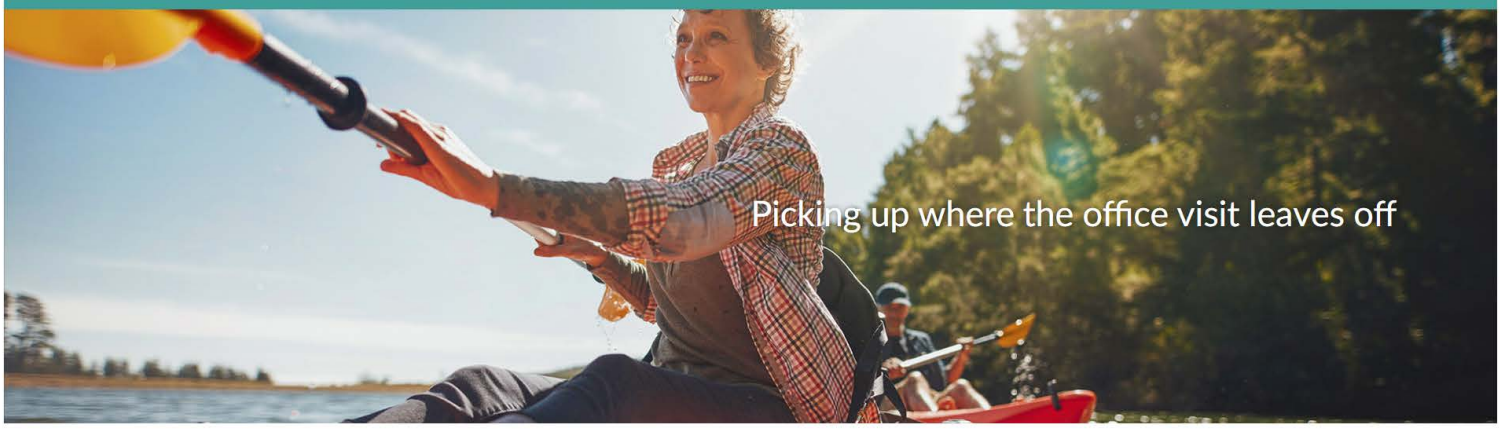

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Blog

Highlights from the 2012 NASPA Alcohol and Other Drug Prevention and Intervention Conference A few weeks ago, four MyStudentBody team members attended the 2012 NASPA Alcohol Abuse Prevention & Intervention Conference in Atlanta, Georgia. It was a great conference and we learned a lot as well as talked with dozens of dedicated, passionate college alcohol and other drug professionals.

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Chronic Opioid Therapy: Preparing for Your Appointments
NEW! If you are prescribed an opioid for pain relief, there are many things that you need to know. This handout, which has been reviewed by people with pain currently taking opioids, will help you to prepare for follow-up medical appointments and better communicate with your healthcare provider. *Note: This handout cannot be personalized.*

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Chronic Opioid Therapy: Dos and Don'ts to Help Avoid Problems
NEW! This handout provides tips for staying safe and avoiding problems related to chronic opioid therapy. Reviewed by people with pain currently taking opioids, this handout can help you to stay on top of your pain care and better communicate with your healthcare provider. *Note: This handout cannot be personalized.*
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In this handout tailored for those caring for older people with persistent pain, we offer tips for recognizing signs of pain, reducing pain and discomfort, and speaking with healthcare providers.
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- Pain Community News: Print Newsletter Archive
- Pain Bulletin Archive
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- Pain Action Guide Word 40KB, PDF 86KB

- Target Chronic Pain Pocket Card PDF 260KB
- Pain Notebook PDF 301KB

- Pain Care Bill Of Rights (English) Word 114KB, PDF 40KB
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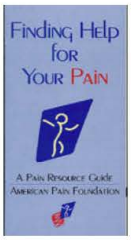

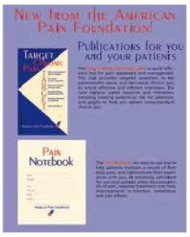

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Highlights

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Pain Question & Answer

Addiction
by Scott M. Fishman, MD

Question: What is addiction, and how is it possible that I won't become addicted if I take pain medication?

Answer: Addiction is a complex disease. It involves the body and the mind. Addiction is very much misunderstood by those of us who work in medicine, as well as by our patients, and by our society at large. There are many myths and misconceptions about addiction, causing a great deal of fear and anxiety, some of which is warranted, but much of which is not.

Addiction is defined differently by many different medical, religious, and social organizations that try to define it. One of the key elements that we do know clearly defines addiction is that it is a biological, psychological, and sociological phenomenon. What this phenomenon means is that addiction involves the body, the mind, one's environment, genetic make-up, and social situation.

When physicians define addiction to a drug it means that a drug is used by the patient in a compulsive manner. This compulsive use of the drug causes dysfunction in the patient's life, and the patient chooses to continue to use the drug compulsively, despite that dysfunction. The continued use of the substance to which one is addicted becomes "out of the control" of the individual and causes harm.

This is quite the opposite of what doctors strive for in treating chronic pain with medications that can be "addictive." This is to say, that when we treat someone with chronic pain, such as with an opioid drug like morphine or a morphine derivative, we are seeking to improve the function of the patient as a result of administering the drug.

Pain is always subjective, so we in Pain Medicine look for an objective marker of improvement when we prescribe any medication. This marker, or milestone, is usually a measure of increased quality of life for the patient, which is typically seen as increased function. If a patient cannot complete the basic activities of daily life because they are in so much pain, (for example, they cannot get out of their reclining chair even to sleep in a bed, or they are unable to take the children to a Little League game, or they cannot physically get out of the house to look for a job), and they start on medication that allows them to complete these activities, then the drug has been successful. Therefore, the marker to determine if the medication is actually a success is measured by the manner in which patients are able to improve the function and the quality of their lives. We therefore often ask patients to bring to the clinic daily written records of their activities, and to also bring a family member to talk about what they couldn't do before the treatment, and what they can now accomplish after starting the treatment. These are things that physicians can objectively measure and evaluate to determine if the drug is working. When someone is addicted to a medication, his or her function usually does not improve and frequently decreases.

There is also a great deal of confusion around terms that are associated with addiction. In many medical circles these confused terms often do not have any central connection to the real phenomenon of addiction. One good example of this problem is the term "physical dependence." Physical dependence is often used as equivalent to addiction, and in fact, it is not equivalent at all. Physical dependence means that one's body has become dependent on a substance. If that substance is taken away, there will be a reaction called "withdrawal." Sometimes, withdrawal can even be life-threatening.

There are many drugs that can cause physical dependence. Physical dependence is an intrinsic pharmacological property of a drug and many of the drugs that cause physical dependence are not addictive. One good example is clonidine, a medicine for high blood pressure. If clonidine is stopped suddenly, a life-threatening withdrawal reaction can occur. Surprisingly, drugs like morphine or other opioid medications, which also can cause physical dependence, usually don't cause life-threatening withdrawal reactions. A familiar substance that often causes physical dependence is caffeine. This withdrawal reaction is typically manifested as a headache and can occur if one becomes accustomed to consuming caffeine and suddenly stops.

Another common term that is associated with addiction but really has more to do with the pharmacological properties of a drug is that of "tolerance." Tolerance means that a drug wears off in the patient's body over time. Patients who have become tolerant to a medication need more and more of the drug to obtain the same effect. In other words, the same amount of the drug over time appears to deliver less and less effect. This

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amount of the drug over time appears to deliver less and less effect. This again is a pharmacological property of a drug and is seen with many drugs and does not necessarily herald addiction as a problem.

Unfortunately, many patients become very concerned about addiction when phenomena like physical dependence and tolerance are either possible or do occur. Unfortunately, many patients resist using medications that might help them because they equate the misconception of physical dependence or tolerance with addiction, which really is not the case.

We know that many of the medications that physicians prescribe can cause addiction. In such cases, doctors must watch closely for the signs of addiction, and if they occur, ease the patient off the drug. This is no different than any other side effect from any other drug. For instance, if one gives an antibiotic, there is always a risk of an allergic reaction, and if it occurs, the doctor simply stops the drug.

In the case of using addictive drugs for chronic pain, pain doctors have the advantage of knowing that the hallmark of addiction is opposite to the hallmark of effective chronic pain management. This vital key to successful pain management is to manage the pain in order to improve the function and quality of the patient's life.

March, 2004

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SAFETY TOOLS & RESOURCES

Consumers

General Resources

- Be MedWise
- Center for Medication Safety
- Drug Interaction Checker (AARP)
- Drug Interaction Checker (Drugs.com)
- FAQ: When Opioids Have Been Prescribed for My Chronic Pain
- Good Medicine, Bad Behavior: Drug Diversion in America
- Institute for Safe Medication Practices (ISMP)
- Medicines in My Home - Information on Using OTC Medicines Safely
- National Council on Patient Information and Education
- Pain Community News – Winter 2010
- The Buzz Takes Your Breath Away . . . Permanently. Misuse of Prescription Pain Relievers Can Kill You
- Using Acetaminophen and Nonsteroidal Anti-inflammatory Drugs Safely
- Your Medicine: Play It Safe

Disposal Resources

- Disposal by Flushing of Certain Unused Medicines: What You Should Know. Updated January 2012
- Proper Disposal of Prescription Drugs. October 2009
- Safe Medicine Disposal for ME Program
- Smart Rx Disposal
- The Drug Take-Back Network: Local Efforts. Find Out What's Happening in Your Area

Family Resources

- Getting High on Prescription and Over-the-Counter Drugs Is Dangerous. A Guide to Keeping Your Teenager Safe in a Changing World.
- Is This Where Your Teen Goes to Get High?
- Keeping Your Teens Drug-Free: A family Guide. National Youth Anti-Drug Media Campaign
- Lock Your Meds
- Not In My House
- Not In My House. What to Do: 3 Steps
- Prescription Drug (Rx) Abuse. National Youth Anti-Drug Media Campaign
- Preventing Drug Use Among Children and Adolescents: A Research-Based Guide for Parents, Educators, and Community Leaders
- Preventing Teen Abuse of Prescription Drugs. Fact sheet

Tools

- Chronic Opioid Therapy: Dos and Don'ts to Help Avoid Problems
- Chronic Opioid Therapy: Preparing for Your Appointments
- Home Medicine Inventory Card
- Six Opioids Safety (SOS) Steps
- Target Chronic Pain Notebook: Taking Charge of Your Pain Care
- The Medicine Safety: A Toolkit for Families

Health Care Professionals

Books

- Webster; LR, Dove B. Avoiding Opioid Abuse While Managing Pain: A Guide for Practitioners. North Branch, MD: Sunrise River Press; 2007.
- Fine PG, Portenoy RK. Fishman SM. A Clinical Guide to Opioid Analgesia. Vendome Group Healthcare Division, 2007.
- Responsible Opioid Prescribing: A Physician's Guide. Federation of State Medical Boards, 2007.

Guidelines/Regulations

- Clinical Guidelines For the Use of Chronic Opioid Therapy in Chronic Noncancer Pain.
  Chou R, Fanciullo GJ, Fine PG, et al. J Pain. 2009;10:113-130.
- Howard A. Heit, MD, FACP, FASAM., Aaron M. Gilson, MS, MSSW, PhD. Federal Regulations on Prescribing a Control Substance, American Society of Addiction Medicine.
- Model policy for the use of controlled substances for the treatment of pain. 2004.
  Federation of State Medical Boards of the United States, Inc.
- Opioids for Chronic Noncancer Pain: Prediction and Identification of Aberrant Drug-Related Behaviors: a review of the evidence for an American Pain Society and American Academy of Pain Medicine clinical practice guideline.
  Chou R, Fanciullo GJ, Fine PG, Miaskowski C, Passik SD, Portenoy RK. J Pain. 2009;10:131-146.
- Practitioner's Manual: An Informational Outline of the Controlled Substances Act, 2010.
  Drug Enforcement Administration, Office of Diversion Control. Washington, DC, Drug Enforcement Administration.
- Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain – Sixth Edition. 2008.
  American Pain Society
- Risk Evaluation and Mitigation Strategies (REMS) Resources, 2010. Emerging Solutions in Pain.>

Tools

- Chronic Opioid Therapy Worksheet: Companion to Chronic Pain Treatment
- Six Opioids Safety (SOS) Steps

Are You PainSAFE?

People who regularly take opioid pain medications are addicted to the medications.

TRUE
FALSE

http://web.archive.org/web/20110429072732/fsmb.org/pain-overview.html

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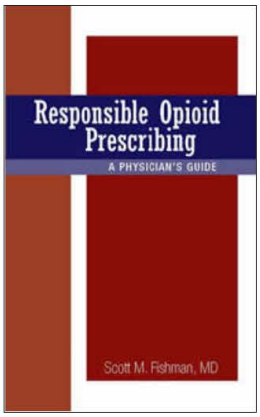
RESPONSIBLE OPIOID PRESCRIBING: A PHYSICIAN'S GUIDE



Inside This Book:

Note:

This activity is approved for AMA PRA Category 1 Credits™. For more information about the CME activity, please click here

Responsible Opioid Prescribing offers physicians effective strategies for reducing the risk of addiction, abuse and diversion of opioids that they prescribe for their patients in pain. Written by pain medicine specialist Scott M. Fishman, M.D., this concise handbook translates the Federation of State Medical Board's *Model Policy for the Use of Controlled Substances for the Treatment of Pain* into pragmatic steps for risk reduction and improved patient care, including:

- Patient evaluation, including risk assessment
- Treatment plans that incorporate functional goals
- Informed consent and prescribing agreements
- Periodic review and monitoring of patients
- Referral and patient management
- Documentation
- Compliance with state and federal law

Scott M. Fishman, M.D., is a leading pain medicine clinician, researcher, teacher, lecturer and writer. He is chief of the Division of Pain Medicine and professor of Anesthesiology at the University of California, Davis. Board-certified in Psychiatry, Internal Medicine, Hospice and Palliative Medicine, and Pain Medicine, Dr. Fishman is past president of the American Academy of Pain Medicine, author of *The War on Pain* and *Listening to Pain*, and coauthor of *The Massachusetts General Hospital Handbook of Pain Management and Essentials of Pain Medicine*.

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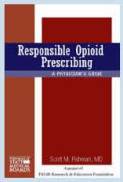
Professional Pain Education



Responsible Opioid Prescribing - CME Accredited Version and Online Activity Now Available!

A Continuing Medical Education (CME) accredited version of *Responsible Opioid Prescribing: A Physician's Guide* is now available for purchase. The activity, which is jointly sponsored by the University of Wisconsin School of Medicine and Public Health, and the Federation of State Medical Boards (FSMB), is approved for *AMA PRA Category 1 Credits™*. For more information about the CME activity, including the accreditation information and how to register for the online CME post-test, please click here.

Pain Resource Nurse Program Curriculum & Planning Guide

This 700+Â page guide which is available on CD and flashdrive, contains educational modules and tools in Word and PowerPoint formats.
It is designed to assist clinicians/educators in hospital settings to coordinate and implement a Pain Resource Nurse (PRN) Program.Â It includes content on the prevalence and impact of pain; basic pain physiology; assessment of pain; pharmacological and non-pharmacological management; methods of drug delivery; treatment of acute, chronic and cancer pain; management of patients with substance abuse disorders; and the PRN Role. The Guide also proves an overview of the PRN Program concept, practical tips on how to coordinate, budget, and evaluate a PRN training course as well as information on how to support and engage the PRNs who are trained.

Detecting Discomfort in Dementia: Focus on Behaviors

This video toolkit is designed to teach nursing assistants to identify the behaviors that cognitively impaired residents may show when they are in pain or discomfort, and to understand the ways they can help cognitively impaired residents get relief of their pain or discomfort.

Discounted: "Building an Institutional Commitment to Pain Management"

This practical resource will help you make high quality, cost-effective pain management a reality in your clinical setting, whether it is a hospital, home care agency, clinic, or long term care facility. It provides a comprehensive plan as well as over 100 sample resource tools contributed by leaders in pain quality improvement around the country.

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MODEL GUIDELINES FOR THE USE OF CONTROLLED SUBSTANCES FOR THE TREATMENT OF PAIN

THE FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC.

(Adopted May 2, 1998)

Section I: Preamble

The (*name of board*) recognizes that principles of quality medical practice dictate that the people of the State of (*name of state*) have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as to reduce the morbidity and costs associated with untreated or inappropriately treated pain. The Board encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially important for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about effective methods of pain treatment as well as statutory requirements for prescribing controlled substances.

Inadequate pain control may result from physicians' lack of knowledge about pain management or an inadequate understanding of addiction. Fears of investigation or sanction by federal, state, and local regulatory agencies may also result in inappropriate or inadequate treatment of chronic pain patients. Accordingly, these guidelines have been developed to clarify the Board's position on pain control, specifically as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

The Board recognizes that controlled substances, including opioid analgesics, may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. Physicians are referred to the U.S. Agency for Health Care and Research Clinical Practice Guidelines for a sound approach to the management of acute[1] and cancer-related pain.[2]

The medical management of pain should be based upon current knowledge and research and includes the use of both pharmacologic and non-pharmacologic modalities. Pain should be assessed and treated promptly and the quantity and frequency of doses should be adjusted according to the intensity and duration of the pain. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

The (*state medical board*) is obligated under the laws of the State of (*name of state*) to protect the public health and safety. The Board recognizes that inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Physicians should be diligent in preventing the diversion of drugs for illegitimate purposes.

Physicians should not fear disciplinary action from the Board or other state regulatory or enforcement agency for prescribing, dispensing, or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice. The Board will consider prescribing, ordering, administering, or dispensing controlled substances for pain to be for a legitimate medical purpose if based on accepted scientific knowledge of the treatment of pain or if based on sound clinical grounds. All such prescribing must be based on clear documentation of unrelieved pain and in compliance with applicable state or federal law.

Each case of prescribing for pain will be evaluated on an individual basis. The board will not take disciplinary action against a physician for failing to adhere strictly to the provisions of these guidelines, if good cause is shown for such deviation. The physician's conduct will be evaluated to a great extent by the treatment outcome, taking into account whether the drug used is medically and/or pharmacologically recognized to be appropriate for the diagnosis, the patient's individual needs including any improvement in functioning, and recognizing that some types of pain cannot be completely relieved.

The Board will judge the validity of prescribing based on the physician's treatment of the patient and on available documentation, rather than on the quantity and chronicity of prescribing. The goal is to control the patient's pain for its duration while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors. The following guidelines are not intended to define complete or best practice, but rather to communicate what the Board considers to be within the boundaries of professional practice.

Section II: Guidelines

The Board has adopted the following guidelines when evaluating the use of controlled substances for pain control:

1. Evaluation of the Patient

A complete medical history and physical examination must be conducted and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record should also document the presence of one or more recognized medical indications for the use of a controlled substance.

2. Treatment Plan

The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

3. Informed Consent and Agreement for Treatment

The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient, or with the patient's surrogate or guardian if the patient is incompetent. The patient should receive prescriptions from one physician and one pharmacy where possible. If the patient is determined to be at high risk for medication abuse or have a history of substance abuse, the physician may employ the use of a written agreement between physician and patient outlining patient responsibilities including (1) urine/serum medication levels screening when requested (2) number and frequency of all prescription refills and (3) reasons for which drug therapy may be discontinued (i.e. violation of agreement).

4. Periodic Review

At reasonable intervals based upon the individual circumstance of the patient, the physician should review the course of treatment and any new information about the etiology of the pain. Continuation or modification of therapy should depend on the physician's evaluation of progress toward stated treatment objectives such as improvement in patient's pain intensity and improved physical and/or psychosocial function, such as ability to work, need of health care resources, activities of daily living, and quality of social life. If treatment goals are not being achieved, despite medication adjustments, the physician should re-evaluate the appropriateness of continued treatment. The physician should monitor patient compliance in medication usage and related treatment plans.

5. Consultation

The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangement pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care, monitoring, documentation, and consultation with or referral to an expert in the management of such patients.

6. Medical Records

The physician should keep accurate and complete records to include (1) the medical history and physical examination (2) diagnostic, therapeutic and laboratory results (3) evaluations and consultations (4) treatment objectives (5) discussion of risks and benefits (6) treatments (7) medications [including date, type, dosage, and quantity prescribed] (8) instructions and agreements and (9) periodic reviews. Records should remain current and be maintained in an accessible manner and readily available for review.

7. Compliance with Controlled Substances Laws and Regulations

To prescribe, dispense, or administer controlled substances, the physician must be licensed in the state, and comply with applicable federal and state regulations. Physicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration and (*any relevant documents issued by the state medical board*) for specific rules governing controlled substances as well as applicable state regulations.

Section III: Definitions

For the purposes of these guidelines, the following terms are defined as follows:

Acute pain: Acute pain is the normal, predicted physiological response to an adverse chemical, thermal, or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time limited and is responsive to opioid therapy, among other therapies.

Addiction: Addiction is a neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to by terms such as "drug dependence" and "psychological dependence." Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

Analgesic Tolerance: Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.

Chronic Pain: A pain state which is persistent and in which the cause of the pain cannot be removed or otherwise treated. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease.

Pain: an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

Physical Dependence: Physical dependence on a controlled substance is a physiologic state of neuroadaptation which is characterized by the emergence of a withdrawal syndrome if drug use is stopped or decreased abruptly, or if an antagonist is administered. Physical dependence is an expected result of opioid use. Physical dependence, by itself, does not equate with addiction.

Pseudoaddiction: Pattern of drug-seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction.

Substance Abuse: Substance abuse is the use of any substance(s) for non-therapeutic purposes; or use of medication for purposes other than those for which it is prescribed.

Tolerance: Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect or a reduced effect is observed with a constant dose.

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[1]Acute Pain Management Guideline Panel. Acute Pain Management: Operative or Medical Procedures and Trauma. Clinical Practice Guideline. AHCPR Publication No. 92-0032. Rockville, Md. Agency for Health Care Policy and Research. U.S. Department of Health and Human Resources, Public Health Service. February 1992.

[2]Jacox A, Carr DB, Payne R, et al. Management of Cancer Pain. Clinical Practice Guideline No. 9. AHCPR Publication No. 94-0592. Rockville, Md. Agency for Health Care Policy and Research, U.S. Department of Health and Human Resources, Public Health Service. March 1994.

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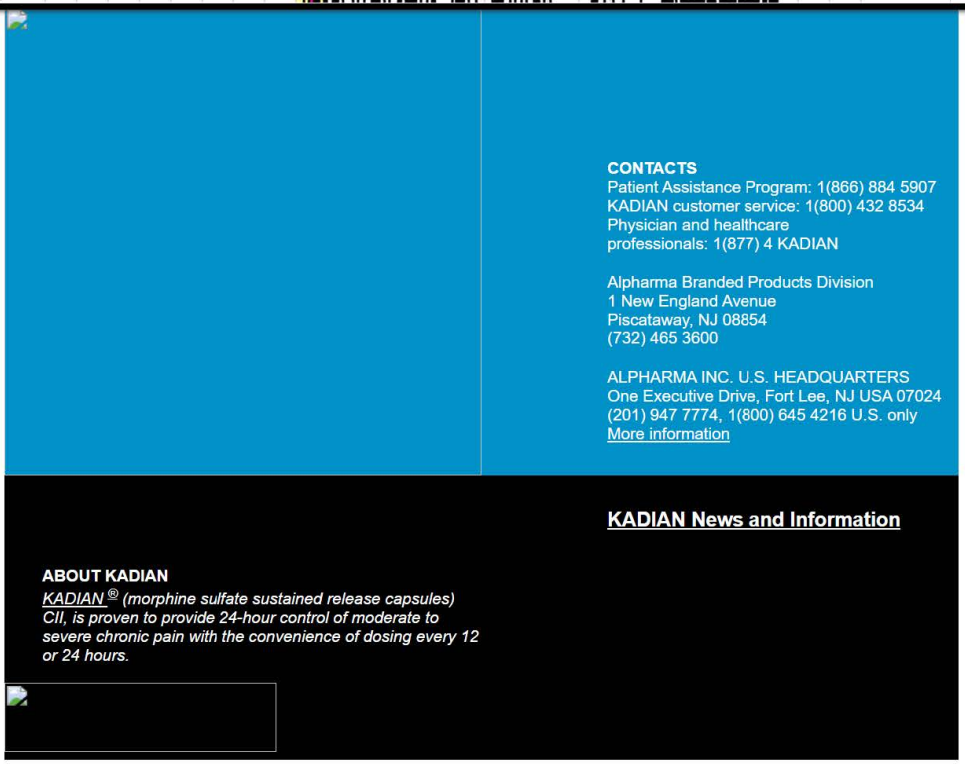

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ABOUT KADIAN
KADIAN® (morphine sulfate sustained release capsules) CII, is proven to provide 24-hour control of moderate to severe chronic pain with the convenience of dosing every 12 or 24 hours.

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PHYSICIANS AND OTHER HEALTHCARE PROVIDERS MUST BECOME FAMILIAR WITH THE IMPORTANT WARNINGS IN THIS LABEL.

FENTORA **contains fentanyl, an opioid agonist and a Schedule II controlled substance, with an abuse liability similar to other opioid analgesics.** ***FENTORA*** **can be abused in a manner similar to other opioid agonists, legal or illicit. This should be considered when prescribing or dispensing** ***FENTORA*** **in situations where the physician or pharmacist is concerned about an increased risk of misuse, abuse or diversion. Schedule II opioid substances which include morphine, oxycodone, hydromorphone, oxymorphone, and methadone have the highest potential for abuse and risk of fatal overdose due to respiratory depression.**

FENTORA **is indicated for the management of breakthrough pain in patients with cancer who are already receiving and who are tolerant to opioid therapy for their underlying persistent cancer pain.** Patients considered opioid tolerant are those who are taking at least 60 mg of oral morphine/day, at least 25 mcg of transdermal fentanyl/hour, at least 30 mg of oxycodone daily, at least 8 mg of oral hydromorphone daily or an equianalgesic dose of another opioid for a week or longer.

Because life-threatening respiratory depression could occur at any dose in opioid non-tolerant patients, *FENTORA* is **contraindicated** in the management of acute or postoperative pain. **This product is not indicated for use in opioid non-tolerant patients.**

Patients and their caregivers must be instructed that ***FENTORA*** **contains a medicine in an amount which can be fatal to a child. Patients and their caregivers must be instructed to keep all tablets out of the reach of children. (See Information for Patients and Their Caregivers for disposal instructions.)**

Due to the higher bioavailability of fentanyl in ***FENTORA*****, when converting patients from other oral fentanyl products, including oral transmucosal fentanyl citrate (OTFC and Actiq®), to** ***FENTORA*****, do not substitute** ***FENTORA*** **on a mcg per mcg basis. Adjust doses as appropriate. (See DOSAGE AND ADMINISTRATION.)**

FENTORA **is intended to be used only in the care of opioid tolerant cancer patients and only by healthcare professionals who are knowledgeable of and skilled in the use of Schedule II opioids to treat cancer pain.**

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A

- Acetasol HC Otic Solution
- Acyclovir Oral Suspension, USP
- Alprazolam Extended-Release Tablets, USP CIV
- Alprazolam Orally Disintegrating Tablets CIV
- Alprazolam Tablets, USP CIV

B

- Bacitracin Zinc Ointment, USP (OTC)
- Betamethasone Diprcpionate Cream, USP
- Betamethasone Dipropionate Ointment, USP
- Betamethasone Diprcpionate Ointment, USP (Augmented)
- Betamethasone Valerate Cream, USP
- Betamethasone Valerate Ointment, USP
- buPROPion Hydrochloride Extended-Release Tablets (XL)
- buPROPion Hydrochloride Extended-Release Tablets, USP (SR)
- buPROPion Hydrochloride Extended-Release Tablets, USP (SR)

C

- Carbidopa and Levodopa Tablets, USP
- Children's Ibuprofen Oral Suspension, USP (OTC)
- Clonazepam Tablets, USP CIV
- Clonidine Hydrochloride Tablets, USP
- Clotrimazole and Betamethasone Dipropionate Cream, USP
- Clotrimazole Vaginal Cream, USP (OTC)
- Constulose (Lactulose Solution, USP)
- Cyproheptadine Hydrochloride Oral Solution, USP

D

- Desipramine Hydrochloride Tablets, USP
- Desonide Lotion
- Diclofenac Sodium Delayed-Release Tablets, USP
- Diclofenac Sodium Extended-Release Tablets, USP
- Diltiazem CD (Diltiazem Hydrochloride Extended-Release Capsules, USP)
- Donepezil Hydrochloride Tablets

E

- Enulose (Lactulose Solution, USP)
- Etodolac Tablets, USP

F

- Fentanyl Transdermal System CII
- FeverAll® Acetaminophen Rectal Suppositories (OTC)
- Finasteride Tablets, USP

G

- Gabapentin Capsules, USP
- Gabapentin Tablets, USP
- Glyburide and Metformin Hydrochloride Tablets, USP
- Griseofulvin Oral Suspension, USP (microsize)

H

- Hydrochlorothiazide Tablets, USP
- Hydrocortisone and Acetic Acid Otic Solution, USP
- Hydrocortisone Cream plus 12 moisturizers (OTC)
- Hydrocortisone Cream, USP (OTC)
- Hydrocortisone Cream, USP (Rx)
- Hydrocortisone Cream, USP with Aloe (OTC)
- Hydrocortisone Ointment, USP (OTC)
- Hydrocortisone Ointment, USP (Rx)
- Hydromet Syrup CIII

I

- Ibuprofen Oral Suspension, USP (Rx)
- Indapamide Tablets, USP
- Isosorbide Mononitrate Tablets, USP

K

- KADIAN® Morphine Sulfate Extended-Release Capsules CII

L

- Levetiracetam Oral Solution
- Lorazepam Tablets, USP CIV
- Lovastatin Tablets, USP

M

- Metoclopramide Tablets, USP
- Metronidazole Lotion
- Metronidazole Topical Cream
- Miconazole Nitrate Cream (OTC)
- Miconazole Nitrate Vaginal Cream, USP (OTC)
- Miconazole Nitrate Vaginal Suppositories (Rx)

Miconazole Nitrate Vaginal Suppositories, USP (OTC)

Minoxidil Topical Solution, USP for Men (OTC)

Minoxidil Topical Solution, USP for Men Extra Strength (OTC)

N

Nifedipine Capsules, USP

Nifedipine Extended-Release Tablets

O

Ondansetron Tablets, USP

Oxazepam Capsules, USP CIV

Oxycodone Hydrochloride and Ibuprofen Tablets CII

Oxycodone Hydrochloride Tablets, USP CII

Oxymorphone Hydrochloride Extended-Release Tablets CII

P

Pantoprazole Delayed Release Tablets, USP

Permethrin Cream

Permethrin Lotion (OTC)

Phenytoin Oral Suspension, USP

Pilocarpine Hydrochloride Tablets

Prometh with Codeine Cough Syrup - CV

Propranolol Hydrochloride Extended-Release Capsules, USP

Propylthiouracil Tablets, USP

R

Ranitidine Syrup (Ranitidine Oral Solution, USP)

S

Spironolactone Tablets, USP

T

Tamsulosin Hydrochloride Capsules, USP

Temazepam Capsules, USP CIV

Tretinoin Cream

Triple Antibiotic Ointment

V

Valacyclovir Hydrochloride Tablets

Z

Zolpidem Tartrate Extended-Release Tablets, USP CIV

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Actavis Completes Allergan Acquisition

MEDIA CONTACTS

Mark Marmur
Tel: +1 (862) 261 7558
Email: mark.marmur@actavis.com

Lisa DeFrancesco
Investor Relations
Tel: +1 (862) 261 7152
Email: investor.relations@actavis.com

DUBLIN, IRELAND – March 17, 2015 – Actavis plc (NYSE: ACT) today announced that it has completed the acquisition of Allergan, Inc. (NYSE: AGN) in a cash and equity transaction valued at approximately $70.5 billion. The combination creates one of the world's top 10 pharmaceutical companies by sales revenue, with combined annual pro forma revenues of more than $23 billion anticipated in 2015.

"The combination of Actavis and Allergan creates an exceptional global pharmaceutical company and a leader in a new industry model – Growth Pharma," said Brent Saunders, CEO and President of Actavis. "Anchored by world-renowned brand franchises, a leading global generics business, a premier pharmaceutical development pipeline and an experienced management team committed to maintaining highly efficient operations across the organization, we are creating an unrivaled foundation for long-term growth.

"Our combined company will be built around a customer-focused commitment to partnering with physicians, pharmacists and patients to deliver innovative treatments and enhance access to important therapies around the world. We have industry-leading global commercial strength, with sustainable blockbuster brand franchises in key therapeutic categories and broad commercial reach extending across approximately 100 countries. Our experienced field-based representatives will continue to deliver exceptional support on a broad range of products to physicians and specialists around the world. And our powerful global supply chain is broadly recognized as a world leader, with continued excellence in quality and customer service.

"Supporting the growth of this innovative industry model is our strategically focused R&D engine, built on novel compounds in specialty and primary care markets where there is significant unmet medical need, and fueled by approximately $1.7 billion in annual investment. With an innovative product development portfolio exceeding 20 near-term projects and a world-class generics pipeline, which continues to hold an industry-leading position in First-to-File opportunities in the U.S. and more than 1,000 marketing authorizations globally, we are uniquely positioned within our industry to ensure our development activities support sustainable long term organic growth.

"With the acquisition now complete, we will immediately begin implementing our comprehensive integration plans to ensure that we leverage our strengthened global organization to generate sustainable organic earnings growth from our newly expanded base, and continue our ascent into the fastest-growing and most dynamic growth pharmaceutical company in global healthcare."

Financially Compelling Transaction

Actavis continues to expect the transaction to generate double-digit accretion to non-GAAP earnings within the first 12 months, including approximately $1.8 billion in operating and financial synergies to be realized within one year following the close. These synergies exclude any additional revenue or manufacturing synergies, and are in addition to the $475 million of annual savings previously announced by Allergan in connection with Project Endurance. Actavis further expects to generate strong operating cash flow in excess of $8 billion in 2016, which would enable the Company to rapidly de-lever the balance sheet.

Review of the Benefits of the Acquisition

The combination of Actavis and Allergan creates a pharmaceutical business with a growth profile unparalleled within the industry.

Significantly Expanded Brand Pharmaceutical Portfolio Supported by a World-Class Sales and Marketing Organization

The close of the transaction creates an exceptional global brand pharmaceutical business with leading positions in key therapeutic categories. The company has six blockbuster franchises with combined pro forma 2015 revenues of approximately $15 billion expected, including franchises with annual revenues in excess of $3 billion in Eye Care, Neurosciences/CNS and Medical Aesthetics/Dermatology/Plastic Surgery, as well as a portfolio of world-renowned brands including BOTOX®, RESTASIS®, JUVEDERM®, NAMENDA XR®, LINZESS® and LO LOESTRIN® Fe among others.

The combined company will continue to be recognized for its strong commitment as the partner of choice with physicians, specialists, pharmacists, regulators and patients. The combination is

committed to creating the best customer experience, based on deeply-held relationships with customers and colleagues in approximately 100 countries around the world. The company's experienced sales and marketing organization will continue to deliver exceptional support to more than a dozen medical specialists, including primary care physicians, ophthalmologists, optometrists, retinal specialists, neurologists, psychiatrists, dermatologists, aesthetic surgeons, medical aesthetic professionals, plastic surgeons, gastroenterologists, pulmonologists, OB-GYNs, urologists, cardiologists, infectious disease specialists, pain specialists and rehabilitation specialists.

Enhanced Commercial Opportunities across Global Markets

The combination greatly enhances Actavis' international commercial opportunities. The company has an expanced commercial presence now including approximately 100 countries, with an enhanced presence across Canada, Europe, Southeast Asia and Latin America and a strong footprint in China and India. The combined company will benefit from Allergan's global brand equity, industry-leading consumer marketing capabilities and strong consumer awareness of key Allergan products in global markets, including BOTOX®, RESTASIS®, JUVEDERM®, LATISSE®, NATRELLE® and others. On a pro forma basis, the company is expected to have approximately $5 billion in 2015 international revenue, and will have the unique opportunity to drive continued growth in international markets through its enhanced portfolio of brands, generics, branded-generic and over-the-counter products.

Strengthened and Expanded Pharmaceutical R&D Pipeline

The combined company will provide a strong commitment to R&D, with an exceptional level of investment of approximately $1.7 billion expected in 2015, focused on the strategic development of innovative and durable value-enhancing products within brands, generics, biologics and OTC portfolios. The company has more than 20 innovative products in near- or mid-term development, including Cariprazine, Eluxadoline, Esmya, Aczone X and Darpin AMD, among other promising candidates. The company's pipeline is strategically focused within its core therapeutic areas, with key candidates in Dermatology and Aesthetics, Eye Care, CNS, GI, Anti-infectives, Women's Health and Urology. The Company's generics pipeline is also positioned to deliver sustainable growth, with approximately 230 Abbreviated New Drug Applications pending at FDA, including approximately 70 first-to-file applications, as well as nearly 1,000 marketing authorization applications filed outside of the U.S. in 2014.

Commitment to Being the Partner of Choice for Physicians, Patients and the Medical Community

The combined company will retain Allergan's foundational commitment to being the partner of choice for physicians, patients and the medical community. The Company will continue to foster deep engagement with medical specialists, listening closely to their needs to help advance patient care and deliver treatments that address significant unmet medical needs. In addition, the Company will continue to go above and beyond to provide education and information - with the highest level of integrity - that helps patients fully understand the choices available to them and make well-informed treatment decisions with their doctors. Through these essential partnerships, the Company will continue to bring to bear scientific excellence and rigor to deliver leading products that improve patient outcomes.

Strong Combined Global Leadership Team with Deep Experience across the Business

The combined company's expanded senior management team is comprised of leaders from both Actavis and Allergan. It is structured to leverage the strong talent from both organizations to ensure that the new company capitalizes on its expanded global commercial footprint and the proven track record of Allergan's powerful and critically important product franchises, while maintaining Actavis' continued dominance as a world leader in generics. With this structure in place beginning on Day 1, the company is immediately positioned to maximize growth across all of its global businesses.

About Actavis

Actavis plc (NYSE: ACT), headquartered in Dublin, Ireland, is a unique, global pharmaceutical company and a leader in a new industry model – Growth Pharma. Actavis is focused on developing, manufacturing and commercializing innovative branded pharmaceuticals, high-quality generic and over-the-counter medicines and biologic products for patients around the world.

Actavis markets a portfolio of best-in-class products that provide valuable treatments for the central nervous system, eye care, medical aesthetics, gastroenterology, women's health, urology, cardiovascular and anti-infective therapeutic categories, and operates the world's third-largest global generics business, providing patients around the globe with increased access to affordable, high-quality medicines. Actavis is an industry leader in research and development, with one of the broadest development pipelines in the pharmaceutical industry and a leading position in the submission of generic product applications globally.

With commercial operations in approximately 100 countries, Actavis is committed to working with physicians, healthcare providers and patients to deliver innovative and meaningful treatments that help people around the world live longer, healthier lives.

Actavis intends to adopt a new global name – Allergan – pending shareholder approval in 2015.

For more information, visit Actavis' website at www.actavis.com

Forward-Looking Statement

Statements contained in this press release that refer to future events or other non-historical facts are forward-looking statements that reflect Actavis' current perspective of existing trends and information as of the date of this release. Except as expressly required by law, Actavis disclaims any intent or obligation to update these forward-looking statements. Actual results may differ materially from Actavis' current expectations depending upon a number of factors affecting Actavis' business. These factors include, among others, the difficulty of predicting the timing or outcome of FDA approvals or actions, if any; the impact of competitive products and pricing; market acceptance of and continued demand for Actavis' products; risks associated with acquisitions, mergers and joint ventures; difficulties or delays in manufacturing; and other risks and uncertainties detailed in Actavis' periodic public filings with the Securities and Exchange Commission, including but not limited to Actavis' Annual Report on Form 10-K for the year ended December 31, 2014. Except as expressly required by law, Actavis disclaims any intent or obligation to update these forward-looking statements.

https://web.archive.org/web/20110613030835/http://www.actavis.us/en/products/group.htm?name=Fentanyl+Transdermal+System+CII

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FENTANYL TRANSDERMAL SYSTEM CII

Brand Equivalent: **Duragesic®**

Trademark: Duragesic® is the registered trademark of Johnson & Johnson

*Note: Products illustrated may not appear at actual size and/or exact color.

Fentanyl Transdermal System CII 25mcg/h

Size:	NDC:	Description:
5 patches per carton	67767-120-18	Individually packaged For prescribing information, please download: FentanylPI102009.pdf For medication guide, please download: Fentanyl_Transdermal_Systemmedguide_Rev_0609.pdf For instructions for applying, please download: Fentanyl_Instructions_for_applying_Rev_0609.pdf

Imprint:
N/A

Fentanyl Transdermal System CII 50mcg/h

Size:	NDC:	Description:
5 patches per carton	67767-121-18	Individually packaged For prescribing information, please download: FentanylPI102009.pdf For medication guide, please download: Fentanyl_Transdermal_Systemmedguide_Rev_0609.pdf For instructions for applying, please download: Fentanyl_Instructions_for_applying_Rev_0609.pdf

Imprint:
N/A

Fentanyl Transdermal System CII 75 mcg/h

Size:	NDC:	Description:
5 patches per carton	67767-122-18	Individually packaged For prescribing information, please download: FentanylPI102009.pdf For medication guide, please download: Fentanyl_Transdermal_Systemmedguide_Rev_0609.pdf For instructions for applying, please download: Fentanyl_Instructions_for_applying_Rev_0609.pdf

Imprint:
N/A

Fentanyl Transdermal System CII 100 mcg/h

Size:	NDC:	Description:
5 patches per carton	67767-123-18	Individually packaged For prescribing information, please download: FentanylPI102009.pdf For medication guide, please download: Fentanyl_Transdermal_Systemmedguide_Rev_0609.pdf For instructions for applying, please download: Fentanyl_Instructions_for_applying_Rev_0609.pdf

Imprint:
N/A

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https://web.archive.org/web/20110613031656/http://www.actavis.us/en/products/group.htm?name=Oxycodone+Hydrochloride+Tablets,+USP+CII

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OXYCODONE HYDROCHLORIDE TABLETS, USP CII

Brand Equivalent: **Roxicodone®**

Trademark: Roxicodone® is the registered trademark of Xanodyne Pharmceuticals, Inc.

*Note: Products illustrated may not appear at actual size and/or exact color.

Oxycodone Hydrochloride Tablets, USP CII 15mg

Size:	NDC:	Description:
100	0228-2878-11	Green, round tablet For prescribing information, please download: 409153OxycodoneHydrochlorideTabletsUSPRev1110.pdf

Imprint:
A214 on bisected side

Oxycodone Hydrochloride Tablets, USP CII 30mg

Size:	NDC:	Description:
100	0228-2879-11	Blue, round tablet For Prescribing Information, please download: 409153OxycodoneHydrochlorideTabletsUSPRev1110.pdf

Imprint:
A215 on bisected side

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https://web.archive.org/web/20110613031345/http://www.actavis.us:80/en/products/group.htm?name=KADIAN%C2%AE+Morphine+Sulfate+Extended-Release+Capsules+CII

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KADIAN® MORPHINE SULFATE EXTENDED-RELEASE CAPSULES CII

Brand Equivalent: **N/A**

Trademark: KADIAN® is the registered trademark of Actavis Elizabeth LLC.

*Note: Products illustrated may not appear at actual size and/or exact color.

KADIAN® Morphine Sulfate Extended-Release Capsules CII 10mg

Size:	NDC:	Description:
100	46987-410-11	Light blue opaque body and cap For prescribing information, please download: Kadian_Morphine_Sulfate_ExtendedRelease_Capsules_Rev_210.pdf

Imprint:
KADIAN on the cap; 10mg printed on the body

Image Kadian tablet 10mg

KADIAN® Morphine Sulfate Extended-Release Capsules CII 20mg

Size:	NDC:	Description:
100	46987-322-11	Yellow opaque body and cap For prescribing information, please download: Kadian_Morphine_Sulfate_ExtendedRelease_Capsules_Rev_210.pdf

Imprint:
KADIAN on the cap; 20mg printed on the body

Image Kadian tablet 20mg

KADIAN® Morphine Sulfate Extended-Release Capsules CII 30mg

Size:	NDC:	Description:
100	46987-325-11	Blue violet opaque body and cap For prescribing information, please download: Kadian_Morphine_Sulfate_ExtendedRelease_Capsules_Rev_210.pdf

Imprint:
KADIAN on the cap; 30mg printed on the body

Image Kadian tablet 30mg

KADIAN® Morphine Sulfate Extended-Release Capsules CII 50mg

Size:	NDC:	Description:
100	46987-323-11	Blue opaque body and cap For prescribing information, please download: Kadian_Morphine_Sulfate_ExtendedRelease_Capsules_Rev_210.pdf

Imprint:
KADIAN on the cap, 50mg printed on the body

Image Kadian tablet 50mg

KADIAN® Morphine Sulfate Extended-Release Capsules CII 60mg

Size:	NDC:	Description:
100	46987-326-11	Pink opaque body and cap For prescribing information, please download Kadian_Morphine_Sulfate_ExtendedRelease_Capsules_Rev_210.pdf

Imprint:
KADIAN on the cap; 60mg printed on the body

Image Kadian tablet 60mg

KADIAN® Morphine Sulfate Extended-Release Capsules CII 80mg

Size:	NDC:	Description:
100	46987-412-11	Light orange opaque body and cap For prescribing information, please download: Kadian_Morphine_Sulfate_ExtendedRelease_Capsules_Rev_210.pdf

Imprint:
KADIAN on the cap; 80mg printed on the body

Image Kadian tablet 80mg

KADIAN® Morphine Sulfate Extended-Release Capsules CII 100mg

Size:	NDC:	Description:
100	46987-324-11	Green opaque body and cap For prescribing information, please download: Kadian_Morphine_Sulfate_ExtendedRelease_Capsules_Rev_210.pdf

Imprint:
KADIAN on the cap; 100mg on the body

Image Kadian tablet 100mg

KADIAN® Morphine Sulfate Extended-Release Capsules CII 200mg

Size:	NDC:	Description:

100	46987-377-11	Light brown opaque cap and body For prescribing information, please download: Kadian_Morphine_Sulfate_ExtendedRelease_Capsules_Rev_210.pdf
Imprint: KADIAN on the cap; 200mg printed on the body		Image Kadian tablet 200mg

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OXYCODONE HYDROCHLORIDE AND IBUPROFEN TABLETS CII

Brand Equivalent: **Combunox®**

Trademark: Combunox® is the registered trademark of Forest Laboratories, Inc.

*Note: Products illustrated may not appear at actual size and/or exact color.

Oxycodone Hydrochloride & Ibuprofen Tablets CII 5mg/400mg

Size:	NDC:	Description:
100	0228-4029-11	Yellow, capsule-shaped, film coated tablet For prescribing information, please download: OxycodoneHydrochlorideandIbuprofenTabletsRev807.pdf
Imprint: Actavis logo and 29 on one side, and bisect on both sides		Image Actavis Oxycodone and Ibuprofen Tablet

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OXYCODONE HYDROCHLORIDE TABLETS, USP CII

Brand Equivalent: **Roxicodone®**

Trademark: Roxicodone® is the registered trademark of Xanodyne Pharmceuticals, Inc.

Oxycodone Hydrochloride Tablets, USP CII 15mg

Size:	NDC:	Description:
100	0228-2878-11	Green, round tablet For prescribing information, please download: 409153OxycodoneHydrochlorideTabletsUSPRev1110.pdf
Imprint: A214 on bisected side		Oxycodone Hydrochloride Tablets, USP CII 15mg

Oxycodone Hydrochloride Tablets, USP CII 30mg

Size:	NDC:	Description:
100	0228-2879-11	Blue, round tablet For Prescribing Information, please download: 409153OxycodoneHydrochlorideTabletsUSPRev1110.pdf
Imprint: A215 on bisected side		Oxycodone Hydrochloride Tablets, USP CII 30mg

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PRODUCT LIST

Actavis is committed to providing its customers with a wide range of affordable, high-quality products covering all significant therapeutic classes.

The US division portfolio includes more than 80 molecules presented in a wide range of dosage forms including: tablets, capsules, liquids, creams, ointments, suppositories, and injectables.

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PRODUCT LIST

A

- Acetasol HC Otic Solution
- Acyclovir Oral Suspension, USP
- Alprazolam Extended-Release Tablets, USP CIV
- Alprazolam Orally Disintegrating Tablets CIV
- Alprazolam Tablets, USP CIV

B

- Bacitracin Zinc Ointment, USP (OTC)
- Betamethasone Diprcpionate Cream, USP
- Betamethasone Dipropionate Ointment, USP
- Betamethasone Diprcpionate Ointment, USP (Augmented)
- Betamethasone Valerate Cream, USP
- Betamethasone Valerate Ointment, USP
- buPROPion Hydrochloride Extended-Release Tablets (XL)
- buPROPion Hydrochloride Extended-Release Tablets, USP (SR)
- buPROPion Hydrochloride Extended-Release Tablets, USP (SR)

C

- Carbidopa and Levodopa Tablets, USP
- Children's Ibuprofen Oral Suspension, USP (OTC)
- Clonazepam Tablets, USP CIV
- Clonidine Hydrochloride Tablets, USP
- Clotrimazole and Betamethasone Dipropionate Cream, USP
- Clotrimazole Vaginal Cream, USP (OTC)
- Constulose (Lactulose Solution, USP)
- Cyproheptadine Hydrochloride Oral Solution, USP

D

- Desipramine Hydrochloride Tablets, USP
- Desonide Lotion
- Diclofenac Sodium Delayed-Release Tablets, USP
- Diclofenac Sodium Extended-Release Tablets, USP
- Diltiazem CD (Diltiazem Hydrochloride Extended-Release Capsules, USP)
- Donepezil Hydrochloride Tablets

E

- Enulose (Lactulose Solution, USP)
- Etodolac Tablets, USP

F

- Fentanyl Transdermal System CII
- FeverAll® Acetaminophen Rectal Suppositories (OTC)
- Finasteride Tablets, USP

G

- Gabapentin Capsules, USP
- Gabapentin Tablets, USP
- Glyburide and Metformin Hydrochloride Tablets, USP
- Griseofulvin Oral Suspension, USP (microsize)

H

- Hydrochlorothiazide Tablets, USP
- Hydrocortisone and Acetic Acid Otic Solution, USP
- Hydrocortisone Cream plus 12 moisturizers (OTC)
- Hydrocortisone Cream, USP (OTC)
- Hydrocortisone Cream, USP (Rx)
- Hydrocortisone Cream, USP with Aloe (OTC)
- Hydrocortisone Ointment, USP (OTC)
- Hydrocortisone Ointment, USP (Rx)
- Hydromet Syrup CIII

I

- Ibuprofen Oral Suspension, USP (Rx)
- Indapamide Tablets, USP
- Isosorbide Mononitrate Tablets, USP

K

- KADIAN® Morphine Sulfate Extended-Release Capsules CII

L

- Levetiracetam Oral Solution
- Lorazepam Tablets, USP CIV
- Lovastatin Tablets, USP

M

- Metoclopramide Tablets, USP
- Metronidazole Lotion
- Metronidazole Topical Cream
- Miconazole Nitrate Cream (OTC)

- Miconazole Nitrate Vaginal Cream, USP (OTC)
- Miconazole Nitrate Vaginal Suppositories (Rx)
- Miconazole Nitrate Vaginal Suppositories, USP (OTC)
- Minoxidil Topical Solution, USP for Men (OTC)
- Minoxidil Topical Solution, USP for Men Extra Strength (OTC)

N

- Nifedipine Capsules, USP
- Nifedipine Extended-Release Tablets

O

- Ondansetron Tablets, USP
- Oxazepam Capsules, USP CIV
- Oxycodone Hydrochloride and Ibuprofen Tablets CII
- Oxycodone Hydrochloride Tablets, USP CII
- Oxymorphone Hydrochloride Extended-Release Tablets CII

P

- Pantoprazole Delayed Release Tablets, USP
- Permethrin Cream
- Permethrin Lotion (OTC)
- Phenytoin Oral Suspension, USP
- Pilocarpine Hydrochloride Tablets
- Prometh with Codeine Cough Syrup - CV
- Propranolol Hydrochloride Extended-Release Capsules, USP
- Propylthiouracil Tablets, USP

R

- Ranitidine Syrup (Ranitidine Oral Solution, USP)

S

- Spironolactone Tablets, USP

T

- Tamsulosin Hydrochloride Capsules, USP
- Temazepam Capsules, USP CIV
- Tretinoin Cream
- Triple Antibiotic Ointment

V

- Valacyclovir Hydrochloride Tablets

Z

- Zolpidem Tartrate Extended-Release Tablets, USP CIV

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PRODUCTS : PRODUCT LIST

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New products

FENTANYL TRANSDERMAL SYSTEM CII

Dosage Form: transdermal system
Compare to: Duragesic®

Product Insert: download PDF
Patient Insert: download PDF

Product Markings Each Dose*	System Size	Fentanyl Content
FENTANYL TRANSDERMAL SYSTEM 25 mcg/hr	10 cm2	2.5 mg
FENTANYL TRANSDERMAL SYSTEM 50** mcg/hr	20 cm2	5 mg
FENTANYL TRANSDERMAL SYSTEM 75** mcg/hr	30 cm2	7.5 mg
FENTANYL TRANSDERMAL SYSTEM 100** mcg/hr	40 cm2	10 mg

* Nominal delivery rate per hour
** FOR USE ONLY IN OPIOID TOLERANT PATIENTS

Indication and Boxed Warning
Fentanyl transdermal system is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by lesser means such as acetaminophen-opioid combinations, nonsteroidal analgesics, or PRN dosing with short-acting opioids.

BECAUSE SERIOUS OR LIFE-THREATENING HYPOVENTILATION COULD OCCUR, FENTANYL TRANSDERMAL SYSTEM IS CONTRAINDICATED:

- In the management of acute or post-operative pain, including use in out-patient surgeries
- In the management of mild or intermittent pain responsive to PRN or non-opioid therapy
- In doses exceeding 25 mcg/hr at the initiation of opioid therapy

(See CONTRAINDICATIONS for further information.)
SAFETY OF FENTANYL TRANSDERMAL SYSTEM HAS NOT BEEN ESTABLISHED IN CHILDREN UNDER 2 YEARS OF AGE. FENTANYL TRANSDERMAL SYSTEM SHOULD BE ADMINISTERED TO CHILDREN ONLY IF THEY ARE OPIOID-TOLERANT AND AGE 2 YEARS OR OLDER (see PRECAUTIONS--Pediatric Use).

Fentanyl transdermal system is indicated for treatment of chronic pain (such as that of malignancy) that:

- Cannot be managed by lesser means such as acetaminophen-opioid combinations, non-steroidal analgesics, or PRN dosing with short-acting opioids and
- Requires continuous opioid administration

The 50, 75, and 100 mcg/hr dosages should ONLY be used in patients who are already on and are tolerant to opioid therapy.

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PRODUCTS : PRODUCT LIST

Actavis US, Product list, Product search
New products

OXYCODONE HYDROCHLORIDE TABLETS, USP 15MG

NDC:
52152-0214-02

Size :
100

Brand Equivalent :
Roxicodone® Tablets

Imprint :
A214

Description:
Green colored, round, bisected tablet

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Products beginning with "F"

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Product Name	Description	Additional Information
FAMOTIDINE - Andrx		
FAMOTIDINE TABLETS 20 mg 100s NDC: 62037-0955-01 *Compare to: Pepcid®	**Color/Shape:** White, Round **Inscription:** Imprinted 955 **Orange Book Rating:** AB	U.S. Prescribing Info Product Image
FAMOTIDINE TABLETS 20 mg 1000s NDC: 62037-0955-10 *Compare to: Pepcid®	**Color/Shape:** White, round **Inscription:** Imprinted 955 **Orange Book Rating:** AB	U.S. Prescribing Info Product Image
FAMOTIDINE TABLETS 40 mg 100s NDC: 62037-0956-01 *Compare to: Pepcid®	**Color/Shape:** White, round **Inscription:** Imprinted 956 **Orange Book Rating:** AB	U.S. Prescribing Info Product Image
FAMOTIDINE TABLETS 40 mg 1000s NDC: 62037-0956-10 *Compare to: Pepcid®	**Color/Shape:** White, round **Inscription:** Imprinted 956 **Orange Book Rating:** AB	U.S. Prescribing Info Product Image
FEMRING		
Femring® 0.05 mg/day (estradiol acetate vaginal ring) NDC: 00430-6201-40		U.S. Prescribing Info U.S. Patient Prescribing Info
Femring® 0.10 mg/day (estradiol acetate vaginal ring) NDC: 00430-6202-40		U.S. Prescribing Info U.S. Patient Prescribing Info
FENTANYL CITRATE		
FENTANYL CITRATE EQ ORAL TRANS CII 200 MCG 30s NDC: 55253-0070-30 *Compare to: Actiq®	**Color/Shape:** White, Bullet Shaped Troche **Inscription:** Fentanyl 200 mcg in blue ink, Gray band on Handle	U.S. Prescribing Info Product Image
FENTANYL CITRATE EQ ORAL TRANS CII 400 MCG 30s NDC: 55253-0071-30 *Compare to: Actiq®	**Color/Shape:** White, Bullet Shaped Trophe **Inscription:** Fentanyl 400 mcg in blue ink, Blue band on Handle	U.S. Prescribing Info Product Image
FENTANYL CITRATE EQ ORAL TRANS CII 600 MCG 30s NDC: 55253-0072-30 *Compare to: Actiq®	**Color/Shape:** White, Bullet Shaped Troche **Inscription:** Fentanyl 600 mcg in blue ink, Orange band on Handle	U.S. Prescribing Info Product Image
FENTANYL CITRATE EQ ORAL TRANS CII 800 MCG 30s NDC: 55253-0073-30 *Compare to: Actiq®	**Color/Shape:** White, Bullet Shaped Troche **Inscription:** Fentanyl 800 mcg in blue ink, Purple band on Handle	U.S. Prescribing Info Product Image
FENTANYL CITRATE EQ ORAL TRANS CII 1200 MCG 30s NDC: 55253-0074-30 *Compare to: Actiq®	**Color/Shape:** White, Bullet Shaped Troche **Inscription:** Fentanyl 1200 mcg in blue ink, Green band on Handle	U.S. Prescribing Info Product Image
FENTANYL CITRATE EQ ORAL TRANS CII 1600 MCG 30s NDC: 55253-0075-30 *Compare to: Actiq®	**Color/Shape:** White, Bullet Shaped Troche **Inscription:** Fentanyl 1600 mcg in blue ink, Burgundy band on Handle	U.S. Prescribing Info Product Image
FENTANYL PATCH		
FENTANYL PATCH 25 mcg 5s CII NDC: 00591-3198-72 *Compare to: Duragesic®	**Color/Shape:** Clear/Rectangular (Roundod Corners) **Inscription:** Fentanyl TS 25 mcg/h **Orange Book Rating:** AB	U.S. Prescribing Info Product Image
FENTANYL PATCH 50 mcg 5s CII NDC: 00591-3212-72 *Compare to: Duragesic®	**Color/Shape:** Clear/Rectangular (Rounded Corners) **Inscription:** Fentanyl TS 50 mcg/h **Orange Book Rating:** AB	U.S. Prescribing Info Product Image
FENTANYL PATCH 75 mcg 5s CII NDC: 00591-3213-72 *Compare to: Duragesic®	**Color/Shape:** Clear/Rectangular (Rounded Corners) **Inscription:** Fentanyl TS 75 mcg/h	U.S. Prescribing Info Product Image

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	Orange Book Rating: AB	
FENTANYL PATCH 100 mcg 5s CII NDC: 00591-3214-72 *Compare to: Duragesic®	**Color/Shape:** Clear/Rectangular (Rounded Corners) **Inscription:** Fentanyl TS 100 mcg/h **Orange Book Rating:** AB	U.S. Prescribing Info Product Image
FERRLECIT		
FERRLECIT® INJECTION 62.5 mg/5 mL 10X5 mL (Sodium Ferric Gluconate Complex in Sucrose Injection) NDC: 52544-0922-26	**Color/Shape:** Colorless glass ampules: Administered by intravenous infusion, Store at 20-25 Celcius:68-77 Fahrenheit: excursions permitted to 15-30 Celcius, 59-86 Fahrenheit - Do nct Freeze	U.S. Prescribing Info Product Image Product Logo Product Website
FERROUS SULFATE		
FER IRON DROPS 50 mL NDC: 00536-0710-80 *Compare to: Fer-in-Sol® Drops	**Color/Shape:** Lt GreenLemon	Product Image
FERROUS SULFATE ELIXIR PT NDC: 00536-0650-85 *Compare to: Feosol® Elixir	**Color/Shape:** YellowCherry	Product Image
FERROUS SULFATE ER TABLETS 160 mg 30s NDC: 00536-3478-07 *Compare to: Slow-Fe®	**Color/Shape:** Off White/Round **Inscription:** TCL 093	Product Image

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people living with pain.

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Short video stories from people and families affected by chronic pain.

Financial support, clinical input, and other expertise for the Pain Matters film were provided by Teva Pharmaceuticals.

Welcome to Pain Perspectives, by Melanie Rosenblatt, MD.

Check back for regular updates from the pain community.

"Chronic pain continues to be a serious issue for millions of Americans, and Teva is committed to supporting responsible pain management that meets the needs of people living with pain and healthcare professionals."[1]

— Michael Hayden, MD, PhD, President of Global R&D and Chief Scientific Officer at Teva Pharmaceuticals

More About Teva Pharmaceuticals →

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- *Pain Matters* Documentary
- Teva Pharmaceuticals' Commitment to Pain Care
- Pain Community Events Calendar

HEALTHCARE PROFESSIONALS

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Pain Perspectives Community Insights

Hear insights and perspectives into today's complex pain management landscape from members of the pain community. These individuals guide you through a variety of topics through a rotating series of presentations, which are available in multiple formats, such as articles, Q&As, and videos.

Pain Perspectives Community Insights

Hear insights and perspectives into today's complex pain management landscape from members of the pain community. These individuals guide you through a variety of topics through a rotating series of presentations, which are available in multiple formats, such as articles, Q&As, and videos.

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Welcome to Pain Perspectives

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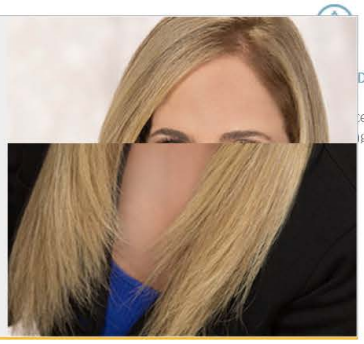

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Pain Matters Film Clips

Short video stories from people and families affected by chronic pain.

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State and federal governments

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Learn how Teva is supporting responsible pain management

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Pain Matters Documentary

Produced by the Discovery Channel

Pain Matters Documentary

Produced by the Discovery Channel

Pain has reached epidemic proportions in America. Almost a third of the population—100 million people—suffer from chronic pain.[1] The problem is real and can impact many aspects of daily life. To take on chronic pain, you must be willing, as both a healthcare professional and a patient, to keep trying and continue searching for a treatment plan that works. This documentary offers an uplifting overview of the journeys of people dealing with a variety of chronic pain conditions and how they have managed their pain. — *Paul Christo, MD, MBA*

Request Your Copy of the *Pain Matters* Documentary →

Financial support, clinical input and other expertise for Pain Matters were provided by Teva Pharmaceuticals. It was produced by the Discovery Channel in collaboration with seven advocacy organizations, including: American Academy of Pain Management, American Academy of Pain Medicine, American Chronic Pain Association, American Pain Society, American Society for Pain Management Nursing, U.S. Pain Foundation and For Grace.

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Teva Pharmaceuticals and Pain Management

Teva Pharmaceuticals and Pain Management

At Teva Pharmaceuticals, we understand that chronic pain affects more than 100 million Americans.[1] It can greatly affect people touching many aspects of their lives, including their physical health and ability to participate in daily tasks.[1]

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Our Commitment to Pain Care

Teva is committed to supporting responsible pain management that meets the needs of people living with pain and healthcare professionals treating pain. With a diverse portfolio and pipeline, we are working to help advance treatments in pain management. Prescription opioid medications are an important part of a treatment plan for many people living with chronic pain, but we know that they carry a serious risk of abuse and misuse.[2] Teva is equally committed to addressing the serious problems of chronic pain and prescription drug abuse.

As part of our ongoing commitment to support healthcare professionals and patients dealing with chronic pain, we are developing an innovative **abuse deterrence technology** platform to address the challenges of opioid abuse and misuse.

To learn more about Teva and our commitment, visit us online at **TevaUSA.com**

Community Collaboration

As a company, Teva takes this commitment beyond its products, leading education and abuse-mitigation efforts. We're also working to develop educational resources and partner with a variety of stakeholders. In this complex pain care environment, Teva is focused on keeping patient needs at the center of all we do.

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The Alliance to Prevent the Abuse of Medicines

In 2013, Teva became one of several leading industry stakeholders including the **American Medical Association**, **CVS Caremark**, **Cardinal Health**, the **Healthcare Distribution Management Association**, **Prime Therapeutics**, **Millennium Health**, and **Kaleo** dedicated to developing policy solutions aimed to address prescription drug abuse. This non-profit partnership includes perspectives from all angles of the prescription drug supply chain—from manufacturers to distributors and pharmacies to physicians.

Learn More →

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Abuse Deterrence Technology Guidance
Recent FDA draft guidance on evolving abuse deterrence technology

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A Multidisciplinary Approach to Managing Chronic Pain

While there are a variety of options available to treat chronic pain, it usually cannot be cured, only managed.[6] There isn't one right way to treat pain.[6]

A Multidisciplinary Approach to Managing Chronic Pain

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Approaches to Pain Management[6,7]

Managing Chronic Pain

The pain experience is individual. Chronic pain is defined by the International Association for the Study of Pain as "a persistent pain that is not amenable, as a rule, to treatments based upon specific remedies or to the routine methods of pain control."[8] It's a serious medical condition that may greatly affect people leaving them unable to work, maintain relationships, or participate in daily tasks.[1]

Chronic pain can affect anyone. The Institute of Medicine estimated that 100 million American adults are impacted by chronic pain, which includes people who reported having "severe pain, moderate pain, joint pain, arthritis, or functional limitation."[1]

The Role of Opioids in Chronic Pain Management

Prescription pain medications, such as opioids, may be an appropriate treatment option for people whose chronic pain is not adequately managed by other methods.[2] Opioids are an important option for the treatment of certain types of chronic pain.[9]

Next Steps

Go to Understanding Opioid Abuse ›

Tools & Resources
Use these tools and downloads to learn more about responsible opioid use

Understanding Opioid Abuse
Statistics and insights into opioid abuse and misuse

Abuse Deterrence Technology
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Understanding Abuse & Misuse

More than 12 million people reported using prescription pain medications nonmedically in 2010.[10] That number encompasses both abuse and misuse. The abuse and misuse of prescription pain medications were responsible for more than 475,000 emergency department visits in 2009, a number that nearly doubled in just five years.[10] Further, opioid overdoses in particular are increasingly due to the abuse of prescription painkillers.[3]

Understanding Abuse & Misuse

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Abuse

- Swallowed whole
- Crushed and swallowed
- Crushed and snorted
- Crushed and smoked
- Crushed, dissolved, and injected

Percent of patients being treated with chronic opioid therapy with high likelihood of abuse/addiction[26]

Alcohol-induced dose dumping, or the associated intake of alcoholic beverages together with oral controlled-release opioid formulations, is another form of abuse that may result in an uncontrolled and immediate drug release.[12]

Misuse

Misuse is using the prescription drug for a reason other than for which it was prescribed.[11] The key differentiator being the drug is not being used for an intentional high, so it is labeled misuse rather than abuse. Misuse can also take many forms, for example[11]:

- Using a drug for a different condition than that for which the drug is prescribed
- Taking more drug than prescribed or at different dosing intervals
- Using a drug not prescribed for them for other therapeutic purposes

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Go to Stakeholder Efforts in Abuse Deterrence ›

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New strategies address abuse

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A Multifaceted Approach to Abuse Deterrence

Key Stakeholders Are Making Strides to Mitigate Risk

As part of the pain care community, we understand that we all have an active role to play to help

Healthcare Professional Training and Education

The FDA has identified three key ways prescribers can help curtail the US opioid epidemic[13]:

- Ensuring that they have adequate training in opioid therapy
- Knowing the content of the most current opioid drug labels
- Educating patients about the appropriate use of opioids, their potential risks, and proper disposal techniques

Understanding Appropriate Use of Medications

Understanding Appropriate Use of Medications

It is important for people who are prescribed pain medications to understand how to appropriately use, store, and dispose of their prescription opioids.[14] Since many people who abuse or misuse prescription opioids are not the person the medication was prescribed to, understanding and following appropriate use, storage, and disposal instructions could help reduce the risk of abuse and diversion. The American Academy of Family Physicians has provided **general guidance and helpful tools** on the appropriate use, storage, and disposal of opioid medications.[15]

Resources are available to help educate around the appropriate use, storage, and disposal of prescription opioid medications.

Policies and Programs Provide Guidance

There are many government **policies and programs** in place to help address the opioid abuse public health issue. Laws and policies of today must simultaneously prevent abuse, addiction, and diversion while allowing and supporting the legal use of prescription drugs by those who need them.[4]

Advocacy Organizations Offer Ongoing Support

Public education programs engage local healthcare professionals and antidrug coalitions to promote and distribute public education materials supporting the appropriate use and storage of prescription pain medications and understanding of the associated risks of abuse and misuse.[3]

Pharmaceutical Industry Drives Evolving Technology

The FDA also encourages the ongoing study of **abuse deterrence technologies** for prescription opioid medications. Currently, the concept of abuse deterrence is viewed as the introduction of some limits or impediments to abuse, as opposed to the outright elimination of abuse.[5]

At Teva Pharmaceuticals, we take our responsibility to help mitigate the risks of abuse seriously. In 2013, we partnered with five leading industry organizations across the prescription drug supply chain to form the **Alliance to Prevent the Abuse of Medicines**. We are dedicated to raising awareness of the risks of opioid drug abuse.

Next Steps

Go to Abuse Mitigation Programs & Policies ›

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Abuse Deterrence Technology
Advances in technology address the challenges of opioid abuse

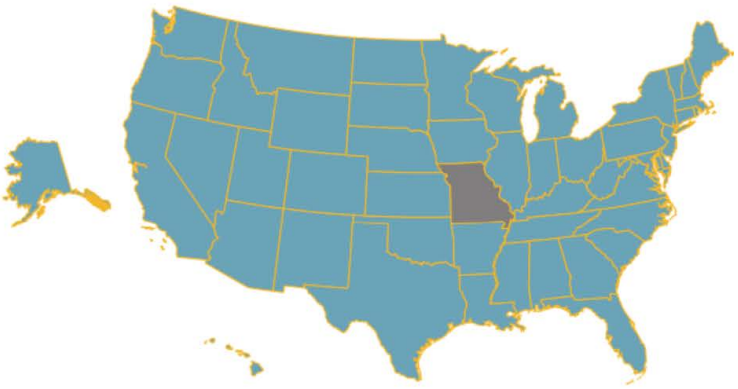
The Role of Government in Mitigating Opioid Abuse

Due to the complex issues surrounding opioid abuse and misuse, various national and state

Prescription Drug Monitoring Programs (PDMPs)

PDMPs are in place in 49 states to help detect and reduce the risk of diversion and abuse of prescription drugs at the practice and retail levels. These state programs allow for the collection and analysis of prescription data.[17] Proactive reporting through the use of PDMPs can help[18]:

- Alert prescribers and pharmacists to potential prescription opioid abuse or diversion among their patients
- Educate prescribers to make better decisions about prescribing controlled substances, thus improving patient care
- Provide an opportunity to intervene and refer patients for substance use disorder treatment when appropriate



Schedules of Controlled Substances[19]

The DEA plays an important role in mitigating abuse and diversion of opioids. This federal agency enforces the controlled substance laws and regulations in the US, including the scheduling of controlled substances, such as opioids.[19] Controlled substances are classified into five categories, or schedules, according to the accepted medical use and the potential for abuse.[19] Schedule I drugs are considered the most dangerous, while Schedule V drugs are seen to have the least risk for abuse.[19] Prescription opioid medications generally fall under Schedules II and III.[19]

SCHEDULE	DESCRIPTION
I	No accepted medical use and a high potential for abuse. Schedule I drugs are the most dangerous drugs of all the drug schedules with potentially severe psychological or physical dependence.
II	Drugs with a high potential for abuse, less abuse potential than Schedule I drugs, with use potentially leading to severe psychological or physical dependence. These drugs are also considered dangerous
III	Drugs with a moderate to low potential for physical and psychological dependence. Abuse potential is less than Schedule I and II, but greater than Schedule IV.
IV	Drugs with a low potential for abuse and low risk of dependence
V	Drugs with lower potential for abuse than Schedule IV, containing limited quantities of certain narcotics.

In addition to classifying potentially dangerous substances by schedule, the DEA's Office of Diversion Control requires physicians who intend to prescribe scheduled (controlled) medications to register in the state where they obtained a valid medical license.[20] The goal of this initiative is to detect and investigate diversion of controlled substances from legitimate sources while ensuring an adequate and uninterrupted supply for legitimate medical, commercial, and scientific needs.[20]

Risk Evaluation and Mitigation Strategies (REMS)

REMS are requirements set by the **Food and Drug Administration (FDA)** for pharmaceutical manufacturers to help ensure that the benefits outweigh the risks for certain drugs.[16] There are several components of REMS that can be used by the pharmaceutical industry, including one or more of the following[16]:

Medication Guides or Patient Package Inserts

- FDA-approved instructions for appropriate use and instructions for patients focused on avoiding serious adverse events

Communication Plans

- A comprehensive plan for providing healthcare professionals with education, information, and increased awareness of risks associated with a drug

Elements To Assure Safe Use

- Some products are required to have additional actions that healthcare professionals need to execute prior to prescribing or dispensing the drug to the patient, known as Elements To Assure Safe Use

prior to prescribing or dispensing the drug to the patient, known as Elements To Assure Safe Use (ETASU)

Implementation Systems

- When ETASU are required as part of a REMS program, the FDA may also require pharmaceutical companies to create a plan to ensure prescribers are complying with ETASU

Timetables for Reporting REMS Assessments

- REMS assessments are intended to determine if the REMS requirements are proving effective. Assessment results may be used to modify the REMS, or even eliminate it, if the assessment shows changes are needed or that the REMS have met its goals

---

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Advancements in Abuse Deterrence

Evolving Strategies Address Abuse Potential

Advancements in Abuse Deterrence

Evolving Strategies Address Abuse Potential

According to the CDC, **opioid abuse** is the nation's fastest growing drug problem and it ranks among the top three for prescription drug abuse.[3] Scientifically driven solutions are needed to help combat this serious public health epidemic, including:

In January 2013, the Food and Drug Administration (FDA) issued **draft guidance** to assist the pharmaceutical industry to develop new formulations of opioid drug products with potentially **abuse-deterrent properties**.[5] The FDA encourages the development of abuse-deterrence formulations and believes that these products have promise to help reduce, though not necessarily prevent, opioid abuse.[5] The FDA draft guidance document explains[5]:

- Current thinking about studies designed to demonstrate abuse-deterrence properties in a given formulation
- How studies will be evaluated
- Labeling claims that may be approved based on study results

When abuse deterrence is proven or expected to lead to a substantial reduction in abuse potential, the data are included in the product labeling. The FDA has designated 4 tiers of abuse claims that correspond to pre-approval studies required to assess abuse potential (Tiers 1-3) and post-approval studies that assess clinical outcomes (Tier 4).[5]

TIER 1	TIER 2	TIER 3	TIER 4
Formulated with physiochemical barriers	Expected to reduce or block opioid effect when manipulated	Expected to result in a meaningful reduction in abuse	Demonstrated reduced abuse in the community

Studies to Evaluate Clinical Abuse Potential

Overview

Clinical Abuse Potential studies, also known as human abuse potential studies, human abuse liability studies, or "drug-liking" studies, evaluate the abuse liability or abuse potential for prescription drugs.[5] These studies provide information on the relative abuse potential of a drug and the likelihood that it will be attractive to abusers ("liked").[5] Companies with potential abuse-deterrent formulations of opioid products are generally expected to conduct these studies to obtain an understanding of the impact of the technology on the product's abuse potential.[5]

For more information see the **FDA's Draft Guidance for Industry: Abuse-Deterrence Opioids —Evaluation and Labeling.**[5]

Methodology

These studies are usually conducted among experienced, recreational drug users who have a recent or current history of using a drug in the pharmaceutical class of the test drug. These studies are typically double-blind, double-dummy, placebo-controlled, and positive-comparator controlled, utilizing a crossover design.[5] For the study to be interpretable, the subjects should be able to reliably report "drug-liking" of the test drug and rate the effects of the test drug compared with placebo and with the positive control, such as an immediate-release formulation.[5] Several instruments have been used to measure the potential for abuse including overall drug-liking, abuse, and likelihood of using the drug again.[5] Key instruments include[5]:

- Visual Analogue Scale (VAS)—a 100-point scale that measures drug-liking, overall high, good effects or euphoria, bad effects or adverse events, and likelihood of repeated use

- Profile of Mood States

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Tools & Resources for Managing Chronic Pain

Tools & Resources for Managing Chronic Pain

Resources for Your Practice

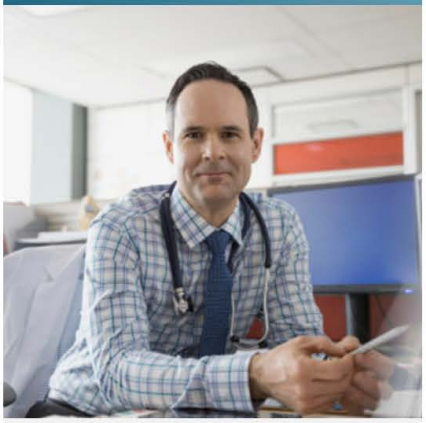
As a prescribing healthcare professional, there are many strategies you can adopt in your practice to help decrease the likelihood of abuse. The following links provide tools and resources to help ensure responsible opioid use.

Academy of Pain Management (AAPM) meeting in Phoenix, Arizona, September 18-21, 2014, this slide deck provides insight into key areas of the changing pain management landscape, including:

- An overview of the pain landscape and common routes of abuse
- The roles of key stakeholders in addressing this serious health epidemic
- Guidance provided to help mitigate opioid abuse and misuse moving forward
- Education on the evolution of abuse deterrence technology, its role in pain management, and how it helps address the challenges of opioid abuse

Download Presentation ↓

Brief Pain Inventory



Exam Room Discussion Guide

Navigating the changing landscape of pain management is becoming increasingly difficult. There is a need for physicians to screen for signs of abuse and misuse and to educate patients on how to appropriately use, store, and dispose of prescription pain medications.

This brochure provided by the **Substance Abuse and Mental Health Service Administration (SAMHSA)** can help guide a discussion with your patients.

View Tool ↓

View Guide ↓

Diagnosing & Treating Pain

The American Pain Society has provided a comprehensive tool, "Pain: Current Understanding of Assessment, Management, and Treatments" to assist healthcare professionals in recognizing, diagnosing, and managing chronic pain.

View Tool ↓

Patient Screener

This screener provides an objective guide to identifying patients who may be appropriate candidates for prescription opioid medication and mitigate risk by identifying those who may be at risk for abuse.

Download to View ↓

Treatment Agreement

It's important for prescribers to build trust and foster an open, honest partnership with their patients through an understanding of the treatment goals in prescribing and taking an opioid medication. Prescriber-patient treatment agreements are available in several forms and can be customized to your practice and the laws in your state including:

- US Department of Veterans Affairs and the Department of Defense
- American Academy of Family Physicians

Drug Disposal Guidelines

The US Department of Justice and the Drug Enforcement Administration have provided a wealth of guidance and information for healthcare professionals and patients on the disposal of opioid medications.

View Guidelines ↓

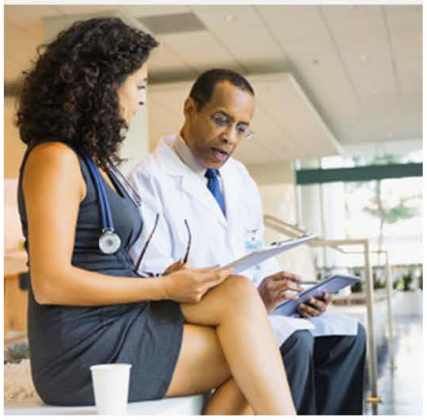
Professional Pain Care Organizations

There are many organizations dedicated to providing ongoing education, programs, and resources for healthcare professionals and people living with chronic pain. These organizations have a commitment to furthering research and policies that shape the future of pain management.

- The American Academy of Pain Medicine
- The American Academy of Pain Management
- The American Pain Society
- Center for Lawful Access and Abuse Deterrence
- Alliance for Patient Access

Professional Events Calendar

Keep track of professional meetings and events throughout 2015



- The American Society for Pain Management Nursing

Visit Calendar ↓

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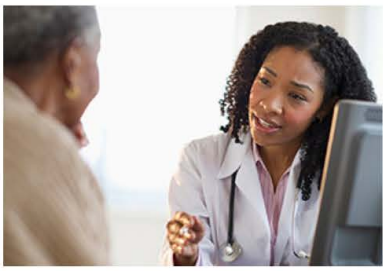

Pain is a serious medical condition that can impact anyone at any time. Pain that lasts only for a short period of time is called acute pain; itâ€™s a normal feeling that typically alerts us to a possible injury.[6] Chronic pain is very different. Chronic pain is often defined as any pain that lasts for 12 weeks or longer.[6] According to the Institute of Medicine, chronic pain is estimated to affect approximately 100 million American adults.[1]

Chronic pain may be caused by an initial injury or there may be an ongoing cause, like a medical illness.[6] But for some people, there may also be no clear cause.[6] Other health problems, such as fatigue, sleep disturbance, decreased appetite, and mood changes, often accompany chronic pain.[6] Chronic pain may affect people's ability to participate in daily tasks.[1]

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Go to Managing Your Pain ›

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Understanding Chronic Pain
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Managing Your Pain
Work with your doctor to find the pain care plan that is right for you

Support for Living With Pain
Links to advocacy and support groups for people with pain

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Finding the Right Pain Care Plan for You

Talking to Your Doctor
Helpful tips on talking to your doctor about your pain and questions to ask
Understanding Chronic Pain
Watch the *Pain Matters* documentary

Working with Your Doctor

How chronic pain is experienced is unique to every person.[6] There is no test to measure how chronic pain feels or exactly where it is located.[6] So, your doctor will rely on you to tell him or her how the pain feels, how often you experience the pain, and where exactly it hurts.[6] Defining pain as sharp or dull, constant, on-and-off, burning, or aching may give the best clues to the cause of the pain.[6] These descriptions are part of what is called the pain history. Your healthcare team will usually start your appointment by discussing your pain so they understand your pain history.[6]

A Pain Treatment Team

Since chronic pain may occur in a variety of locations in the body and for many different reasons, it is important for you to work with your doctor to identify the causes and symptoms of your pain to find the treatment plan that works for you.[6] The best treatment plans are tailored to each individual person with input from healthcare team members.[6] It may be helpful to work with several healthcare professionals who have different training backgrounds and an understanding of chronic pain.[6] The person in pain and his or her loved ones must also be actively involved in the treatment plan.[6]

Types of Pain Management

The overall goal of chronic pain management is to reduce the pain to help people return to daily living.[6] While there are a variety of options available to treat chronic pain, it usually cannot be cured, only managed.[6] A variety of options exist for you and your pain care team to create the treatment plan that is right for you.[7] These options include[6,7]:

treatment plan that is right for you. These options include:

- Psychotherapy
- Meditation
- Massage therapy
- Behavior modification
- Acupuncture
- Electrical stimulation
- Nerve blocks
- Surgery
- Medicines (aspirin, acetaminophen, nonsteroidal anti-inflammatory drugs, topical anesthetics, opioid medicines)

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Helpful tips on talking to your doctor about your pain and questions to ask

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Appropriate use, storage and disposal guidelines for your prescriptions

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Managing Your Pain
Work with your doctor to find the pain care plan that is right for you
Support for Living with Pain
Links to advocacy and support groups for people with pain

Prescription Opioid Medicines

What You Need to Know About Prescription Opioid Medicines

What You Need to Know

Your doctor may decide to prescribe a prescription pain medicine known as an opioid.[9] These prescription medicines may be an appropriate treatment option for people living with chronic pain that is not adequately managed by other methods.[9] It's important to understand that all prescription opioid medicines have the potential to be abused and misused.[10] If you are prescribed a prescription opioid medicine, it is important to understand the risks and who else The person prescribed the medicine isn't necessarily the only person who is at risk for abuse. More than three out of four people who misuse prescription pain medications do so by using medication prescribed to someone else.[21] Some factors that may contribute to higher risk potential could include living in a household with adolescents or teenagers, living in a home with a high traffic volume of visitors or household staff, having a history of substance abuse or misuse, or living with someone who does.

What should I know about abuse and misuse?

It's important to know the difference between prescription drug abuse and misuse to understand who may be at risk.

Abuse

Abuse is a nonmedical use of a drug, repeatedly, or even sporadically, for the positive psychoactive effects it produces.[11] The most common form of opioid abuse is swallowing a number of whole pills or tablets for the feeling or "high" it can cause.[5] While swallowing pills is the most common form of abuse, prescription opioids can also be abused by being crushed or dissolved.[5]

Misuse

Misuse is using the prescription drug for a reason other than for which it was prescribed.[11] The key difference in abuse and misuse is that the medicine is not being used for an intentional high, so it is labeled misuse rather than abuse. Misuse can take many forms most people may not realize is misuse, for example[11]:

- Using a drug for a different condition than that for which the drug is prescribed

- Taking more drug than prescribed or at different dosing intervals

Diversion

Diversion is a type of misuse that happens when people take prescription opioids that were not prescribed for them.[22] Unaware of the dangers of sharing medications, people often unknowingly support diversion by sharing their unused pain medication with their family members.[23]

What can I do to reduce the risk of abuse?

Everyone who is prescribed an opioid medicine can play a role in reducing the risk of those medicines being abused. Understanding how to appropriately use, store, and dispose of prescription opioid medicines can help decrease the chances that they will be abused or misused.

What else is being done to reduce the risk of abuse of prescription medicines?

Because prescription drug abuse is the nation's fastest growing drug problem, it's important for everyone involved to play a role if we are going to reduce the impact of prescription drug abuse on society.[3] This means that doctors, pharmacists, government policy makers, advocacy organizations, pharmaceutical companies, and people who are prescribed opioid medications must work together.[13]

In order to help reduce the risk of prescription opioid medicines being abused, the pharmaceutical industry is changing the way they make, or manufacture, these medicines. Abuse deterrence technologies may make it more difficult to crush or dissolve opioid medicines and may help reduce how much someone likes the drug when they use it with the intention of getting high.[5]

Next Steps

Go to Appropriate Use, Storage & Disposal ›

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About Pain

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Prescription Opioid Medicine

Appropriate Use, Storage &

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Prescription Drug Abuse

Appropriate Use, Storage & Disposal

Using Prescription Opioid Medicines Appropriately

Following guidelines on appropriate use, storage, and disposal of your prescription pain medications is important. Prescription drug abuse is a serious public health issue.[3] Remember, the person who was prescribed a prescription opioid medicine is always the only one

- Be aware of risks
- Understand inappropriate use
- Never give prescription medicines to anyone else

Storage[14,15]

- Hide or lock up opioid medications to avoid access by family, friends, or houseguests
- Keep prescription medications in their original packaging so it is clear for whom the medications were prescribed and to save the directions for appropriate use

Disposal[15]

- Opioids may be disposed of through **community-sponsored take-back programs**
- If there are none available in your area, follow the Office of Drug Control National Policy recommendations for **environmentally friendly disposal**[5]
- Learn more about appropriate **use, storage and disposal** of prescription opioid medications. Many communities also host drug take-back days to make proper prescription drug disposal easy

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Tools & Resources
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Practical Resources

Finding a pain care plan that is right for you starts by working with your doctor. Find tools and resources to help you get the information you need to reduce the risk of prescription medicine

Appropriate Use, Storage & Disposal

Each person experiences chronic pain differently.[6] While you may live with the pain every day, describing it to someone can be challenging. This assessment tool can help you prepare for a conversation with your doctor about the pain you experience and its impact on your life.

Get Started Today ↓

The feeling of pain can impact life by interfering with activities. Use the results of this assessment to help you have a clear conversation with your doctor.

Take The Assessment ↓

Appropriate Use and Storage of Opioid Medications

Prescription medications must be appropriately stored. They should be in a locked container that does not allow others to gain access to them.[15]

- Taking opioids responsibly from the US Department of Veterans Affairs and the Department of Defense
- Eight Opioid Safety Principles for Patients and Caregivers from the American Academy of Pain Medicine

Appropriate Disposal of Opioids

The FDA has provided a variety of downloadable resources on the proper disposal of prescription opioid medications.

Appropriate disposal of opioids resources are also available en EspaĆ±ol

View Tool ↓

Pain Support & Advocacy Organizations

Several national organizations are dedicated to supporting people living with chronic pain and their families by providing ongoing education, community programs, and support research that helps shape the future of this complex condition.

- American Chronic Pain Association
- US Pain Foundation
- Pain Action Alliance

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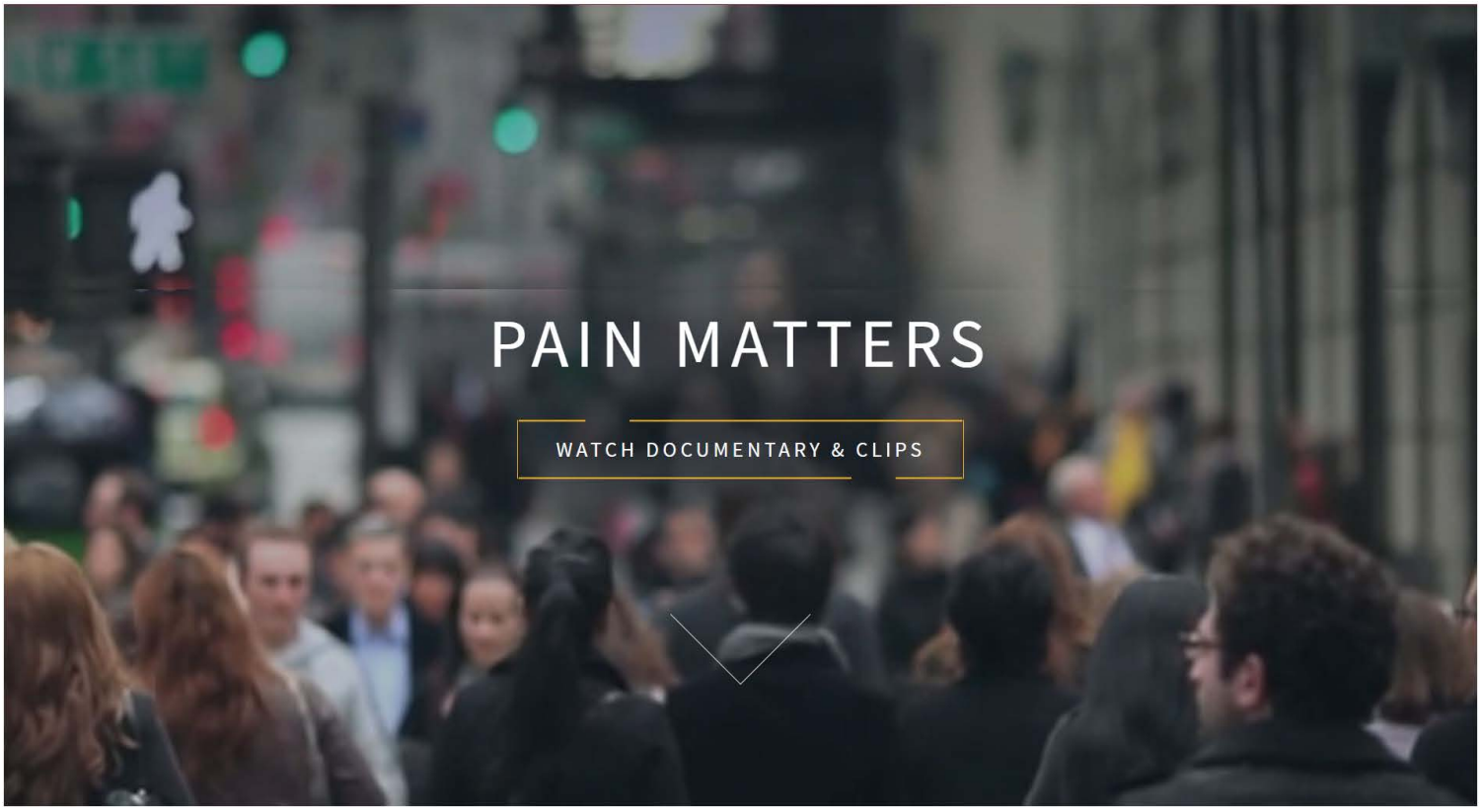

Pain Perspectives

The State Pain Policy Advocacy Network (SPPAN) works at the federal and state levels to advance responsible pain management through legislative advocacy and education.

READ MORE

Register for Resources

Download complimentary clinical slide decks. Have the Pain Matters documentary delivered to your door.

GET YOUR RESOURCES

"Chronic pain continues to be a serious issue for millions of Americans, and Teva is committed to supporting responsible pain management that meets the needs of people living with pain and healthcare professionals. [1] *"*

— Michael Hayden, MD, PhD, President of Global R&D and Chief Scientific Officer at Teva Pharmaceuticals

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Pain Matters Mission

Pain Matters brings to life Teva Pharmaceuticals' commitment to working with the pain care community to educate the public, healthcare providers, and other stakeholders about chronic pain, appropriate use of prescription pain medicines, and opioid abuse and misuse.

About Pain Matters

The Pain Matters program offers practical information and resources for healthcare professionals and people affected by chronic pain as they navigate the evolving and complex pain care landscape. Painmatters.com and the **Pain Matters Facebook page** are updated regularly with contributions from stakeholders across the pain care community. The **Pain Perspectives series** and the **Pain Matters documentary**, produced by the Discovery Channel, offer first-hand insights on the impact of chronic pain from those who live with it, healthcare professionals, and community advocates.

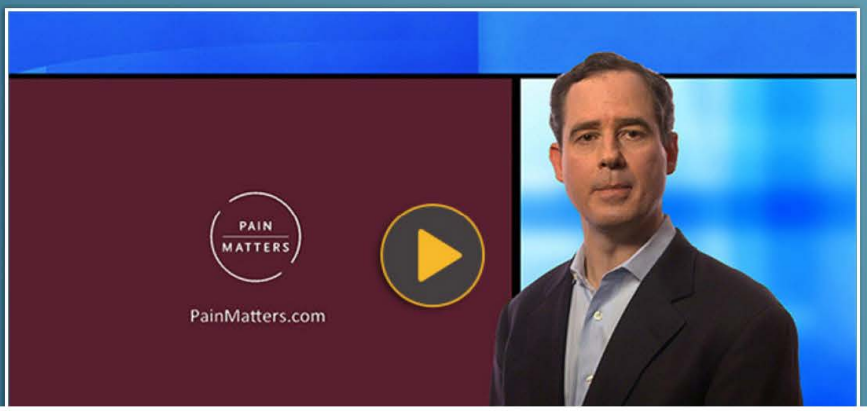
Information for Healthcare Professionals in pain care:

- **Understanding pain management and opioid abuse**
- **Stakeholder programs and policies for abuse deterrence**
- **Advancements in abuse deterrence**

Support for people and families affected by chronic pain:

- Information to help you take an active role in **finding your pain management plan**
- Education around **prescription opioid medicines**
- Instructions for **appropriate use, storage, and disposal** of prescription opioids
- Downloadable tools such as **"Questions to ask your doctor"**
- Support to help you **connect to the larger pain community**

Watch an introductory video about PainMatters.com



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Resources for Healthcare Professionals

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Resources for People Affected by Pain

Information and resources for people and families living with chronic pain

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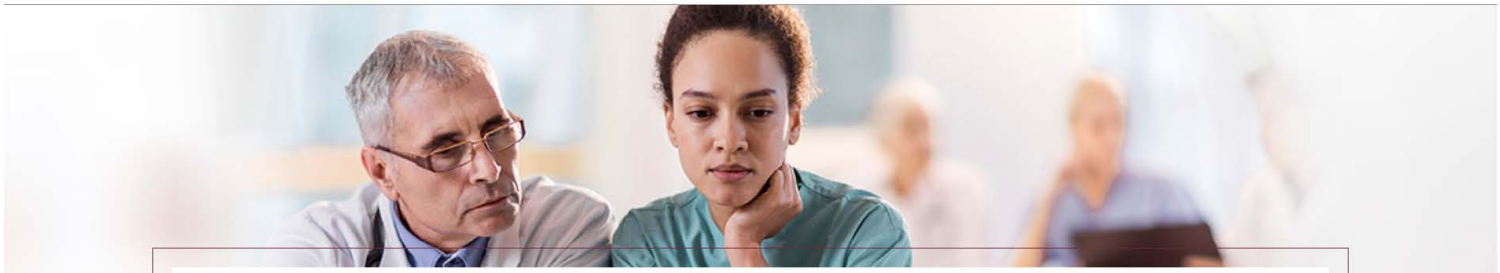

Pain Perspectives Community Blog

Read insights and perspectives about today's complex pain management landscape from members of the pain community.

SEPT 2016

Going from Patient to Person: How I Live Fully With Pain

SEPT 2016

You're Not Alone: Finding Support from Others Living with Pain

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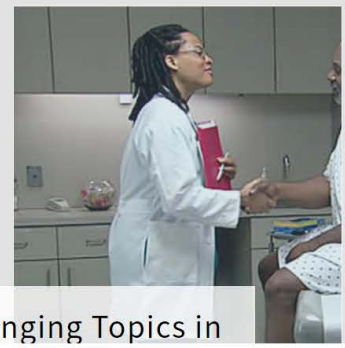
Advocating for Pain Policy,



SEPT 2015

Addressing Challenging Topics in

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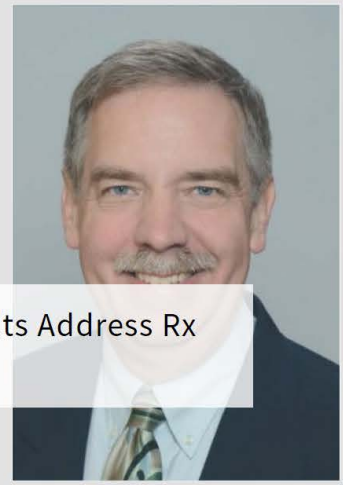
JULY 2015

2015 Survey Results Address Rx Abuse



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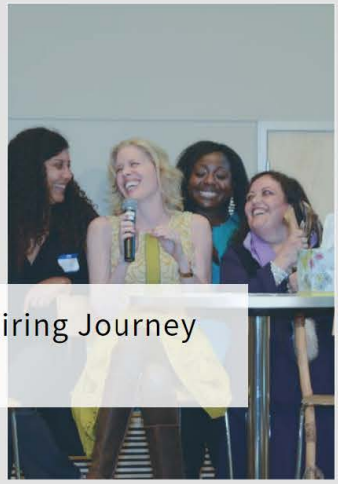

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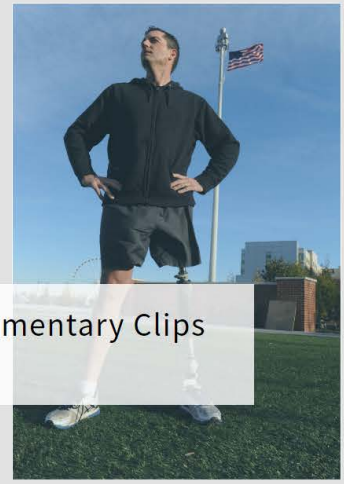

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Welcome to Pain Perspectives Community Blog

https://web.archive.org/web/20190310053032/http://painmatters.com/community-engagement/pain-matters-documentary.aspx

Pain Matters Documentary

Produced by the Discovery Channel

Pain has reached epidemic proportions in America. Almost a third of the population—100 million people—suffer from chronic pain.[1] The problem is real and can impact many aspects of daily life. To take on chronic pain, you must be willing, as both a healthcare professional and a patient, to keep trying and continue searching for a treatment plan that works. This documentary offers an uplifting overview of the journeys of people dealing with a variety of chronic pain conditions and how they have managed their pain. — *Paul Christo, MD, MBA*

REQUEST YOUR COPY OF THE *PAIN MATTERS* DOCUMENTARY

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Financial support, clinical input and other expertise for Pain Matters were provided by Teva Pharmaceuticals. It was produced by the Discovery Channel in collaboration with seven advocacy organizations, including: American Academy of Pain Management, American Academy of Pain Medicine, American Chronic Pain Association, American Pain Society, American Society for Pain Management Nursing, U.S. Pain Foundation and For Grace.

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Teva Pharmaceuticals and Pain Management

At Teva Pharmaceuticals, we understand that chronic pain affects more than 100 million Americans.[1] It can greatly affect people, touching many aspects of their lives, including their physical health and ability to participate in daily tasks.[1]

Our Commitment to Pain Care

Teva is committed to supporting responsible pain management that meets the needs of people living with pain and healthcare professionals treating pain. With a diverse portfolio and pipeline, we are working to help advance treatments in pain management. Prescription opioid medications are an important part of a treatment plan for many people living with chronic pain, but we know that they carry a serious risk of abuse and misuse.[2] Teva is equally committed to addressing the serious problems of chronic pain and prescription drug abuse.

As part of our ongoing commitment to support healthcare professionals and patients dealing with chronic pain, we are developing an innovative **abuse deterrence technology** platform to address the challenges of opioid abuse and misuse.

To learn more about Teva and our commitment, visit us online at **TevaUSA.com**.

Community Collaboration

As a company, Teva takes this commitment beyond its products, leading education and abuse-mitigation efforts. We're also working to develop educational resources and partner with a variety of stakeholders. In this complex pain care environment, Teva is focused on keeping patient needs at the center of all we do.

VIEW CALENDAR

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Recent FDA guidance on evolving abuse deterrence technology

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Understanding Pain Management & Opioid Abuse and Misuse

Integrated Care Addresses the Multiple Features of Chronic Pain

This graphic was adapted from an infographic created by the **Alliance for Patient Access**.

Opioids in Chronic Pain Management

Prescription pain medications, such as opioids, may be an appropriate and important treatment option for people whose chronic pain is not adequately managed with other methods.[2,9] The Surgeon General offers a **comprehensive checklist** for prescribing opioids for chronic pain.

Understanding Opioid Abuse & Misuse

More than 12 million people reported the abuse or misuse of pain medications in 2010.[10] The prior year, abuse and misuse of prescription pain medications sent more than 475,000 people to emergency departments, a number that nearly doubled in just five years.[10]

Abuse is the nonmedical use of a drug for the positive psychoactive effects it produces.[11] The most common form of opioid abuse is swallowing a number of intact pills[5], but opioid analgesics can be abused in a number of ways:[5]

- Crushed and swallowed
- Crushed and snorted
- Crushed and smoked
- Crushed, dissolved, and injected

Percent of patients being treated with chronic opioid therapy with high likelihood of abuse/addiction[26]

Alcohol-induced dose dumping, or the associated intake of alcoholic beverages together with oral controlled-release opioid formulations, is another form of abuse that may result in an uncontrolled and immediate drug release.[12]

Misuse is using the prescription drug for a reason other than for which it was prescribed.[11] It differs from abuse in that the user is not seeking an intentional high. Misuse can take many forms:[11]

- Using a drug for a different condition than that for which the drug is prescribed
- Taking more drug than prescribed or at different dosing intervals
- Using a drug without a prescription for therapeutic purposes

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Go to Stakeholder Programs & Policies for Abuse Deterrence ›

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Stakeholder Programs & Policies for Abuse Deterrence

As part of the pain care community, we understand that we all have an active role to play to help advance responsible pain management and deter abuse.[13] Pain Matters is committed to providing the resources and guidance needed to mitigate opioid abuse and misuse.

Key Stakeholders Are Making Strides to Mitigate Risk

In a recent statement on prescription opioid abuse, the FDA underscored the need for various stakeholders to work together to invest in strategies and responsible approaches that deter or mitigate abuse, while preserving access to pain medications for the patients that need them most.[13] Click on the stakeholder groups below to learn more.

Healthcare Professionals

The FDA has identified three key ways prescribers can help curtail the US opioid epidemic [12] – by obtaining adequate training in opioid therapy, knowing the content of the most current opioid drug labels, and educating patients about the appropriate use of opioids, their potential risks, and proper disposal techniques.

Advocacy Organizations

Various advocacy groups offer educational programs to engage healthcare providers and antidrug coalitions in the promotion and distribution of public education materials. Many people who abuse or misuse opioids have obtained them without a prescription, so understanding and following appropriate use, storage, and disposal instructions could help reduce the risk of abuse and diversion. **Resources are available**.

Pharmaceutical Industry

The FDA encourages the ongoing study of **abuse deterrence technologies** for new prescription opioid medications. Teva Pharmaceuticals takes the responsibility to help mitigate the risks of abuse seriously and is leading education and abuse-mitigation efforts, working to develop educational resources, and partnering with a variety of stakeholders. **Please register** and follow us on **Facebook** to be notified when new information and resources become available.

Government

Due to the complex issues surrounding opioid abuse and misuse, various national and state programs and policies have been put in place to help mitigate the epidemic. These simultaneously prevent abuse, addiction, and diversion, while allowing and supporting the legal use of prescription drugs by those who need them.[4] Abuse mitigation programs and policies include:

Prescription Drug Monitoring Programs (PDMPs) are in place in 49 states to help detect and reduce the risk of diversion and abuse of prescription drugs at the practice and retail levels. These state programs allow for the collection and analysis of prescription data.[17] Click here to see the benefits of proactive reporting.

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The Drug Enforcement Administration's Schedules of Controlled Substances classify controlled substances into five categories according to the accepted medical use and the potential for abuse.[19] Schedule I drugs are considered the most dangerous, while Schedule V drugs are seen to have the least risk for abuse.[19] Prescription opioid medications generally fall under Schedules II and III.[19] The DEA plays an important role in mitigating abuse and diversion of opioids by enforcing the controlled substance laws and regulations in the US.[19] Click here to see a list of the DEA drug scheduling categories. SHOW MORE

Risk Evaluation and Mitigation Strategies (REMS) are requirements set by the **Food and Drug Administration (FDA)** for pharmaceutical manufacturers to ensure that the benefits outweigh the risks for certain drugs.[16] Click here to learn more about the components of REMS that can be used by the pharmaceutical industry.[16] SHOW MORE

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Advancements in Abuse Deterrence

Scientifically driven solutions are needed to help combat opioid abuse, including potential abuse deterrent technologies.

Evolving Strategies Address Abuse Potential

According to the CDC, **opioid abuse** is the nation's fastest growing drug problem and it ranks among the top three for prescription drug abuse. [3] Scientifically driven solutions are needed to help combat this serious public health epidemic, including: **Strategies to mitigate risk**, Abuse deterrence technology, and continued scientific research.[5]

In April 2015, the Food and Drug Administration (FDA) issued **guidance** to assist the pharmaceutical industry in developing new formulations of opioid drug products with potentially abuse-deterrent properties,[5] which it believes have promise to help reduce, though not necessarily prevent, opioid abuse.[5]

Studies Evaluate New Potentially Abuse Deterrent Technologies

In order to assess the impact of a potentially abuse-deterrent product, the FDA recommends looking at data from the below categories of pre-and postmarket studies.

Category 1: Laboratory Manipulation and Extraction Studies

Category 2: Pharmacokinetic Studies

Category 3: Clinical Abuse Potential Studies

Category 4: Postmarket Studies

Labeling for Abuse Deterrent Opioid Formulations

Labeling for an abuse deterrent product should include a description of the abuse deterrent properties, as well as the specific routes of abuse that the product has been developed to deter, to inform healthcare professionals, the patient community, and the public about a product's abuse potential. The FDA also encourages pharmaceutical companies to include the results of premarket studies in Categories 1, 2, and 3,

and formal Category 4 postmarket studies.

When premarket data show that a product's abuse-deterrent properties can be expected to result in a meaningful reduction in that product's abuse, these data are included in product labeling. When postmarket data become available, that data may also be added to the product labeling. If the postmarket data do not demonstrate a reduction in abuse, or if the data demonstrate a shift in routes of abuse that represent a greater risk, the FDA may determine that labeling revisions are needed.

Understanding Abuse Deterrence Technology and How It Works in the Changing Chronic Pain Management Landscape

Abuse deterrence technology must continue to adapt to the changing chronic pain management landscape, though this technology does not completely eliminate the risk of abuse.[5] Abuse deterrence technologies are just one of the measures physicians can employ to help mitigate the risk of opioid abuse and misuse. This video provides an overview of opioid abuse, including the FDA guidance on abuse deterrence technology.[5]

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Abuse Deterrence Technology Formulations Target Known Routes of Abuse

In April 2015, the FDA issued guidance to assist the pharmaceutical industry to develop new formulations of opioid drugs with abuse-deterrence properties.[5] Most abuse-deterrence technologies developed to date are designed to make product manipulation more difficult, and abuse of the manipulated product less attractive or rewarding.

Physical & Chemical Barriers

Physical and chemical barriers can limit drug release following mechanical manipulation, or change the physical form of a drug, rendering it less amenable to abuse.[5]

- Physical barriers can prevent chewing, crushing, cutting, grating, or grinding
- Chemical barriers resist extraction of the opioid using common liquids like water, alcohol, or other organic solvents

Next Steps

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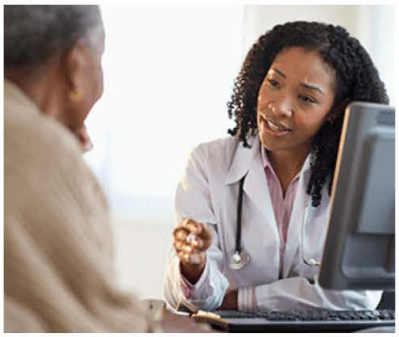
Understanding Chronic Pain



Chronic and Acute Pain

Pain is a serious medical condition that can impact anyone at any time. Pain that lasts only for a short period of time is called acute pain; it's a normal feeling that typically alerts us to a possible injury.[6] Chronic pain is very different. Chronic pain is often defined as any pain that lasts for 12 weeks or longer.[6] According to the Institute of Medicine, chronic pain is estimated to affect approximately 100 million American adults.[1]

Chronic pain may be caused by an initial injury or there may be an ongoing cause, like a medical illness.[6] But for some people, there may also be no clear cause.[6] Other health problems, such as fatigue, sleep disturbance, decreased appetite, and mood changes, often accompany chronic pain.[6] Chronic pain may affect people's ability to participate in daily tasks.[1]

Next Steps

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Finding the Right Chronic Pain Care Plan for You

Working with Your Doctor

How chronic pain is experienced is unique to every person.[6] There is no test to measure how chronic pain feels or exactly where it is located.[6] So, your doctor will rely on you to tell him or her how the pain feels, how often you experience the pain, and where exactly it hurts.[6] Defining pain as sharp or dull, constant, on-and-off, burning, or aching may give the best clues to the cause of the pain.[6] These descriptions are part of what is called the pain history. Your healthcare team will usually start your appointment by discussing your pain so they understand your pain history.[6]

A Pain Treatment Team

Since chronic pain may occur in a variety of locations in the body and for many different reasons, it is important for you to work with your doctor to identify the causes and symptoms of your pain to find the treatment plan that works for you.[6] The best treatment plans are tailored to each individual person with input from healthcare team members.[6] It may be helpful to work with several healthcare professionals who have different training backgrounds and an understanding of chronic pain.[6] The person in pain and his or her loved ones must also be actively involved in the treatment plan.[6]

Types of Chronic Pain Management

The overall goal of chronic pain management is to reduce the pain to help people return to daily living.[6] While there are a variety of options available to treat chronic pain, it usually cannot be cured, only

managed.˅ A variety of options exist for you and your pain care team to create the treatment plan that is right for you.[7] These options include[6,7]:

- Psychotherapy
- Meditation
- Massage therapy
- Behavior modification
- Acupuncture
- Electrical stimulation
- Nerve blocks
- Surgery
- Medicines (aspirin, acetaminophen, nonsteroidal anti-inflammatory drugs, topical anesthetics, opioid medicines)

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Prescription Opioid Medicines

What You Need to Know

Your doctor may decide to prescribe a prescription pain medicine known as an opioid.[9] These prescription medicines may be an appropriate treatment option for people living with chronic pain that is not adequately managed by other methods.[2 43] It's important to understand that all prescription opioid medicines have the potential to be abused and misused.[10] If you are prescribed a prescription opioid medicine, it is important to understand the risks and who else may be affected.

Safeguarding those around you

The person prescribed a medicine isn't necessarily the only one at risk for abuse. More than three out of four people who misuse prescription pain medications do so by using medication prescribed to someone else.[21] Recognizing environmental factors that may contribute to a greater potential for abuse could keep those around you safe. These risk factors include living in a household with adolescents, teenagers, someone with a history of substance abuse, or a high volume of visitors or staff.

What should I know about abuse and misuse?

It's important to know the difference between prescription drug abuse and misuse to understand who may be at risk.

Abuse

Abuse is a nonmedical use of a drug, repeatedly, or even sporadically, for the positive psychoactive effects it produces.[11] The most common form of opioid abuse is swallowing a number of whole pills or tablets for the feeling or "high" it can cause.[5] While swallowing pills is the most common form of abuse, prescription opioids can also be abused by being crushed or dissolved.[5]

Misuse

Misuse is using the prescription drug for a reason other than for which it was prescribed.[11] The key difference in abuse and misuse is that the medicine is not being used for an intentional high, so it is labeled misuse rather than abuse. Misuse can take many forms most people may not realize is misuse, for example[11]:

- Using a drug for a different condition than that for which the drug is prescribed

- Taking more drug than prescribed or at different dosing intervals

Diversion

Diversion is a type of misuse that happens when people take prescription opioids that were not prescribed for them.[22] Unaware of the dangers of sharing medications, people often unknowingly support diversion by sharing their unused pain medication with their family members.[23]

What can I do to reduce the risk of abuse?

Everyone who is prescribed an opioid medicine can play a role in reducing the risk of those medicines being abused. Understanding how to appropriately use, store, and dispose of prescription opioid medicines can help decrease the chances that they will be abused or misused.

What else is being done to reduce the risk of abuse of prescription medicines?

Because prescription drug abuse is the nation's fastest growing drug problem, it's important for everyone involved to play a role if we are going to reduce the impact of prescription drug abuse on society.[3] This means that doctors, pharmacists, government policy makers, advocacy organizations, pharmaceutical companies, and people who are prescribed opioid medications must work together.[13]

In order to help reduce the risk of prescription opioid medicines being abused, the pharmaceutical industry is changing the way they make, or manufacture, these medicines. Abuse deterrence technologies may make it more difficult to crush or dissolve opioid medicines and may help reduce how much someone likes the drug when they use it with the intention of getting high.[5]

Next Steps

Go to Appropriate Use, Storage & Disposal ›

Related Content

Use, Storage & Disposal
Appropriate use, storage and disposal guidelines for your prescriptions

Managing Your Chronic Pain
Work with your doctor to find the pain care plan that is right for you

Support for Living With Pain
Links to advocacy and support groups for people with pain

https://web.archive.org/web/20190228142339/http://painmatters.com/people-affected-by-pain/appropriate-use-storage-disposal.aspx

Appropriate Use, Storage & Disposal

Using Prescription Opioid Medicines Appropriately

Following guidelines on appropriate use, storage, and disposal of your prescription pain medications is important. Prescription drug abuse is a serious public health issue.[3] Remember, the person who was prescribed a prescription opioid medication isn't always the only one who is at risk for abuse.

Use[14]

- Take medications only as prescribed
- Be aware of risks
- Understand inappropriate use
- Never give prescription medicines to anyone else

Storage[14,15]

- Hide or lock up opioid medications to avoid access by family, friends, or houseguests
- Keep prescription medications in their original packaging so it is clear for whom the medications were prescribed and to save the directions for appropriate use

Disposal[15]

- Opioids may be disposed of through community-sponsored take-back programs
- If there are none available in your area, follow the Office of Drug Control National Policy recommendations for **environmentally friendly disposal**
- Learn more about appropriate **use, storage and disposal** of prescription opioid medications.

Next Steps

Go to Resources for People Affected by Pain ›

Related Content

Understanding Chronic Pain
Watch the *Pain Matters* documentary to learn about the impact of chronic pain

Resources for Living with Pain
Links to advocacy and support groups for people with pain

Managing Your Chronic Pain
Work with your doctor to find the pain care plan that is right for you

SIGN UP FOR UPDATES

https://web.archive.org/web/20190228142355/http://painmatters.com/healthcare-professionals/tools-resources-for-managing-chronic-pain.aspx

Tools & Resources for Healthcare Professionals

Having the right resources can help foster productive dialogue with people affected by pain and support responsible pain management. Find tools here to help grow your understanding of the evolving pain care landscape and to share with your patients. Please register and follow us on Facebook to be notified when new information and resources become available.

Explore the resources below

Clinical Presentations | Videos | Diagnosing Pain | Assessment Tools | Opioid Storage Guidance | Events Calendar | Articles

Pain management experts address complexities of treating pain and the issue of prescription drug abuse.

Evolving Roles Same Goals Presentation

Chapter 1

Jeffrey A. Gudin, MD

WATCH

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Chapter 2

Charles E. Argoff, MD

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Chapter 3

Michael J. Brennan, MD

WATCH

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Putting Patients First—Developing Abuse Deterrent Opioids Presentation

Chapter 4

Abuse Deterrence Technology Clinical Presentation

Chapter 5

Charles E. Argoff, MD
Michael J. Brennan, MD

WATCH

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Joseph P Valenza, MD
Gregory L Holmquist, PharmD

WATCH

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REGISTER TO DOWNLOAD THESE PRESENTATIONS

Joseph P Valenza, MD, Gregory L Holmquist, PharmD, Jeffrey A. Gudin, MD, Charles E. Argoff, MD, and Michael J. Brennan, MD, have been compensated for their work on Pain Matters.

Next Steps

Go to People Affected by Pain ›

https://web.archive.org/web/20190228142344/http://painmatters.com/people-affected-by-pain/community-resources-people-affected-chronic-pain.aspx#videos

Community Resources for People Affected by Chronic Pain

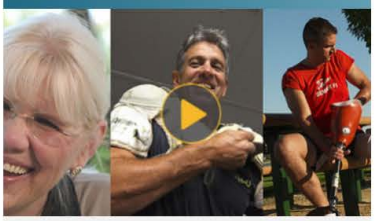
Finding a pain care plan that is right for you starts by working with your doctor. Find tools and resources to help you get the information you need to reduce the risk of prescription medicine abuse and misuse.

Explore the resources below

Videos | Pain Self Assessment & Discussion Tools | Opioid Use Storage and Disposal | Advocacy Organizations & Community Connection

Short videos explore responsible opioid use and real stories from people affected by chronic pain and their families.

Pain Matters Documentary Film Clips



Watch short clips from the documentary to see first-hand the impact of chronic pain.

WATCH

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Introducing Pain Matters

Watch an introductory video about PainMatters.com.

WATCH

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NSAIDs Safety

This video from the American Chronic Pain Association discusses how to use NSAIDs safely and effectively.

WATCH

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Pathways through Pain: Priorities and Goals

This video from the American Chronic Pain Association will empower you to take control of managing your pain.

WATCH

SHARE

Next Steps

Go to Pharmacists Resources Page ›

Related Content

Understanding Chronic Pain
Watch the *Pain Matters* documentary to learn about the impact of chronic pain

Tools & Resources
Use these tools and downloads to learn more about responsible opioid use

Appropriate Use, Storage & Disposal
Appropriate use, storage and disposal guidelines for your prescriptions

https://web.archive.org/web/20190227200600/http://painmatters.com/tools-resources/for-pharmacists.aspx#videos

Tools and Guidelines for Pharmacists Filling Prescriptions for Chronic Pain

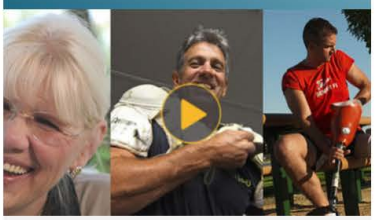
Filling prescriptions allows you to play a vital role in both effective pain management and the prevention of opioid abuse and misuse. Find tools here to help understand the appropriate use of opioids and advocate for their proper use and disposal.

Explore the resources below

Videos | Opioid Disposal | The Pharmacist's Role | Event Calendar

Short videos explore responsible opioid use and real stories from people and their families who are affected by chronic pain.

Pain Matters Documentary Film Clips



Watch short clips from the documentary to understand first-hand what it is like to live with chronic pain.

WATCH NOW

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Introducing Pain Matters

Watch an introductory video about PainMatters.com

WATCH VIDEO

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Next Steps

Sign Up for Updates ›

https://web.archive.org/web/20190228142344/http://painmatters.com/people-affected-by-pain/community-resources-people-affected-chronic-pain.aspx#pain-self-assessment-discussion-tools

Community Resources for People Affected by Chronic Pain

Finding a pain care plan that is right for you starts by working with your doctor. Find tools and resources to help you get the information you need to reduce the risk of prescription medicine abuse and misuse.

Explore the resources below

Videos | Pain Self Assessment & Discussion Tools | Opioid Use Storage and Disposal | Advocacy Organizations & Community Connection

Download tools to help prepare for your next appointment and discuss your pain symptoms with your doctor.

Questions to Ask Your Doctor

Prepare for an exam room discussion about your pain experience using this guide.

DOWNLOAD

SHARE

Design for Dialogue

Join the pain community as we reimagine the exam room experience and a more open dialogue. Be the voice that inspires change.

VIEW

SHARE

Quality of Life Scale

A tool to assess the impact of pain on daily life provided by the American Chronic Pain Association.

DOWNLOAD

SHARE

Pain Scales

Measure pain numerically through these scales provided by the US Department of Veterans Affairs.

VIEW

SHARE

Pain Management Log

Track daily pain with this log from MD Anderson.

VIEW

SHARE

Wong-Baker FACES Pain Rating Scale

Using faces to describe pain intensity, this tool provides a more visual approach to pain assessment.

DOWNLOAD

SHARE

Before Your Visit

Prepare for your health care visit with this guide from the American Chronic Pain Association.

Pain Log

Measure and track pain over time with this pain log from the American Chronic Pain Association.

Ability Chart

Track how pain is affecting daily activities with this chart from the American Chronic Pain Association.

LEARN MORE

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Back Pain Map

Identify back pain symptoms with this interactive map from the American Chronic Pain Association.

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Head Pain Map

Identify head pain symptoms with this interactive map from the American Chronic Pain Association.

VIEW TOOL

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Next Steps

Go to Pharmacists Resources Page ›

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Understanding Chronic Pain
Watch the *Pain Matters* documentary to learn about the impact of chronic pain

Tools & Resources
Use these tools and downloads to learn more about responsible opioid use

Appropriate Use, Storage & Disposal
Appropriate use, storage and disposal guidelines for your prescriptions

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Community Resources for People Affected by Chronic Pain

Finding a pain care plan that is right for you starts by working with your doctor. Find tools and resources to help you get the information you need to reduce the risk of prescription medicine abuse and misuse.

Explore the resources below

Videos | Pain Self Assessment & Discussion Tools | Opioid Use Storage and Disposal | Advocacy Organizations & Community Connection

Find support groups and community resources for people affected by pain.

Support & Advocacy Organizations

Several national organizations are dedicated to supporting people living with chronic pain and their families.

- American Chronic Pain Association
- US Pain Foundation
- Pain Action Alliance

SHARE

Pain Centers of Excellence

The American Pain Society's annual award honors programs or services that exemplify outstanding clinical care.

VIEW

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Pain Perspectives Blog

Hear insights and perspectives into today's complex pain management landscape from members of the pain community.

VIEW

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Aches & Gains SiriusXM Radio Show

Hosted by Paul Christo, MD., this weekly radio show on SiriusXM Family Talk 131, provides information on pain management.

VIEW

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Legislation Tracker

The U.S. Pain Foundation tracks pain policy at the state level.

VIEW LEGISLATION

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Next Steps

Go to Pharmacists Resources Page ›

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Watch the *Pain Matters* documentary to learn about the impact of chronic pain

Tools & Resources
Use these tools and downloads to learn more about responsible opioid use

Appropriate Use, Storage & Disposal
Appropriate use, storage and disposal guidelines for your prescriptions

https://web.archive.org/web/20171221152000mp_/https://theacpa.org/backpainapp/

Chronic Back Pain Map

This Tool Recommended for:

- People with back pain
- People who experience headaches
- Printing for use during doctor visits to communicate information about your symptoms quickly
- Tracking your progress over time

Related Tools:

- Pain Log
- More Pain Mapping Tools

American Chronic Pain Association

Chronic Back Pain Map

Welcome,

This interactive tool can help you in two ways.

Back pain can be complex and difficult to describe in the short time you may have with your health care provider. This tool can help you create a detailed picture of your pain---where it is, how it feels, how much it hurts, and what triggers it. Fill it out before your visit, print it, and share it with your provider. It will provide a lot of important information fast, so you and your provider can begin to address your issues more quickly.

In addition, this tool can help you track your progress over time. Keep printouts of your results; they will help you see which treatments and activities reduce your pain and which don't. That can be a big step in gaining better control over your pain and improving your quality of life.

Image Courtesy of 3d4medical.com

Funded by: ZogenIX

START

MALE FEMALE

Last Updated: 12/13/2017

Development of this new ACPA web site was made possible through an unrestricted educational grant from Medtronic Foundation and Purdue Pharma.

Medtronic Foundation and Purdue have no influence on the editorial content of the site. Ongoing funding also comes from memberships/donations from a range of individual contributors.

https://web.archive.org/web/20171001123355/https://www.cdc.gov/RxAwareness/

Rx Awareness

VIDEOS

Watch stories of people impacted by opioids.

More >

RADIO SPOTS

Hear how opioids have affected lives & families.

More >

SOCIAL MEDIA

Get social media images to share in your channels.

More >

SIGNS & BILLBOARDS

Get signs and billboards to share in your community.

More >

ONLINE ADS

Share images and messages to use on the web.

More >

ALL CAMPAIGN RESOURCES

View all of the Rx Awareness campaign resources.

More >

ABOUT THE CAMPAIGN

Overview of the Rx Awareness campaign

PREVENT OVERDOSE

Find out how you can prevent opioid overdose

TREATMENT AND RECOVERY

Resources that may help aid in treatment

REAL STORIES

Real people sharing their stories about prescription opioids

NEWSROOM

See how Rx Awareness is being used and promoted online and through the media

OPIOID OVERDOSE WEBSITE

Learn more about opioid misuse and overdose, data, and prevention

Page last reviewed: September 25, 2017
Page last updated: September 25, 2017
Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention

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https://web.archive.org/web/20171104174424/https://www.cdc.gov/rxawareness/resources/video.html

Rx Awareness

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Videos

The *Rx Awareness* campaign videos tell the real stories of people whose lives have been negatively impacted by prescription opioid use and abuse.

View the *Rx Awareness* YouTube playlist.

Rx Awareness Campaign Trailer

Low Resolution Video

About the Campaign >

Rx Awareness Campaign

Low Resolution Video

About the Campaign >

Ann Marie's Story

Transcript Low Resolution Video

Learn More about Ann Marie >

Brenda's Story

Transcript Low Resolution Video

Learn More about Brenda >

Devin's Story

Transcript Low Resolution Video

Learn More about Devin >

Judy's Story

Transcript Low Resolution Video

Learn More about Judy >

Mike's Story

Noah's Story

Transcript Low Resolution Video

Learn More about Mike >

Transcript Low Resolution Video

Learn More about Noah >

Tamera's Story

Transcript Low Resolution Video

Learn More about Tamera >

Teresa's Story

Transcript Low Resolution Video

Learn More about Teresa >

Related Pages

- Campaign Resources
- Radio
- Online Ads
- Signs and Billboards
- Social Media
- Newsroom

YouTube Playlist

View the *Rx Awareness* YouTube playlist.

View the Playlist >

CDC's Opioid Overdose Website

Learn more about opioid misuse and overdose, data, and prevention resources at www.cdc.gov/drugoverdose.

More >

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Rx Awareness

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Radio Spots

Rx Awareness campaign radio ads are stories from real people whose lives have been directly impacted by prescription opioid. The files can be downloaded and shared across social media platforms.

To save a sound file, right-mouse-click on the link and select "Save Target As ..." or "Save Link As..."

Ann Marie's Story

Ann Marie's Radio Spot [MP3 – 477 KB]

Ann Marie's Radio Spot [WAV – 11 MB]

Ann Marie's Radio Spot Transcript [PDF – 98 KB]

Learn More about Ann Marie >

Judy's Story

Judy's Radio Spot [MP3 – 477 KB]

Judy's Radio Spot [WAV – 11 MB]

Judy's Radio Spot Transcript [PDF – 98 KB]

Learn More about Judy >

Mike's Story

Mike's Radio Spot [MP3 – 476 KB]

Mike's Radio Spot [WAV – 11 MB]

Mike's Radio Spot Transcript [PDF – 97 KB]

Learn More about Mike >

Noah's Story

Noah's Radio Spot [MP3 – 483 KB]

Noah's Radio Spot [WAV – 11 MB]

Noah's Radio Spot Transcript [PDF – 98 KB]

Learn More about Noah >

Tamera's Story

Tamera's Radio Spot [MP3 – 476 KB]

Tamera's Radio Spot [WAV – 11 MB]

Tamera's Radio Spot Transcript [PDF – 97 KB]

Learn More about Tamera >

Related Pages

- Campaign Resources
- Video
- Online Ads
- Signs and Billboards
- Social Media
- Newsroom

CDC's Opioid Overdose Website

Learn more about opioid misuse and overdose, data, and prevention resources at www.cdc.gov/drugoverdose.

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Rx Awareness

Social Media

These graphics and images optimized for social media, feature *Rx Awareness* campaign participants and their key messages. You may use this content across social media platforms.

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Related Pages

- Campaign Resources
- Video
- Radio
- Online Ads
- Signs and Billboards
- Newsroom

CDC's Opioid Overdose Website

Learn more about opioid misuse and overdose, data, and prevention resources at www.cdc.gov/drugoverdose.

More >

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Rx Awareness

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Signs and Billboards

Below are *Rx Awareness* campaign billboards, posters, and newspaper advertisement files that can be downloaded and used to help raise awareness about the risks of prescription opioids.

Download

- Newspaper Ads 7.98×5.25 in [PDF – 1 MB]
- Newspaper Ads 12×10.5 in [PDF – 1 MB]
- Sign 6×3 in [PDF – 251 KB]
- Billboard 22×10 in [PDF – 4 MB]
- Billboard 12×24 in [PDF – 3 MB]

Related Pages

- Campaign Resources
- Video
- Radio
- Online Ads
- Social Media
- Newsroom

CDC's Opioid Overdose Website

Learn more about opioid misuse and overdose, data, and prevention resources at www.cdc.gov/drugoverdose.

More

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Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

Rx Awareness

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Campaign Resources

The materials and resources from this campaign are evidence-based and tested.

Contact Us

For questions about campaign resources or implementation, please contact us.

Contact Us

Related Pages

- Video
- Radio
- Online Ads
- Signs and Billboards
- Social Media
- Newsroom

CDC's Opioid Overdose Website

Learn more about opioid misuse and overdose, data, and prevention resources at www.cdc.gov/drugoverdose.

More

Other Resources

- CDC Guideline for Prescribing Opioids for Chronic Pain
- CDC Guideline for Prescribing Opioids for Chronic Pain: COCA Call Series
- Online Training Series for Healthcare Providers
- Guideline Information for Providers
- Guideline Information for Patients

File Formats Help:

How do I view different file formats (PDF, DOC, PPT, MPEG) on this site?

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Rx Awareness

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About the campaign

The Rx Awareness campaign tells the real stories of people whose lives were torn apart by prescription opioids. The goal of the campaign is to increase awareness that prescription opioids can be addictive and dangerous. The campaign also strives to decrease the number of individuals who use opioids recreationally or overuse them.

When the Prescription Becomes the Problem

Nearly half of all U.S. opioid overdose deaths involve a prescription opioid. Overdose deaths involving prescription opioids have tripled since 1999, and so have sales of these prescription drugs. From 1999 to 2015, more than 183,000 people have died in the U.S. from overdoses related to prescription opioids, with more than 15,000 prescription opioid overdose deaths in 2015.

Take Action and Help

Whether you are a healthcare provider, first responder, law enforcement officer, public health official, or community member, the opioid epidemic is likely affecting you and your community. No matter who you are, you can take action to end the opioid overdose epidemic ravaging the United States. We all have a role to play on the frontlines of this fight—it starts with addressing prescription opioid misuse, abuse, and overdose.

- Learn more about prescription opioids so you can help those at risk for opioid use disorder and overdose in your community.
- Help those struggling with addiction find the right care and treatment. Anyone who takes prescription opioids can become addicted and help is available if you or someone you know is battling opioid use disorder.
- Spread the word and increase awareness in your community about the risk and dangers of prescription opioids.

State and local health departments and community organizations can also take part in the Rx Awareness campaign and use the tested campaign materials and resources to launch campaigns, support local prevention activities, and raise awareness about the risks of prescription opioids.

Read this overview of the campaign [PDF – 5 MB], and learn how to launch the campaign in your local community.

Campaign Overview Fact Sheet

Rx Awareness Campaign Overview Fact Sheet [PDF – 334 KB]

Related Pages

- Real Stories
- Prevent Prescription Opioid Overdose
- Treatment and Recovery
- Campaign Resources

CDC's Opioid Overdose Website

Learn more about opioid misuse and overdose, data, and prevention resources at www.cdc.gov/drugoverdose.

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Rx Awareness

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Prevent Prescription Opioid Overdose

Saving lives from opioid overdose through the Rx Awareness campaign relies on the efforts of state and local agencies and organizations across the country. By sharing the campaign materials in your communities, you can broaden the reach of the message that, "**It only takes a little to lose a lot.**"

Related Pages

- About the campaign
- Real Stories
- Treatment and Recovery
- Campaign Resources
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CDC's Opioid Overdose Website

Learn more about opioid misuse and overdose, data, and prevention resources at www.cdc.gov/drugoverdose.

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Rx Awareness

Rx Awareness
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Real Stories −
Ann Marie
Brenda
Devin
Judy
Mike
Noah
Tamera
Teresa
Prevent Prescription Opioid Overdose
Treatment and Recovery
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CDC > Opioid Overdose > Rx Awareness

Real Stories

Ann Marie's Story

Ann Marie is a mother who lost her 22-year-old son, Chris, to a prescription opioid overdose.

Ann Marie's Story >

Brenda's Story

Brenda shares her experiences with addiction to prescription opioids and the toll pain medication took on her life.

Brenda's Story >

Devin's Story

Devin shares his Rx Awareness story of using prescription opioids after a minor surgery as a teenager and his path to recovery from opioid use disorder.

Devin's Story >

Judy's Story

Judy lost her son, Steve, to a prescription opioid overdose. Before he died, he wrote, "At first it was a lifeline, now it is a noose around my neck."

Judy's Story >

Mike's Story

Mike became addicted to a prescription opioid and ended up leaving school and no longer playing college sports. At the time he "didn't understand the dangers of the drug and was addicted after a matter of months."

Mike's Story >

Noah's Story

Noah shares his experience losing his father to prescription opioid addiction. He states that he learned "it's likely that everybody knows somebody who's struggling with this very problem."

Noah's Story >

Tamera's Story

Tamera shares her experience losing almost everything she had to prescription opioid addiction.

She says that knowing it "could have been prevented" makes her experience seem so much worse. Tamera reminds us that it "only takes one."

Tamera's Story >

Teresa's Story

Teresa lost her brother RJ at age 32 to a prescription opioid overdose. He convinced people to "believe he knew exactly what he was taking."

Teresa's Story >

Related Pages

- About the campaign
- Prevent Prescription Opioid Overdose
- Treatment and Recovery
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Opioid Overdose

Interactive Training Series

Applying CDC's Guideline for Prescribing Opioids

An Online Training Series for Healthcare Providers

More than 40 people die every day from prescription opioid-involved overdose. The *CDC Guideline for Prescribing Opioids for Chronic Pain* provides recommendations for safer and more effective prescribing of opioids for chronic pain in patients 18 and older in outpatient settings outside of active cancer treatment, palliative care, and end-of-life care.

This online training series aims to help you apply CDC's recommendations in your clinical setting through interactive patient scenarios, videos, knowledge checks, tips, and resources. You will gain a better understanding of the recommendations, the risks and benefits of prescription opioids, nonopioid treatment options, patient communication, and risk mitigation. See below for the trainings that are available for the series, as well as those that are proposed, throughout this year. Please routinely check back for updates and availability.

Training Courses

Reducing the Risks of Opioids

Providers will learn best risk mitigation strategies and when to employ them when prescribing an opioid.

More >

Communicating With Patients

Providers will learn communication strategies they can use when treating chronic pain, including motivational interviewing.

More >

Treating Chronic Pain Without Opioids

This module presents providers with various options for managing chronic pain, giving them the tools they need to identify appropriate nonopioid medications and nonpharmacologic treatments and facilitate a patient-centered approach.

More >

Addressing the Opioid Epidemic: Recommendations from CDC

This module presents an overview of the CDC Guideline for Prescribing Opioids for Chronic Pain: It explains the rationale for the Guideline's creation, highlights key recommendations, and describes the benefits of implementing the Guideline.

More >

Additional Training Courses Coming Soon

- **Deciding Whether to Prescribe**
  In this section of the training, providers learn mechanisms for deciding if opioids should be prescribed, and next steps for treatment – whether opioid or non-opioid treatments are selected.

- **Dosing and Titration of Opioids: How Much, How Long, and How and When to Stop?**
  When providers choose to prescribe opioids, they need to know how to properly dose and titrate opioids to reduce risk of opioid use disorder and overdose. This module explains methods of dosing and titration.
- **Reducing the Risks of Opioids**
  Providers will learn best risk mitigation strategies and when to employ them after prescribing an opioid.
- **Assessing and Addressing Opioid Use Disorder**
  This module describes methods available to a provider for assessing and addressing an opioid use disorder when it is suspected.
- **Implementing the CDC Guideline**
  This module provides strategies and tools for implementing the CDC Guideline for Prescribing Opioids for Chronic Pain in a provider's own practice, while outlining steps to overcome common barriers to implementation.

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- Child Safety and Injury Prevention
- HEADS UP to Brain Injury Awareness
- Home and Recreational Safety
- Motor Vehicle Safety
- Parents Are The Key to Safe Teen Drivers
- STEADI Initiative for Health Care Providers
- Traumatic Brain Injury
- Violence Prevention
- WISQARS (Injury & Death Data)

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Frequently Asked Questions

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The CDC Guideline for Prescribing Opioids for Chronic Pain and related resources were developed to support you as you provide the best possible healthcare to your patients. See below for a collection of frequently asked questions about the Guideline.

What is the Main Purpose of the Guideline? expanded

The Guideline provides recommendations to primary care providers about the appropriate prescribing of opioids to improve pain management and patient safety. Recommendations focus on the use of opioids in treating chronic pain (i.e., pain lasting longer than three months or past the time of normal tissue healing) in patients 18 years and older. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective treatment while reducing the number of people who suffer from opioid use disorder or overdose from these drugs. CDC aims to save lives and prevent prescription opioid overdoses by equipping providers with the knowledge, tools, and guidance they need.

For more information: visit the Guideline Overview page(https://www.cdc.gov/drugoverdose/prescribing/guideline.html).

Why is the Guideline Needed in the United States? collapsed

What are the Risks of Using Prescription Opioids for Chronic Pain? collapsed

Who is the Guideline for? collapsed

What are the Main Recommendations in the Guideline? collapsed

Why Does CDC Recommend Exercising Caution at Specific Opioid Dosages? collapsed

Why is CDC Recommending a Specific Duration of Opioid Prescription for Acute Pain? collapsed

Will the Guideline Discourage Use of Opioids for Patients in Chronic Pain? collapsed

Will Providers be Required to Follow This Guideline? collapsed

Are There Resources to Help Providers Use the Guideline? collapsed

Will the Guideline Result in Patients No Longer Being Able to Obtain Opioids? collapsed

Will CDC Evaluate the Guideline after It is Released? collapsed

How Can the Guideline Make Strong Recommendations When the Evidence is Low Quality? collapsed

How is the Final Version of the Guideline Different from the Draft Posted for Public Comment? collapsed

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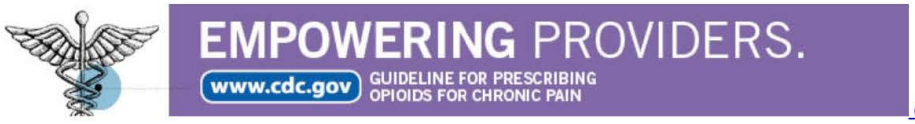

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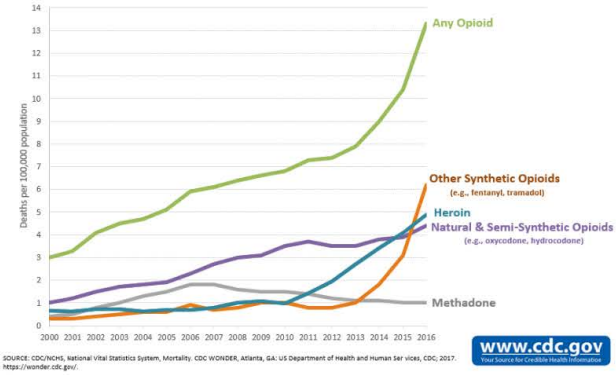
Opioid Overdose

Opioid Data Analysis

CDC looks at four categories of opioids:

1. **Natural opioid analgesics,** including morphine and codeine, and **semi-synthetic opioid analgesics,** including drugs such as oxycodone, hydrocodone, hydromorphone, and oxymorphone;
2. **Methadone,** a synthetic opioid;
3. **Synthetic opioid analgesics** other than methadone, including drugs such as tramadol and fentanyl; and
4. **Heroin,** an illicit (illegally-made) opioid synthesized from morphine that can be a white or brown powder, or a black sticky substance.

Overdose Deaths Involving Opioids, by Type of Opioid, United States, 2000-2016



(https://www.cdc.gov/drugoverdose/images/data/OpioidDeathsByTypeUS.PNG)
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Prescription Opioids

Opioid analgesics (commonly referred to as prescription opioids) have been used to treat moderate to severe pain in some patients. Natural opioids, semi-synthetic opioids, methadone (a synthetic opioid), and some other synthetic opioids are commonly available by prescription.

Fentanyl

Fentanyl is a synthetic opioid that is legally made as a pharmaceutical drug to treat pain, or illegally made as a non-prescription drug and is increasingly used to intensify the effects (or "high") of other drugs, such as heroin.

How the data are calculated

Historically, CDC's standard analysis approach combined the natural, semi-synthetic, and synthetic opioid categories (including methadone) when reporting deaths involving opioid analgesics, also referred to as prescription opioids. Using this method, in 2015 there were over 22,000 deaths involving prescription opioids, equivalent to about 62 deaths per day. This was an increase from approximately 19,000 in 2014.[1] However, a significant portion of the increase in deaths was due to deaths involving synthetic opioids other than methadone, which includes fentanyl. Law enforcement agencies have reported recent increases in seizures of illegally-made (non-pharmaceutical) fentanyl.[2] It is presumed that a large proportion of the increase in deaths is due to illegally-made fentanyl and not prescription opioids.[1] Unfortunately, information reported about overdose deaths does not distinguish pharmaceutical fentanyl from illegally-made fentanyl.

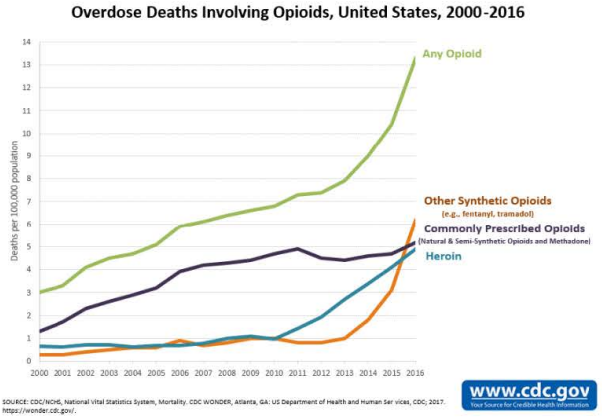
Given the recent surge in illegally-made fentanyl, the CDC Injury Center is now analyzing synthetic opioids (other than methadone) separately from other prescription opioids. This new analysis can provide a more detailed understanding of the increase in different categories of opioid deaths from previous years. Using this analysis, in 2015 there were more than 15,000 deaths involving this more limited category of prescription opioids (an increase in this category of 443 deaths since 2014), equivalent to about 42 deaths per day.[3] Changing the way deaths are analyzed seems to result in a decrease in deaths involving prescription opioids. But, this new number is likely an undercount of deaths related to prescription opioids, because it does not include deaths that are associated with pharmaceutical fentanyl, tramadol, and other synthetic opioids that are used as pain relievers.

What this means

Safe Teen Drivers
- STEADI Initiative for Health Care Providers
- Traumatic Brain Injury
- Violence Prevention
- WISQARS (Injury & Death Data)

What this means

Regardless of the analysis strategy used, prescription opioids continue to be involved in more overdose deaths than any other drug, and all the numbers are likely to underestimate the true burden given the large proportion of overdose deaths where the type of drug is not listed on the death certificate. The findings show that two distinct but interconnected trends are driving America's opioid overdose epidemic: a 16-year increase in deaths from prescription opioid overdoses, and a recent surge in illicit opioid overdoses driven mainly by heroin and illegally-made fentanyl. Both of these trends continued in 2016.[3]



(https://www.cdc.gov/drugoverdose/images/data/ODDeathUS.PNG)
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Drug overdose deaths can be hard to categorize

In approximately 1 in 5 drug overdose deaths, no specific drug is listed on the death certificate. In many deaths, multiple drugs are present, and it is difficult to identify which drug or drugs caused the death (for example, heroin or a prescription opioid, when both are present).[3]

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1. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2017. Available at http://wonder.cdc.gov.
2. Centers for Disease Control and Prevention. CDC Health Advisory: Increases in Fentanyl Drug Confiscations and Fentanyl-related Overdose Fatalities. HAN Health Advisory. October 26, 2015. http://emergency.cdc.gov/han/han00384.asp
3. Hedegaard H, Warner M, Miniño AM. Drug overdose deaths in the United States, 1999–2016. NCHS Data Brief, no 294. Hyattsville, MD: National Center for Health Statistics. 2017

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Opioid Overdose

Opioid Overdose
Opioid Basics
Data
Overdose Prevention
Information for Patients
Information for Providers
State Information
CDC Publications
Resource Center

National Center for Injury Prevention and Control

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HEADS UP to Brain Injury Awareness
Home and Recreational Safety
Motor Vehicle Safety
Parents Are The Key to Safe Teen Drivers
STEADI Initiative for Health Care Providers
Traumatic Brain Injury
Violence Prevention
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Drug Overdose Death Data

Opioids—prescription and illicit—are the main driver of drug overdose deaths. Opioids were involved in 42,249 deaths in 2016, and opioid overdose deaths were five times higher in 2016 than 1999.

In 2016, the five states with the highest rates of death due to drug overdose were West Virginia (52.0 per 100,000), Ohio (39.1 per 100,000), New Hampshire (39.0 per 100,000), Pennsylvania (37.9 per 100,000) and (Kentucky (33.5 per 100,000).

Significant increases in drug overdose death rates from 2015 to 2016 were seen in the Northeast, Midwest and South Census Regions. States with statistically significant increases in drug overdose death rates included Connecticut, Delaware, Florida, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wisconsin.[1]

Read the entire study, *Increases in Drug and Opioid Overdose Deaths – United States, 2000 to 2014* >
Read the entire study, *Increases in Drug and Opioid Overdose Deaths – United States, 2010 to 2015* >

References

1. Hedegaard H, Warner M, Miniño AM. Drug overdose deaths in the United States, 1999–2016. NCHS Data Brief, no 294. Hyattsville, MD: National Center for Health Statistics. 2017/ CDC. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2016. Available at http://wonder.cdc.gov

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Opioid Overdose

Prescribing Data

Updated Data Available

Please note: A recent CDC Surveillance Summary contains updated data. To view the report, please visit the Annual Surveillance Report of Drug-Related Risks and Outcomes, United States, 2017 [PDF – 1 MB].

Sales of prescription opioids in the U.S. nearly quadrupled from 1999 to 2014,[1] but there has not been an overall change in the amount of pain Americans report.[2,3] During this time period, prescription opioid overdose deaths increased similarly.

The supply of prescription opioids remains high in the U.S.[4] An estimated 1 out of 5 patients with non-cancer pain or pain-related diagnoses are prescribed opioids in office-based settings.[3] From 2007 – 2012, the rate of opioid prescribing has steadily increased among specialists more likely to manage acute and chronic pain. Prescribing rates are highest among pain medicine (49%), surgery (37%), and physical medicine/rehabilitation (36%). However, primary care providers account for about half of opioid pain relievers dispensed.[3]

Health care providers, including those in primary care settings, report concern about opioid-related risks of addiction and overdose, as well as insufficient training in pain management. Although prescription opioids can help manage some types of pain, there is not enough evidence that opioids improve chronic pain, function, and quality of life. Moreover, long-term use of opioid pain relievers for chronic pain can be associated with abuse and overdose, particularly at higher dosages.

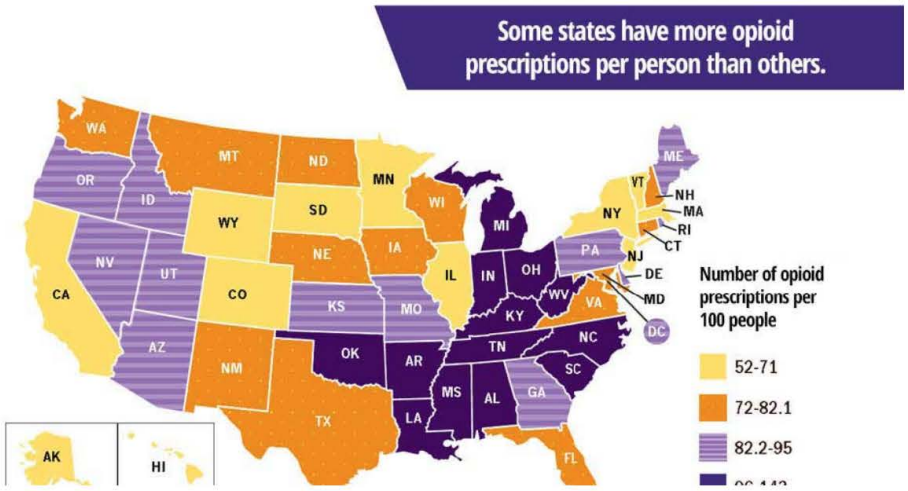
Prescription Opioid Use Among Subgroups

Prescription opioid use varies according to age, gender, and ethnicity:

- Older adults (aged 40 years and older) are more likely to use prescription opioids than adults aged 20 – 39.
- Women are more likely to use prescription opioids than men.
- Non-Hispanic whites are more likely to use prescription opioids than Hispanics. There are no significant differences in prescription opioid use between non-Hispanic whites and non-Hispanic blacks.[5,6]

State-to-State Variability

Prescribing rates for opioids vary widely across different states. In 2012, health care providers in the highest-prescribing state wrote almost 3 times as many opioid prescriptions per person as those in the lowest prescribing state.[4] Health issues that cause people pain do not vary much from place to place, and do not explain this variability in prescribing. Some other factors that may influence prescribing rates include:



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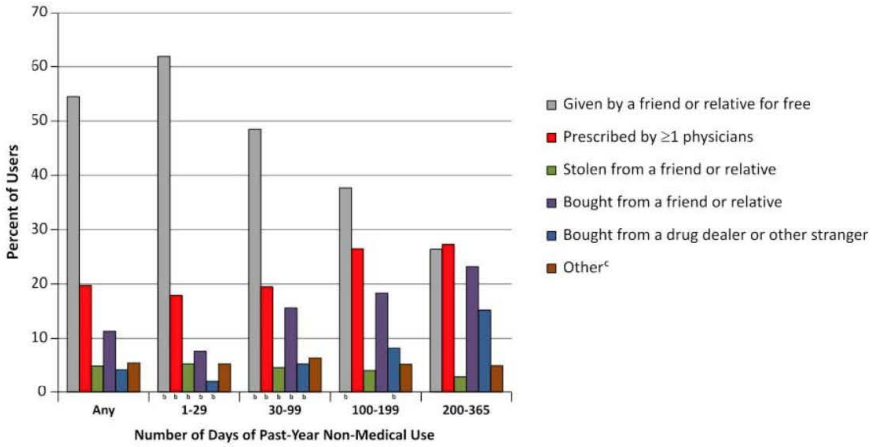
SOURCE: IMS, National Prescription Audit (NPA™), 2012.

Sources of Prescription Opioids

Most people who abuse prescription opioids get them for free from a friend or relative. However, those who are at highest risk of overdose (using prescription opioids nonmedically 200 or more days a year) get them in ways that are different from those who use them less frequently. These people get opioids using their own prescriptions (27 percent), from friends or relatives for free (26 percent), buying from friends or relatives (23 percent), or buying from a drug dealer (15 percent). Those at highest risk of overdose are about four times more likely than the average user to buy the drugs from a dealer or other stranger.[3]

Sources of Prescription Opioids Among Past-Year Non-Medical Users[a]



[a] Obtained from the US National Survey on Drug Use and Health, 2008 through 2011.[3]
[b] Estimate is statistically significantly different from that for highest-frequency users (200-365 days) ($P < .05$).
[c] Includes written fake prescriptions and those opioids stolen from a physician's office, clinic, hospital, or pharmacy; purchases on the Internet; and obtained some other way.

SOURCE: Jones C, Paulozzi L, Mack K. Sources of prescription opioid pain relievers by frequency of past-year nonmedical use: United States, 2008–2011. JAMA Int Med 2014; 174(5):802-803.

Related Pages

- Data Overview
- Prescription Opioid Overdose Data
- Understanding the Epidemic
- CDC Guideline for Prescribing Opioids for Chronic Pain
- State Information
- CDC Publications

Additional Data Sources

WONDERCDC's WONDER (Wide-ranging Online Data for Epidemiologic Research) an easy-to-use, menu-driven system that makes the information resources of the Centers for Disease Control and Prevention (CDC) available to public health professionals and the public at large. It provides access to a wide array of public health information.

WISQARSCDC's WISQARS™ (Web-based Injury Statistics Query and Reporting System) is an interactive, online database that provides fatal and nonfatal injury, violent death, and cost of injury data from a variety of trusted sources.

CDC Data & StatisticsThis web site features interactive tools, surveys, publications, databases, and more.

CMS Medicare Part D Opioid Drug Mapping Tool Interactive mapping tool that shows geographic comparisons, at the state, county, and local levels, of de-identified Medicare Part D opioid prescription prescriptions written and submitted to be filled within the United States.

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Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015

Weekly / December 30, 2016 / 65(50-51);1445–1452

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On December 16, 2016, this report was posted online as an MMWR *Early Release.*

Please note: *An erratum has been published for this report. To view the erratum, please click here.*

Rose A. Rudd, MSPH[1]; Puja Seth, PhD[1]; Felicita David, MS[1]; Lawrence Scholl, PhD[1,2] (View author affiliations)

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The U.S. opioid epidemic is continuing, and drug overdose deaths nearly tripled during 1999–2014. Among 47,055 drug overdose deaths that occurred in 2014 in the United States, 28,647 (60.9%) involved an opioid (*1*). Illicit opioids are contributing to the increase in opioid overdose deaths (*2,3*). In an effort to target prevention strategies to address the rapidly changing epidemic, CDC examined overall drug overdose death rates during 2010–2015 and opioid overdose death rates during 2014–2015 by subcategories (natural/semisynthetic opioids, methadone, heroin, and synthetic opioids other than methadone).* Rates were stratified by demographics, region, and by 28 states with high quality reporting on death certificates of specific drugs involved in overdose deaths. During 2015, drug overdoses accounted for 52,404 U.S. deaths, including 33,091 (63.1%) that involved an opioid. There has been progress in preventing methadone deaths, and death rates declined by 9.1%. However, rates of deaths involving other opioids, specifically heroin and synthetic opioids other than methadone (likely driven primarily by illicitly manufactured fentanyl) (*2,3*), increased sharply overall and across many states. A multifaceted, collaborative public health and law enforcement approach is urgently needed. Response efforts include implementing the CDC *Guideline for Prescribing Opioids for Chronic Pain* (*4*), improving access to and use of prescription drug monitoring programs, enhancing naloxone distribution and other harm reduction approaches, increasing opioid use disorder treatment capacity, improving linkage into treatment, and supporting law enforcement strategies to reduce the illicit opioid supply.

The National Vital Statistics System multiple cause-of-death mortality files were used to record drug overdose deaths.† Drug overdose deaths were identified using the *International Classification of Disease, Tenth Revision* (ICD-10), based on the ICD-10 underlying cause-of-death codes X40–44 (unintentional), X60–64 (suicide), X85 (homicide), or Y10–Y14 (undetermined intent). Among deaths with drug overdose as the underlying cause, the type of opioid is indicated by the following ICD-10 multiple cause-of-death codes: opioids (T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6); natural/semisynthetic opioids (T40.2); methadone (T40.3); synthetic opioids other than methadone (T40.4); and heroin (T40.1). Some deaths involved more than one type of opioid; these deaths were included in the rates for each subcategory. Therefore, categories of deaths presented are not mutually exclusive.§

Changes in drug overdose death rates were analyzed for all 50 states and the District of Columbia (DC) from 2010 to 2015 using joinpoint regression.¶ Opioid overdose death rates were examined for the period 2014–2015 by subcategories (natural/semisynthetic opioids, methadone, heroin, and synthetic opioids other than methadone) and by demographics, region, and across states. State-level analyses were conducted for 28 states meeting the following criteria: 1) >80% of drug overdose death certificates named at least one specific drug in 2014; 2) change from 2014 to 2015 in the percentage of death certificates reporting at least one specific drug was <10 percentage points**; and 3) ≥20 deaths occurred during 2014 and 2015 in at least two opioid subcategories examined. Analyses comparing changes in age-adjusted death rates from 2014 to 2015 used z-tests when deaths were ≥100 and nonoverlapping confidence intervals based on a gamma distribution when deaths were <100.††

The drug overdose death rate increased significantly from 12.3 per 100,000 population in 2010 to 16.3 in 2015. Death rates increased in 30 states and DC and remained stable in 19 states (Figure). Two states had changing trends during this period of decreasing rates followed by increases.§§ During 2015, a total of 52,404 persons in the United States died from a drug overdose, an increase from 47,055 in 2014; among these deaths, 33,091 (63.1%) involved an

Summary

What is already known about this topic?

The U.S. opioid epidemic is continuing. Drug overdose deaths nearly tripled during 1999–2014. In 2014, among 47,055 drug overdose deaths, 61% involved an opioid. During 2013–2014, deaths associated with the most commonly prescribed opioids (natural/semisynthetic opioids) continued to increase slightly; however, the rapid increase in deaths appears to be driven by heroin and synthetic opioids other than methadone.

What is added by this report?

From 2014 to 2015, the death

opioid, an increase from 28,647 in 2014. The age-adjusted opioid-involved death rate increased by 15.6%, from 9.0 per 100,000 in 2014 to 10.4 in 2015, driven largely by increases in deaths involving heroin and synthetic opioids other than methadone. Death rates for natural/semisynthetic opioids, heroin, and synthetic opioids other than methadone increased by 2.6%, 20.6%, and 72.2%, respectively (Table 1) (Table 2). Methadone death rates decreased by 9.1% (Table 1).

During 2014–2015, rates of natural/semisynthetic opioid deaths increased among males overall, both sexes aged 25–44 years, and non-Hispanic whites. Methadone death rates decreased among males and females overall, but increased among persons aged ≥65 years (Table 1). Death rates involving heroin and synthetic opioids other than methadone increased in both males and females, persons aged ≥15 years, and all racial/ethnic populations; however, heroin death rates among males aged 15–24 years remained stable. In 2015, death rates involving synthetic opioids other than methadone were highest among males aged 25–44 years (8.9 per 100,000), increasing 102.3% from 2014 to 2015 (Table 2). Heroin death rates also were highest in this demographic group (13.2), increasing 22.2% from 2014 to 2015. Natural/semisynthetic opioid death rates increased in the Northeast and South U.S. Census regions, and methadone death rates decreased in the South (Table 1). Death rates involving synthetic opioids other than methadone and heroin increased in all regions from 2014 to 2015 (Table 2).

Among the 28 states meeting inclusion criteria for state-level analyses, 16 (57.1%) experienced increases in death rates involving synthetic opioids other than methadone, and 11 (39.3%) experienced increases in heroin death rates from 2014 to 2015. The largest absolute rate change in deaths from synthetic opioids other than methadone occurred in Massachusetts, New Hampshire, Ohio, Rhode Island and West Virginia. The largest percentage increases in rates occurred in New York (135.7%), Connecticut (125.9%) and Illinois (120%) (Table 2). Connecticut, Massachusetts, Ohio, and West Virginia experienced the largest absolute rate changes in heroin deaths, while the largest percentage increases in rates occurred in South Carolina (57.1%), North Carolina (46.4%), and Tennessee (43.5) (Table 2). Three states (New Mexico, Oklahoma, and Virginia) experienced decreases in natural/semi-synthetic opioid death rates, while increases occurred in five states (Massachusetts, New York, North Carolina, Ohio, and Tennessee) (Table 1).

Discussion

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During 2010–2015, the rate of drug overdose deaths in the United States increased in 30 states and DC, remained stable in 19 states, and showed decreasing trends followed by increases in two states.[§§,¶¶] From 2014 to 2015, drug overdose deaths increased by 5,349 (11.4%), signifying a continuing trend observed since 1999 (*1*). Opioid death rates increased by 15.6% from 2014 to 2015. These significant increases in death rates were driven by synthetic opioids other than methadone (72.2%), most likely illicitly-manufactured fentanyl (*2*,*3*), and heroin (20.6%). Increases in these opioid subcategories occurred overall and across all demographics and regions. Natural/semisynthetic opioid death rates increased by 2.6%, whereas methadone death rates decreased by 9.1%.

These findings are consistent with recent reports highlighting the increasing trend in deaths involving heroin and synthetic opioids other than methadone (*1*–*3*,*5*). The number of deaths involving synthetic opioids other than methadone have been associated with the number of drug products obtained by law enforcement testing positive for fentanyl, but not with fentanyl prescribing rates (*2*,*3*). A recent report found that these increases, likely attributable to illicitly manufactured fentanyl, were concentrated in eight of 27 states examined (*2*).

The decline in methadone death rates, a trend observed since 2008, followed efforts to reduce methadone use for pain, including Food and Drug Administration warnings, limits on high dose formulations, and clinical guidelines (*6*). The small increase in natural/semisynthetic opioid death rates illustrates an ongoing problem with prescription opioids; however, the increase has slowed from 2013–2014, potentially because of policy and health system changes, required prescription drug monitoring program review, legislative changes in naloxone distribution, and prescribing guidelines (*7*,*8*).[***]

The findings in this report are subject to at least five limitations. First, factors related to death investigation might affect rate estimates involving specific drugs. At autopsy, the substances tested for, and circumstances under which tests are performed to determine which drugs are present, might vary by jurisdiction and over time. Second, the percentage of deaths with specific drugs identified on the death certificate varies by jurisdiction and over time. Nationally, 19% (in 2014) and 17% (in 2015) of drug overdose death certificates did not include the specific types of drugs involved. Additionally, the percentage of drug overdose deaths with specific drugs identified on the death certificate varies widely by state, ranging from 47.4% to 99%. Variations in reporting across states prevent comparison of rates between states. Third, improvements in testing and reporting of specific drugs might have contributed to some observed increases in opioid-involved death rates. Fourth, because heroin and morphine are metabolized similarly (*9*), some heroin deaths might have been misclassified as morphine deaths, resulting in underreporting of heroin deaths. Finally, the state-specific analyses of opioid deaths are restricted to 28 states, limiting generalizability.

The ongoing epidemic of opioid deaths requires intense attention and action. In a November 2016 report, the Drug Enforcement Administration referred to prescription drugs, heroin, and fentanyl as the most significant drug-related threats to the United States.[†††] The misuse of prescription opioids is intertwined with that of illicit opioids; data have demonstrated that nonmedical use of prescription opioids is a significant risk factor for heroin use (*10*), underscoring the need for continued prevention efforts around prescription opioids. Intensifying efforts to distribute naloxone (an antidote to reverse an opioid overdose), enhancing access to treatment, including medication-assisted treatment, and implementing harm reduction services are urgently needed. It is important to focus efforts on expanding opioid disorder treatment capacity, including medication-assisted treatment and improving linkage into treatment.[§§§] Implementing harm reduction approaches, such as the scaling up comprehensive syringe services programs can reach persons with opioid use disorders and provide them with access to naloxone and medication-assisted treatment, reduce transmission risk for human immunodeficiency virus or hepatitis C, and

rate from synthetic opioids other than methadone, which includes fentanyl, increased by 72.2%, and heroin death rates increased by 20.6%. Rates of death involving heroin and synthetic opioids other than methadone increased across all demographic groups, regions, and in numerous states. Natural/semisynthetic opioid death rates increased by 2.6%, whereas, methadone death rates decreased by 9.1%.

What are the implications for public health practice?

There is an urgent need for a multifaceted, collaborative public health and law enforcement approach to the opioid epidemic, including implementing the CDC *Guideline for Prescribing Opioids for Chronic Pain*; improving access to and use of prescription drug monitoring programs; expanding naloxone distribution; enhancing opioid use disorder treatment capacity and linkage into treatment, including medication-assisted treatment; implementing harm reduction approaches, such as syringe services program; and supporting law enforcement strategies to reduce the illicit opioid supply.

reduce other harms from drug use. Law enforcement strategies to reduce the illicit opioid supply must also be supported. A recent report did not find evidence that efforts to reduce opioid prescribing were leading to heroin overdoses; rather, such policies could help reduce the number of persons who are exposed to opioids (*7*). Continued improvements in guideline-recommended opioid prescribing practices for chronic pain (*4*), increased improving access to and use of prescription drug monitoring programs, and increased utilization of nonopioid pain treatments are needed. A multifaceted, coordinated approach between public health and public safety is also necessary to address the U.S. opioid epidemic.

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Corresponding authors: Rose A. Rudd, rvr2@cdc.gov, 770-488-3712; Puja Seth, pseth@cdc.gov, 404-639-6334.

[1]Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, CDC, [2]Epidemic Intelligence Service, CDC.

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* Natural opioids include morphine and codeine, and semisynthetic opioids include drugs such as oxycodone, hydrocodone, hydromorphone, and oxymorphone. Methadone is a synthetic opioid. Synthetic opioids, other than methadone, include drugs such as tramadol and fentanyl. Heroin is an illicit opioid synthesized from morphine that can be a white or brown powder, or a black sticky substance.

†https://www.cdc.gov/nchs/nvss/mortality_public_use_data.htm.

§ For example, a death involving both a synthetic opioid other than methadone and heroin would be included in both the "synthetic other than methadone" and heroin death rates.

¶ For all analyses, a p-value of <0.05 was considered to be statistically significant. https://surveillance.cancer.gov/joinpoint/ .

** States whose reporting of any specific drug or drugs involved in an overdose changed by ≥10 percentage points from 2014 to 2015 were excluded, because drug-specific overdose numbers and rates might change substantially from 2014 to 2015 because of changes in reporting.

†† Age-adjusted death rates were calculated by applying age-specific death rates to the 2000 U.S. Census standard population age distribution https://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_04.pdf . For z-tests, a p-value of <0.05 was considered to be statistically significant.

§§ Florida and South Carolina, had both decreasing and increasing trends during this period. In Florida, rates decreased from 2010 to 2013, then increased to 2015; in South Carolina, rates decreased from 2010 to 2012, then increased to 2015.

¶¶https://www.cdc.gov/drugoverdose/data/statedeaths.html.

*** Some state examples are available. New Mexico: https://nmhealth.org/news/information/2016/6/?view=429 ; https://nmhealth.org/news/information/2016/9/?view=484 ; and http://hscnews.unm.edu/news/education-program-successful-in-reducing-opioid-abuse010715 ; Oklahoma: https://www.ok.gov/health2/documents/UP_Oklahoma_Office_Based_Guidelines.pdf ; Oregon: http://www.orpdmp.com . Washington: https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2014.302367?journalCode=ajph .

†††https://www.dea.gov/resource-center/2016%20NDTA%20Summary.pdf .

§§§http://aspe.hhs.gov/sites/default/files/pdf/107956/ib_OpioidInitiative.pdf .

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FIGURE. Age-adjusted rate* of drug overdose deaths,† by state — 2010 and 2015§

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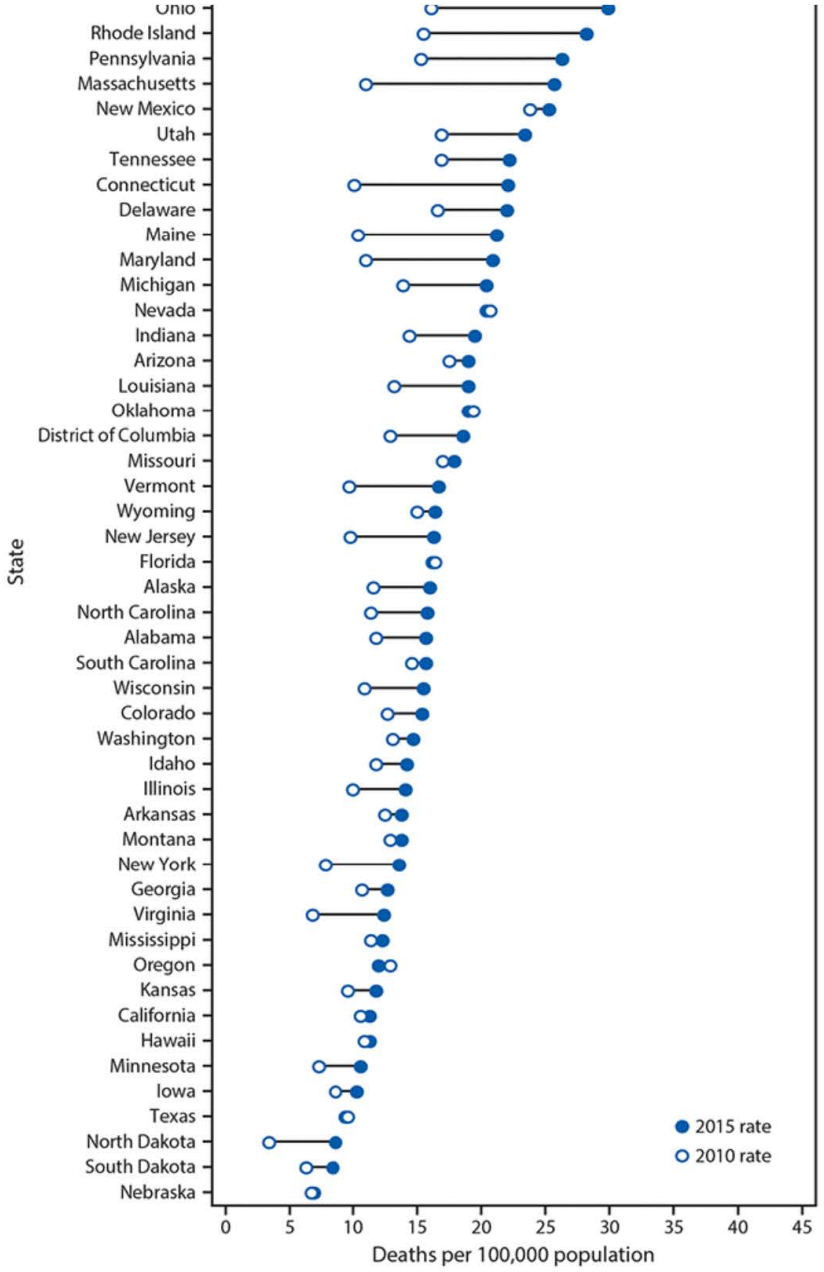

Source: CDC. National Vital Statistics System, Mortality. CDC WONDER. Atlanta, GA: US Department of Health and Human Services, CDC; 2016. https://wonder.cdc.gov/.

* Rates shown are the number of deaths per 100,000 population. Age-adjusted death rates were calculated by applying age-specific death rates to the 2000 U.S standard population age distribution.

† Deaths were classified using the *International Classification of Diseases, Tenth Revision* (ICD–10). Drug overdose deaths were identified using underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14.

§ Joinpoint regression examining changes in trends from 2010 to 2015 indicated that 30 states had significant increases from 2010 to 2015 (Alabama, Arizona, Connecticut, Delaware, District of Columbia, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Rhode Island, Tennessee, Utah, Vermont, Virginia, Wisconsin). In two states, Florida and South Carolina, decreases were followed by increases during this period. In Florida, there was a decrease from 2010 to 2013, followed by an increase to 2015. In South Carolina, there was a decrease from 2010 to 2012, followed by an increase to 2015. All remaining states had nonsignificant trends during this period.

TABLE 1. Number and age-adjusted rate of drug overdose deaths* involving natural and semisynthetic opioids† and methadone,§,¶ by sex, age group, race/ethnicity, U.S. Census region, and selected states†† — United States, 2014 and 2015**

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	Natural and semisynthetic opioids			Methadone		
	2014	2015		2014	2015	
Characteristic	No. (Rate)	No. (Rate)	% change in rate, 2014 to 2015	No. (Rate)	No. (Rate)	% change in rate, 2014 to 2015
Overall	12,159 (3.8)	12,727 (3.9)	2.6§§	3,400 (1.1)	3,301 (1.0)	-9.1§§

Sex						
Male	6,732 (4.2)	7,117 (4.4)	4.8[§§]	2,009 (1.3)	1,939 (1.2)	-7.7[§§]
Female	5,427 (3.3)	5,610 (3.4)	3.0	1,391 (0.9)	1,362 (0.8)	-11.1[§§]
Age group (yrs)						
0–14	42 (0.1)	48 (0.1)	0.0	14 –[¶¶]	13 –[¶¶]	–[¶¶]
15–24	726 (1.7)	715 (1.6)	-5.9	241 (0.5)	201 (0.5)	0.0
25–34	2,115 (4.9)	2,327 (5.3)	8.2[§§]	796 (1.8)	735 (1.7)	-5.6
35–44	2,644 (6.5)	2,819 (6.9)	6.2[§§]	768 (1.9)	739 (1.8)	-5.3
45–54	3,488 (8.0)	3,479 (8.1)	1.3	854 (2.0)	843 (2.0)	0.0
55–64	2,437 (6.1)	2,602 (6.4)	4.9	629 (1.6)	642 (1.6)	0.0
≥65	706 (1.5)	736 (1.5)	0.0	98 (0.2)	127 (0.3)	50.0[§§]
Sex/Age group (yrs)						
Male						
15–24	529 (2.3)	493 (2.2)	-4.3	173 (0.8)	149 (0.7)	-12.5
25–44	2,869 (6.8)	3,139 (7.4)	8.8[§§]	969 (2.3)	926 (2.2)	-4.3
45–64	3,015 (7.4)	3,095 (7.5)	1.4	808 (2.0)	777 (1.9)	-5.0
Female						
15–24	197 (0.9)	222 (1.0)	11.1	68 (0.3)	52 (0.2)	-33.3
25–44	1,890 (4.5)	2,007 (4.8)	6.7[§§]	595 (1.4)	548 (1.3)	-7.1
45–64	2,910 (6.8)	2,986 (6.9)	1.5	675 (1.6)	708 (1.6)	0.0
Race/Ethnicity**						
White, non-Hispanic	10,308 (5.0)	10,774 (5.3)	6.0[§§]	2,845 (1.4)	2,725 (1.4)	0.0
Black, non-Hispanic	814 (2.0)	878 (2.1)	5.0	256 (0.6)	247 (0.6)	0.0
Hispanic	727 (1.4)	780 (1.5)	7.1	228 (0.5)	235 (0.5)	0.0
U.S. Census region of residence						
Northeast	1,851 (3.3)	2,095 (3.6)	9.1[§§]	587 (1.0)	643 (1.1)	10.0
Midwest	2,205 (3.3)	2,302 (3.4)	3.0	675 (1.0)	673 (1.0)	0.0
South	5,101 (4.2)	5,374 (4.4)	4.8[§§]	1,298 (1.1)	1,228 (1.0)	-9.1[§§]
West	3,002 (3.9)	2,956 (3.8)	-2.6	840 (1.1)	757 (1.0)	-9.1
Selected states[††]						
States with very good or excellent reporting (n = 21)						
Alaska	40 (5.6)	51 (6.5)	16.1	12 –[¶¶]	10 –[¶¶]	–[¶¶]
Connecticut	157 (4.3)	183 (4.8)	11.6	50 (1.4)	72 (1.9)	35.7
Iowa	81 (2.7)	75 (2.5)	-7.4	16 –[¶¶]	24 (0.8)	–[¶¶]
Maine	80 (6.1)	102 (7.7)	26.2	29 (2.2)	36 (2.8)	27.3
Maryland	388 (6.2)	398 (6.5)	4.8	153 (2.4)	182 (2.9)	20.8
Massachusetts	178 (2.6)	225 (3.3)	26.9[§§]	88 (1.3)	82 (1.2)	-7.7
Nevada	224 (7.4)	259 (8.6)	16.2	64 (2.2)	57 (1.9)	-13.6
New Hampshire	81 (5.8)	63 (4.4)	-24.1	29 (2.3)	25 (1.9)	-17.4
New Mexico	223 (10.9)	160 (8.1)	-25.7[§§]	45 (2.3)	33 (1.6)	-30.4
New York	608 (3.0)	705 (3.4)	13.3[§§]	231 (1.1)	246 (1.2)	9.1
North Carolina	462 (4.7)	554 (5.5)	17.0[§§]	131 (1.4)	108 (1.1)	-21.4

Oklahoma	370 (9.6)	277 (7.2)	-25.0§§	67 (1.7)	62 (1.7)	0.0
Oregon	137 (3.2)	150 (3.6)	12.5	59 (1.4)	70 (1.7)	21.4
Rhode Island	70 (6.7)	95 (8.3)	23.9	24 (2.2)	30 (2.4)	9.1
South Carolina	319 (6.5)	322 (6.5)	0.0	77 (1.6)	57 (1.2)	-25.0
Utah	367 (13.6)	357 (12.7)	-6.6	47 (1.7)	45 (1.6)	-5.9
Vermont	21 (3.4)	25 (3.9)	14.7	–¶¶	–¶¶	–¶¶
Virginia	323 (3.9)	276 (3.3)	-15.4§§	105 (1.2)	67 (0.8)	-33.3§§
Washington	288 (3.8)	261 (3.5)	-7.9	115 (1.5)	111 (1.4)	-6.7
West Virginia	363 (20.2)	356 (19.8)	-2.0	35 (2.0)	29 (1.7)	-15.0
Wisconsin	279 (4.8)	249 (4.3)	-10.4	78 (1.4)	73 (1.3)	-7.1
States with good reporting (n = 7)						
Colorado	259 (4.6)	259 (4.5)	-2.2	51 (0.9)	34 (0.6)	-33.3
Georgia	388 (3.8)	435 (4.2)	10.5	124 (1.2)	115 (1.1)	-8.3
Illinois	253 (1.9)	271 (2.0)	5.3	106 (0.9)	99 (0.8)	-11.1
Minnesota	102 (1.9)	125 (2.2)	15.8	81 (1.6)	55 (1.0)	-37.5
Missouri	237 (4.0)	237 (3.9)	-2.5	53 (0.9)	62 (1.0)	11.1
Ohio	618 (5.4)	690 (6.1)	13.0§§	107 (0.9)	109 (1.0)	11.1
Tennessee	554 (8.6)	643 (9.7)	12.8§§	71 (1.1)	67 (1.0)	-9.1

Source: CDC. National Vital Statistics System, Mortality. CDC WONDER. Atlanta, GA: US Department of Health and Human Services, CDC; 2016. https://wonder.cdc.gov/.

* Rates are for the number of deaths per 100,000 population. Age-adjusted death rates were calculated using the direct method and the 2000 standard population. Deaths were classified using the *International Classification of Diseases, Tenth Revision* (ICD–10). Drug overdose deaths were identified using underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14.

† Drug overdose deaths, as defined, that have natural and semisynthetic opioids (T40.2) as contributing causes.

§ Drug overdose deaths, as defined, that have methadone (T40.3) as a contributing cause.

¶ Categories of deaths are not exclusive because deaths might involve more than one drug. Summing categories will result in a number greater than the total number of deaths in a year.

** Data for Hispanic ethnicity should be interpreted with caution; studies comparing Hispanic ethnicity on death certificates and on census surveys have shown inconsistent reporting.

†† Analyses were limited to states meeting the following criteria. For states with very good to excellent reporting, ≥90% of drug overdose death certificates mention at least one specific drug in 2014, with the change in percentage of drug overdose deaths mentioning at least one specific drug differing by <10 percentage points from 2014 to 2015. States with good reporting had 80% to <90% of drug overdose death certificates mention at least one specific drug in 2014, with the change in the percentage of drug overdose deaths mentioning at least one specific drug differing by <10 percentage points from 2014 to 2015. Rate comparisons between states should not be made because of variations in reporting across states.

§§ Statistically significant at p<0.05 level. Gamma tests were used if the number of deaths was <100 in 2014 or 2015, and z-tests were used if the number of deaths was ≥100 in both 2014 and 2015.

¶¶ Cells with nine or fewer deaths are not reported, and rates based on <20 deaths are not considered reliable and not reported.

TABLE 2. Number and age-adjusted rate of drug overdose deaths* involving synthetic opioids other than methadone† and heroin,§,¶ by sex, age group, race/ethnicity, U.S. Census region, and selected states†† — United States, 2014 and 2015**

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	Synthetic opioids other than methadone			Heroin		
	2014	2015		2014	2015	
Characteristic	No. (Rate)	No. (Rate)	% change in rate, 2014 to 2015	No. (Rate)	No. (Rate)	% change in rate, 2014 to 2015
Overall	**5,544 (1.8)**	**9,580 (3.1)**	**72.2§§**	**10,574 (3.4)**	**12,989 (4.1)**	**20.6§§**
Sex						
Male	3,465 (2.2)	6,560 (4.2)	90.9§§	8,160 (5.2)	9,881 (6.3)	21.2§§
Female	2,079 (1.3)	3,020 (1.9)	46.2§§	2,414 (1.6)	3,108 (2.0)	25.0§§
Age group (yrs)						
0–14	10 –¶¶	14 –¶¶	–¶¶	–¶¶	–¶¶	–¶¶

15–24	514 (1.2)	999 (2.3)	91.7[§§]	1452 (3.3)	1,649 (3.8)	15.2[§§]
25–34	1474 (3.4)	2,896 (6.6)	94.1[§§]	3493 (8.0)	4,292 (9.7)	21.3[§§]
35–44	1264 (3.1)	2,289 (5.6)	80.6[§§]	2398 (5.9)	3,012 (7.4)	25.4[§§]
45–54	1359 (3.1)	1,982 (4.6)	48.4[§§]	2030 (4.7)	2,439 (5.6)	19.1[§§]
55–64	742 (1.9)	1,167 (2.9)	52.6[§§]	1064 (2.7)	1,407 (3.4)	25.9[§§]
≥65	181 (0.4)	232 (0.5)	25.0[§§]	136 (0.3)	184 (0.4)	33.3[§§]
Sex/Age group (yrs)						
Male						
15–24	376 (1.7)	718 (3.2)	88.2[§§]	1,079 (4.8)	1,172 (5.2)	8.3
25–44	1,845 (4.4)	3,764 (8.9)	102.3[§§]	4,566 (10.8)	5,602 (13.2)	22.2[§§]
45–64	1,176 (2.9)	1,948 (4.7)	65.5[§§]	2,397 (5.9)	2,953 (7.2)	22.0[§§]
Female						
15–24	138 (0.6)	281 (1.3)	116.7[§§]	373 (1.7)	477 (2.2)	29.4[§§]
25–44	893 (2.1)	1,421 (3.4)	61.9[§§]	1,325 (3.2)	1,702 (4.0)	25.0[§§]
45–64	925 (2.2)	1,201 (2.8)	27.3[§§]	697 (1.6)	893 (2.1)	31.3[§§]
Race/Ethnicity**						
White, non-Hispanic	4,685 (2.4)	7,995 (4.2)	75.0[§§]	8,253 (4.4)	10,050 (5.4)	22.7[§§]
Black, non-Hispanic	449 (1.1)	883 (2.1)	90.9[§§]	1,044 (2.5)	1,310 (3.1)	24.0[§§]
Hispanic	302 (0.6)	524 (0.9)	50.0[§§]	1,049 (1.9)	1,299 (2.3)	21.1[§§]
U.S. Census region of residence						
Northeast	1,485 (2.7)	3,071 (5.6)	107.4[§§]	2,755 (5.1)	3,461 (6.3)	23.5[§§]
Midwest	1,319 (2.0)	2,548 (3.9)	95.0[§§]	3,385 (5.2)	3,959 (6.1)	17.3[§§]
South	2,087 (1.8)	3,303 (2.8)	55.6[§§]	2,733 (2.4)	3,722 (3.2)	33.3[§§]
West	653 (0.8)	658 (0.9)	12.5[§§]	1,701 (2.2)	1,847 (2.4)	9.1[§§]
Selected states[††]						
States with very good or excellent reporting (n = 21)						
Alaska	14 –[¶¶]	14 –[¶¶]	–[¶¶]	25 (3.3)	37 (4.7)	42.4
Connecticut	94 (2.7)	211 (6.1)	125.9[§§]	299 (8.9)	390 (11.3)	27.0[§§]
Iowa	29 (1.0)	44 (1.5)	50.0	37 (1.3)	45 (1.6)	23.1
Maine	62 (5.2)	116 (9.9)	90.4[§§]	38 (3.1)	52 (4.5)	45.2
Maryland	230 (3.8)	357 (5.8)	52.6[§§]	313 (5.2)	405 (6.6)	26.9[§§]
Massachusetts	453 (6.9)	949 (14.4)	108.7[§§]	469 (7.2)	634 (9.6)	33.3[§§]
Nevada	32 (1.0)	32 (1.1)	10.0	64 (2.2)	82 (2.7)	22.7
New Hampshire	151 (12.4)	285 (24.1)	94.4[§§]	98 (8.1)	78 (6.5)	-19.8
New Mexico	66 (3.3)	42 (2.1)	-36.4	139 (7.2)	156 (8.1)	12.5
New York	294 (1.4)	668 (3.3)	135.7[§§]	825 (4.2)	1,058 (5.4)	28.6[§§]
North Carolina	217 (2.2)	300 (3.1)	40.9[§§]	266 (2.8)	393 (4.1)	46.4[§§]
Oklahoma	73 (1.9)	93 (2.4)	26.3	26 (0.7)	36 (1.0)	42.9
Oregon	33 (0.8)	34 (0.9)	12.5	124 (3.2)	102 (2.5)	-21.9
Rhode Island	82 (7.9)	137 (13.2)	67.1[§§]	66 (6.8)	45 (4.3)	-36.8
South Carolina	110 (2.3)	161 (3.3)	43.5[§§]	64 (1.4)	100 (2.2)	57.1[§§]
Utah	68 (2.5)	62 (2.3)	-8.0	110 (3.8)	127 (4.3)	13.2

Vermont	21 (3.6)	33 (5.6)	55.6	33 (5.8)	33 (5.8)	0.0
Virginia	176 (2.1)	270 (3.3)	57.1[§§]	253 (3.1)	353 (4.3)	38.7[§§]
Washington	62 (0.8)	65 (0.9)	12.5	289 (4.1)	303 (4.2)	2.4
West Virginia	122 (7.2)	217 (12.7)	76.4[§§]	163 (9.8)	194 (11.8)	20.4
Wisconsin	90 (1.6)	112 (2.1)	31.3	270 (4.9)	287 (5.3)	8.2
States with good reporting (n = 7)						
Colorado	80 (1.5)	64 (1.2)	-20.0	156 (2.9)	159 (2.8)	-3.4
Georgia	174 (1.7)	284 (2.8)	64.7[§§]	153 (1.6)	222 (2.2)	37.5[§§]
Illinois	127 (1.0)	278 (2.2)	120.0[§§]	711 (5.6)	844 (6.7)	19.6[§§]
Minnesota	44 (0.8)	55 (1.0)	25.0	100 (1.9)	115 (2.2)	15.8
Missouri	109 (1.9)	183 (3.1)	63.2[§§]	334 (5.8)	303 (5.3)	-8.6
Ohio	590 (5.5)	1,234 (11.4)	107.3[§§]	1,208 (11.1)	1,444 (13.3)	19.8[§§]
Tennessee	132 (2.1)	251 (4.0)	90.5[§§]	148 (2.3)	205 (3.3)	43.5[§§]

Source: CDC. National Vital Statistics System, Mortality. CDC WONDER. Atlanta, GA: US Department of Health and Human Services, CDC; 2016. https://wonder.cdc.gov/.

* Rates are for the number of deaths per 100,000 population. Age-adjusted death rates were calculated using the direct method and the 2000 standard population. Deaths were classified using the *International Classification of Diseases, Tenth Revision* (ICD–10). Drug overdose deaths were identified using underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14.

† Drug overdose deaths, as defined, that have synthetic opioids other than methadone (T40.4) as contributing causes.

§ Drug overdose deaths, as defined, that have heroin (T40.1) as a contributing cause.

¶ Categories of deaths are not exclusive because deaths might involve more than one drug. Summing categories will result in a number greater than the total number of deaths in a year.

** Data for Hispanic ethnicity should be interpreted with caution; studies comparing Hispanic ethnicity on death certificates and on census surveys have shown inconsistent reporting.

†† Analyses were limited to states meeting the following criteria. For states with very good to excellent reporting, ≥90% of drug overdose death certificates mention at least one specific drug in 2014, with the change in percentage of drug overdose deaths mentioning at least one specific drug differing by <10 percentage points from 2014 to 2015. States with good reporting had 80% to <90% of drug overdose death certificates mention at least one specific drug in 2014, with the change in the percentage of drug overdose deaths mentioning at least one specific drug differing by <10 percentage points from 2014 to 2015. Rate comparisons between states should not be made because of variations in reporting across states.

§§ Statistically significant at p<0.05 level. Gamma tests were used if the number of deaths was <100 in 2014 or 2015, and z-tests were used if the number of deaths was ≥100 in both 2014 and 2015.

¶¶ Cells with nine or fewer deaths are not reported, and rates based on <20 deaths are not considered reliable and not reported.

Top

Suggested citation for this article: Rudd RA, Seth P, David F, Scholl L. Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015. MMWR Morb Mortal Wkly Rep 2016;65:1445–1452. DOI: http://dx.doi.org/10.15585/mmwr.mm655051e1 .

Page last reviewed: August 14, 2017

Page last updated: August 14, 2017

Content source: Centers for Disease Control and Prevention

1600 Clifton Road Atlanta, GA 30329-4027 USA
800-CDC-INFO (800-232-4636), TTY: 888-232-6348
Email CDC-INFO

window.CDC.Policy.External.init();

https://web.archive.org/web/20211011062741/https://www.cdc.gov/rxawareness/

Rx Awareness

Prescription opioids can be addictive and dangerous. CDC's Rx Awareness campaign tells the stories of people whose lives were impacted by prescription opioids.

Real Stories
Real people sharing their stories about prescription opioids

Social Media
Find graphics for sharing on social media platforms

All Campaign Resources
Learn, share, and promote campaign materials and resources

About the Campaign
Overview of the Rx Awareness campaign

Key Resources

- Save a Life
- Recovery Is Possible
- Get Informed
- Opioid Overdose

Page last reviewed: January 12, 2021
Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

https://web.archive.org/web/20211108210856/https://www.cdc.gov/rxawareness/stories/index.html

Rx Awareness
About the Campaign +
Real Stories +
Save a Life
Recovery Is Possible
Get Informed
Campaign Resources +
Newsroom

Real Stories

Real Stories from real people who have shared their personal accounts about dealing with prescription opioids.

Britton, a United States Veteran, struggled with prescription opioids following an injury and shares his path to recovery.

David used prescription opioids after knee surgery. He found hope and support in recovery.

Jeni shares how she withdrew from her culture because of prescription opioids, but reconnected through recovery.

Tessa took prescription opioids while pregnant. Her children led her to recovery.

Tele misused prescription opioids beginning at age 13 and shares its impact on his life and recovery.

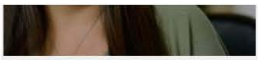
Stevi Rae struggled with addiction after a car crash and tells how sharing her story with other Alaska Natives helped.

Ann Marie is a mother who lost her 22-year-old son, Chris, to a prescription opioid overdose.

Brenda shares her experiences with addiction and the toll it had on her life.

Mike left school and stopped playing sports because he "didn't understand the dangers" of prescription opioids.

Judy lost her son, Steve, to an overdose after he suffered a back injury and began misusing prescription opioids.



Tamera was prescribed opioids to manage chronic pain and almost lost everything to her addiction.

Teresa lost her brother to an overdose. He convinced people "he knew exactly what he was taking."

Noah lost his father to prescription opioids. He learned that everyone knows someone struggling with addiction.

Related Pages

- Save a Life
- Treatment and Recovery
- Get Informed
- Campaign Materials

CDC's Opioid Overdose Website

Learn more about opioid misuse and overdose, data, and prevention resources at CDC's Opioid Overdose website.

More

Learn more about opioid data and resources.

www.cdc.gov

Page last reviewed: December 3, 2020

Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

https://web.archive.org/web/20211205071947/https://www.cdc.gov/rxawareness/about/index.html

About the Campaign

Campaign Overview

CDC's Rx Awareness campaign tells the stories of people whose lives were impacted by prescription opioids. The goals of the campaign are to increase awareness that prescription opioids can be addictive and dangerous, to reinforce that help is available for those suffering from an opioid use disorder, and to encourage those struggling with prescription opioids to visit the campaign website to locate help and resources. Rx Awareness launched in 2017 and focuses on adults ages 25–54 who have taken opioids for medical use or have misused opioids at least once.

Expanding Messages and Reach

In 2019, CDC filmed and captured more real stories to add to the suite of campaign materials. The new ads focus on audiences heavily impacted by the opioid overdose epidemic, including pregnant women, veterans, younger adults (25-to-34-year-olds), older adults (45-to-54-year-olds), and American Indians/Alaska Natives. State and local health departments and community organizations can use the tested Rx Awareness campaign materials and resources to launch campaigns, support local prevention activities, and raise awareness about the risks of prescription opioids.

The goals of the campaign are to:

- Increase awareness that prescription opioids can be addictive and dangerous.
- Lower prescription opioid misuse.
- Increase the number of patients seeking nonopioid pain management options.
- Increase awareness about recovery and reduce stigma.

Campaign Trailer

Take Action and Help

The CDC Rx Awareness Executive Summary offers guidance and support for implementing the

View Transcript Low Resolution Video

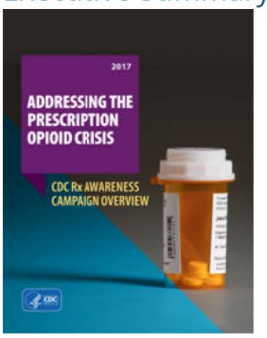
campaign and communicating about the dangers of prescription opioids. Use the resource to:

- Learn about available campaign resources
- Share campaign materials in your community
- Promote the campaign online, in print, radio, and media
- Evaluate your efforts in raising awareness of the opioid overdose epidemic

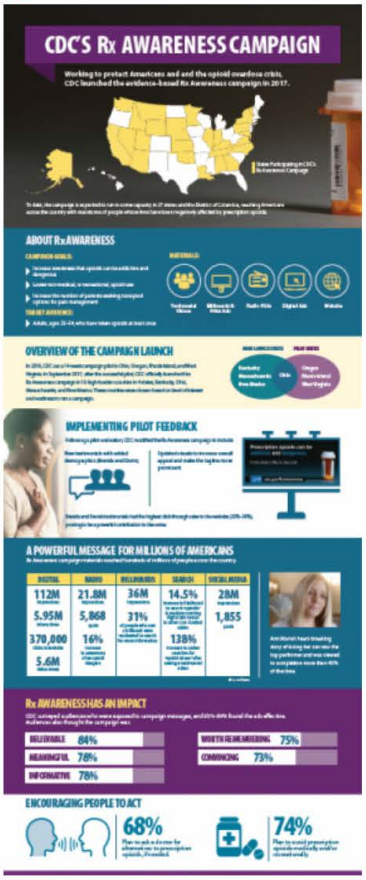
About the Rx Awareness Campaign

Overview Fact Sheet

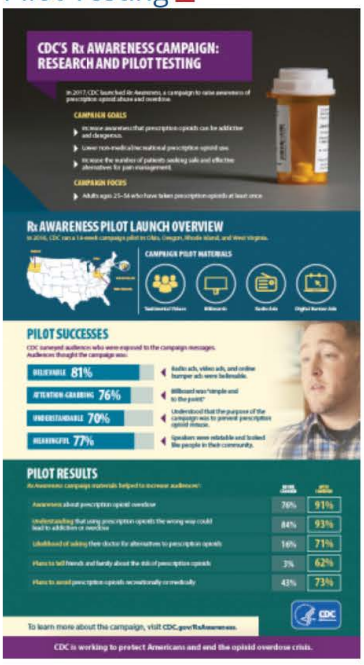
Executive Summary



CDC's Rx Awareness Campaign: Launch Metrics

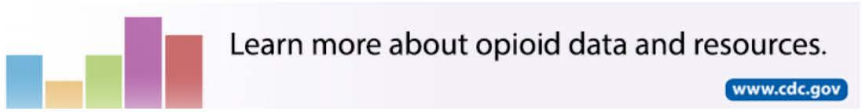


CDC's Rx Awareness Campaign: Research and Pilot Testing



Related Pages

- Real Stories
- Prevent Prescription Opioid Overdose
- Treatment and Recovery
- Campaign Resources
- Newsroom



Page last reviewed: October 13, 2020
Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

https://web.archive.org/web/20211029062122/https://www.cdc.gov/rxawareness/information/index.html

Rx Awareness
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Newsroom

Get Informed

Prescription Opioids: The Basics

Prescription opioids can be used to treat moderate-to-severe pain and are often prescribed following surgery or injury, or for health conditions such as cancer. The most commonly prescribed opioids include the following:

- Hydrocodone (Vicodin®)
- Oxycodone (OxyContin®, Percocet®)
- Oxymorphone (Opana®)
- Morphine (Kadian®, Avinza®)
- Codeine
- Fentanyl
- Hydromorphone
- Tapentadol
- Methadone

Low Resolution Video

When the Prescription Becomes the Problem

In recent years, there has been a dramatic increase in the acceptance and use of prescription opioids for the treatment of chronic, non-cancer pain, such as back pain or osteoarthritis, despite serious risks and the lack of evidence about their long-term effectiveness.

In addition to the serious risks of addiction, abuse, and overdose, the use of prescription opioids can have a number of side effects, even when taken as directed:

- Tolerance—meaning you might need to take more of the medication for the same pain relief
- Physical dependence—meaning you have symptoms of withdrawal when the medication is stopped
- Increased sensitivity to pain

- Constipation
- Nausea, vomiting, and dry mouth
- Sleepiness and dizziness
- Confusion
- Depression
- Low levels of testosterone that can result in lower sex drive, energy, and strength
- Itching and sweating

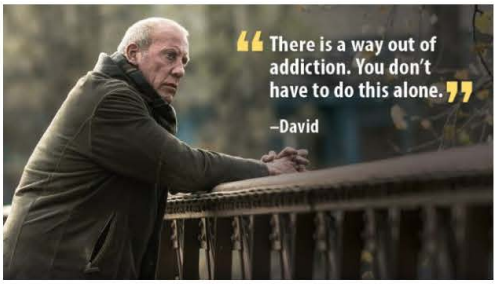
Prevent Addiction Fact Sheet [PDF]

Overdose deaths involving prescription opioids were more than four times higher in 2018 than in 1999. In 2018, almost 32 percent of all U.S. opioid overdose deaths involved a prescription opioid. Even though the number of overdose deaths involving prescription opioids decreased in 2018, more than 232,000 people have died in the United States from overdoses involving prescription opioids since 1999[1]. Overdose is not the only risk related to prescription opioids. Anyone who takes prescription opioids can become addicted to them.

Talk to Your Doctor

Talk to your doctor about ways to manage your pain that do not involve prescription opioids. Some of these options may actually work better and have fewer risks and side effects. Depending on the type of pain you are experiencing, options may include:

- Acetaminophen (Tylenol®) or ibuprofen (Advil®)
- Cognitive behavioral therapy – a psychological, goal-directed approach in which patients learn how to modify physical, behavioral, and emotional triggers of pain and stress



- Exercise therapy, including physical therapy
- Medications for depression or for seizures
- Interventional therapies (injections)
- Exercise and weight loss
- Other therapies such as acupuncture and massage

Your health and safety are important. Start the conversation with your doctor [PDF] and work together to set pain management goals and develop a treatment plan that will help you. Follow-up if your pain is not resolving as quickly as expected.

If you are struggling, there is hope. Recovery is possible.

Related Pages

Save a Life

Treatment and Recovery

Get Informed

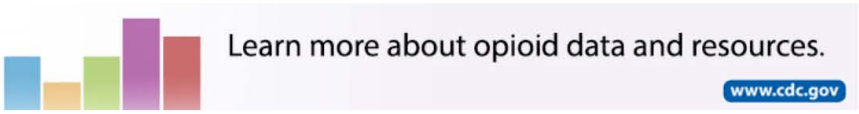
Campaign Materials

Other Federal Resources

- Facts and Recommendations for Individuals and Families (Surgeon General)
- Mental Health and Addiction Insurance Help (HHS)
  This site can help consumers solve insurance coverage issues related to mental health and substance use disorders.

Reference

1. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2020. Available at http://wonder.cdc.gov.



Page last reviewed: October 7, 2020
Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

https://web.archive.org/web/20211220172907/https://www.cdc.gov/rxawareness/resources/index.html

Rx Awareness
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Campaign Resources

Help us spread the word. CDC's *Rx Awareness* campaign offers a variety of materials and resources you can share.

- Video
- Ads
- Facebook
- Fact Sheets and Infographics
- Matte Articles and Blogs
- Radio
- Signs, Billboards, and Posters
- Twitter
- Postcards
- Spanish Language Materials

Social Media Kit

CDC Rx Awareness Social Media Kit
[PDF – 4MB]

Connect with us on Social Media

- CDC's Rx Awareness YouTube playlist
- CDC's Opioids YouTube playlist
- @CDCInjury: CDC Injury Center's Twitter account
- @CDCgov: CDC's Twitter account
- CDC's Facebook page
- CDC's Instagram

For questions about campaign resources or implementation, please contact us.

Related Pages

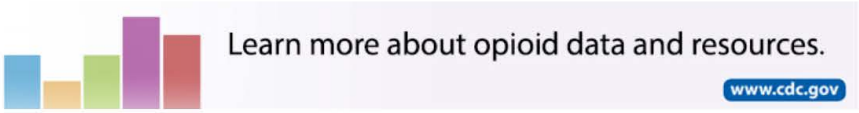
Save a Life

Treatment and Recovery

Treatment and Recovery

Get Informed

Campaign Materials



Page last reviewed: October 16, 2020
Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

https://web.archive.org/web/20210419170522/https://www.cdc.gov/rxawareness/resources/factsheets-infographics.html

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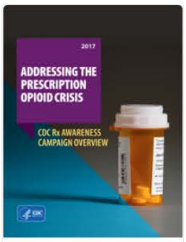
Fact Sheets and Infographics

Below are Rx Awareness campaign fact sheets and infographics that can be downloaded and used to understand campaign goals and activities.

Factsheets

The Overview Fact Sheet



Executive Summary

Take Action

Treatment and Recovery Fact Sheet
[PDF – 351 KB]

Infographics

CDC's Rx Awareness Campaign: Research and Pilot Testing

CDC's Rx Awareness Campaign: Launch Metrics

Learn more about opioid data and resources.

www.cdc.gov

Page last reviewed: November 17, 2020
Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

https://web.archive.org/web/20220120140737/http://www.cdc.gov/rxawareness/resources/video.html

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Videos

The *Rx Awareness* campaign videos tell the real stories of people whose lives have been negatively impacted by prescription opioid use and abuse.

View the *Rx Awareness* YouTube playlist.

Rx Awareness Campaign Trailer

View Transcript Low Resolution Video

About the Campaign

Rx Awareness Campaign Teaser

View Transcript Low Resolution Video

About the Campaign

Ann Marie's Story

View Transcript Low Resolution Video

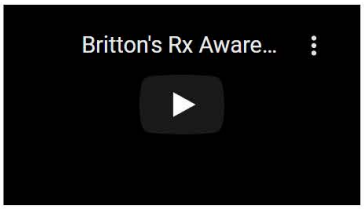
Learn more about Ann Marie

Brenda's Story

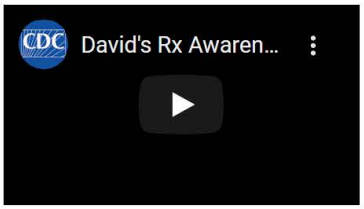
View Transcript Low Resolution Video

Learn more about Brenda

Britton's Story



David's Story



View Transcript Low Resolution Video

Learn more about Britton

View Transcript Low Resolution Video

Learn more about David

Jeni's Story

View Transcript Low Resolution Video

Learn more about Jeni

Judy's Story

View Transcript Low Resolution Video

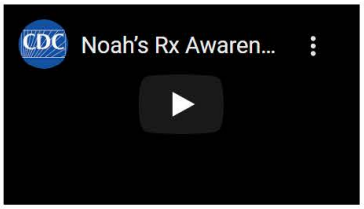
Learn more about Judy

Mike's Story

View Transcript Low Resolution Video

Learn more about Mike

Noah's Story



View Transcript Low Resolution Video

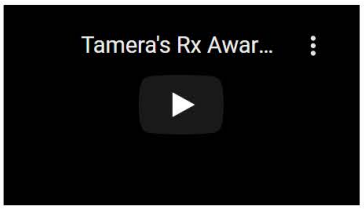
Learn more about Noah

Stevi Rae's Story

View Transcript Low Resolution Video

Learn more about Stevi Rae

Tamera's Story



View Transcript Low Resolution Video

Learn more about Tamera

Tele's Story

Teresa's Story

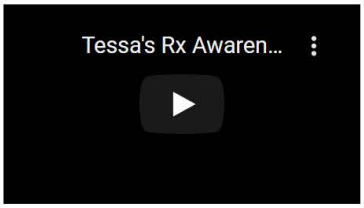
View Transcript Low Resolution Video

Learn more about Tele

View Transcript Low Resolution Video

Learn more about Teresa

Tessa's Story



View Transcript Low Resolution Video

Tessa's Story

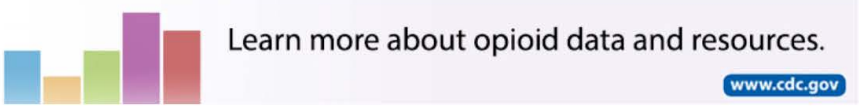
Related Pages

- Campaign Resources
- Radio
- Online Ads
- Signs and Billboards
- Social Media
- Newsroom

YouTube Playlist

View the *Rx Awareness* YouTube playlist.

View the Playlist



Page last reviewed: October 13, 2020
Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

https://web.archive.org/web/20210506110712/https://www.cdc.gov/rxawareness/resources/radio.html

Rx Awareness
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Campaign Resources +
Newsroom

Radio Spots

Rx Awareness campaign radio ads are stories from real people whose lives have been directly impacted by prescription opioid. The files can be downloaded and shared across social media platforms.

To save a sound file, right-mouse-click on the link and select "Save Target As ..." or "Save Link As..."

Britton's Story

Britton's Radio Spot [MP3]

Britton's Radio Spot Transcript [PDF]

Learn More about Britton

David's Story

David's Radio Spot [MP3]

David's Radio Spot Transcript [PDF]

Learn More about David

Jeni's Story

Jeni's Radio Spot [MP3]

Jeni's Radio Spot Transcript [PDF]

Learn More about Jeni

Tele's Story

Tele's Radio Spot [MP3]

Tele's Radio Spot Transcript [PDF]

Learn More about Tele

Stevi Rae's Story

Stevi Rae's Radio Spot [MP3]

Stevi Rae's Radio Spot Transcript [PDF]

Learn More about Stevi Rae

Tessa's Story

Tessa's Radio Spot [MP3]

Tessa's Radio Spot Transcript [PDF]

Learn More about Tessa

Ann Marie's Story

Ann Marie's Radio Spot [MP3 – 477 KB]

Ann Marie's Radio Spot Transcript [PDF – 98 KB]

Learn More about Ann Marie

Judy's Story

Judy's Radio Spot [MP3]

Judy's Radio Spot Transcript [PDF]

Learn More about Judy

Mike's Story

Mike's Radio Spot [MP3]

Mike's Radio Spot Transcript [PDF]

Learn More about Mike

Noah's Story

Noah's Radio Spot [MP3]

Noah's Radio Spot Transcript [PDF]

Learn More about Noah

Tamera's Story

Tamera's Radio Spot [MP3]

Tamera's Radio Spot Transcript [PDF]

Learn More about Tamera

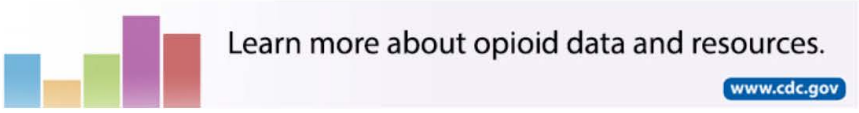
Related Pages

- Campaign Resources
- Video
- Online Ads
- Signs and Billboards
- Social Media
- Newsroom

CDC's Opioid Overdose Website

Learn more about opioid misuse and overdose, data, and prevention resources at CDC's Opioid Overdose website.

More



Page last reviewed: July 10, 2020
Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

https://web.archive.org/web/20210417062856/https://www.cdc.gov/rxawareness/resources/signs.html

Get Email Updates

To receive email updates about this topic, enter

Signs, Billboards, and Posters

Below are Rx Awareness campaign signs, billboards, and poster files that can be downloaded and used to help raise awareness about the risks of prescription opioids.

Signs

Sign 6×3 in [PDF – 251 KB]

Rx_CDC_AIAN_Sign__THMB_600pxx300px

Sign 6×3 in [PDF – 386 KB]

Rx_CDC_Lower-48_Sign__THMB_600pxx300px

Sign 6×3 in [PDF – 2 MB]

Rx_CDC_Lower-48_Sign_Blue_THMB_600pxx300px

Sign 6×3 in [PDF – 1 MB]

Billboards

Rx_CDC_Lower-48_Billboard_THMB_600pxx273px

Billboard 22×10 in [PDF – 285 KB]

Billboard 22×10 in [PDF – 4 MB]

Rx_CDC_AIAN_Billboard_THMB_600pxx273px

Billboard 22×10 in [PDF – 2 MB]

Rx_CDC_Pill-Bottle-with-Quotes_Billboard_THMB_600pxx279px

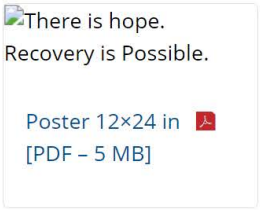
Billboard 22×10 in [PDF – 4 MB]

Posters

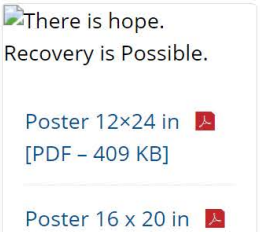
your email address:

Email Address

What's this? Submit



Poster 12×24 in [PDF – 5 MB]



Poster 12×24 in [PDF – 409 KB]

Poster 16 x 20 in [PDF – 5 MB]

Poster 12×24 in [PDF – 3 MB]

Related Pages

- Campaign Resources
- Video
- Radio
- Online Ads
- Social Media
- Newsroom

CDC's Opioid Overdose Website

Learn more about opioid misuse and overdose, data, and prevention resources at CDC's Opioid Overdose website.

More

Learn more about opioid data and resources.

Page last reviewed: November 16, 2020
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https://web.archive.org/web/20210421091358/https://www.cdc.gov/rxawareness/prevent/index.html

Rx Awareness
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Newsroom

Save a Life from Prescription Opioid Overdose

Death from an opioid overdose happens when too much of the drug overwhelms the brain and interrupts the body's natural drive to breathe. During an overdose, breathing can be dangerously slowed or stopped, causing brain damage or death. It's important to recognize the signs and act fast. Signs include:

- Small, constricted "pinpoint pupils"
- Falling asleep or loss of consciousness
- Slow, shallow breathing
- Choking or gurgling sounds
- Limp body
- Pale, blue, or cold skin

It may be hard to tell if a person is high or experiencing an overdose. If you aren't sure, it's best to treat it like an overdose— you could save a life.

1. Call 911 immediately.
2. Administer naloxone, if available.
3. Try to keep the person awake and breathing.
4. Lay the person on their side to prevent choking.
5. Stay with him or her until emergency workers arrive.

Start a Conversation with Your Doctor

Make sure you know all the risks and benefits of treatments and how to reduce the risk of opioid addiction and overdose.

- Make sure you're getting care that is safe, effective, and right for you. Talk with your doctor about setting goals for your pain management.
- Talk with your doctor about acute pain, chronic pain, and how to avoid addiction.
- Ask your doctor about non-opioid options for treating pain, including medications other than opioids as well as nonpharmacologic options, like exercise.
- Always let your doctor know about any side effects or concerns you may have.

If Prescribed Opioids, Practice Responsible Use

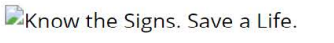
- Never take prescription opioids in greater amounts or more often than prescribed.
- Always let your doctor know about any side effects or concerns you may have about your medications.
- Avoid taking opioids with alcohol and other substances or medications. It is very dangerous to combine opioids with other drugs, especially those that

very dangerous to combine opioids with other drugs, especially those that cause drowsiness:

  - Benzodiazepines (such as Xanax® and Valium®)
  - Muscle relaxants (such as Soma® or Flexeril®)
  - Hypnotics (such as Ambien® or Lunesta®)
  - Other prescription opioids

- Do not share or sell your prescription opioids.
- **Keep medicines in a safe and secure place.** Store opioids in a place that is locked, like a keyed medicine cabinet or drawer, to keep them secure from children, family, friends, and visitors.
- **Properly discard expired or unused prescription opioids.** Remove them from your home as soon as possible to reduce the chances of misuse. To get rid of prescription opioids and other medications safely:
  - Find a medicine take-back option near you: TakeBackDay.DEA.gov
  - Check with your pharmacist to see if you can return unused medication to the pharmacy.

Help a Person Who May be Struggling with Addiction



- If you or someone close to you needs help for a substance use disorder, talk to your doctor or call SAMHSA's National Helpline at **1-800-662-HELP** or go to SAMHSA's Behavioral Health Treatment Services Locator .
- Learn about naloxone , a life-saving drug that can reverse the effects of an opioid overdose when administered in time.
  - Find out more about naloxone laws and naloxone access in your state .
- Good Samaritan Laws in your state protect overdose victims and people seeking medical help for an overdose victim from drug possession charges.
- Explore resources available to help with overdose prevention.

Learn More

CDC Opioid Overdose Tip Card

CDC Feature: Talk to Your Doctor About Managing Your Pain

CDC's Up and Away public education campaign

Food and Drug Administration (FDA) Remove the Risk toolkit

Drug Enforcement Agency (DEA) Secure Your Meds campaign

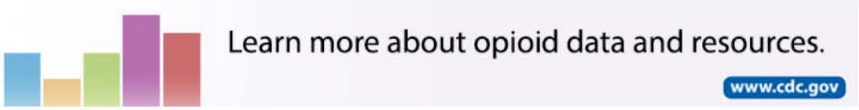
Related Pages

Save a Life

Treatment and Recovery

Get Informed

Campaign Materials



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Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

https://web.archive.org/web/20210416190447/https://www.cdc.gov/injury/features/manage-your-pain/index.html

Injury Center
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Data, Statistics & Reporting +
Funded Programs, Activities and Research +
Newsroom +
Featured Topics +
Publications

Data & Statistics
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Motor Vehicle Safety

Talk to Your Doctor About Managing Your Pain

You and your doctor both play a role in finding the best way to manage your pain.

Doctors prescribe opioids – like hydrocodone, oxycodone, and morphine – to treat moderate to severe pain. Opioids are often prescribed following a surgery or injury or for certain health conditions. These medications carry serious risks of addiction and overdose, especially with prolonged use.

Some patients may experience negative side effects like the ones listed below, even when they take their opioid medication as directed:

- **Tolerance**—meaning you might need to take more of a medication for the same pain relief
- **Physical dependence**—meaning you have symptoms of withdrawal when a medication is stopped
- Increased sensitivity to pain
- Nausea, vomiting, and dry mouth
- Confusion
- Sleepiness and dizziness
- Depression
- Itching and sweating

While opioids can be an important part of treatment, they also come with serious risks. That is why it is important to work with your doctor to make sure you are getting the safest, most effective care. **A simple conversation with your doctor can help prevent opioid addiction and overdose.**

The Dangers of Prescription (Rx) Opioids

Opioids can be dangerous, and anyone can become addicted. Studies have shown **that even just three days of opioid treatment can increase**

Facts about Opioid

Prescription Drug Overdose

Traumatic Brain Injury

Violence Prevention

the likelihood of chronic opioid use.[1] It only takes a little to lose a lot. Risks include misuse, abuse, opioid use disorder (addiction), and overdose.

Opioids affect the part of the brain that controls breathing. If you take a dosage that is too high, it can slow your breathing and cause death.

Combining opioids with alcohol or certain other drugs – like benzodiazepines (Xanax or Valium), sleep aids, muscle relaxants, hypnotics (Ambien or Lunesta), and other prescription opioids – **increases your risk of overdose and death**.[2]

Start a Conversation with Your Doctor about Prescription (Rx) Opioids

You can help prevent prescription opioid misuse by first starting a conversation with your doctor. Protect yourself, loved ones, and others by talking about your questions and concerns regarding opioid medications.

- Ask about the **risks and benefits** of prescription opioids, so you and your doctor can together decide what's best.
- Ask your doctor about **non-opioid options** for pain relief.
- Let your doctor know about **any other medications** you take.

Misuse & Overdose

- **10 million** Americans (age 12+) reported misusing opioids in 2018.[3]
- Most of the opioid misuse from the past year is from prescription opioids, specifically **9.9 million** people.[3]

Treatment Support

Call SAMHSA's National Helpline: 1-800-622-HELP.

See SAMHSA's Opioid Treatment Program Directory and FindTreatment.gov for quality treatment centers in your state.

Tips to Reduce the Risk of Prescription (Rx) Opioid Addiction

- **Do not share medication with others.** Only take prescription medication that is prescribed to you.
- **Take medication as directed by your doctor.** Never take opioids in greater amounts or more often than prescribed.
- **Keep medicines in a safe and secure place.** It's best to store opioids in a place that is locked, like a keyed medicine cabinet or drawer, to keep them secure from children, family, friends, and visitors.
- **Properly discard expired or unused prescription opioids.** Remove them from your home as soon as possible to reduce the chances of misuse. To get rid of prescription opioids and other medications safely:
  - Find a medicine take-back option near you: TakeBackDay.DEA.gov;
  - Check with your pharmacist to see if you can return unused medication to the pharmacy.

More Information

- Rx Awareness Campaign
- Rx Awareness – Real Stories
- Prescription Opioids
- Opioid Information for Patients

- Prevent Prescription Opioid Overdose
- Opioid Prescribing Vital Signs

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1. Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269.
2. Center for Drug Evaluation and Research, U.S. Food and Drug Administration. FDA Drug Safety Communication: FDA Warns about Serious Risks and Death When Combining Opioid Pain or Cough Medicines with Benzodiazepines; Requires Its Strongest Warning: FDA. Food and Drug Administration, FDA, 2017.
3. Substance Abuse and Mental Health Services Administration. *Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health.* Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Page last reviewed: December 16, 2020
Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

https://web.archive.org/web/20210416203024/https://www.cdc.gov/drugoverdose/opioids/prescribed.html

Prescription Opioids

Prescription opioids can be used to treat moderate-to-severe pain and are often prescribed following surgery or injury, or for health conditions such as cancer. In recent years, there has been a dramatic increase in the acceptance and use of prescription opioids for the treatment of chronic, non-cancer pain, such as back pain or osteoarthritis, despite serious risks and the lack of evidence about their long-term effectiveness.

On This Page

When the Prescription Becomes the Problem

- More than 191 million opioid prescriptions were dispensed to American patients in 2017—with wide variation across states.[1]
- There is a wide variation of opioid prescription rates across states. Health care providers in the highest prescribing state, Alabama, wrote almost three times as many of these prescriptions per person as those in the lowest prescribing state, Hawaii.[1]
- Studies suggest that regional variation in use of prescription opioids cannot be explained by the underlying health status of the population.[2]
- The most common drugs involved in prescription opioid overdose deaths include:
  - Methadone
  - Oxycodone (such as OxyContin®)
  - Hydrocodone (such as Vicodin®)[3]

To reverse this epidemic, we need to improve the way we treat pain. We must prevent abuse, addiction, and overdose before they start.

Addiction and Overdose

Anyone who takes prescription opioids can become addicted to them. In fact, as many as one in four patients receiving long-term opioid therapy in a primary care setting struggles with opioid addiction.[4,5,6] Once addicted, it can be hard to stop. In 2016, more than 11.5 million Americans reported misusing prescription opioids in the past year.[1]

Taking too many prescription opioids can stop a person's breathing—leading to death.

Prescription opioid overdose deaths also often involve benzodiazepines

Prescription opioid overdose deaths also often involve benzodiazepines. Benzodiazepines are central nervous system depressants used to sedate, induce sleep, prevent seizures, and relieve anxiety. Examples include alprazolam (Xanax®), diazepam (Valium®), and lorazepam (Ativan®). Avoid taking benzodiazepines while taking prescription opioids whenever possible.

Side Effects

In addition to the serious risks of addiction, abuse, and overdose, the use of prescription opioids can have a number of side effects, even when taken as directed:

- Tolerance—meaning you might need to take more of the medication for the same pain relief
- Physical dependence—meaning you have symptoms of withdrawal when the medication is stopped
- Increased sensitivity to pain
- Constipation
- Nausea, vomiting, and dry mouth
- Sleepiness and dizziness
- Confusion
- Depression
- Low levels of testosterone that can result in lower sex drive, energy, and strength
- Itching and sweating

Related Pages

Opioid Basics

Understanding the Epidemic

Data Overview

Information for Patients

Overdose Prevention

References

1. Centers for Disease Control and Prevention. 2018 Annual Surveillance Report of Drug-Related Risks and Outcomes — United States. Surveillance Special Report 2 . Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Published August 31, 2018.
2. Centers for Disease Control and Prevention. Vital Signs: Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines — United States, 2012. MMWR 2014; 63(26);563-568.
3. Ossiander EM. Using textual cause-of-death data to study drug poisoning deaths. Am J Epidemiol 2014 Apr 1;179(7):884-94.
4. Banta-Green CJ, Merrill JO, Doyle SR, Boudreau DM, Calsyn DA. Opioid use behaviors, mental health and pain—development of a typology of chronic pain patients. Drug Alcohol Depend 2009;104:34–42.
5. Boscarino JA, Rukstalis M, Hoffman SN, et al. Risk factors for drug dependence among out-patients on opioid therapy in a large US health-care system. Addiction 2010;105:1776–82.
6. Fleming MF, Balousek SL, Klessig CL, Mundt MP, Brown DD. Substance use disorders in a primary care sample receiving daily opioid therapy. J Pain 2007;8:573–82.

Page last reviewed: August 29, 2017
Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

https://web.archive.org/web/20210413221123/https://www.cdc.gov/drugoverdose/prescribing/guideline.html

Opioid Overdose
Opioid Basics +
Data +
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Information for Patients +
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State Information +
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Resource Center +

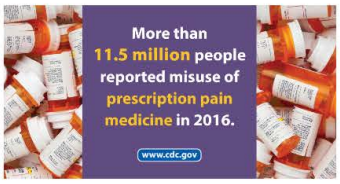
About CDC's Opioid Prescribing Guideline

Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse or overdose from these drugs.

CDC developed and published the *CDC Guideline for Prescribing Opioids for Chronic Pain* to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (pain lasting longer than 3 months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care.

On this page

The Need



Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing the risk of opioid use disorder, overdose, and death. More than 11.5 million Americans, aged 12 or older, reported misusing prescription opioids in 2016.[1]

- An estimated 11% of adults experience daily pain
- Millions of Americans are treated with prescription opioids for chronic pain
- Primary care providers are concerned about patient addiction and report insufficient training in prescribing opioids

Guideline Overview

The CDC Guideline addresses patient-centered clinical practices including conducting thorough assessments, considering all possible treatments, closely monitoring risks, and safely discontinuing opioids. The three main focus areas in the Guideline include:

1. **Determining when to initiate or continue opioids for chronic pain**

Read the full CDC

- Selection of non-pharmacologic therapy, nonopioid pharmacologic therapy, opioid therapy
- Establishment of treatment goals
- Discussion of risks and benefits of therapy with patients

2. **Opioid selection, dosage, duration, follow-up, and discontinuation**
   - Selection of immediate-release or extended-release and long-acting opioids
   - Dosage considerations
   - Duration of treatment
   - Considerations for follow-up and discontinuation of opioid therapy
3. **Assessing risk and addressing harms of opioid use**
   - Evaluation of risk factors for opioid-related harms and ways to mitigate patient risk
   - Review of prescription drug monitoring program (PDMP) data
   - Use of urine drug testing
   - Considerations for co-prescribing benzodiazepines
   - Arrangement of treatment for opioid use disorder

Guideline for Prescribing Opioids for Chronic Pain [PDF – 725 KB]

MME for Commonly Prescribed Opioids

Opioid	Conversion Factor
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone: 1-20 mg/day	4
Methadone: 21-40 mg/day	8
Methadone: 41-60 mg/day	10
Methadone: ≥61-80 mg/day	12
Morphine	1

Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.

To determine dose in MMEs, multiply the dose for each opioid by the conversion factor. For example, tablets containing hydrocodone 5 mg and acetaminophen 300 mg taken four times a day would contain a total of 20 mg of hydrocodone daily, equivalent to 20 MME daily; extended-release tablets containing oxycodone 10mg and taken twice a day would contain a total of 20mg of oxycodone daily, equivalent to 30 MME daily.

1. All doses should be in mg/day, except for fentanyl which should be in mcg/hr, before multiplying by the conversion factor.
2. Equianalgesic dose conversions are only estimates and cannot account for individual variability in genetics and pharmacokinetics.
3. Do not use the calculated dose in MMEs to determine the doses to use when converting opioid to

Oxycodone	1.5
Oxymorphone	3
Tapentadol†	0.4

†Tapentadol is a mu receptor agonist and norepinephrine reuptake inhibitor. MMEs are based on degree of mu-receptor agonist activity, but it is unknown if this drug is associated with overdose in the same dose-dependent manner as observed with medications that are solely mu receptor agonists.

use when converting opioid to another; when converting opioids the new opioid is typically dosed at substantially lower than the calculated MME dose to avoid accidental overdose due to incomplete cross-tolerance and individual variability in opioid pharmacokinetics.

4. Use particular caution with methadone dose conversions because the conversion factor increases at higher doses.
5. Use particular caution with fentanyl since it is dosed in mcg/hr instead of mg/day, and its absorption is affected by heat and other factors.

SOURCE: Adapted from Von Korff M, Saunders K, Thomas Ray G, et al. De facto long-term opioid therapy for noncancer pain. Clin J Pain. 2008 Jul–Aug; 24(6):521–527 and Washington State interagency guideline on prescribing opioids for pain; 2015.

For clinical guidance on dosage of opioids for treatment of chronic pain, please see these resources:

- MMWR: CDC Guideline for Prescribing Opioids for Chronic Pain
- Factsheet: Calculating Total Daily Dose of Opioids for Safer Dosage
- Mobile App: CDC Opioid Guideline

Additional clinical guidance, including opioid prescribing for acute pain, may be available through manufacturers' full prescribing information or consultation with other clinicians with expertise and experience in pain management. Conversion factors for drugs prescribed or provided as part of medication-assisted treatment for opioid use disorder should not be used to benchmark against MME dosage thresholds meant for opioids prescribed for pain.

References

1. Centers for Disease Control and Prevention. 2018 Annual Surveillance Report of Drug-Related Risks and Outcomes — United States. Surveillance Special Report 2 . Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Published August 31, 2018.

Page last reviewed: February 17, 2021
Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

https://web.archive.org/web/20210416202932/https://www.cdc.gov/drugoverdose/training/index.html

Training for Providers

Interactive Training Series

This interactive, web-based training features self-paced learning, case-based content, knowledge checks, and integrated resources to help healthcare providers gain a deeper understanding of the *CDC Guideline for Prescribing Opioids for Chronic Pain*. Find tips on implementing the Guideline in primary care practice and overcoming challenges. Earn free CE.

More

COCA Call Webinar Series

Learn about applying the *CDC Guideline for Prescribing Opioids for Chronic Pain* in primary care practice settings. This webinar series comes from CDC and University of Washington experts. Watch archived webinars which include slides, real case examples, and question-and-answer sessions. Earn free CE.

More

Coordinating Responses to Opioid Overdoses

Coordinating Clinical and Public Health Responses to Opioid Overdoses Treated in Emergency Departments: a joint Vital Signs Town Hall and COCA webinar. Speakers included the U.S. Surgeon General, Acting CDC Director, CDC Vital Signs MMWR author, and experts from Rhode Island. CE credit can be earned by participating through the archived recording and related resources, available on demand.

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FENTORA
fentanyl buccal tablet

Welcome to *FENTORA*.com

For breakthrough pain in opioid tolerant patients with cancer

- Find out more about breakthrough pain
- Learn how *FENTORA* works
- Stay SECURE with *FENTORA*

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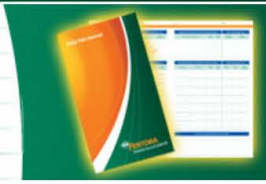
- Safe use, storage, and disposal
- For caregivers
- Staying SECURE with *FENTORA*
- Reimbursement resources
- Educational resources



Daily Pain Journal

Keep track of your pain and the medicine you take to get relief.

DOWNLOAD JOURNAL

1 3

Many patients with chronic cancer pain experience breakthrough pain — sudden flares of intense pain that usually come on fast and strike without warning — in addition to their all-day pain.

If you or someone you love suffers from breakthrough pain, *FENTORA* may be an appropriate treatment option.

***FENTORA* is used to treat breakthrough pain in adult patients with cancer (18 years of age and older) who are regularly using other opioid pain medicines around-the-clock for their constant cancer pain.**

Here, you can find useful information about *FENTORA* — what it is, how to take it, important safety information, and more.

IMPORTANT:

1. **Do not use *FENTORA* unless you are regularly using other opioid pain medicines around-the-clock for your constant cancer pain and your body is used to these medicines.**
2. **Keep *FENTORA* in a safe place away from children. Accidental use by a child is a medical emergency and can result in death. If a child accidentally takes *FENTORA*, get emergency help right away.**

Read the Medication Guide that comes with *FENTORA* before you start taking it and each time you get a new prescription. There may be new information. This Medication Guide does not take the place of talking to your doctor about your medical condition or your treatment. Share this important information with members of your household.

The most important information you should know about *FENTORA* is:

1. ***FENTORA* can cause life-threatening breathing problems which can lead to death:**
   - **If you are not regularly using other opioid pain medicines around-the-clock for your constant cancer pain and your body is not used to these medicines. This means that you are not opioid tolerant**
   - **If you do not use it exactly as prescribed by your doctor**
2. **Your doctor will prescribe a starting dose of *FENTORA* that is different than other fentanyl containing medicines you may have been taking. Do not substitute *FENTORA* for other fentanyl medicines, including Actiq®, without talking with your doctor.**

https://web.archive.org/web/20080707195612/http://www.fentora.com/1100-pain-in-cancer-patients.aspx

Breakthrough pain in patients with cancer

What is chronic pain?

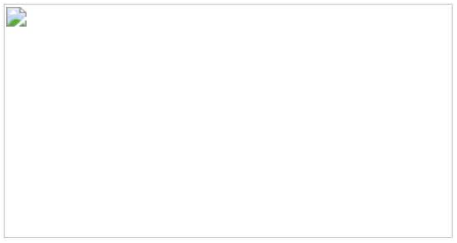
Chronic pain is pain that lasts for more than 3 months. Chronic pain often has 2 parts: *persistent pain* and *breakthrough pain*.

What is persistent pain?

Persistent pain is constant (around-the-clock) pain. Your doctor can give you an around-the-clock opioid pain medicine to control your persistent pain.

What is breakthrough pain?

Breakthrough pain is sudden pain that "breaks through" your around-the-clock opioid pain medicine. Breakthrough pain is commonly associated with sudden onset. It is an intense flare or spike of pain on top of otherwise stable pain. Breakthrough pain is one part of chronic pain experienced by many patients with cancer.



The importance of treatment for breakthrough pain

Even if your around-the-clock opioid medicine controls your persistent pain most of the time, you can still experience sudden flares of moderate-to-severe breakthrough pain. Breakthrough pain can strike suddenly and without warning in many cases. The pain can become severe in minutes. Left untreated, breakthrough pain may impact your ability to function.

FENTORA is used to treat breakthrough pain in adult patients with cancer (18 years of age and older) who are regularly using other opioid pain medicines around-the-clock for their constant cancer pain.

Click here for more information about *FENTORA*.

IMPORTANT:

1. **Do not use *FENTORA* unless you are regularly using other opioid pain medicines around-the-clock for your constant cancer pain and your body is used to these medicines.**
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   - **If you do not use it exactly as prescribed by your doctor**
2. **Your doctor will prescribe a starting dose of *FENTORA* that is different than other fentanyl containing medicines you may have been taking. Do not substitute *FENTORA* for other fentanyl medicines, including Actiq®, without talking with your doctor.**

Preparing for Your Doctor Visit

Get tips from Dr. Leal about what to do before you go to see your doctor.

PLAY VIDEO

Personal Pain Assessment

Answer a few questions to help you and your doctor better understand your pain and how to treat it.

DOWNLOAD TOOL

Making Pain Talk Painless

Learn different terms for types of pain, common medicines, and potential side effects related to pain medicines.

DOWNLOAD BROCHURE

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About *FENTORA*

What is *FENTORA*

FENTORA is an opioid pain medicine used to treat breakthrough pain in adult patients with cancer (18 years of age and older) who are regularly using other opioid pain medicines around-the-clock for their constant cancer pain. *FENTORA* is started only after you have been taking other opioid pain medicines and your body has gotten used to them (you are opioid tolerant). Being opioid tolerant means that you are taking other opioid pain medicines and your body has gotten used to them, so you are at reduced risk for serious breathing problems. **Do not use *FENTORA* if you are not opioid tolerant.**

You must stay under your doctor's care while taking *FENTORA*.

***FENTORA* must not be used for short-term pain from injuries, surgery, and headaches, including migraines.**

Staying SECURE with FENTORA

Continue to use your around-the-clock opioid while you are using *FENTORA*

- *FENTORA* must only be used if you are regularly using other opioid pain medicines and your body is used to these medicines (your body is "opioid tolerant")
- Never stop using your around-the-clock opioid pain medicine while you are using *FENTORA* without talking to your doctor
- Never use *FENTORA* for the treatment of short-term pain from injuries, surgery, or headaches/migraines

Learn More About Staying Secure with FENTORA

IMPORTANT:

1. **Do not use *FENTORA* unless you are regularly using other opioid pain medicines around-the-clock for your constant cancer pain and your body is used to these medicines.**
2. **Keep *FENTORA* in a safe place away from children. Accidental use by a child is a medical emergency and can result in death. If a child accidentally takes *FENTORA*, get emergency help right away.**

Read the Medication Guide that comes with *FENTORA* before you start taking it and each time you get a new prescription. There may be new information. This Medication Guide does not take the place of talking to your doctor about your medical condition or your treatment. Share this important information with members of your household.

The most important information you should know about *FENTORA* is:

1. ***FENTORA* can cause life-threatening breathing problems which can lead to death:**
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   - **If you do not use it exactly as prescribed by your doctor**
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Safe use, storage, and disposal

Click on the links below for more information.

Safe use
Storage
Disposal
Staying SECURE with FENTORA

Learn More About Staying Secure with FENTORA

Safe use

What to tell your doctor before starting *FENTORA*

Tell your doctor about all medical and mental problems, especially the following:

- Trouble breathing or lung problems such as asthma, wheezing, or shortness of breath
- A head injury or brain problem
- Liver or kidney problems
- Seizures (convulsions or fits)
- Slow heart rate or other heart problems
- Low blood pressure
- Mental problems including major depression or hallucinations (seeing or hearing things that are not there)
- A past or present drinking problem or alcoholism, or a family history of this problem
- A past or present drug abuse or addiction problem, or a family history of this problem

Tell your doctor if you are

- Pregnant or planning to become pregnant. *FENTORA* may harm your unborn baby
- Breast-feeding. Fentanyl passes through breast milk, and it may cause serious harm to your baby. Therefore, you should not use *FENTORA* while breast-feeding

Using medicines other than your pain medicine, and herbal products while taking *FENTORA*

Do not start any new prescription medicine, nonprescription medicine, vitamins, or herbal supplements while using FENTORA until you have talked with your doctor. Your doctor will tell you if it is safe to take other medicines while you are using FENTORA.

Tell your doctor about all the medicines you take, including

- Prescription and nonprescription medicines
- Vitamins
- Herbal supplements

Avoid alcohol

You should avoid alcoholic beverages while using *FENTORA*. Drinking alcohol can produce dangerous side effects, resulting in serious injury or death.

Do not take *FENTORA* if you

- Are not already taking other opioid pain medicines for your persistent cancer pain
- Only have short-term pain from injuries, surgery, or headaches/migraines
- Are allergic to anything in *FENTORA*. The active ingredient in *FENTORA* is fentanyl. The other ingredients are mannitol, sodium starch glycolate, sodium bicarbonate, sodium carbonate, citric acid, and magnesium stearate
- Have not been prescribed *FENTORA*

What to do if someone else takes your *FENTORA*

Call 911 or call emergency help immediately.

Are pain medicines addictive?

Addiction is a chronic disease that is characterized by one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving of a medicine. Addiction rarely occurs when you take medicine under your doctor's supervision.

There is a chance you could get addicted to *FENTORA*. The chance is higher if you are or were ever addicted to other medicines, street drugs, or alcohol, or if you abused them. The chance is also higher if you have a history of mental problems. Talk with your doctor about the risk of addiction.

You can develop "physical dependence" on an opioid. This means that stopping the opioid suddenly makes you feel sick because your body has become used to it. Physical dependence is not unusual and is different from addiction.

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Storage

Keep *FENTORA* in a safe place away from children and from anyone for whom it has not been prescribed. Accidental use by a child is a medical emergency and can result in death. If a child accidentally takes *FENTORA*, get emergency help right away.

FENTORA is supplied in single sealed child-resistant blister packages. Keep tablets in their blister

packages until you are ready to take *FENTORA*. Do not store *FENTORA* in pillboxes. Once a blister is opened, the tablet must be taken immediately.

Store *FENTORA* at room temperature, 59°F to 86°F (15°C 30°C) until ready to use.

Always keep *FENTORA* in a secure place to protect from theft.

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Disposal

Dispose of any unopened *FENTORA* tablets remaining from a prescription as soon as they are no longer needed.

To dispose of unused *FENTORA*, remove *FENTORA* tablets from blister packages and flush down the toilet. Do not flush the *FENTORA* blister packages or cartons down the toilet.

If you need help with disposal of *FENTORA*, call Cephalon Medical Services at 1-800-896-5855.

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IMPORTANT:

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Giving care to a person in pain

As a caregiver for a person in pain, you have a lot of support. Doctors today have a better understanding of pain than ever before, and they have more ways to treat pain. Obtaining the right support can help make your job simpler. Focus on three things:

Working with the pain management team
Understanding the pain management plan
Taking care of yourself
Download Guide
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Staying SECURE with FENTORA

Keep *FENTORA* out of the reach of children

- Keep *FENTORA* in a safe and secure place away from children and anyone to whom it has not been prescribed. If a child accidentally takes *FENTORA*, call 911 or call emergency help right away
- Keep tablets in their blister packages until you are ready to take *FENTORA*. Do not store *FENTORA* in pillboxes. Once a blister is opened, the tablet must be taken immediately

Learn More About Staying Secure with FENTORA

The pain management team

Teamwork is needed to treat cancer pain. A patient's healthcare team may include many individuals involved with pain management.

- A ***family doctor*** may work with the patient through all stages of treatment
- A ***nurse*** serves an important role, and can provide you with information and support
- A ***pain specialist*** is specially trained to assess, understand, and create a treatment program for the pain
- A ***physical therapist*** can provide information on appropriate exercises and massage techniques that can help the patient be more comfortable and move around more easily and safely
- A ***social worker*** can tell you about resources in your community, such as support groups and pain clinics
- A ***pharmacist*** can discuss how medicines are taken, how they work, and possible side effects
- A ***psychologist/psychiatrist*** can provide support for depression and anxiety and help you and the patient understand and cope with pain

Many hospitals today have a special pain clinic. If your hospital does not, find out if there is one in your area by asking a hospital social worker.

Two-way communication

Caregivers should be present with the patient during meetings with the pain management team, and help ensure that information is successfully communicated by

- Listening
- Taking notes
- Asking questions about anything you or the person in your care may not understand

Help out by keeping a pain journal

A pain journal can promote the success of a pain management program by recording what pain medicines are used and how well they are working.

Click here to download a Daily Pain Journal.

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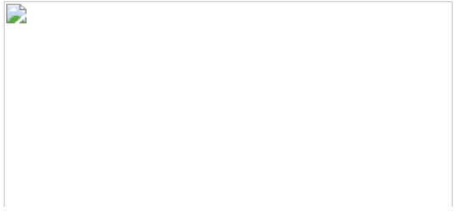
The pain management plan

A pain management plan typically has several parts:

- Pain assessment (persistent pain and breakthrough pain)
- Treatment of underlying cause of pain, if possible
- Pain medicines
- Treatments for side effects
- Other forms of therapy

The pain management plan may also include ways of handling potential side effects of the medicines, and it may even include other forms of therapy such as exercise or massage.

Chronic pain (pain that lasts for more than 3 months) often has 2 parts, and doctors often treat each part with a different medicine. For pain that lasts all day long, called *persistent* or *constant pain*, a doctor can give *around-the-clock opioid pain medicine*. This is medicine that may work for 8 hours or more. However, even if the around-the-clock opioid pain medicine controls persistent pain most of the time, a patient can still have sudden flares of moderate-to-severe pain. This is called *breakthrough pain* — pain that "breaks through" the around-the-clock opioid medicine.



Breakthrough pain is commonly associated with sudden onset. In most cases, it is an intense flare or spike of pain on top of otherwise stable pain.

Learn about the pain medicines prescribed

Be sure you understand

- The purpose of each medicine and how it works, how quickly it works, and how long it works
- When each medicine should be taken
- How each medicine should be taken
- What side effects you should watch for
- What the safety risks are for each medicine
- How each medicine should be stored and disposed
- Learn what medications should not be taken with FENTORA
- *FENTORA* is used to treat breakthrough pain in adult patients with cancer (18 years of age and older) who are regularly using other opioid pain medicines around-the-clock for their constant cancer pain

Click here for more information about *FENTORA*.

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Taking care of yourself

Caregiving can be very stressful. Remember that your well-being is important too, so get the help you need and deserve.

- Take regular breaks to rest, restore, and renew yourself
- Find positive ways to relieve stress. Exercise, meditate, or socialize — find what works best for you and do it
- Build a support network. Let friends, family, and others know what's going on and how they can help. Make connections with support groups and other community resources

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Staying SECURE with *FENTORA*

Read the Medication Guide that comes with *FENTORA* before you start using it and each time you get a new prescription. Share this important information with members of your household.

As part of the SECURE program to promote the safe and appropriate use of *FENTORA*, your doctor, your pharmacist, and the makers of *FENTORA* all want you to understand the following important information:

1. Know what it means to be "opioid tolerant"

FENTORA contains fentanyl, which is one of the strong pain medicines called opioids. If you are taking *FENTORA*, you must already have been taking another opioid pain medicine around the clock for your constant cancer pain for a week or longer. This means your body is used to these medicines (your body is "opioid tolerant"), and you may be at less risk for serious breathing problems.

What you can do to help

- Never stop taking your around-the-clock opioid pain medicine while you are taking *FENTORA* without first talking to your doctor
- Never use *FENTORA* for the treatment of short-term pain from injuries, surgery, or headaches/migraines

2. Protect against misuse, abuse, and diversion of *FENTORA*

FENTORA contains fentanyl, a strong, federally controlled medicine that can be abused by people who abuse prescription medicines or street drugs.

What you can do to help

- Keep *FENTORA* in a safe place both in and outside the home to protect it from being stolen since it can be a target for people who abuse medicines
- Never give *FENTORA* to anyone else, even if they have the same symptoms you have
- Selling or giving away *FENTORA* is against the law
- Tell your doctor about all your medical and mental-health problems, especially any past or present drug or alcohol abuse or addiction problem, or a family history of this problem

3. Protect against accidental use of *FENTORA*

FENTORA contains a medicine in an amount that can be fatal to a child and can cause life-threatening breathing problems in anyone who takes it accidentally.

What you can do to help

- Keep *FENTORA* in a safe and secure place away from children and anyone to whom it has not been prescribed. If a child accidentally takes *FENTORA*, call 911 or call emergency help right away
- Keep tablets in their blister packages until you are ready to take *FENTORA*. Do not store *FENTORA* pillboxes. Once a blister is opened, the tablet must be taken immediately
- To dispose of unused *FENTORA*, remove tablets from blister packs and flush down the toilet, or contact Cephalon Medical Services at 1-800-896-5855 for assistance

IMPORTANT:

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Get tips from Dr. Leal about what to do before you go to see your doctor.

PLAY VIDEO

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Answer a few questions to help you and your doctor better understand your pain and how to treat it.

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Making Pain Talk Painless

Learn different terms for types of pain, common medicines, and potential side effects related to pain medicines.

DOWNLOAD BROCHURE

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Reimbursement resources

If you and your doctor have decided that *FENTORA* is an appropriate treatment option for you, you may have questions about reimbursement. For assistance with reimbursement issues, you may call the *FENTORA* Reimbursement Program toll-free at 1-877-4*FENTORA* (1-877-433-6867). Reimbursement specialists can answer your questions about insurance coverage, reimbursement, and limitations. For patients with limited or no insurance or limited financial resources, Cephalon offers a *FENTORA* Patient Assistance Program.

Staying SECURE with FENTORA

Use *FENTORA* exactly as prescribed by your doctor

- It is important that you understand the proper way to use *FENTORA*. Read the instructions in the Medication Guide, and ask your doctor or pharmacist about anything you don't understand
- Do not take another dose if you have trouble breathing, have extreme drowsiness with slowed breathing, or feel very dizzy. Call your doctor or get emergency help right away
- Wait at least 4 hours before treating another flare, and treat no more than 6 flares in a single day

Learn More About Staying Secure with FENTORA

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Patient Assistance Program

For patients with limited or no insurance or limited financial resources, Cephalon offers a *FENTORA* Patient Assistance Program. If you would like to know whether you qualify, call the *FENTORA* Reimbursement Program at 1-877-4*FENTORA* (1-877-433-6867). A specialist can help you with

- Providing a program application for you and your physician to complete and sign
- Determining program eligibility
- Arranging for eligible patients to receive FENTORA at no cost
- Re-enrollment when appropriate

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To learn more about breakthrough pain in patients with cancer, there are many online resources available to you. If you and your doctor have decided that *FENTORA* is an appropriate treatment option for you, you may wish to download helpful brochures or visit our Video Library and hear from Dr. Liza Leal about preparing for your doctor visit.

Staying SECURE with FENTORA

Use *FENTORA* exactly as prescribed by your doctor

- Wait at least 30 minutes before taking an additional dose of *FENTORA* for an unrelieved flare
- Wait at least 4 hours before treating another flare

Learn More About Staying Secure with FENTORA

Preparing for Your Doctor Visit

Get tips from Dr. Leal about what to do before you go to see your doctor.

Play Video

Personal Pain Assessment

Answer a few questions to help you and your doctor better understand your pain and how to treat it.

Download Tool

Daily Pain Journal

Keep track of your pain and the medicine you take to get relief.

Download Journal

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Types of breakthrough pain

Breakthrough pain occurs when moderate-to-severe pain "breaks through" your around-the-clock opioid pain medicine. Episodes may last from a few minutes to an hour or more, and may occur several times a day, even when the proper dose of medicine is given to treat the all-day (persistent) pain.

Breakthrough pain can occur during everyday activities, such as getting out of bed, taking a walk, or coughing. It may occur without a specific cause or reason — your doctor may call this spontaneous breakthrough pain.

This chart may help you understand how breakthrough pain is often classified:

This is breakthrough pain that occurs during a particular activity, like getting dressed in the morning or even breathing. It is important to remember that even when your breakthrough pain is predictable, you may not be able to foresee the timing of the onset or the severity of the pain.

This type of breakthrough pain happens unexpectedly, like when you're just sitting in a chair reading , and it can happen with no readily identifiable cause.

This type of breakthrough pain may occur before taking a scheduled dose of around-the-clock pain medication.

Talk to your doctor about the types of breakthrough pain you experience so you can work together to determine the best treatment approach.

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Personal Pain Assessment

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Download Tool

Daily Pain Journal

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Download Journal

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Download Brochure

Preparing for your doctor visit

One way to help manage your breakthrough pain with your doctor is to be prepared for your appointments. Preparing helps promote clear and organized communication with your doctor.

Dr. Liza Leal
Board-certified pain management specialist

Play Video

To best prepare for your upcoming doctor visit, Dr. Liza Leal, a board-certified pain management specialist who treats patients with cancer, recommends that you

- **"Talk the talk":** Understanding different terms for cancer pain and using them when talking with your doctor may help your doctor get a better idea of what you experience and how to personalize your treatment. Click here for helpful information about describing breakthrough pain
- **Keep a pain journal:** It may be very beneficial to your doctor if you put into writing when your pain gets better or worse, when you experience a breakthrough pain flare, and the effect of the medicines you are taking. Detailed descriptions can help your doctor customize your medication to treat your pain. Click here to download your own Daily Pain Journal
- **Be organized during your doctor visit:** Before you arrive for your appointment, make a list of questions to ask your doctor and bring these with you. You should also bring your pain journal. You may want to take notes during your visit, or bring a friend or family member to listen, remember, and help organize the information shared during your visit

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How *FENTORA* works

FENTORA should be placed above a rear molar tooth between your cheek and gum. You may feel a gentle bubbling sensation between your cheek and gum as the tablet dissolves. *FENTORA* should not be chewed or swallowed.

About half of the fentanyl in *FENTORA* is absorbed through the lining of your mouth and into your bloodstream. The other portion gets swallowed and absorbed more slowly through your stomach and intestines, like the medicine in a pill.

As soon as the fentanyl enters the bloodstream, it is carried throughout your body. It travels to your central nervous system — the brain and spinal cord — where it works to relieve your pain.

Staying SECURE with FENTORA

Learn More About Staying Secure with FENTORA

When can I expect *FENTORA* to work?

Some patients may start to feel relief as early as 15 minutes.

If a flare or episode of breakthrough pain is not relieved within 30 minutes, your doctor may instruct you to take only one additional dose. Click here to learn more or see the special instructions for taking an additional dose in the Medication Guide.

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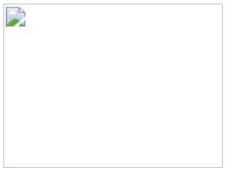
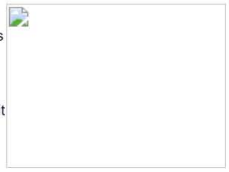


1. **Peel it.**
   - Keep tablets in blister packs until ready to use. Do not store in pillboxes
   - Separate one of the blister units from its blister card by bending and tearing apart at the perforations
   - Bend the blister unit along the line where indicated
   - Peel back the foil on the blister pack to expose the tablet
   - Do not push the tablet through the foil because this could damage the tablet
   - Do not attempt to split the tablet

2. **Place it.**
   - Immediately place the *FENTORA* tablet in your mouth. Place it above a rear molar tooth between the upper cheek and gum
   - Your doctor may instruct you to switch sides of the mouth with each new tablet used
   - Do not bite, chew, or suck *FENTORA* tablets. If you do so, you will swallow more of the medicine before it can cross the lining of your mouth, and you may get less pain relief for your breakthrough cancer pain



3. **Feel it.**
   - Leave the *FENTORA* tablet in place until it dissolves. This may take about 14 to 25 minutes. As the tablet dissolves, you may feel a slight bubbling sensation between your cheek and gum
   - If there is any tablet remaining after 30 minutes, swallow it with a glass of water

Staying SECURE with FENTORA

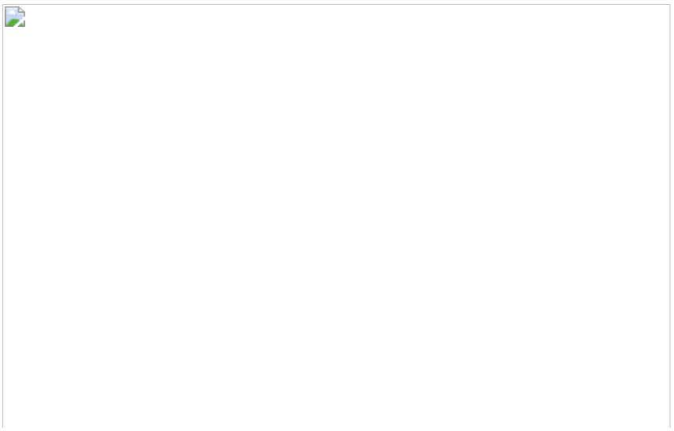
Learn More About Staying Secure with FENTORA

Finding the right dose to relieve your breakthrough pain

- To start you on *FENTORA*, your doctor will likely prescribe you a low dosage strength. This initial dose may include more than 1 tablet (***see Situation 1** below*)
- Next, your doctor may gradually increase the dosage strength of *FENTORA* to find the right dose for you. To help with this process, your doctor may instruct you to use multiple tablets at the same time (***see Situation 1** below*)
- You must wait at least 4 hours before taking *FENTORA* for another flare of breakthrough pain
  - Do **not** treat more than 6 flares in a single day
- Once you are on a regular dose of *FENTORA*, you should generally use only 1 *FENTORA* tablet per breakthrough pain flare
- *FENTORA* comes in multiple dosage strengths (100 mcg, 200 mcg, 300 mcg, 400 mcg, 600 mcg, and 800 mcg)

If you still have pain 30 minutes after taking a single dose

- If your pain is not relieved within 30 minutes, your doctor may instruct you to take only 1 additional dose of the same strength for that flare. Please note, no more than 2 doses should be used per breakthrough pain flare (***see Situation 2** below*)



IMPORTANT:

1. **Do not use *FENTORA* unless you are regularly using other opioid pain medicines around-the-clock for your constant cancer pain and your body is used to these medicines.**
2. **Keep *FENTORA* in a safe place away from children. Accidental use by a child is a medical emergency and can result in death. If a child accidentally takes *FENTORA*, get emergency help right away.**

Read the Medication Guide that comes with *FENTORA* before you start taking it and each time you get a new prescription. There may be new information. This Medication Guide does not take the place of talking to your doctor about your medical condition or your treatment. Share this important information with members of your household.

The most important information you should know about *FENTORA* is:

1. ***FENTORA* can cause life-threatening breathing problems which can lead to death:**
   - **If you are not regularly using other opioid pain medicines around-the-clock for your constant cancer pain and your body is not used to these medicines. This means that you are not opioid tolerant**
   - **If you do not use it exactly as prescribed by your doctor**
2. **Your doctor will prescribe a starting dose of *FENTORA* that is different than other fentanyl containing medicines you may have been taking. Do not substitute *FENTORA* for other fentanyl medicines, including Actiq®, without talking with your doctor.**

https://web.archive.org/web/20080629084803/http://www.fentora.com/1230-fentora-side-effects.aspx

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Side effects of *FENTORA*

FENTORA may cause side effects. The most common side effects of *FENTORA* are nausea, vomiting, dizziness, sleepiness, headache, and constipation. *FENTORA* can cause pain or sores at the application site (on your gum or the inside of your cheek). Tell your doctor if this is a problem for you.

Constipation (not often enough or hard bowel movements) is a very common side effect of opioid pain medicines and may happen with *FENTORA*. Constipation is unlikely to go away without treatment. Talk with your doctor about changes in your diet and the use of special medicines to prevent or treat constipation while taking *FENTORA*.

Before starting treatment with *FENTORA*, you should be aware of these other potential side effects:

- ***FENTORA* can cause your blood pressure to drop.** This can make you feel dizzy if you get up too fast from sitting or lying down
- ***FENTORA* can cause physical dependence.** Do not stop taking *FENTORA* or any other opioid without talking to your doctor. You could become sick with uncomfortable withdrawal symptoms because your body has become used to these medicines. Physical dependence is not the same as drug addiction
- **There is a chance of abuse or addiction with *FENTORA*.** The chance is higher if you are or have been addicted to or abused other medications, street drugs, or alcohol, or if you have a history of mental problems

These are not all the possible side effects of *FENTORA*. For a complete list, ask your doctor.

Talk with your doctor about any unusual side effects or side effects that do not go away.

Staying SECURE with FENTORA

Use *FENTORA* exactly as prescribed by your doctor

- It is important that you understand the proper way to use *FENTORA*. Read the instructions in the Medication Guide, and ask your doctor or pharmacist about anything you don't understand
- Do not take another dose if you have trouble breathing, have extreme drowsiness with slowed breathing, or feel very dizzy. Call your doctor or get emergency help right away
- Wait at least 4 hours before treating another flare, and treat no more than 6 flares in a single day

Learn More About Staying Secure with FENTORA

When you need emergency help

FENTORA can cause serious side effects — including slow, shallow breathing that can become life-threatening — especially if *FENTORA* is used the wrong way.

Call your doctor or get emergency medical help right away if you

- Have trouble breathing
- Have extreme drowsiness, with slowed breathing
- Have slow, shallow breathing (little chest movement while breathing)
- Feel faint, very dizzy, confused, or have unusual symptoms

These can be symptoms that you have taken too much *FENTORA* (overdose) or the dose is too high for you. **These symptoms may lead to serious problems or death if not treated right away.**

If you experience these symptoms, call 911 or call emergency help immediately.

For further information, please see the Medication Guide. For a complete list of side effects, ask your doctor.

IMPORTANT:

1. **Do not use *FENTORA* unless you are regularly using other opioid pain medicines around-the-clock for your constant cancer pain and your body is used to these medicines.**
2. **Keep *FENTORA* in a safe place away from children. Accidental use by a child is a medical emergency and can result in death. If a child accidentally takes *FENTORA*, get emergency help right away.**

Read the Medication Guide that comes with *FENTORA* before you start taking it and each time you get a new prescription. There may be new information. This Medication Guide does not take the place of talking to your doctor about your medical condition or your treatment. Share this important information with members of your household.

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   - **If you are not regularly using other opioid pain medicines around-the-clock for your constant cancer pain and your body is not used to these medicines. This means that you are not opioid tolerant**
   - **If you do not use it exactly as prescribed by your doctor**
2. **Your doctor will prescribe a starting dose of *FENTORA* that is different than other fentanyl containing medicines you may have been taking. Do not substitute *FENTORA* for other fentanyl medicines, including Actiq®, without talking with your doctor.**

https://web.archive.org/web/20080629171454/http://www.fentora.com/1250-fentora-faq.aspx

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Frequently asked questions about *FENTORA*

What is *FENTORA*?

FENTORA is a prescription medicine that contains the medicine fentanyl. *FENTORA* is a federally controlled substance (CII) because it is a strong opioid pain medicine that can be abused by people who abuse medicines.

FENTORA is used to treat breakthrough pain in adult patients with cancer (18 years of age and older) who are regularly using other opioid pain medicines around-the-clock for their constant cancer pain.

The SECURE program for *FENTORA* is designed to promote safe and appropriate use of the product. Click here to learn more about how you can stay SECURE with *FENTORA*.

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How does *FENTORA* work?

FENTORA should be placed above a rear molar tooth between the upper cheek and gum. You may feel a gentle bubbling sensation between your cheek and gum as the tablet dissolves. *FENTORA* should not be sucked, chewed, or swallowed.

About half of the fentanyl in *FENTORA* is absorbed through the lining of your mouth and into your bloodstream. The other portion gets swallowed and absorbed more slowly through your stomach and intestines, like the medicine in a pill.

As soon as the fentanyl enters the bloodstream, it is carried throughout your body. It travels to your central nervous system — the brain and spinal cord — where it works to relieve your pain.

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How is *FENTORA* different from the medicine I already take for my persistent pain?

The medicine you already take for your persistent pain is a strong around-the-clock opioid pain medicine that works for 8 hours or more.

FENTORA is a treatment for breakthrough pain (an intense flare or spike that rises above persistent pain). You must continue to use your around-the-clock opioid medicine while you are using *FENTORA*.

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Who should not take *FENTORA*?

Do not take *FENTORA* if you

- Are not regularly using other opioid pain medicines around the clock for your persistent cancer pain
- Only have short-term pain from injuries, surgery, or headaches/migraines
- Are allergic to anything in *FENTORA*. The active ingredient in *FENTORA* is fentanyl. The other ingredients are mannitol, sodium starch glycolate, sodium bicarbonate, sodium carbonate, citric acid, and magnesium stearate
- Have not been prescribed *FENTORA*

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What should I tell my doctor before starting *FENTORA*?

Tell your doctor about all medical and mental problems, especially the ones listed below.

- Trouble breathing or lung problems such as asthma, wheezing, or shortness of breath
- A head injury or brain problem
- Liver or kidney problems
- Seizures (convulsions or fits)
- Slow heart rate or other heart problems
- Low blood pressure
- Mental problems including major depression or hallucinations (seeing or hearing things that are not there)
- A past or present drinking problem or alcoholism, or a family history of this problem
- A past or present drug abuse or addiction problem, or a family history of this problem

Tell your doctor if you are

- Pregnant or planning to become pregnant. *FENTORA* may harm your unborn baby
- Breast-feeding. Fentanyl passes through breast milk, and it may cause serious harm to your baby.

Therefore, you should not use *FENTORA* while breast-feeding

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When do I take *FENTORA*?

Once your doctor has determined that you are an appropriate patient for *FENTORA*, you should take *FENTORA* as soon as you start to feel a flare of breakthrough pain. Click here to learn more about the proper way to take a *FENTORA* tablet.

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When can I expect *FENTORA* to work?

Some patients may start to feel relief as early as 15 minutes.

If a flare or episode of breakthrough pain is not relieved within 30 minutes, your doctor may instruct you to take an additional dose.

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Does *FENTORA* have a taste?

FENTORA contains no added flavors. You may sense a slight taste, or you may notice nothing at all.

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Is there sugar in *FENTORA*?

No. *FENTORA* is sugar-free.

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How is *FENTORA* packaged?

FENTORA comes in individually sealed, child-resistant blister packs. Once removed from the blister pack, a *FENTORA* tablet must be taken immediately.

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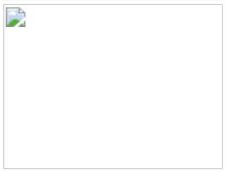
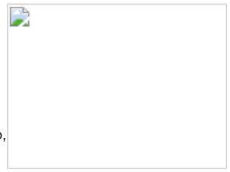
How do I take *FENTORA*?

1. **Peel it.**
   - Keep tablets in blister packs until ready to use. Do not store in pillboxes
   - Separate one of the blister units from its blister card by bending and tearing apart at the perforations
   - Bend the blister unit along the line where indicated
   - Peel back the foil on the blister pack to expose the tablet
   - Do not push the tablet through the foil because this could damage the tablet
   - Do not attempt to split the tablet



2. **Place it.**
   - Immediately place the *FENTORA* tablet in your mouth. Place it above a rear molar tooth between the upper cheek and gum
   - Your doctor may instruct you to switch sides of the mouth with each new tablet used
   - Do not bite, chew, or suck *FENTORA* tablets. If you do so, you will swallow more of the medicine before it can cross the lining of your mouth, and you may get less pain relief for your breakthrough cancer pain



3. **Feel it.**
   - Leave the *FENTORA* tablet in place until it dissolves. This may take about 14 to 25 minutes. As the tablet dissolves, you may feel a slight bubbling sensation between your cheek and gum
   - If there is any tablet remaining after 30 minutes, swallow it with a glass of water

If you cannot take *FENTORA* this way, ask your doctor what to do.

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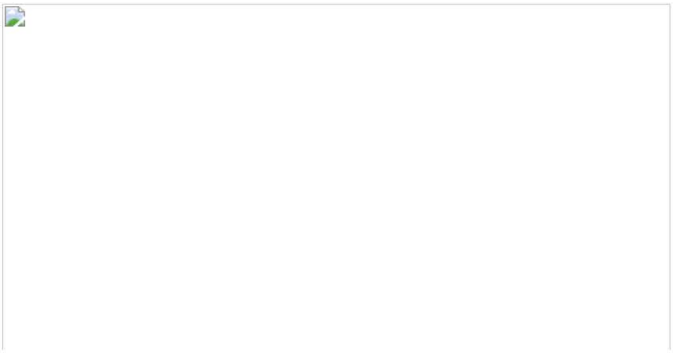
How does my doctor find the right dose of *FENTORA* to relieve my breakthrough pain?

FENTORA comes in multiple dosage strengths. To start you on *FENTORA*, your doctor will likely prescribe you a low dosage strength. This initial dose may include more than 1 tablet (***see Situation 1** below*).

Next, your doctor may gradually increase the dosage strength of *FENTORA* to find the right dose for you. To help with this process, your doctor may instruct you to use multiple tablets at the same time (***see Situation 1** below*).

By following your doctor's instructions during this adjustment period, and telling the doctor how you're feeling, you can help your doctor determine a correct dose. A pain journal can be a useful tool for remembering your experiences and talking with your doctor about them. Click here to download your own Daily Pain Journal.

Once you are on a regular dose of *FENTORA*, you should generally use only 1 *FENTORA* tablet per breakthrough pain flare.



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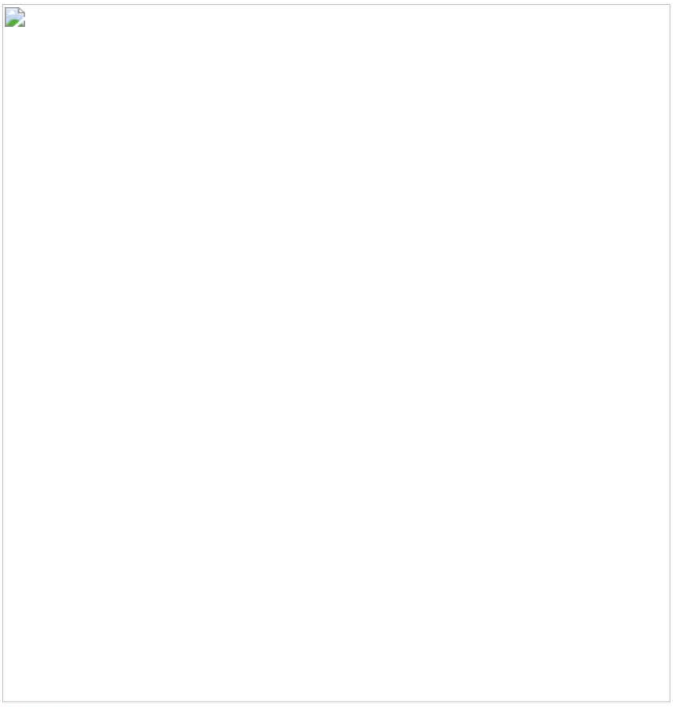
What if I still have pain after taking a single dose of *FENTORA*?

If your pain is not relieved within 30 minutes, your doctor may instruct you to take only 1 additional dose of the same strength from that flare. Please note, no more than 2 doses should be used per breakthrough pain flare (***see Situation 2** below*).



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When can I treat another breakthrough pain flare with *FENTORA*?

Follow the instructions that you received from your doctor or pharmacist about how often to take *FENTORA*.

Wait at least 4 hours before treating another breakthrough pain flare, and treat no more than 6 flares in a single day.

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Can I bite, chew, suck, or swallow *FENTORA*?

No. Do not bite, chew, or suck on a *FENTORA* tablet. Do not swallow tablets whole. If you do so, you will swallow more of the medicine before it can cross the lining of your mouth, and you may get less relief for your breakthrough cancer pain.

If you have accidentally swallowed a FENTORA tablet, talk with your doctor. He or she may allow you to take another *FENTORA* tablet, but you can only take that tablet 30 minutes after having started the one you swallowed.

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Can I take *FENTORA* if I have a dry mouth?

Yes. If you have difficulty producing saliva, please talk with your doctor. You may drink some water before taking *FENTORA*, but you should not eat or drink anything while taking *FENTORA*.

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While taking *FENTORA*, can I take my around-the-clock pain medicine?

You **must** take your around-the-clock pain medicine as long as you are taking *FENTORA*. Do not stop taking your around-the-clock opioid pain medicine. Talk with your doctor before making an adjustment to any of your other medicines.

Always discuss any questions about your medicine with your doctor.

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What are the possible or reasonably likely side effects of *FENTORA*?

FENTORA may cause side effects. The most common side effects of *FENTORA* are nausea, vomiting, dizziness, sleepiness, headache, and constipation. *FENTORA* can cause pain or sores at the application site (on your gum or inside your cheek). Tell your doctor if this is a problem for you.

Constipation (not often enough or hard bowel movements) is a very common side effect of opioid pain medicines and may happen with *FENTORA*. Constipation is unlikely to go away without treatment. Talk with your doctor about changes in your diet and the use of special medicines to prevent or treat constipation while taking *FENTORA*.

- ***FENTORA* can cause your blood pressure to drop.** This can make you feel dizzy if you get up too fast from sitting or lying down
- ***FENTORA* can cause physical dependence.** Do not stop taking *FENTORA* or any other opioid without talking to your doctor. You could become sick with uncomfortable withdrawal symptoms because your body has become used to these medicines. Physical dependence is not the same as drug addiction
- **There is a chance of abuse or addiction with *FENTORA*.** The chance is higher if you are or have been addicted to or abused other medications, street drugs, or alcohol, or if you have a history of mental problems

These are not all the possible side effects of *FENTORA*. For a complete list, ask your doctor.

Talk with your doctor about any unusual side effects or side effects that do not go away.

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When should I call emergency help?

FENTORA can cause serious side effects — including slow, shallow breathing that can become life-threatening — especially if *FENTORA* is used the wrong way.

Call your doctor or get emergency medical help right away if you

- Have trouble breathing
- Have slow, shallow breathing (little chest movement while breathing)
- Have extreme drowsiness, with slowed breathing
- Feel faint, very dizzy, confused, or have unusual symptoms

These can be symptoms that you have taken too much (overdose) *FENTORA* or the dose is too high for you. **These symptoms may lead to serious problems or death if not treated right away.**

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Can I use medicines (other than my pain medicine) and herbal products while taking *FENTORA*?

Do not start any new prescription medicine, nonprescription medicine, vitamins, or herbal supplements while using *FENTORA* until you have talked with your doctor. Your doctor will tell you if it is safe to take other medicines while you are using *FENTORA*.

Tell your doctor about all the medicines you take, including

- Prescription and nonprescription medicines
- Vitamins
- Herbal supplements

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Can I drink alcoholic beverages while taking *FENTORA*?

No. You should avoid alcoholic beverages while using *FENTORA*. Drinking alcohol can produce dangerous side effects, resulting in serious injury or death.

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How should I store *FENTORA*?

Keep *FENTORA* in a safe place away from children and from anyone for whom it has not been prescribed. Accidental use by a child is a medical emergency and can result in death. If a child accidentally takes *FENTORA*, get emergency help right away.

FENTORA is supplied in single sealed child-resistant blister packages. Keep tablets in their blister packages until you are ready to take *FENTORA*. Do not store *FENTORA* in pillboxes. Once a blister is opened, the tablet must be taken immediately.

Store *FENTORA* at room temperature, 59°F to 86°F (15°C-30°C) until ready to use.

Always keep *FENTORA* in a secure place to protect from theft.

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How should I dispose of unopened *FENTORA* tablets when they are no longer needed?

Dispose of any unopened *FENTORA* tablets remaining from a prescription as soon as they are no longer needed.

To dispose of unused *FENTORA*, remove *FENTORA* tablets from blister packages and flush down the toilet. Do not flush the *FENTORA* blister packages or cartons down the toilet.

If you need help with disposal of *FENTORA*, call Cephalon Medical Services at 1-800-896-5855.

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What happens if someone else takes my *FENTORA*?

Call 911 or call emergency help immediately.

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Are opioid pain medicines addictive?

Addiction is a chronic disease that is characterized by one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving of a medicine. Addiction does not often occur when you take medicine under your doctor's supervision.

There is a chance you could get addicted to *FENTORA*. The chance is higher if you are or were ever addicted to other medicines, street drugs, or alcohol, or if you abused them. The chance is also higher if you have a history of mental problems. Talk with your doctor about the risk of addiction.

You can develop "physical dependence" on an opioid. This means that stopping the opioid suddenly makes you feel sick because your body has become used to it. Physical dependence is not the same as addiction.

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Will my insurance or Medicaid cover the cost of *FENTORA*?

FENTORA is eligible for Medicaid reimbursement in all 50 states; however, coverage may vary from state to state.

If you have questions about whether *FENTORA* is covered under your insurance plan, you can call the *FENTORA* Reimbursement Program toll-free at 1-877-4*FENTORA* (1-877-433-6867). Reimbursement specialists can answer your questions about insurance coverage, reimbursement, and limitations. They can help you and your physician with preauthorizations and denied claims.

Cephalon does not formally conduct appeals for callers. The responsibility for obtaining prior authorization and seeking appeals ultimately must rest with patients and providers.

While Cephalon provides tools and services that may facilitate the reimbursement process, third-party payment for *FENTORA* is affected by several factors — not all of which can be resolved by the *FENTORA* Reimbursement Program staff. As a result, Cephalon cannot guarantee success in obtaining insurance authorizations or payments.

For patients with limited or no insurance, or limited financial resources, Cephalon offers a *FENTORA* Patient Assistance Program. If you would like to know whether you qualify, call the *FENTORA* Reimbursement Program at 1-877-4*FENTORA* (1-877-433-6867).

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IMPORTANT:

1. **Do not use *FENTORA* unless you are regularly using other opioid pain medicines around-the-clock for your constant cancer pain and your body is used to these medicines.**
2. **Keep *FENTORA* in a safe place away from children. Accidental use by a child is a medical emergency and can result in death. If a child accidentally takes *FENTORA*, get emergency help right away.**

Read the Medication Guide that comes with *FENTORA* before you start taking it and each time you get a new prescription. There may be new information. This Medication Guide does not take the place of talking to your doctor about your medical condition or your treatment. Share this important information with members of your household.

The most important information you should know about *FENTORA* is:

1. ***FENTORA* can cause life-threatening breathing problems which can lead to death:**
   - **If you are not regularly using other opioid pain medicines around-the-clock for your constant cancer pain and your body is not used to these medicines. This means that you are not opioid tolerant**
   - **If you do not use it exactly as prescribed by your doctor**
2. **Your doctor will prescribe a starting dose of *FENTORA* that is different than other fentanyl containing medicines you may have been taking. Do not substitute *FENTORA* for other fentanyl medicines, including Actiq®, without talking with your doctor.**

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Pain management links

For more information regarding cancer and pain management, you may wish to visit these sites:

American Cancer Society
http://www.cancer.org

American Chronic Pain Association
http://www.theacpa.org

American Pain Foundation
http://www.painfoundation.org

American Pain Society
http://www.ampainsoc.org/

CancerCare, Inc.
http://www.cancercare.org

National Coalition for Cancer Survivorship
http://www.canceradvocacy.org

National Pain Foundation
http://www.nationalpainfoundation.org

Preparing for Your Doctor Visit

Get tips from Dr. Leal about what to do before you go to see your doctor.

Play Video

Personal Pain Assessment

Answer a few questions to help you and your doctor better understand your pain and how to treat it.

DOWNLOAD TOOL

Daily Pain Journal

Keep track of your pain and the medicine you take to get relief.

Download Journal

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Helpful brochures

You may wish to download the following materials to help you and your caregiver gain a better understanding of breakthrough pain (BTP) and management with *FENTORA*.

Daily Pain Journal
Keep track of your pain and the medicine you take to get relief.
Download Now

Using *FENTORA*
Get information about dosing, administration, storage, and disposal.
Download Now

A Caregiver's Guide to *FENTORA*
This brochure can help your caregivers understand BTP, treatment with *FENTORA*, and how they can work with the pain management team.
Download Now

Making Pain Talk Painless
Learn different terms for types of pain, common medicines, and potential side effects related to pain medicines.
Download Now

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Preparing for Your Doctor Visit

Get tips from Dr. Leal about what to do before you go to see your doctor.

PLAY VIDEO

Personal Pain Assessment

Answer a few questions to help you and your doctor better understand your pain and how to treat it.

DOWNLOAD TOOL

Staying SECURE with FENTORA

Prevent theft and misuse of *FENTORA*

- Keep *FENTORA* in a safe place to protect it from being stolen since it can be a target for people who abuse medicines
- Never give *FENTORA* to anyone else, even if they have the same symptoms you have, as it may cause serious or life-threatening side effects
- Selling or giving away this medicine is against the law

Learn More About Staying Secure with FENTORA

https://web.archive.org/web/20080530091754/http://www.fentora.com/1730-fentora-video-library.aspx

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Video library

Preparing for your doctor visit

Get tips from Dr. Liza Leal about how to promote clear and organized communication with your doctor.

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More videos COMING SOON!

Personal Pain Assessment

Answer a few questions to help you and your doctor better understand your pain and how to treat it.

DOWNLOAD TOOL

Daily Pain Journal

Keep track of your pain and the medicine you take to get relief.

Download Journal

Making Pain Talk Painless

Learn different terms for types of pain, common medicines, and potential side effects related to pain medicines.

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Learn how *FENTORA* (fentanyl buccal tablet) CII may help you with breakthrough pain in cancer[1,2]

FENTORA is a prescription medicine that contains fentanyl and is used to manage breakthrough pain in adults with cancer who are already routinely taking other opioid pain medicines around-the-clock for cancer pain. *FENTORA* is only available through the TIRF REMS Access program.

Copay and reimbursement, simplified

FENTORA C.A.R.E. TEAM
Copay Assistance and Reimbursement

- First month FREE*
- $5 copays*
- Dedicated reimbursement support
  Call 1-877-4FENTORA (1-877-433-6867)
  (Open Monday - Friday 8 am - 7 pm CST)

*In accordance with the Terms and Limitations >

SAVINGS CARD AND CONSENT FORM >

FENTORA Patient Brochure

A booklet to help you better understand breakthrough pain in cancer and how *FENTORA* can help manage it.

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FENTORA & BTP

FENTORA provides relief that generally matches the pattern of breakthrough pain in opioid-tolerant adults with cancer.[1,2]

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Taking *FENTORA*

FENTORA is an oral tablet placed inside your mouth to dissolve.[2]

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IMPORTANT SAFETY INFORMATION

IMPORTANT:

Do not use FENTORA unless you are regularly using another opioid pain medicine around-the-clock for your cancer pain and your body is used to these medicines (this means you are opioid tolerant). You can ask your healthcare provider if you are opioid tolerant.

Keep FENTORA in a safe place away from children.

Get emergency help IMMEDIATELY if:

- A child takes FENTORA. FENTORA can cause an overdose and death in any child who takes it
- An adult who has not been prescribed FENTORA uses it
- An adult who is not already taking opioids around-the-clock uses FENTORA

These are medical emergencies that can cause death. If possible, try to remove FENTORA from the mouth.

What important information should I know about *FENTORA*?

***FENTORA* can cause life-threatening breathing problems.**

- **Use *FENTORA* exactly as prescribed by your healthcare provider**
  - DO NOT use more than 2 doses of *FENTORA* for each episode of breakthrough cancer pain
  - Wait at least 4 hours before treating a new episode of breakthrough cancer pain with *FENTORA*
- **Do not switch from *FENTORA* to other medicines that contain fentanyl or change your *FENTORA* dose without talking with your healthcare provider**
- **Never give *FENTORA* to anyone else**, even if they have the same symptoms you have. It may harm them or even cause death and is against the law. Keep *FENTORA* in a safe place

FENTORA is available only through a program called the Transmucosal Immediate-Release Fentanyl (TIRF) Risk Evaluation and Mitigation Strategy (REMS) Access program. To receive *FENTORA*, you must talk to your healthcare provider about the benefits and risks of *FENTORA*, agree to all of the instructions, and sign the Patient-Prescriber Agreement Form.

Who should not use *FENTORA*?

Do not use *FENTORA*:

- **If you are not opioid tolerant. Opioid tolerant means that you are already taking other opioid pain medicines around-the-clock for your cancer pain, and your body is used to these medicines**

- For short-term pain that you would expect to go away in a few days, such as pain after surgery, headaches or migraine, and/or dental pain
- If you are allergic to any of the ingredients in *FENTORA*

What should I tell my healthcare provider before using *FENTORA*?

Tell your healthcare provider about all the medicines you take, including prescription medicines, vitamins, and herbal supplements. Some medicines may cause serious or life-threatening side effects when taken with *FENTORA*.

- **Do not take any medicine while using *FENTORA* until you have talked to your healthcare provider. Your healthcare provider will tell you if it is okay to take other medicines while you are using *FENTORA***
- Be very careful about taking other medicines that may make you sleepy, such as other pain medicines, antidepressant medicines, sleeping pills, anti-anxiety medicines, antihistamines, or tranquilizers

What should I avoid while using *FENTORA*?

- **Do not drive, operate heavy machinery, or do other dangerous activities** until you and your healthcare provider know how *FENTORA* affects you
- **Do not drink alcohol while using *FENTORA*.** It can increase the chance of dangerous side effects

What are possible side effects of *FENTORA*?

***FENTORA* can cause serious side effects, including:**

1. **Breathing problems that can become life-threatening.**
   Stop taking *FENTORA* and call your healthcare provider or get emergency medical help IMMEDIATELY if you:
   - Have trouble breathing
   - Have drowsiness with slowed breathing
   - Have slow, shallow breathing (little chest movement with breathing)
   - Feel faint, very dizzy, confused, or have unusual symptoms

These symptoms can be a sign that you have taken too much *FENTORA* or the dose is too high for you.
These symptoms may lead to serious problems or death if not treated right away.

2. **Decreased blood pressure.** This can make you feel dizzy or lightheaded when you stand up.
3. **Physical dependence. Do not stop taking *FENTORA* or taking any other opioid without talking to your healthcare provider.** You could become sick with uncomfortable withdrawal symptoms because your body has become used to these medicines. Physical dependency is not the same as drug addiction.
4. **A chance of abuse or addiction.** This chance is higher if you are or have been addicted to or abused other medicines, street drugs, or alcohol, or have a history of mental health problems.
5. **Pain, irritation, or sores at the application site (on your gum, on the inside of your cheek, or under your tongue).**

The most common side effects of *FENTORA* are:

- Nausea
- Vomiting
- Dizziness
- Low red blood cell count
- Tiredness
- Swelling of the arms, hands, legs and feet
- Headache

Constipation is a very common side effect of opioid pain medicines including *FENTORA* and is unlikely to go away without treatment. Talk to your healthcare provider about prevention or treatment of constipation while taking *FENTORA*.

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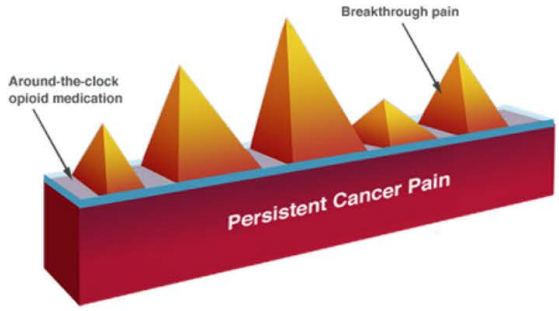
https://web.archive.org/web/20150221211225/http://fentora.com/btp.aspx

Cancer can cause breakthrough pain[1]

For patients with cancer, experiencing pain throughout the day is common. This persistent pain can be controlled with daily around-the-clock (ATC) pain medications.[1,2]

However, relief can be disrupted by breakthrough pain – intense "flares" of pain that "break through" ATC medications. Studies have shown that breakthrough pain is experienced by over half (51%-89%) of patients with cancer who take ATC medications daily to control persistent pain.[1-3]



Breakthrough pain has unique characteristics that differentiate it from persistent cancer pain[2-4]

- Comes on rapidly
- It is often unpredictable
- Usually lasts only for a short period of time
- Can happen several times a day

Breakthrough pain requires a specific management therapy

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FENTORA & BTP

FENTORA provides relief that generally matches the pattern of breakthrough pain in opioid-tolerant adults with cancer.[5,6]

LEARN MORE >

Taking *FENTORA*

FENTORA is an oral tablet placed inside your mouth to dissolve.[6]

LEARN MORE >

IMPORTANT SAFETY INFORMATION

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  - Wait at least 4 hours before treating a new episode of breakthrough cancer pain with *FENTORA*
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- Never give ***FENTORA*** to anyone else, even if they have the same symptoms you have. It may harm them or even cause death and is against the law. Keep *FENTORA* in a safe place

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- For short-term pain that you would expect to go away in a few days, such as pain after surgery, headaches or migraine, and/or dental pain
- If you are allergic to any of the ingredients in *FENTORA*

What should I tell my healthcare provider before using *FENTORA*?

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- Be very careful about taking other medicines that may make you sleepy, such as other pain medicines, antidepressant medicines, sleeping pills, anti-anxiety medicines, antihistamines, or tranquilizers

What should I avoid while using *FENTORA*?

- **Do not drive, operate heavy machinery, or do other dangerous activities** until you and your healthcare provider know how *FENTORA* affects you
- **Do not drink alcohol while using *FENTORA*.** It can increase the chance of dangerous side effects

What are possible side effects of *FENTORA*?

***FENTORA* can cause serious side effects, including:**

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   - Have trouble breathing
   - Have drowsiness with slowed breathing
   - Have slow, shallow breathing (little chest movement with breathing)
   - Feel faint, very dizzy, confused, or have unusual symptoms

These symptoms can be a sign that you have taken too much *FENTORA* or the dose is too high for you.
These symptoms may lead to serious problems or death if not treated right away.

2. **Decreased blood pressure.** This can make you feel dizzy or lightheaded when you stand up.
3. **Physical dependence. Do not stop taking *FENTORA* or taking any other opioid without talking to your healthcare provider.** You could become sick with uncomfortable withdrawal symptoms because your body has become used to these medicines. Physical dependency is not the same as drug addiction.
4. **A chance of abuse or addiction.** This chance is higher if you are or have been addicted to or abused other medicines, street drugs, or alcohol, or have a history of mental health problems.
5. **Pain, irritation, or sores at the application site (on your gum, on the inside of your cheek, or under your tongue).**

The most common side effects of *FENTORA* are:

- Nausea
- Vomiting
- Dizziness
- Low red blood cell count
- Tiredness
- Swelling of the arms, hands, legs and feet
- Headache

Constipation is a very common side effect of opioid pain medicines including *FENTORA* and is unlikely to go away without treatment. Talk to your healthcare provider about prevention or treatment of constipation while taking *FENTORA*.

Talk to your healthcare provider if you have any side effects.

These are not all the possible side effects of *FENTORA*. For more information, ask your healthcare provider or pharmacist or call 1-800-896-5855.

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References: 1. Weinstein SM, Messina J, Xie F. Fentanyl buccal tablet for the treatment of breakthrough pain in opioid-tolerant patients with chronic cancer pain: a long-term, open-label safety study. *Cancer.* 2003;115(11):2571-2579. **2.** Portenoy RK, Hagen NA. Breakthrough pain: definition, prevalence and characteristics. *Pain.* 1990;41(3):273-281. **3.** Zeppetella G, O'Doherty CA, Collins S. Prevalence and characteristics of breakthrough pain in cancer patients admitted to a hospice. *J Pain Symptom Manage.* 2000;20(2):87-92. **4.** Portenoy RK, Payne D, Jacobsen P. Breakthrough pain: characteristics and impact in patients with cancer pain. *Pain.* 1999;81(1-2):129-134. **5.** Portenoy RK, Taylor D, Messina J, Tremmel L. A randomized placebo-controlled study of fentanyl buccal tablet for breakthrough pain in opioid-treated patients with cancer. *Clin J Pain.* 2006;22(9):805-811. **6.** Fentora [package insert]. Frazer, PA: Cephalon Inc.; 2013.

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Important Safety Information

***FENTORA* can cause life-threatening breathing problems.**
Do not use *FENTORA* unless you are regularly using another opioid medication around-the-clock for your cancer pain and your body is used to these medicines (this means you are opioid tolerant). You can ask your healthcare provider if you are opioid tolerant. Keep *FENTORA* in a safe place away from children.
Read More Important Safety Information >>

For opioid-tolerant adult patients with cancer

FENTORA (fentanyl buccal tablet) CII helps manage individual episodes of breakthrough pain[1,2]

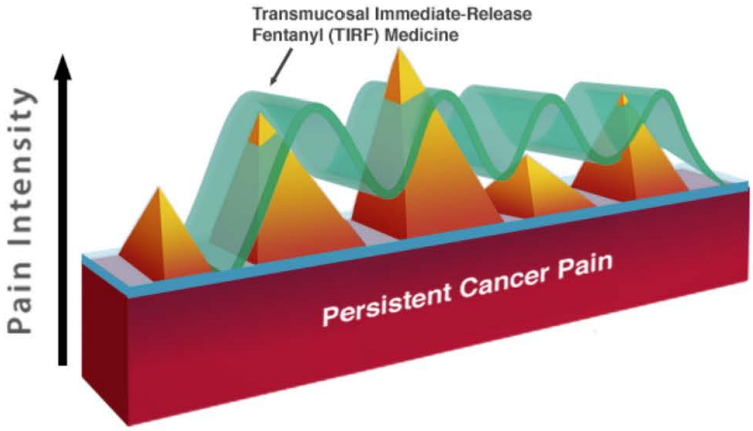
What is *FENTORA*?[2]

FENTORA (fentanyl buccal tablet) CII is a prescription medicine that contains the drug fentanyl. It belongs to a class called Transmucosal Immediate-Release Fentanyl, or TIRF, medicines. Treatment with *FENTORA* is reserved for adult patients with cancer who are experiencing episodes of breakthrough pain and are opioid-tolerant (meaning patients whose bodies have become used to around-the-clock opioid medications).

Do not use *FENTORA* if you are not opioid-tolerant. *FENTORA* can only be prescribed by your doctor, and you must remain under his or her care as long as you are being treated.

How does *FENTORA* help you manage breakthrough pain?

FENTORA provides relief that generally matches the pattern of breakthrough pain[1,2]



***FENTORA* is designed to begin working in as soon as 15 minutes, and provides relief for about 1 hour.[1]**

What are possible side effects of *FENTORA*?[2]

FENTORA can cause serious side effects, including breathing problems that can become life-threatening. Other possible serious side effects include:

- Decreased blood pressure
- Physical dependence
- A chance of abuse or addiction
- Pain, irritation, or sores at the application site (on your gum, on the inside of your cheek, or under your tongue)

Common side effects of *FENTORA* are nausea, vomiting, dizziness, low red blood cell count, tiredness, swelling of the arms, hands, legs and feet, and headache.

Constipation is a very common side effect of opioid pain medicines including *FENTORA* and often does not go away without treatment.

These are not all the possible side effects of *FENTORA*. For more information, ask your healthcare provider, and read the *FENTORA* Medication Guide.

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Provides dedicated support for copay savings, reimbursement, and prior authorizations

LEARN MORE ›

FENTORA Patient Brochure

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Taking _FENTORA_

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LEARN MORE ›

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These symptoms may lead to serious problems or death if not treated right away.

2. **Decreased blood pressure.** This can make you feel dizzy or lightheaded when you stand up.
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The most common side effects of *FENTORA* are:

- Nausea
- Vomiting

- vomiting
- Dizziness
- Low red blood cell count
- Tiredness
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Taking *FENTORA* (fentanyl buccal tablet) CII

FENTORA has two options for administration: between the upper cheek and gum (buccal cavity) and beneath the tongue (sublingual cavity)[1]

Your doctor will determine an appropriate dose using buccal administration, after which time *FENTORA* (fentanyl buccal tablet) CII can be used buccally or sublingually.

Buccal administration

When starting treatment, *FENTORA* should always be placed in the buccal cavity, above the rear molar, between the upper cheek and gum. Switch sides of your mouth for each dose.

Sublingual administration

Once your doctor determines your maintenance dose, you may have the option of taking *FENTORA* sublingually. Place the tablet under your tongue and let it dissolve.

For more information on how to take *FENTORA*, talk to your doctor and click here to see the Medication Guide.

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What are possible side effects of *FENTORA*?

***FENTORA* can cause serious side effects, including:**

1. **Breathing problems that can become life-threatening.**
   Stop taking *FENTORA* and call your healthcare provider or get emergency medical help IMMEDIATELY if you:
   - Have trouble breathing
   - Have drowsiness with slowed breathing
   - Have slow, shallow breathing (little chest movement with breathing)
   - Feel faint, very dizzy, confused, or have unusual symptoms

These symptoms can be a sign that you have taken too much *FENTORA* or the dose is too high for you.
These symptoms may lead to serious problems or death if not treated right away.

2. **Decreased blood pressure.** This can make you feel dizzy or lightheaded when you stand up.
3. **Physical dependence. Do not stop taking *FENTORA* or taking any other opioid without talking to your healthcare provider.** You could become sick with uncomfortable withdrawal symptoms because your body has become used to these medicines. Physical dependency is not the same as drug addiction.
4. **A chance of abuse or addiction.** This chance is higher if you are or have been addicted to or abused other medicines, street drugs, or alcohol, or have a history of mental health problems.
5. **Pain, irritation, or sores at the application site (on your gum, on the inside of your cheek, or under your tongue).**

The most common side effects of *FENTORA* are:

- Nausea
- Vomiting
- Dizziness
- Low red blood cell count
- Tiredness
- Swelling of the arms, hands, legs and feet
- Headache

Constipation is a very common side effect of opioid pain medicines including *FENTORA* and is unlikely to go away without treatment. Talk to your healthcare provider about prevention or treatment of constipation while taking *FENTORA*.

Talk to your healthcare provider if you have any side effects.

These are not all the possible side effects of *FENTORA*. For more information, ask your healthcare provider or pharmacist or call 1-800-896-5855.

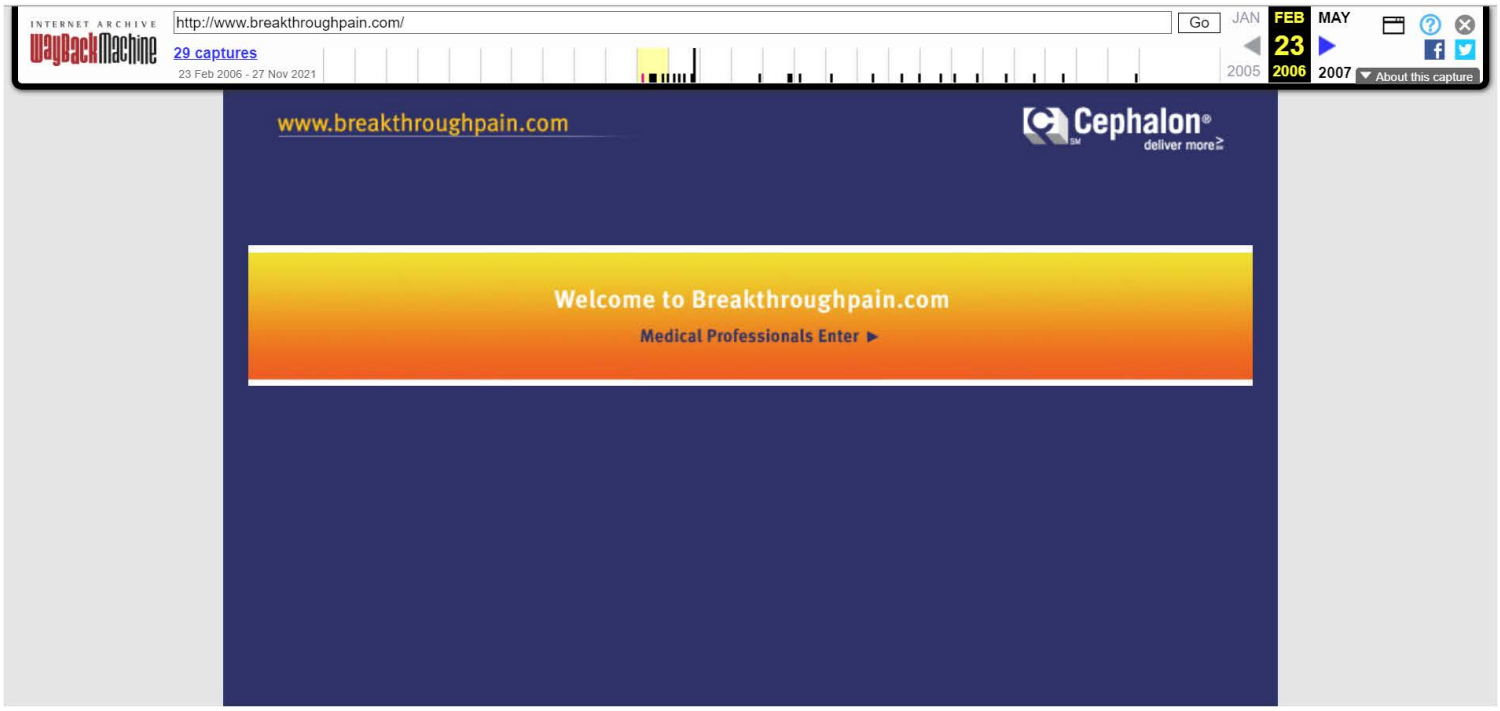
You are encouraged to report side effects of prescription drugs to the FDA. Visit www.FDA.gov/medwatch, call 1-800-FDA-1088, or fax to 1-800-FDA-0178.

This information does not take the place of talking with your doctor for medical advice about your condition or treatment.

Please see the Medication Guide located at the end of the Full Prescribing Information.

References: 1. Fentora [package insert]. Frazer, PA: Cephalon Inc.; 2013. **2.** Portenoy RK, Taylor D, Messina J, Tremmel L. A randomized, placebo-controlled study of fentanyl buccal tablet for breakthrough pain in opioid-treated patients with cancer. *Clin J Pain*. 2006;22(9):805-811.

https://web.archive.org/web/20060223050746/http://www.breakthroughpain.com/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Chronic Pain Assessment Tool

Ensure proper documentation of Persistent Pain and Breakthrough Pain (BTP).

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Welcome to breakthroughpain.com, where healthcare professionals treating BTP find the information and support they need. In addition to general information about breakthrough pain, on this Web site you can learn about the common characteristics and symptoms of BTP, quality of life implications, facts related to the cost and burden of BTP, and much more.

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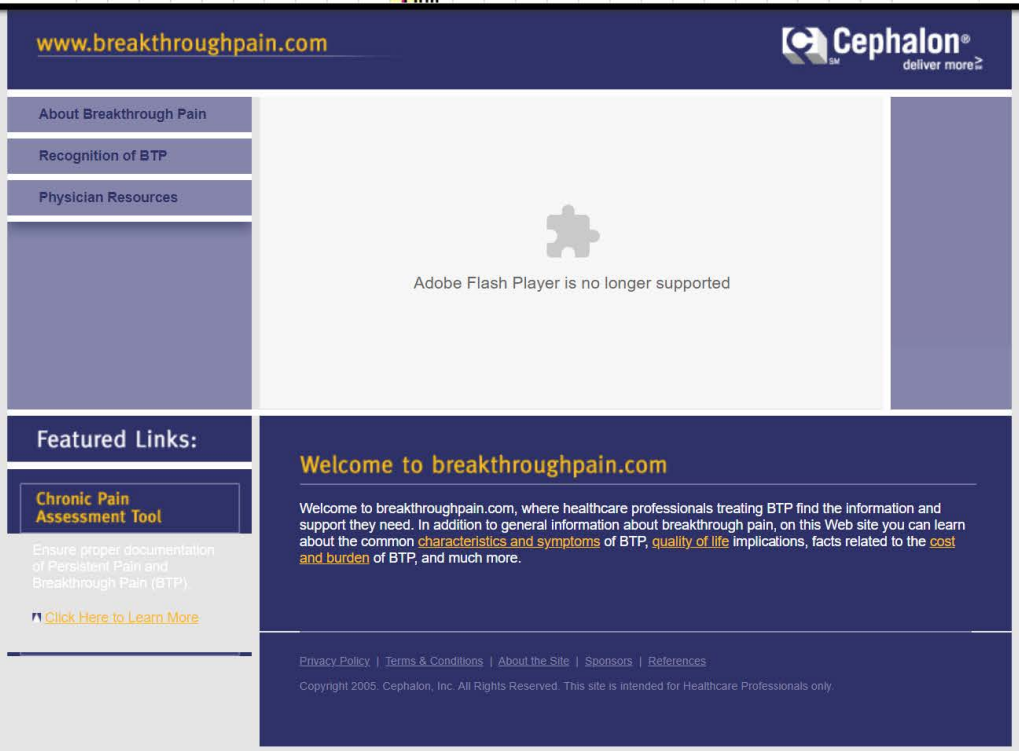

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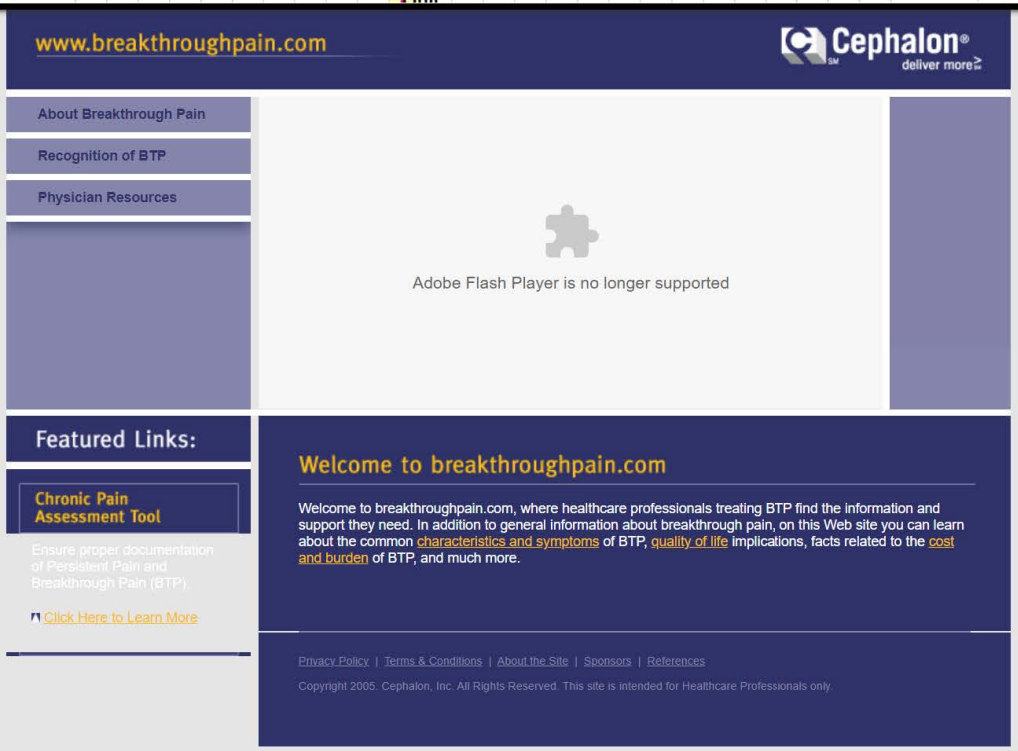

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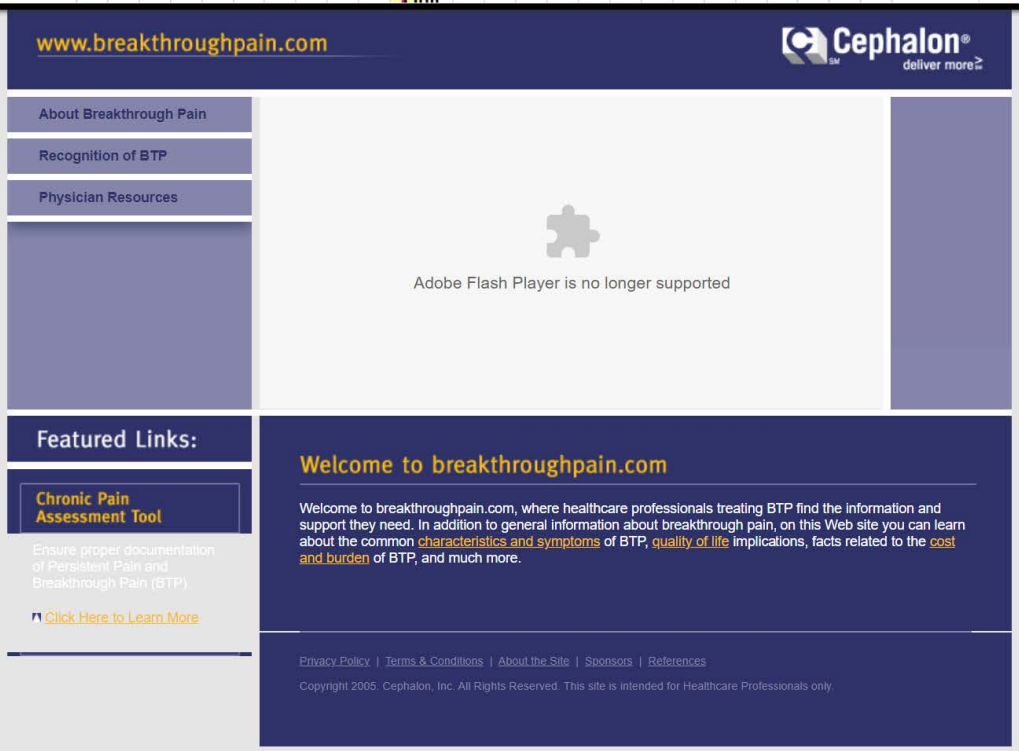

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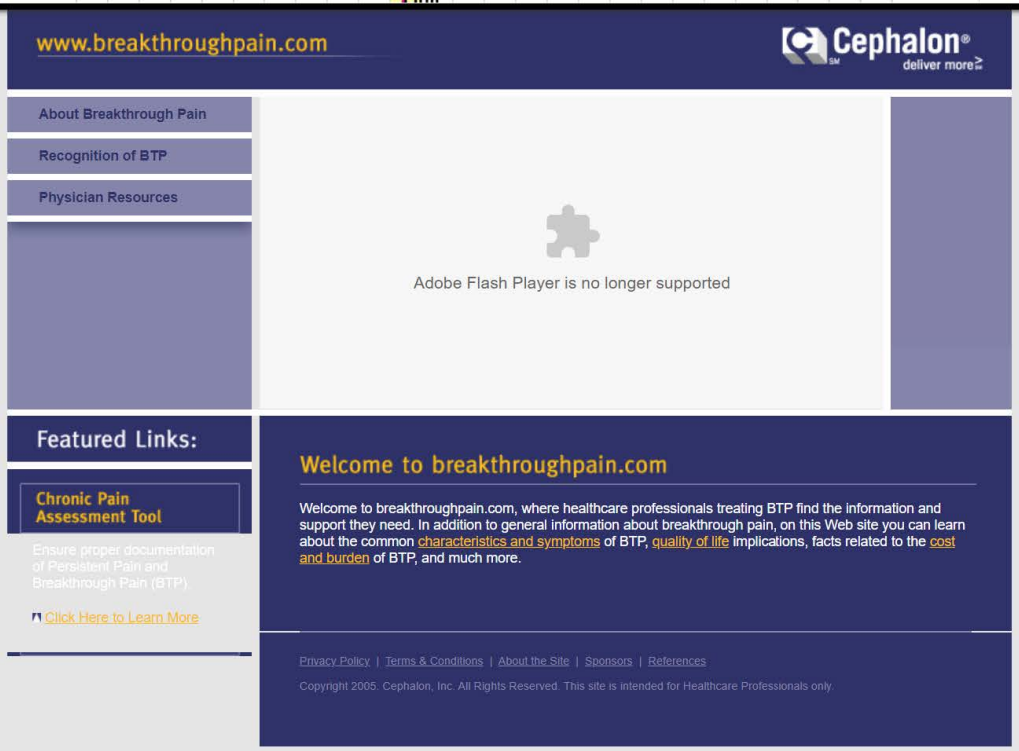

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Breakthrough Pain

Chronic Non-Malignant Breakthrough Pain: Clinical Manifestations and Treatment Options

Released: October 2003
Expiration Date for Credit: September 30, 2005
Presented by
Michael Brennan, MD Physical Medicine and Rehabilitation of Cancer and Non-Cancer Related Pain Syndromes Senior Attending Physician Department of Medicine Bridgeport Hospital Bridgeport, CT
» **Click Here To Begin This Activity**

Breakthrough Pain in Musculoskeletal Disorders: Clinical Manifestations and Treatment Options

Released: November 2003
Expiration Date for Credit: October 31, 2005
Presented by
Steve Simon, M.D., RPh, Assistant Clinical Professor, Department of Physical Medicine & Rehabilitation, University of Kansas Medical Center, Director of Pain Management Institute, Overland Park, Kansas.
» **Click Here To Begin This Activity**

Breakthrough Pain as a Treatment Model in Migraine

Released: December 2003
Expiration Date for Credit: November 30, 2005
Presented by
Marc Irwin Sharfman, MD, Director, Headache and Neurological Treatment Institute, Winter Park, FL; Clinical Assistant Professor, Department of Neurology, University of South Florida College of Medicine, Tampa, FL
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Home : Pain Resources

Pain Resources

Pain Library
A compilation of full text articles and abstracts solely dedicated to pain.
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Pain News
Simple tests may help predict patients' pain after surgery
Karen Richardson; krchrdsn@wfubmc.edu
October 26, 2005
WINSTON-SALEM, N.C. – New research at Wake Forest University Baptist Medical Center shows that having patients complete a series of simple tests befor.....
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Pain Glossary
Comprehensive compilation of medical and layman's terms used in the perioperative setting
» A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Message Boards
Open-ended forum for the exchange of information, resources, experiences, and support for the community of participants.
» Click Here To View

Bookstore
Browse the latest books available on pain. Ranging from disease process, diagnosis, and treatment to practical advice on daily living and encouragement. Level and intensity span from healthcare professional to sufferer and caregiver.
» Click Here To View

Associations
Detailed listing of active organized associations devoted to the issues related to pain, its treatment, research, educational and support resources for healthcare professions and patients and their families.
» Click Here To View

Pain Publications
A directory of regularly published periodicals, pamphlets, magazines, and newspapers, which are dedicated to pain education, research, or resource support for healthcare professionals and/or pain sufferers and their families.
» Click Here To View

Pain Studies & Libraries
Roster of ongoing research studies on pain, from policy and protocol, diagnosis evaluation and treatment, to patient response. Includes links to additional resource libraries.
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Health Resources
Extensive directory of current health and pain related resources on the Internet.
» Click Here To View

Health Newsstand
Comprehensive listing of today's current health and pain related resources and Internet sites.
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Pain Program Accreditation
Detailed itemizing of the criteria mandated for programs to gain official approval for credentialing purposes.
» Click Here To View

Programs on Pain
Healthcare Professionals can gain access to accredited category I Continuing Educational Credits while deepening their knowledge base.
» Click Here To View

Free CD-ROMs on Pain and Its Management
Click here for more information and to order your free copy.
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Associations

Pain Societies & Associations

◄ Page 1 of 2 ►

36 Resources Listed

- American Academy of Head, Neck and Facial Pain
- American Academy of Orofacial Pain
- American Academy of Pain Management
- American Academy of Pain Medicine
- American Association for Chronic Fatique Syndrome
- American Back Pain Association
- American Board of Pain Medicine
- American Chronic Pain Association
- American College of Osteopathic Pain Management and Sclerotherapy
- American Pain Foundation
- American Pain Society
- American Podiatric Medical Association
- American Society for Action on Pain
- American Society of Interventional Pain Physicians
- American Society of Law, Medicine & Ethics
- American Society of Pain Management Nurses
- American Society of Regional Anesthesia
- Back Pain Association of America
- CFIDS Association of America
- International Association for the Study of Pain

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The Westin Riverwalk San Antonio, TX
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The URL's indicated below are the entrance to the activity whether you are a CMSA member or non-member. If you are a non-member then click the "Register" button in the top black bar. Once you have registered, you can opt to either pay and take the tests, or simply review them.

» Cox-2 Conundrum
» AMA 12 Part On-line Series on Pain Management
» The Nurse Reporter (Vol 1, Issue 3, June 2004)
» The Law and Controlled Substances Prescribing for Primary Care Clinicians
» Family Physicians Managing Pain: A Case Based Approach
» Community of Interest Network (COIN) in Pain Management & Palliative Care CME Courses
» Abuse and Diversion: The Role of the Health System Pharmacist
» Life After JCAHO: Keeping Up The Momentum in Pain Management
» Fearful To Do What's Right: Legal Trends in a Changing Environment
» Johns Hopkins Pain Management Grand Rounds
» HPNA and the American Academy of Hospice and Palliative Medicine Documents
» Duty To Dispense: Overcoming Uncertainty, Doubt and Fear
» Pharmacist e Link
» National Community Pharmacists Association
» Pain Management Grand Rounds
» Pain Management in a Hospitalist Model
» American Pain Society Guidelines for the Management of Osteoarthritis Pain
» Abuse and Diversion: The Role of the Health System Pharmacist
» Society of Surgical Oncology
» CMSA Orlando 2002

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Home : Consumers

Consumers

Ask The Doctor
Practicing physicians provide personal responses to your pain related inquiries.
» **Click Here To View**

Pain Support
Full array of support resources compiled to encourage, educate, and empower you.
» **Click Here To View**

Pain Clinics
An extensive database of Pain Management Clinics dedicated to the specialized treatment of pain.
» **Click Here To View**

Expert Interviews
Selected pain topics are discussed by experts to enhance your knowledge and understanding.
» **Click Here To View**

E-Letter
The E Letter provides you with the latest information and resources available on Pain.com. It is also an excellent way to get to know the Advisory Panel of Physicians. Click here to begin receiving the monthly Pain.com E Letter.
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Ask The Pain Doctors

Welcome to "Ask the Pain Doctor" - designed to allow you to Ask The Pain Doctor a question and obtain general advice from a practicing pain professional. Pain.com is not in position to independently evaluate any of the advice or claims on behalf of any particular therapy. Pain.com offers the Ask the Pain Doctor forum to provide additional resources to patients, who would be prudent to learn as much as they can from as many sources as possible.

Select a Topic

- » Submit a question to the pain doctors
- » Read today's questions
- » Read about our doctors

Search our Archived Questions by Topic

ABDOMINAL PAIN begin search

Disclosure The "Ask the Pain Doctor" service is for information only. It does not diagnose medical conditions, offer specific medical advice, or endorse specific products, treatments or services. Pain.com is not in position to independently evaluate any of the advice or claims on behalf of any particular therapy. Pain.com offers the Ask the Pain Doctor forum to provide additional resources to patients, who would be prudent to learn as much as they can from as many sources as possible. This service does not replace consultation with your own physician for the care and treatment of any medical condition.

Discussions of possible treatment options are just that, discussions. Any treatment plan discussed at pain.com is significantly limited by the incomplete information provided by the patient or caregiver requesting advice. These discussions are meant to be general discussions of the POSSIBLE treatment options which exist, not specific recommendations for care. Those decisions should be left to the treatment provider who has a more complete knowledge of the patient history and physical examination.

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Expert Interviews

Selected pain topics are discussed by experts to enhance your knowledge and understanding.

- Managing pain in dying patients
- Treatment of noncancer pain with oral transmucosal fentanyl citrate (OTFC)
- Politics and Pain Management
- Addiction
- The use of long-acting opioids and other medications for chronic pain.
- Cancer Doesn't Have to Hurt
- Evidence Based Pain Management and Palliative Care
- Breakthrough Pain in the hospital setting.
- Breakthrough Pain Treatment Across the Continuum
- Postoperative Orthopaedic Care
- Headache pain
- Back pain
- Interventional pain
- Cancer pain
- Foot pain
- Concerning the oral route of analgesia in cancer pain.
- Overcoming obstacles to pain management.
- Prolotherapy
- The Need for New JCAHO Pain Standards
- Opioid Addiction and Abuse.
- A Practitioner's View of New JCAHO Standards on Pain Practice

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Pain Support

Drug Assistance Program
Many pharmaceutical companies provide prescription medicine free of charge to patients who cannot afford their medications. You and/or your health care provider should contact the appropriate company for information specific to their program.
» Click Here To View

Pain Assessment Tools
Before visiting your health care provider, you may find it beneficial to print out and complete these forms.
» Click Here To View

Support Groups
List of organizations that utilize the giving and receiving of emotional support and practical help for common pain problems.
» Click Here To View

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PAIN.COM

Pain Support

Pain Assessment Tools

» Target Chronic Pain Notebook
» Brief Pain Inventory (Short Form)
» Initial Pain Assessment Tool

Useful forms that can be used by your clinician
(Courtesy of Abbott Labs).

» Pre Surgical Patient Survey (Requires Adobe Acrobat).
» Post Surgical Patient Survey (Requires Adobe Acrobat).

Useful Pain Rating Scale
(Courtesy of Abbott Labs).

» Happy Face Pain Rating Scale (Requires Adobe Acrobat).

Information about pain management for patients considering surgery.
(Courtesy of Abbott Labs).

» Putting Pain After Surgery To Rest (Requires Adobe Acrobat).
» Answers to Patient Questions on Post Operative Pain (Requires Adobe Acrobat).

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B2. Initial Pain Assessment Tool

Date:_____

Patient's name:_____ Age:_____ Room:_____

Diagnosis:_____ Physician:_____
Nurse:_____

I. **Location:** Patient or nurse marks drawing

II. **Intensity:** Patient rates the pain. Scale used: _____
Present:_____
Worst pain gets:_____
Best pain gets:_____
Acceptable level of pain:_____

III. **Quality:** (Use patient's own words, e.g., prick, ache, burn, throb, pull, sharp)
_____

IV. **Onset, duration, variations, rhythms:**_____
_____

V. **Manner of expressing pain:**_____

VI. **What relieves the pain?**_____

VII. **What causes or increases the pain?**_____

VIII. **Effects of pain:** (Note decreased function, decreased quality of life.)
Accompanying symptoms (e.g., nausea)_____
Sleep_____
Appetite_____
Physical activity_____
Relationship with others (e.g., irritability)_____
Emotions (e.g., anger, suididal, crying)_____
Concentration_____
Other_____

IX. **Other comments:**_____

X. **Plan:**_____
_____

Note: May be duplicated and used in clinical practice
Source: McCaffery and Beebe, 1989. Used with permission.

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PRODUCTS
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Drug Safety
Quality

Products

Products

Actavis' comprehensive Product Database is provided as a resource for our customers.

To access a full list of Allergan products and related resources, please visit http://www.allergan.com/products/index.htm

The product information presented here is intended for use in the United States only. The U.S. Prescribing Information in this product database represents the current product labeling information as of the date of the document.

Countries outside the United States may have different regulatory requirements and review practices that may require referencing different or additional information.

While every effort has been made to ensure this information is current, you should contact our Medical Communications team at (800) 272-5525 to obtain the most current product information available.

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PRODUCT CATEGORY | ALL GROUPS

Product Name	Description	Additional Information
ACAMPROSATE CALCIUM		
ACAMPROSATE CALCIUM Delayed-Release Tablets 333 mg 180s NDC: 00258-4000-60	**Color/Shape:** white/round/ biconvex **Inscription:** black "333" on body	U.S. Prescribing Info
ACARBOSE - Cobalt		
ACARBOSE TABLETS 25 mg 100s 25 mg NDC: 16252-0523-01 *Compare to: Precose®	**Color/Shape:** White to Off-white/Round **Inscription:** AR **Orange Book Rating:** AB	U.S. Prescribing Info Product Image
ACARBOSE TABLETS 50 mg 100s 50 mg NDC: 16252-0524-01 *Compare to: Precose®	**Color/Shape:** White to Off-white/Round **Inscription:** AR/50 **Orange Book Rating:** AB	U.S. Prescribing Info Product Image
ACARBOSE TABLETS 100 mg 100s NDC: 16252-0525-01 *Compare to: Precose®	**Color/Shape:** White to Off-white/Round **Inscription:** AR/100 **Orange Book Rating:** AB	U.S. Prescribing Info Product Image
ACETASOL		
ACETASOL HC OTIC SOLUTION 1%/2% 10 mL NDC: 00472-0882-82 *Compare to: Vosol® HC Otic Solution		U.S. Prescribing Info

INSTITUTIONAL PORTFOLIO

Institutional Generic Injectable Drugs (pdf, 925kb)

PRODUCT RESOURCES

For use in the U.S.

- 2013 U.S. Rx Product Catalog
- CPSIA (Watson)
- CPSIA (Actavis)
- US Generic Return Goods Policy
- Actavis Terms and Conditions
- Actavis ADRs
- Anda ADRs

ACITRETIN CAPSULES USP		
ACITRETIN 10MG CAP 30 NDC: 00591-2263-30 *Compare to: Soriatane®	**Color/Shape:** White to Off-White Body & Brown Cap / Capsular **Inscription:** WPI 2263	U.S. Prescribing Info
ACITRETIN 17.5MG CAP 30 NDC: 00591-2264-30 *Compare to: Soriatane®	**Color/Shape:** Yellow to Light Yellow Body & Cap / Capsular **Inscription:** WPI 2264	U.S. Prescribing Info
ACITRETIN 25MG CAP 30 NDC: 00591-2266-30 *Compare to: Soriatane®	**Color/Shape:** Yellow to Light Yellow Body & Brown Cap / Capsular **Inscription:** WPI 2266	U.S. Prescribing Info
ACYCLOVIR OINTMENT		
ACYCLOVIR 5% OINTMENT 30G TUBE NDC: 00591-1159-30 *Compare to: Zovirax®	**Color/Shape:** White/ Ointment	U.S. Prescribing Info
ACYCLOVIR SUSPENSION		
ACYCLOVIR 200MG/5ML ORAL SUSPENSION 16 oz NDC: 00472-0082-16 *Compare to: Zovirax® Suspension		U.S. Prescribing Info
ADAPALENE		
ADAPALENE 0.3% GEL NDC: 00472-0126-45 *Compare to: Differin®	**Color/Shape:** Clear, Colorless	U.S. Prescribing Info
ALBUTEROL SULFATE		
ALBUTEROL SULFATE 0.63mg/3mL INHALATION SOLUTION 25 x 3mL NDC: 00591-3467-53 *Compare to: Accuneb®	**Color/Shape:** Clear, colorless/Aqueuos Solution **Orange Book Rating:** AN	U.S. Prescribing Info Product Image
ALBUTEROL SULFATE 1.25 mg/3mL INHALATION SOLUTION 25 x 3mL NDC: 00591-3468-53 *Compare to: Accuneb®	**Color/Shape:** Clear, colorless/Aqueuos Solution **Orange Book Rating:** AN	U.S. Prescribing Info Product Image
ALBUTEROL SULFATE INH		
ALBUTEROL SULFATE INH 0.083% SOLN 25x3ML NDC: 00591-3797-83	**Color/Shape:** Clear Colorless to Yellow/Solution **Orange Book Rating:** AN	U.S. Prescribing Info
ALBUTEROL SULFATE INH 0.083% SOLN 30x3ML NDC: 00591-3797-30	**Color/Shape:** Clear Colorless to Yellow/Solution **Orange Book Rating:** AN	U.S. Prescribing Info
ALBUTEROL SULFATE INH 0.083% SOLN 60x3ML	**Color/Shape:** Clear Colorless to Yellow/Solution	U.S. Prescribing Info

NDC: 00591-3797-60

Orange Book Rating: AN

ALBUTEROL SULFATE SYRUP		
ALBUTEROL SULFATE 2MG/5ML SYRUP 473ml NDC: 00472-0825-16 *Compare to: Ventolin®	**Color/Shape:** Clear-Yellow **Inscription:** Liquid	U.S. Prescribing Info

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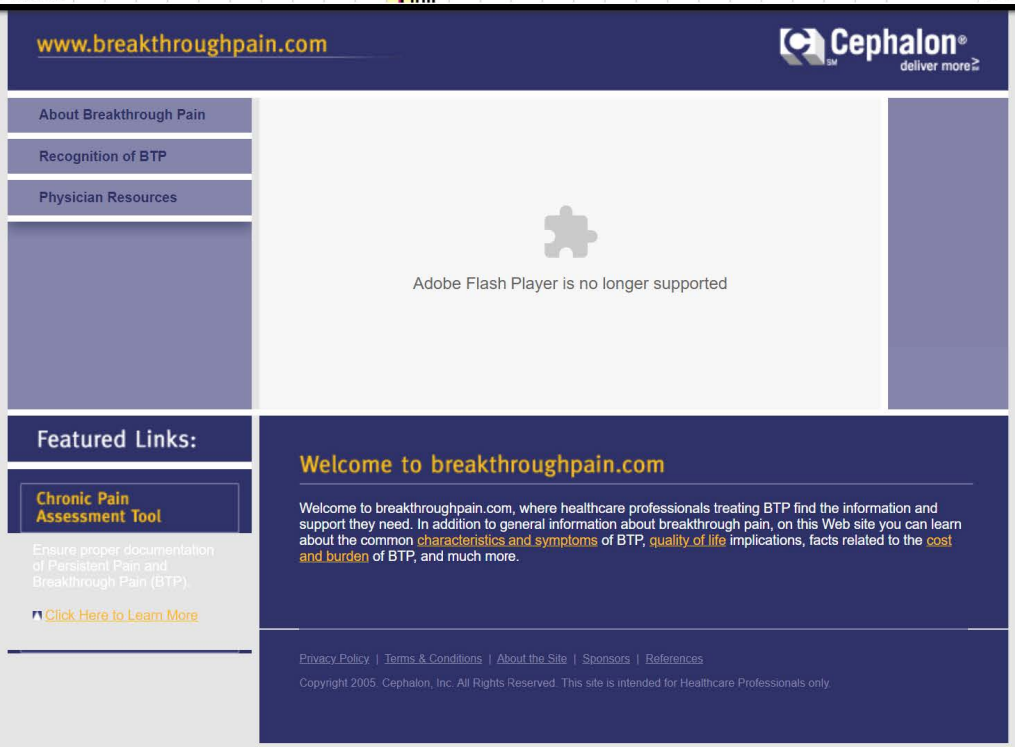

EXHIBIT B

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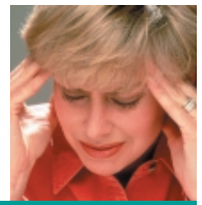


Understanding

Your

Pain

*Using a Pain Rating Scale**

*Adapted from McCaffery M, Pasero C. *Pain: Clinical Manual*, 2nd ed., 1999: Mosby, Inc.

At some point, everyone experiences pain. You may have pain now, or you may experience pain in the future as a result of disease, injury, surgery, or a medical procedure. It's important to know that most pain can be controlled, and that unrelieved pain can lead to problems such as loss of function, sleep problems, and depression. Everyone has the right to have their pain assessed and treated, and your doctor, nurse, or pharmacist will work with you to assure your pain is prevented or relieved.

When you feel pain, will you be able to describe it to your doctor or nurse? Is there a way to communicate exactly what you're feeling so they will understand?

The Pain Rating Scale

What Is It?

A *pain rating scale* is a helpful tool you can use to describe how much pain you are feeling and to measure how well treatments are relieving your pain.

How to Use a Pain Rating Scale

1. Get acquainted with it. Look at the figure below. On a scale of 0 to 10, 0 means "no pain," and 10 means "the worst possible pain." The middle of the scale (around 5) describes "moderate pain." A 2 or 3 rating would be "mild pain"; a rating of 7 or higher is "severe pain."

2. Understand what the word "pain" means. Pain includes many types of discomfort and can occur anywhere in your body. It can feel like a dull ache, or it can be severe and unbearable. Pain can include pulling, tightness, cramping, burning, stabbing, or other unpleasant sensations.

3. Practice using the scale. Do you have pain now? If not, think about pain you've had in the past. Look at the pain rating scale and answer these questions:

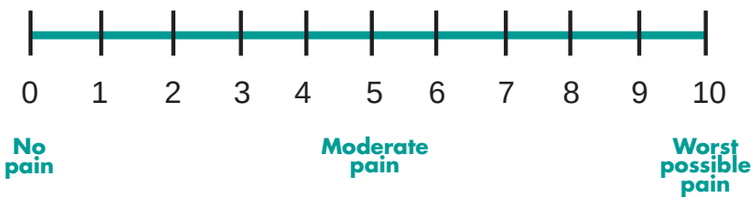
   A. On a scale of 0 to 10, what is the *usual* amount of this pain? _____

   B. On a scale of 0 to 10, what is the pain at its *worst*? _____

(Your answer to Question B should be higher than your answer to Question A.)

If you have questions on how to use this scale, be sure to ask your doctor or nurse for help.

0-10 Numeric Pain Rating Scale



When Will I Use a Pain Rating Scale?

Your doctor or nurse will ask you to rate your pain on a regular basis. You may be asked to rate your pain once a day or as often as every hour.

If Pain Interferes With Your Daily Activities:

- **Tell your doctor or nurse.** They may not know you have pain unless you alert them. Plan with them how to communicate about the pain and its treatment.
- **Write down** what (if anything) may have caused your pain or made it worse, such as bending to pick up a newspaper or getting in or out of a car.
- **Rate your pain** before *and* after you take your pain medication. By doing this, you can help your doctor know whether or not your medication is working.

***Example:** Mr. Jones rates his pain as a 6. He takes his pain medication, and one hour later he rates his pain as a 2. His pain medication worked, because his rating fell from 6, which is moderate pain, to 2, which is mild pain.*

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Setting Goals for Pain Control

Why Do I Need Pain Relief?

Many people think they should "tough it out" with pain. But research has shown that unrelieved pain can be harmful to you. Pain can make it hard to do things like getting out of bed or walking. Pain can also stop you from getting a good night's sleep or from going to work.

How Do I Set Goals for Pain Control?

In order to perform your day-to-day activities, you need to set a goal for pain control. This goal should be a rating that allows you to continue your important activities easily. To help set your goal, answer the following questions:

1. What activities do I need to do?

_____

_____

_____

_____

For example, if you have surgery, you will probably need to cough and breathe deeply after the operation to prevent complications. Or, if you have chronic pain, you may need enough pain relief to be able to drive, work, or shop.

2. What rating will make it easier for me to do these activities? _____

Everyone is different. Many people need a pain rating of 3 or less to be able to function without problems. Studies show that ratings of 4 or higher make it difficult for patients to carry out daily activities.

You may prefer to use the *Faces Pain Rating Scale* below instead of the *0-to-10 Numeric Scale*.

How to Use the Faces Pain Rating Scale

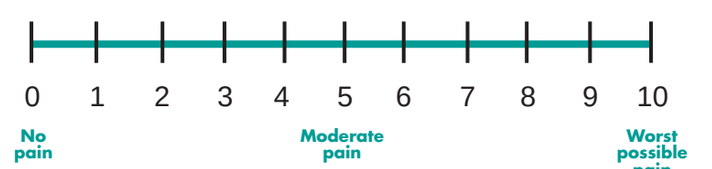
Each face on this scale shows a different amount of pain. Look at each of the faces. The first face on the left of the scale is smiling because it feels no pain or hurt. The last face on the right of the scale is crying because it feels the worst hurt or pain, but you don't have to be crying to rate your pain a 10.

You can tell your doctor or nurse about your pain by pointing to the face that shows how much you hurt.

Faces Pain Rating Scale†

Which face shows how much hurt you have now?

0-10 Numeric Pain Rating Scale



†Adapted from McCaffery M, Pasero C. *Pain: Clinical Manual*, 1999: p. 67, Mosby, Inc. Faces pain rating scale modified from Wong DL. *Whaley & Wong's Essentials of Pediatric Nursing*, 5th ed., 1997: pp. 1215-1216, Mosby, Inc.

Don't Be Afraid to Talk About Your Pain

It is very important to talk with your doctor, nurse, or pharmacist honestly and openly about your pain, so that you can receive the proper treatment.

If, after reading this brochure, you still have questions about pain or how to manage it, talk to your doctor or nurse. He or she will answer your questions and work with you to find the treatment that will be best for your pain.

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This brochure was developed by Margo McCaffery, RN, MS, FAAN, and Chris Pasero, RN, MS, authors of *Pain: Clinical Manual* (2nd ed. Mosby; 1999). Edited by Russell K. Portenoy, MD.

 ENDO-0076/MAR2001

http://web.archive.org/web/20101228070316/http://www.opana.com/pdf/long_acting_opioids_brochure_english.pdf

Information on Taking a Long-Acting Opioid

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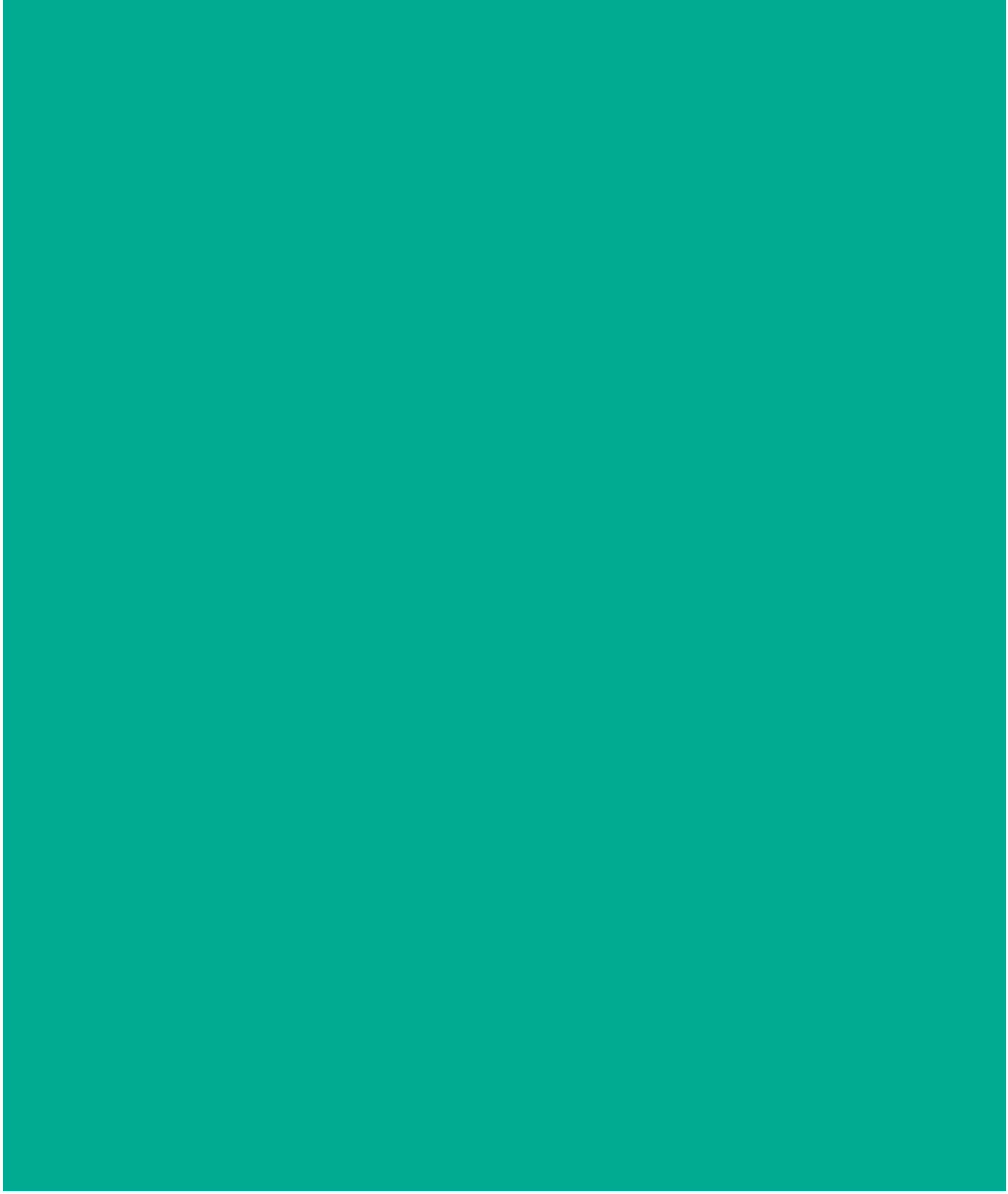

Taking a long-acting opioid: What does it mean to me?

The management of moderate to severe chronic pain can be achieved in different ways. This brochure answers some of the most frequently asked questions about the use of long-acting opioids to treat moderate to severe chronic pain.

The information contained in this brochure does not replace talking with your healthcare provider about your pain treatment options including medication.

This brochure has 4 sections:

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Long-Acting Opioids

What is a long-acting opioid?

Long-acting opioids are a type of pain medicine used for moderate to severe chronic pain that lasts most of the day. They are sometimes called "controlled-release" or "extended-release" because the medicine is gradually released into the body over an 8-24 hour period or longer. Examples of long-acting opioids taken by mouth include:

- AVINZA® (morphine sulfate extended-release capsules)
- KADIAN® (morphine sulfate extended-release) Capsules
- MS CONTIN® (morphine sulfate controlled-release) Tablets
- OPANA® ER (oxymorphone hydrochloride) Extended-Release Tablets
- ORAMORPH® SR (morphine sulfate) Sustained-Release Tablets
- OXYCONTIN® (oxycodone HCl controlled-release) Tablets

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How do long-acting opioids differ from short-acting opioids?

Compared to long-acting opioids, short-acting opioids are primarily used to treat acute pain and are taken as needed. Short-acting opioids may be used alone or combined with opioid or non-opioid analgesics. Examples of short-acting opioids include the following products:

- TYLENOL® WITH CODEINE (acetaminophen and codeine phosphate) Tablets
- ZYDONE® (hydrocodone bitartrate and acetaminophen tablets, usp)
- VICODIN® (hydrocodone bitartrate and acetaminophen tablets, usp)
- DILAUDID® (hydromorphone hydrochloride)
- PERCOCET® (oxycodone and acetaminophen tablets, usp)
- TYLOX® (oxycodone and acetaminophen capsules usp)
- ROXICODONE® (oxycodone hydrochloride tablets, usp)
- OPANA® (oxymorphone hydrochloride) Tablets

What is the risk of becoming addicted to a long-acting opioid?

Addiction is defined as compulsive drug seeking that is beyond a person's voluntary control even it if may cause harm. Most healthcare providers who treat patients with pain agree that patients treated with prolonged opioid medicines usually do not become addicted.

Physical dependence, which is different from addiction, may develop when taking opioids for pain relief for a long time. This means that your body adapts to the drug and you will have withdrawal symptoms if the medicine is stopped or decreased suddenly. Taking opioids for pain relief is **NOT** addiction.

What if I feel I need more medicine over time?

Some people taking opioids may need to take a higher dose after a period of time in order to continue to have relief from their pain. This is a "tolerance" to opioid medications that doesn't affect everyone who takes them, and does **NOT** mean addiction.

If tolerance develops, it does not mean you will "run out" of pain relief. Your healthcare provider can adjust your dose or prescribe another medicine.

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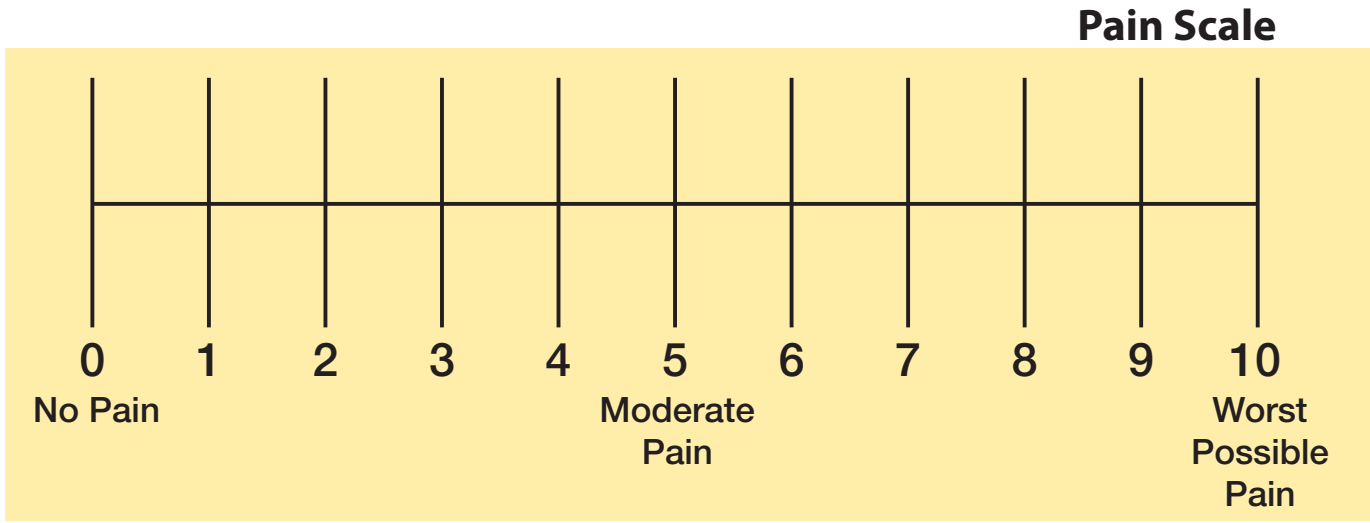
How should I take my long-acting pain relief medicine to get the best pain relief?

People who are in pain for most of the day should take their pain medicine at regularly scheduled times as directed by their healthcare provider. Taking medicine in this way may prevent the return of pain several times a day, as often occurs with "as needed" or non-scheduled dosing.

How can I tell my healthcare provider about my pain?

It's best to describe your pain as clearly and in as much detail as possible. Keep a daily journal or diary of your level of pain and how the pain affects you. This will help your healthcare provider and you determine how your medicines are working. When your pain occurs, record the following information:

- Location of pain
- Intensity of the pain (most people use the 0 to 10 scale to rate their pain; see below)



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- What were you doing when the pain occurred
- What you used to treat the pain (medicines, supplements, and other treatments)
- How effective the treatment was

Bring your diary with you to your next appointment with your healthcare provider.

My friends and family want to help me. What can they do?

Friends and family can do many things to make your life easier. They can run errands or help around the house. They can help you complete your journal and keep written records of your pain level and the medicines you take each day. They can also go with you to see your healthcare provider so you do not miss important information.

SECTION 2

What you should know about taking long-acting opioids

How should I take my long-acting opioid?

Long-acting opioids are usually taken at regularly scheduled times, such as every 12 hours. Always take your long-acting opioid exactly as directed by your healthcare provider and as written on the prescription label. Never take larger or more frequent doses before talking with your healthcare provider.

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If you take an opioid regularly for longer than a week, don't suddenly stop, or decrease the dose by a large amount, because "withdrawal" symptoms such as abdominal cramping or sweating can occur. When you no longer need this medicine, your healthcare provider will slowly decrease your dose safely.

What should I do if I develop pain between doses of my long-acting opioid?

Some people taking long-acting opioids to treat chronic pain experience flare-ups of otherwise stable pain between doses of pain medicine. This is referred to as "breakthrough pain." Breakthrough pain can occur many times during the day and usually strikes quickly.

Your long-acting opioid should NOT be used to treat breakthrough pain. The ideal medicine for breakthrough pain is a pain medicine that begins to work quickly and lasts a short period of time. These are called short-acting drugs or rescue medicines. Do not wait until pain becomes severe to take your rescue medicine. Breakthrough pain is easier to control when it is just starting. Remember to follow your healthcare provider's instructions closely.

What should I do if I miss a dose?

If you miss a dose, take that dose as soon as you remember. However, if you remember that you missed a dose at about the time for the next dose, only take the next dose – **DO NOT take two doses**. Then, take future doses at the time prescribed by your healthcare provider.

What happens if I take too much medicine?

Seek **emergency medical attention** if you think you have used too much (overdose) of your opioid medicine.

What are the common symptoms seen following an overdose?

Seek emergency room care if you have any of the following side effects:

- Slow breathing
- Shallow breathing (little chest movement with breathing)
- Sleepiness
- Slow heart beat
- Extremely small pupils
- Low blood pressure
- Confusion
- Dizziness
- Feeling faint
- Other unusual symptoms

Can I drink wine or other alcoholic beverages while taking long-acting opioids?

All opioids have warning labels not to drink alcohol while taking the opioid. This is because of the potential for serious and even fatal reactions.

SECTION 3

Common side effects

What side effects will I have during treatment with a long-acting opioid?

The most common side effects are constipation, nausea and/or vomiting, sleepiness, and slowed breathing.

Constipation

Constipation from opioids is common. Your healthcare provider may prescribe a laxative or combination laxative-stool softener to treat constipation before it begins. You can help ease constipation by drinking plenty of water each day and adding more fiber too.

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Nausea and/or vomiting

Nausea and/or vomiting are common as you begin treatment, or just after your dose is increased. Your healthcare provider can also provide medication to relieve the nausea and vomiting. Once your body adjusts to the opioid, that uneasy, uncomfortable feeling that you need to vomit may disappear.

Sleepiness

Some degree of sleepiness is normal when you start taking an opiod analgesic or when the dose is increased, but after a few days the drowsiness usually goes away. You may notice sleepiness because the pain you had been feeling has left you tired. However, keep in mind that taking opioids may affect your ability to perform some tasks like driving or operating heavy machinery.

Be careful if you are drowsy, and steady yourself when you walk.

Slowed breathing

Seek **emergency medical attention** immediately. Slowed breathing is very rare when oral opioids are used appropriately for pain relief. However, taking too much of an opioid pain medicine or taking doses when you are not experiencing any pain may cause slowed breathing – also known as "respiratory depression." If you have a history of

troubled breathing, be sure to tell your healthcare provider and be especially careful to follow the instructions on the prescription. If you become so sleepy that you cannot make yourself stay awake, you may be in danger of slowed breathing.

Can opioids cause seizures?

Seizures have been reported in patients taking opioids. Your healthcare provider should be told if you have had a seizure in the past and if you are taking other opioids or medicines that are commonly used to treat depression (eg, amitriptyline, fluoxetine).

Will I be able to drive?

It is possible to drive if you have normal mental acuity (clear thinking and alertness) and take stable doses of long-acting opioids. You should ask your healthcare provider if the medication you have been prescribed might impair your driving ability. Additionally, state laws regarding driving while taking a medication that may impair your ability to drive vary greatly.

I take several other medicines to treat other conditions. Is there a risk of an interaction between my pain medicine and these other drugs?

It's always possible that two medicines will interact. Therefore, it is important to make your healthcare provider aware of all other medicines you are taking to treat your pain or other medical problems. These include medicines prescribed by other healthcare providers, non-prescription medicines, and herbal supplements. Your healthcare provider can select medication combinations that will give the greatest benefit while minimizing the risk of a drug interaction or toxicity.

SECTION 4

Questions to ask your healthcare provider

By prescribing opioids, your healthcare provider is trying to help you control your pain and maintain a productive life. Here are some questions you might want to discuss with your healthcare provider:

- What is the name of this medicine?
- How often do I take this medicine?
- At what time do I take this medicine?

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- What do I do if I miss a dose?
- Should I take this medicine before meals, after meals, with meals or on an empty stomach?
- Should I avoid certain foods or drinks with this medicine?
- What are the side effects?
- What should I do if I experience a side effect?
- How should I store it?
- Will I be able to drive?
- How will this medicine affect my work?
- Will this medicine work safely with other medicines I am taking?
- Can I do anything along with taking my medicine to help my symptoms?

Only you and your doctor can determine the treatment regimen, including dosing, that is right for you.

Notes

Notes

Notes

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SAMPLE FOR ADAPTATION AND REPRODUCTION ON PHYSICIAN LETTERHEAD

PLEASE CONSULT WITH YOUR ATTORNEY

Long-term Controlled Substances Therapy for Chronic Pain

SAMPLE AGREEMENT

*A consent form from the **American Academy of Pain Medicine***

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you.

The long-term use of such substances as opioids (narcotic analgesics), benzodiazepine tranquilizers, and barbiturate sedatives is controversial because of uncertainty regarding the extent to which they provide long-term benefit. There is also the risk of an addictive disorder developing or of relapse occurring in a person with a prior addiction. The extent of this risk is not certain.

Because these drugs have potential for abuse or diversion, strict accountability is necessary when use is prolonged. For this reason the following policies are agreed to by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider the initial and/or continued prescription of controlled substances to treat your chronic pain.

1. All controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. (Multiple sources can lead to untoward drug interactions or poor coordination of treatment.)

2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is:

   _____ phone: _____.

3. You are expected to inform our office of any new medications or medical conditions, and of any adverse effects you experience from any of the medications that you take.

4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide your health care for purposes of maintaining accountability.

5. You may not share, sell, or otherwise permit others to have access to these medications.

6. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.

7. Unannounced urine or serum toxicology screens may be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder.

8. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.

9. Original containers of medications should be brought in to each office visit.

10. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, you must keep them out of reach of such people.

11. Medications may not be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made.

12. Early refills will generally not be given.

13. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.

14. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substances administration.

15. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment.

16. Renewals are contingent on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.

17. It should be understood that any medical treatment is initially a trial, and that continued prescription is contingent on evidence of benefit.

18. The risks and potential benefits of these therapies are explained elsewhere [and you acknowledge that you have received such explanation].

19. You affirm that you have full right and power to sign and be bound by this agreement, and that you have read, understand, and accept all of its terms.

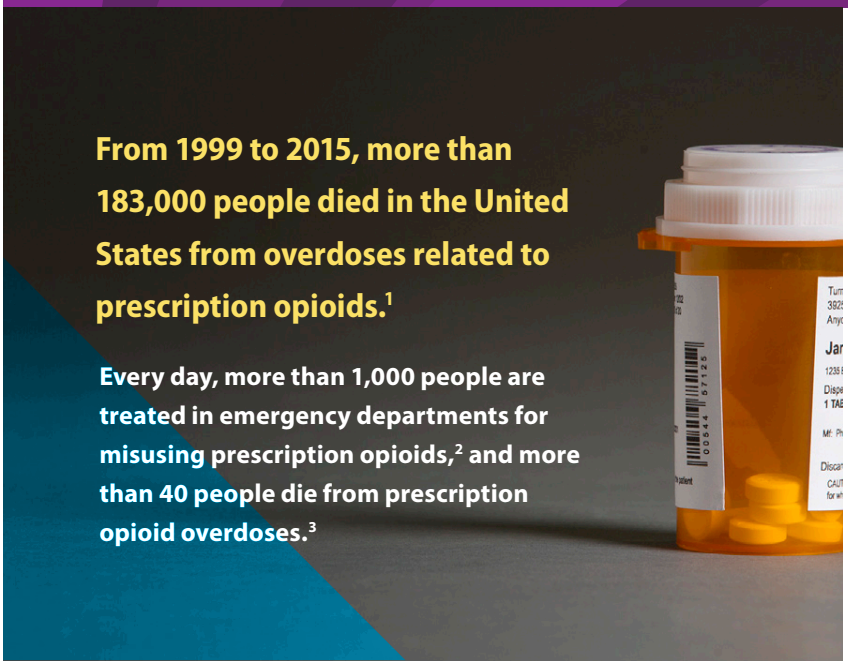
Physician Signature	Patient Signature
Date	Patient Name (Printed)

Approved by the AAPM Executive Committee on April 2, 2001.

AAPM
4700 W. Lake Avenue
Glenview, IL 60025-1485
847/375-4731 Fax 877/734-8750
E-mail aapm@amctec.com
Web site http://www.painmed.org/

https://web.archive.org/web/20180627135810/https://www.cdc.gov/rxawareness/pdf/RxAwareness-Campaign-Overview-a.pdf

CDC Rx AWARENESS CAMPAIGN OVERVIEW



From 1999 to 2015, more than 183,000 people died in the United States from overdoses related to prescription opioids.[1]

Every day, more than 1,000 people are treated in emergency departments for misusing prescription opioids,[2] and more than 40 people die from prescription opioid overdoses.[3]

THE NEED

The Centers for Disease Control and Prevention's (CDC) National Center for Injury Prevention and Control, along with other federal agencies, recognizes this critical threat to public health and has made it a priority to raise awareness about the risks of prescription opioid misuse. Critical to achieving this goal is the development of an evidence-based, consumer-directed communications campaign that resonates with those at risk for prescription opioid misuse and overdose.

THE APPROACH

CDC's Rx Awareness campaign focuses on adults ages 25–54 who have taken opioids at least once for medical or nonmedical use. The goals of CDC's Rx Awareness campaign are to:

- Increase awareness that prescription opioids can be addictive and dangerous, and
- Increase the number of individuals who avoid using opioids nonmedically (recreationally) or who choose options other than opioids for safe and effective pain management.

Based on past success with using testimonials to effectively communicate about complex and sensitive health behaviors, CDC incorporated first-person stories into its public campaign to educate and raise awareness about the dangers of prescription opioid use and abuse. CDC developed a series of videos and television ads as the cornerstone of the campaign, featuring individuals living in recovery or recovering from opioid use disorder, as well as family members who have lost someone to prescription opioid overdose. The testimonials provide compelling real-life accounts to help make others aware of the risks and dangers of prescription opioids.

Rx AWARENESS CAMPAIGN MATERIALS

DIGITAL

- 30-second testimonial videos
- Web banner ads
- Online search ads
- 5-second bumper digital video ads

CAMPAIGN WEBSITE

- cdc.gov/RxAwareness

RADIO

- 30-second ads

OUT-OF-HOME

- Billboards
- Newspaper ads

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

Findings from CDC's formative research guided the development of the campaign tagline, "It only takes a little to lose a lot," and the reality statement, "Prescription opioids can be addictive and dangerous." For the campaign, the tagline and reality statement are paired with compelling visuals that were also developed with guidance from the research.

In addition to these testimonials, the campaign includes radio ads, web banners, social media ads, newspaper ads, and billboards. CDC conducted two rounds of formative research to learn which concepts, messages, and materials resonate with target audiences and motivate them to talk with family, friends, and health care providers about the risks of prescription opioid use, abuse, and overdose. Research participants included male and female adults from ages 25 to 35 and 45 to 54, which is the target audience for the current campaign.

PILOT TESTING

CDC conducted a pilot that implemented all components of the Rx Awareness campaign for 14 weeks in 9 high-burden counties in 4 states: Ohio, Oregon, Rhode Island, and West Virginia. CDC based this placement on criteria such as reach, participants' readiness to implement a campaign, and level of interest. The pilot presented an important message to these areas—which are highly affected by prescription opioid overdose—while also allowing CDC to test creative campaign materials in the field and obtain valuable input on the ads before the campaign is launched. An assessment of the pilot campaign explored target audiences' exposure to and perceptions of a series of campaign messages and materials.

CAMPAIGN LAUNCH

CDC created the Rx Awareness campaign for states, coalitions, and communities to implement across the country. These groups can use all the Rx Awareness campaign materials and tag them for local use. The launch also includes a campaign implementation guide to support states in using the campaign materials. These materials are available to CDC-funded states and will also be publicly available in the future through an online resource center.

This CDC public health effort includes many other materials, such as a new campaign website (cdc.gov/RxAwareness), patient-centered resources, and provider clinical tools (cdc.gov/drugoverdose/training).

---

[1] Centers for Disease Control and Prevention. Wide-ranging Online Data for Epidemiologic Research (WONDER). Atlanta, GA: National Center for Health Statistics; 2016. http://wonder.cdc.gov. Accessed December 2016.

[2] Substance Abuse and Mental Health Services Administration. *Highlights of the 2011 Drug Abuse Warning Network (DAWN) findings on drug-related emergency department visits*. The DAWN Report. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration; 2013. http://www.samhsa.gov/data/2k13/DAWN127/sr127-DAWN-highlights.htm. Accessed December 2016.

[3] U.S. Department of Health and Human Services, Office of the Surgeon General. *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: U.S. Department of Health and Human Services; November 2016.

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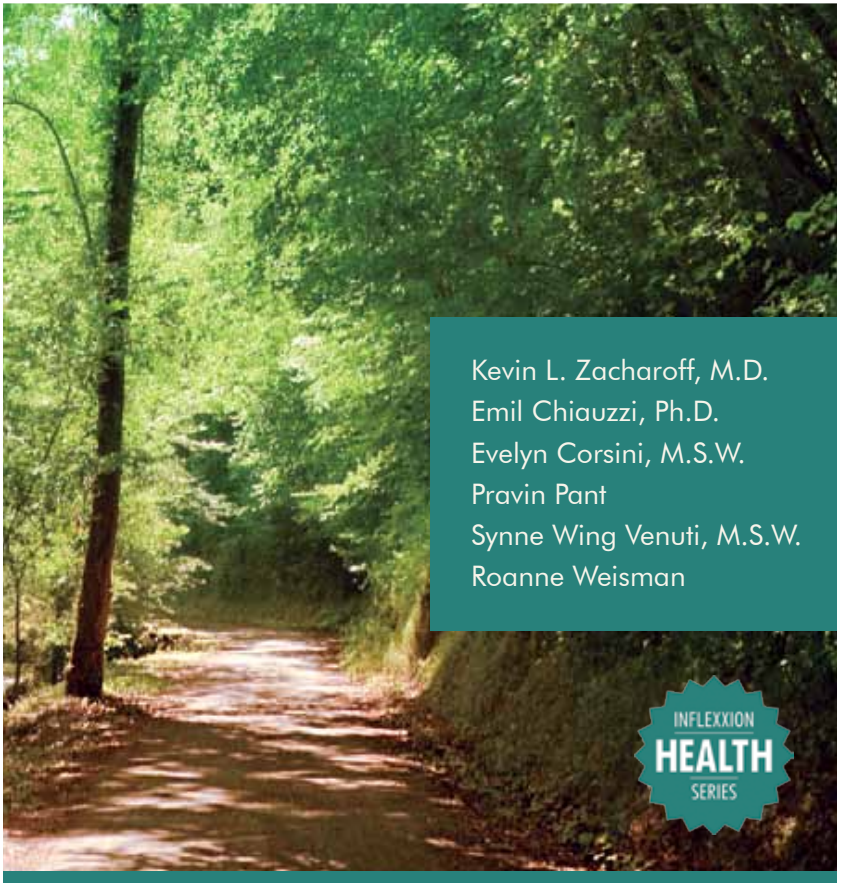
Your Guide to Pain Management

A Road Map for painACTION



Kevin L. Zacharoff, M.D.
Emil Chiauzzi, Ph.D.
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INFLEXXION HEALTH SERIES

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Preface

When you are in pain, nothing else seems to matter. All of your attention is focused with a laser-like intensity on the sensations within your body. Whether your pain comes from an aching back, throbbing in your head or the total body discomfort of cancer and its treatment, you feel as if your world has been circumscribed: You may not be able to go to work or participate in the relationships and activities you enjoy. You may find yourself feeling depressed or hopeless because you see no end to your suffering.

Help is at hand. This *Guide to Pain Management*, along with the *painACTION* website, on which it is based, will give you the information and unique tools you need to understand your pain, choose the best treatments, adopt effective lifestyle changes, and find a supportive, informed community to help you.

Your Road Map to Pain Management

At times, you might feel as if you are the helpless victim of your pain. We at *painACTION* want to help you change that perspective. With the information and tools available to you in this *Guide* and on the website, you can try to take control of your pain. Think of yourself as an explorer in search of the best ways to manage your pain and live a full, satisfying life. This journey may lead you to new places that are unfamiliar to you, but you can use this book as your "road map" and travel guide. It will direct you to the resources and information you need on your journey, while helping you avoid pitfalls and wrong turns.

In particular, this *Guide* will give you detailed information about building a productive partnership with your healthcare provider, as well as developing effective skills for self-management, communication and coping. You will also learn about the safe use of prescription pain medications. While there are many kinds of pain that people experience, our focus here is specifically on back pain, migraine pain,

and cancer-related pain. However, you will find that much of the information is useful even if you are dealing with other kinds of pain. Are you ready to set off on your journey to effective pain management? If so, read on to learn more about the *painACTION* website and this companion *Guide to Pain Management*.

painACTION: Helping You Take Control

The *painACTION* website is a useful online resource that helps people with chronic pain take control of their pain and live fulfilling, satisfying lives. Together with this companion *Guide to Pain Management*, *painACTION* will provide you with the tools and resources you need to manage back pain, migraine pain and cancer-related pain:

- The latest scientifically proven pain treatment strategies including complementary/alternative methods
- Expert advice tailored to your personal needs
- Informative articles, comprehensive lessons, and interactive self-assessment and self-help tools to use in your journey toward effective pain management
- Inspiring stories of people who are successfully managing their chronic pain
- A supportive community of fellow "travelers" and renowned pain experts to call upon whenever you need them

Turn the page to learn more about pain and the effective techniques that will help you take control of your pain!

Introduction

Not all pain is bad, and sometimes it serves an important purpose. Sudden pain can warn you that a stove is too hot or be an early warning sign of a potentially serious illness or a tumor. Chronic pain[1], however, usually serves no useful purpose. The International Association for the Study of Pain defines pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. *It is always subjective in nature*." What does this mean, "Always subjective in nature?" It means that *your pain is real*, and you have the right to treatment, even if your healthcare provider can't find a physical cause for your discomfort, or even test for it. Recently, in fact, pain has been categorized as "the fifth vital sign," meaning that during *every* medical encounter, health care professionals should ask if you are in pain, in addition to checking your pulse, temperature, blood pressure, and respiratory rate.

Chronic pain—pain that persists for three months or longer, even after the original cause has healed—can itself become a major focus of disability or dysfunction. Chronic pain can evoke an overlay of fear, depression and hopelessness (because we can see no end in sight), despair and isolation. These emotions may be coupled with the feeling of being out of control and the victim of your body. Because of this complex interplay of emotions, the effective treatment of chronic pain requires a broad, multi-dimensional approach—focusing not only on the physical cause, but also on your feelings, beliefs and life-coping skills. This approach is precisely what the *painACTION* website and *Guide* offer you. Before we begin, however, let's take a closer look at chronic pain.

1. Acute pain, which generally has a specific cause such as injury, disease or surgery and lasts for less than a month, is not the focus of this book or the *painACTION* website.

All About Chronic Pain

You are probably reading this book because you are experiencing some form of chronic pain. If so, you are not alone. Pain affects more Americans than diabetes, heart disease and cancer combined, according to the American Pain Foundation. In 2006, more than one quarter of Americans over 20—an estimated 76.5 million people— reported that they have had a problem with pain of any sort, though this number does not account for acute pain. About one-third of people who report having chronic pain indicate that their pain is "disabling," defined as both severe and having a high impact on functions of daily life.

If you are experiencing back pain or migraine pain, you also have plenty of company. These are the two most common forms of pain. In addition, among people undergoing active treatments for cancer, an estimated 30 to 50 percent experience significant levels of pain. This rises to 70 percent for those with advanced stages of the disease, according to the National Cancer Institute. This is why *painACTION* focuses on these three main causes of pain. The annual cost of all kinds of pain in the United States, including healthcare expenses, lost income, and lost productivity, is estimated to be $100 billion. Of course, this does not include the additional tolls that pain may be taking on your family life, your social relationships, your self-esteem, and your happiness. In fact, the psychological component of chronic pain is so important that it is featured in a *painACTION* article titled *"Pain and the brain"*.

You will find many articles that are equally informative on *painACTION*, so be sure to take time to explore the website as you read this book.

Pain and the Brain

"Pain is complicated. It is a result of much more than the initial disease or injury that sets it off," writes psychologist Robert N. Jamison, Ph.D. In the past, explains Jamison in his article on *painACTION*

entitled *Pain and the brain,* people believed that pain signals traveled only one way—from a nerve injury up to the brain. Scientists have now learned that the brain has the ability to act like a "gate," controlling the messages that are received and sent out from it. They call this the "Gate Control Theory" of pain. An important part of this theory is that in addition to *receiving* pain signals from the body, the brain can also *send* messages that block painful sensations to different parts of the body.

The power of the brain to block painful sensations is one of the reasons why pain is such a deeply personal experience, so the more you understand about your pain and its particular "triggers," the more you can play a role in blocking them. And the more active a role you can take in managing your pain, the better your chance of success. Research, for example, tells us that people who feel a sense of control—of ownership—of their health actually do better clinically than those who feel that they are helpless victims of their illness.

One way to take control of your pain, is to use physical, mental and emotional factors to "close the gate," on pain, thus reducing pain sensations. The same article gives several examples of these pain "gatekeepers," and the rest of this *Guide*, as well as the website, tells you how to use them:

Physical gatekeepers include:

- Medications
- Surgery
- Stimulation by heat, massage or acupuncture
- Techniques to reduce muscle tension

Emotional gatekeepers include:

- Your optimistic feeling that things will get better
- Social support from family, friends, co-workers and healthcare providers

- A healthy mental attitude
- A lowered level of anxiety
- Management of depression

Mental gatekeepers include:

- Distraction (taking your mind off the pain)
- Humor
- Actively taking charge, rather than passively waiting to see what happens
- Having feelings of control over the pain

An important part of the *painACTION* program is to help you break the vicious cycle of chronic pain: The pain makes you feel anxious or depressed, which then contributes to more pain, which then causes more anxiety and depression...

Dr. Jamison's article shows how you can break the cycle and take control of your pain by using the *painACTION* program to gain a better understanding and control of how you perceive pain. You will also identify how your personality, family history and level of emotional distress contribute to your pain. Pain experts have discovered that people who are not too anxious, worried, or depressed, have strong social support, and a generally optimistic outlook, are better able to be distracted, keep a more objective, realistic outlook, and find good ways to actively cope with their pain.

Part I

The Pain Management Journey: Starting Off

No matter what your chronic pain experience—back pain, migraine, cancer-related pain, or some other form of pain—the chapters in this section will help with several aspects of your journey to pain management. The skills and ideas in this section apply to all forms of chronic pain. Topics include working with your healthcare team, finding reliable information, taking responsibility for your pain, dealing with your emotions and understanding your prescription medications.

Part II of this book gets more specific, with chapters focused specifically on back pain, migraine pain and cancer-related pain. Before you delve into the chapters most relevant to you, however, it is a good idea to read the introduction to that section. It will help you understand what these kinds of pain have in common and how they are different, and will give you a better understanding of your own personal journey to pain management.

Chapter 1

Productive Partnerships: Working With Your Healthcare Providers

When it comes to pain, you don't have to go it alone. It may not take a village, but it certainly does take a team to manage pain—and *you* are a very important member of this team! This chapter is about working as a partner with your doctors, nurses and other healthcare providers to control and manage your pain. On your journey to controlling your pain, these people will be your "tour guides," but in order to guide you properly, they need to know where you want to go: What is pain stopping you from doing? Perhaps you want to be able to:

- ☑ Have more fun with your children
- ☑ Sleep more comfortably
- ☑ Play golf or tennis with your friends
- ☑ Travel
- ☑ Spend more time at work
- ☑ Walk with less pain
- ☑ Perform daily tasks easily

Whatever your goals are, it is important that you talk with your healthcare providers about them, along with the best ways to achieve them. Some of your goals may not be realistic, at least for now: If you have severe pain, you may not be able to train for a five-mile run! However, you may be able to use a guided weight-training program and exercises to build up to a couple of miles of brisk walking. After that, who knows what your limits will be?

To begin, make two lists on a sheet of paper about who is on your health care team: In one column, write down the names of your healthcare providers. This might include:

- Your primary care doctor
- Nurse or nurse practitioner

- Physician assistant
- Pain specialist
- Bodywork or massage therapist
- Physical therapist
- Alternative practitioners such as an acupuncturist
- Psychologist or social worker

The second column should include your own name, as well as any family members or friends who are, or could be, helping you. These two columns form the two sides of your "partnership team." This chapter will describe the roles and responsibilities on each side of this team to help you create kinds of health care partnerships that will help you manage and control your pain.

Ideally, each side of the team should have *equal responsibility*, split 50-50 between you and your family or friends on one side, and all of your healthcare providers on the other.

You should have a say in every decision that is made about your pain and how it is managed:

- Medications
- Exercise plan
- Special procedures
- Other treatments
- Surgery

If there is more than one provider on your team, it would be good to pick *the one best person*—most likely your primary care doctor or nurse practitioner—to oversee the "big picture." This person should coordinate all prescription medications, medical advice, exercise programs, and your diet (including herbal supplements and over-the-counter medicines). In order for this to happen safely, you should share all information about what you are doing and taking with this

"big picture" provider. This person should be the one who knows you best, understands your needs and concerns as well as the details of your home and work life. A *Medical Home* is a new way to refer to this"big picture" provider and his or her office, which simply means that this is the person (or clinic) you go to for trusted medical advice. Your medical home is a source you can rely on to help you sort through all the information you may be hearing on TV or reading in the news or on the Internet. (For details about finding medical information you can trust, please also see Chapter 3 about knowledge-based skills.)

What to Expect From Your Medical Home

The provider you choose to coordinate your care has several responsibilities. Here are some ideas of what you can expect. You should feel free to discuss with this provider how you would like to work together to:

- Figure out what is causing your pain

  When you have unexplained chronic pain, it is a good idea to make your *first visit* to the person you have chosen as your medical home provider, such as your primary care doctor or nurse. By listening and talking with you, this provider will have the best chance of determining the source of your pain and helping you choose the best combination of ways you can help yourself, along with medicine or treatments. (For more about taking control of your pain, please see Chapter 2.) Whenever you talk to your medical home provider, it is very important that you *freely ask every question that occurs to you,* as well as *share details about your life, your diet—including supplements and over-the-counter medicines—and your regular activities*. This is the kind of information that will help your provider make an accurate diagnosis of your pain.

- Help you decide on realistic treatment goals

  As mentioned earlier, it may be difficult to eliminate your pain completely. However, it is the responsibility of your provider, always in consultation with you, to recommend the best ways to

at least reduce the pain and improve your ability to live a satisfying life. In order to do this, your provider needs to know what your goals are and the ways in which the pain is preventing you from reaching those goals. This "destination" of your pain management journey will change over time, so it is important for you and your provider to keep talking and listening to each other. There are several articles and lessons on the *painACTION* website that help you communicate with your provider. One example is the lesson *"How to work effectively with your doctor"*.

One way to think about your partnership with your provider is as if you were working together to fight a forest fire. Even if you can't completely put out the fire, you can stop it from burning out of control or at least you can slow it down, so that it only flares up once in a while. In working with your provider to control your pain, you will always be balancing two goals:

1. What you would *like* to do: for work, family life, recreation, etc.
2. What you *need* to do for your pain: including medication, exercise, diet, and cutting down on some activities

The trick is to find the *best balance for you at any given time*.

Personal Perspective: Your Half of the Partnership

You, as the patient, have as much responsibility as your healthcare provider team for managing your pain. Even if you share this responsibility with a family member, friend, spouse or other non-medical person, you should have the "big picture" view, just like your medical home provider. No one else is in your body, so no one else knows exactly how you are feeling. This is especially important in the treatment of pain, *since pain is the only medical condition in which the patient has the final say in how successful the treatment is*. Here are some ways you can take charge of your pain treatment:

Coordinate your team

You may decide, in the course of your treatment, that you wish to add another provider to your "team," such as a chiropractor, a massage therapist, an acupuncturist, psychologist or other mental health professional. This is fine, as long as you keep your "Medical Home" provider informed of what you are doing and whom you are seeing, and make those decisions together.

Keep it going

No matter whom you bring onto your team, however, the key to successful pain management is a *long-term relationship with your medical home provider*. Ideally, this person has known you for some time and understands your life goals, treatment preferences, stresses, relationships and history. You trust and respect each other and feel comfortable challenging and raising questions in an open discussion of treatment options.

An Expert Opinion

Some examples of productive partnerships

Here are examples of some questions you might ask your health care provider as part of a "productive partnership" discussion about your pain:

Q Why can't my healthcare providers relieve my pain completely when there are so many "miracles" that medicine can provide, like organ transplants?

A This is an excellent question, and a source of distress for many patients, who see live photographs of Mars on their TV set, yet can hardly walk because of their aching backs. The simple truth is contained in your question: the fact is that despite all available medical technologies we are often able to control chronic pain, but are almost never able to completely get rid of a chronic pain problem, unless the reason behind it is easily

correctable. In fact, the patients who succeed most in benefiting from pain management techniques are the ones who accept that they will not be able to get rid of their pain problem, and seek help to reduce their level of pain and improve their level of functioning. Why have we not done better? This is a matter for speculation, and people will have different opinions. One important reason is that very little funding has gone to improving the understanding and treatment of chronic pain: for example, only a tiny fraction of federal funding for medical research goes to pain research.

Q I've been told to exercise, but every time I do, my pain increases. Doesn't my healthcare provider understand I can't exercise?

A It would be very helpful for you to communicate with your healthcare provider about your difficulty with exercising, if you haven't done so already. Pain experts tend to encourage their patients to exercise because exercise can help patients with chronic pain in many ways: exercise can increase your ability to function in your day to day life, help reduce pain, improve mood, improve sleep, etc. Of course, if you can't exercise because it increases your pain, you will not be able to reap these benefits. The good news is that there are a variety of things you can do to get around this problem. The first thing is to "take small bites", beginning with exercises that you *can* do before moving onto the more difficult ones. Next, use ice or heat before, during, or after the exercise; take a pain medication an hour before you plan to exercise. A good physical therapist, and an attentive healthcare provider, should be able to guide you through this problem.

In Summary...

- Identify your "destination" - with regard to what you want to achieve when managing your pain
- Construct a list of your healthcare providers, and their role in managing your pain
- Find a "Medical Home" that can coordinate all of your care and understand all of the pieces of the puzzle
- Understand your responsibility in managing your pain
- Become a partner in your pain management, not a "passenger"

Chapter 2
Take Control of Your Pain

When you are in pain, do you sometimes feel like a helpless victim, just waiting for it to go away? Many people have this experience. It is easy to become overwhelmed and hopeless when it seems like pain has taken over your body.

This chapter is about a new way to deal with your pain, by *taking control* and directing your own journey to pain management. While you may not be able to eliminate your pain entirely, you can, with the *self-management skills* you will learn in this chapter, manage it and feel less helpless.

What Are Self-Management Skills and How Will They Help Me?

Self-management skills can be learned. They are not based on who you are, but on what you are able to do for yourself. The *painACTION* lesson on self-management skills, *"How to take control: self management and pain",* explains it this way: "Self-management means taking care of yourself and your needs, in a healthy way. A person with self-management skills understands how to keep track of her symptoms and treatments. She also knows that her thoughts and actions can change how her illness behaves on any given day."

Self-management does *not* mean taking over from your healthcare providers. It means working as an equal partner with them to manage your pain. After all, you only see your healthcare provider for about fifteen minutes or half an hour at a time. What about the hours, days and weeks between your appointments? During these times, you need to be able to take care of yourself, just as a "savvy traveler" may head off to a destination without a tour guide for parts of the trip. Yes, you need to take the prescribed medication and follow the advice you are given, but there is much more you can do as well. Here are some examples:

Notice How You Are Thinking About Your Pain

What you believe really does make a difference in how you feel. For example, do you believe the following facts about pain? (Hint: they are all true.)

- Successful pain management usually takes several different approaches, rather than one "magic bullet."
- Studies show that *passive* methods–using only rest, hot/cold packs and medications to treat pain –are less effective and are linked to more chronic pain and disability than *active* treatments (exercise, for example).
- Confident people usually have better results with pain management.
- Getting more control over your stress and feelings like depression and anxiety can help to manage your pain.

If you would like help with changing the way you think about your pain, talk to your healthcare provider or ask for a consultation with a social worker or psychologist.

Keep Track Of Your Pain

In order to help you, your providers must learn how, when, and where you're hurting, and *you* are the only one who can tell them. The ***Daily Tracker***, which can be found on the *painACTION* ***My Page***, will help you to gather the information you need to bring to your medical appointments. This includes:

- The intensity of the pain
- How well your medications work
- Your ability to manage the pain
- How the pain interferes with your daily routines, sleep, mood and relationships.

The *Daily Tracker* will also teach you accurate ways to describe your pain, because some days it may be worse than others. You can think of this as your "travel journal."

Take an Active Role

There are many ways to be active in your pain management program. Here are just three of them:

- Become physically active by exercising

  Exercise is truly the most active part of self-management, although it works best when it's started gradually and paced properly. Exercise builds strength and flexibility and gives a natural "antidepressant" effect–which is important, as many people with chronic pain become depressed. Need more motivation? If you *don't* exercise, this can lead to stiffer joints, weak muscles, less "staying power" and lower pain tolerance.

- Become an active learner

  Find out everything you can from your providers and the sources they recommend about your diagnosis and your medications (including side effects and the dangers of missed doses).

- Become a problem solver

  Problems are inevitable. These might include pain flare-ups, medication that no longer works, or difficult life events. How are you going to deal with them? First, take a deep breath, then consider the following steps:

  - Clearly identify the problem. This may take some time, as the actual problem may not be immediately obvious.
  - Decide on your goals. What do you want to accomplish in this situation?
  - Figure out your options. What are the possible solutions?
  - Pick the most likely solution.
  - Take action.

Be Your Own Advocate

Advocates are those who fight for the rights of others. You, as the person who knows your pain best, are your own best advocate. So don't be shy! Ask questions. State your preferences, and let your voice be heard. If, for example, you prefer not to take pain medications, ask if there are alternatives. Sometimes exercise programs, such as "back pain boot camp," or changes in your diet to control migraines, can help avoid or limit the need for pain medications. Other options, described on *painACTION*, include biofeedback, and alternative treatments such as massage and acupuncture.

Another important advocacy role is preparing to participate fully in your visit to your healthcare provider. An article from *painACTION*, *"Medical appointments: making the most of your visit"* lists ways you can do this. Items on this list are: transferring your records, collecting and bringing important information, making a list of questions, bringing someone with you to take notes and remember what was said, scheduling enough time, repeating back what you hear in summary at the end of the visit, and requesting a copy of any important materials. The article also discusses ways to make important medical decisions, how to keep a pain diary, and how to make your follow-up plans.

Even as you advocate for yourself, there is always a community of others to support you. This can be your personal relationships, including family, friends, or clergy, or it can be pain organizations and support groups, such as those listed on *painACTION*. If you join the website, you will also find a ready-made community of professionals and other patients, always available for questions, guidance and support.

Taking Control of Pain

Here are examples of questions from patients who are taking control of their pain. These questions show patients following some of the advice in this chapter by acting as advocates for themselves, becoming active learners, and making their preferences known.

An Expert Opinion

Some examples of taking control of pain

Q My pain keeps me from sleeping. What can I do to help me get at least one good night of sleep?

A Difficulty sleeping is one of the main problems experienced by patients with chronic pain. Sleeplessness in turn seems to make pain worse, causes anxiety, irritability, depression, and daytime fatigue, and makes it much more difficult to cope with the pain problem. Therefore, getting a decent night's sleep every night is a critical goal for patients with chronic pain. There are many ways to approach this problem, and your physician should be able to provide you advice on this.

The basic approaches, called "sleep hygiene," are those followed by any patient with insomnia. Such approaches include avoiding napping during the day, avoiding caffeine, exercising during the day (but not close to bedtime), avoiding stimulating activities (such as TV) in bed, and reserving the bed for sleeping. A nighttime snack or glass of milk or tea may also help.

For patients with chronic pain, other techniques may be needed. First, it is worthwhile remembering that many medications, and some medical problems, may cause insomnia as a side effect. When it is the pain itself keeping you awake, changing your sleep surface (e.g. a different mattress) may help. Finally, a number of medications may help with this problem. Taking an extra dose of a pain medication at bedtime may help keep your pain from waking you up in the middle of the night, although it's worth remembering that short-acting medications may wear off in the middle of the night, and some may even cause a "rebound effect," leaving you with more insomnia when they wear off. For that reason, long-acting pain medications are better for maintaining sleep than short-acting

ones. Finally, there are a number of "sleeping pills" that can be used to help with this problem. It is important to remember that none of these strategies are intended for you to try on your own. These are issues you need to discuss with your healthcare provider and decide to try *together*.

Q Ever since my pain began I have been steadily gaining weight. What can I do to lose weight? Is there a special diet?

A First remember that there are many reasons a person with chronic pain may gain weight, and it is important to figure out the correct reason. Weight gain can be caused by a variety of medical problems, such as hypothyroidism or edema (swelling), so you need a thorough medical evaluation, including blood tests, if you are starting to have unexplained weight gain. Second, some medications can cause weight gain as a side effect. People who develop mood disturbances, such as anxiety or depression, can have changes in their weight. Finally, the most common reason for weight gain in a patient with chronic pain is that they are eating more, exercising less, or both. This can be caused by a change in daily routine, such as not working any more, or not sleeping as well, which creates more opportunities to eat. There are many ways to deal with this that your healthcare provider can direct you to. Finding a good nutritionist to help on the eating side, and a physical therapist to help on the exercise side, may be useful.

Q Physical therapy only makes my pain worse, but every doctor prescribes physical therapy. Why do they keep prescribing treatments that don't work?

A You may have a legitimate complaint, in that healthcare providers who are not as aware of all the options for pain management may continue to prescribe in vain the only treatments

they know about, including physical therapy. But there may be another explanation: providers know that exercise is critical for the recovery of most patients with chronic pain. A good physical therapist will try to help you gradually increase the amount and type of exercise you do, and will give you specific advice on tricks you can use in order to tolerate your increasing exercise (such as ice, heat, massage, exercising in water, and pacing yourself). Many patients fear exercise because they are concerned about harming themselves; it is critical to get a clear statement from your healthcare provider that even though you may feel increased pain while exercising, it does not mean you will harm yourself. Finally, your provider may be able to work with your physical therapist to find medical strategies (such as taking your pain medication an hour before exercise) that allow you to tolerate your increasing level of exercise.

In Summary...

- Notice how you are thinking about your pain
- Keep track of your pain
- Take an active role in managing your pain
- Be your own advocate
- Take control of the situation; don't let it control you

Chapter 3
Knowledge is Power

When it comes to pain, just like when it comes to travel, what you don't know can hurt you. It is important to know where the pitfalls are and what to trust. This chapter tells you why. It also tells you how to find out what you need to know as you begin your pain management journey, and how to figure out which information you can safely rely on. When you are in pain, it is important to learn about your condition and the various possible treatments. Why? So that you will be able to work in partnership with your healthcare provider to make the best choices. As you embark on your "search and discover" fact-finding mission, there are two main ways to find out what you need to know:

- From your healthcare provider
- On your own.

This chapter tells you how to make the best of both sources.

Your Medical Home: The First Stop On Your Journey

In Chapter 1, you learned about the idea of a medical home. This is the provider or clinic overseeing your care, where you can feel as if you are "at home." It is also your best source for trustworthy advice and information. Often, the person you have contact with in your medical home is your primary care doctor, but it can also be a nurse or other healthcare provider. The key is that the medical home has all of the information about you, your pain condition, your other health conditions, your activities, your life situation, your family, any treatments you are having—including "alternative" therapies, and all medications you are taking, including herbal remedies and all over-the-counter medicine or supplements.

Your medical home is an excellent first stop on your fact-finding journey, since this provider knows enough about you to be able to direct you to information that is relevant to your pain, your preferences and

your treatment. *It is important to realize, however, that this is not a one-way flow of knowledge—from provider to you. It is also important for knowledge to flow in the other direction—from you to your provider, especially about any treatments you are having (such as chiropractic, massage or acupuncture), and any over-the-counter supplements or medications you are taking.* You can also ask for clarification about information you received from another source, for example, "my massage therapist thinks that I would benefit from a yoga class, what do you think?"

Questions to Ask

Now that you know where to begin your fact-finding journey, what other kinds of questions should you ask? Here are a few examples. The answers may be spoken during a conversation, or your provider may give you written materials or direct you to a reputable website for more information:

- What is my exact diagnosis?
- What are the likely causes of my pain?
- What can I do on my own, including diet, exercise, and stress reduction? (Please see Chapter 5 on Emotional Coping.)
- What tests do you recommend (e.g. MRI, CT scan)? Can you explain how they are done?
- What procedures do you recommend? Can you explain them?
- What medications do you recommend? What are the side effects?
- When would surgery be indicated, and what kind? (You would also want to talk to a surgeon in this situation.)
- What can I expect, realistically, in terms of feeling better?
- What websites do you recommend?

Second Opinions

If you are not satisfied with the answers to these questions—or even if you are—you might want to hear from another healthcare provider. This is a good idea because it gives you different perspectives on the same problem. You don't have to worry about hurting someone's feelings by asking for a second opinion. Any reputable healthcare provider would welcome your right to talk to another provider, and would not be threatened or insulted in any way. After all, you are the "boss" of your own body and you need to be completely comfortable about any treatments.

A few guidelines about second opinions however:

- *Do* make sure that any second opinion that you seek is from another provider of the same type as your first one.
- *Don't,* for example, seek a second opinion from a chiropractor and try to compare that to the opinion you received from a primary care doctor. These people have different types of training, so it would be like trying to compare apples and oranges! If you are comparing opinions from specialists, make sure they are of the same kind: For example, two neurologists, two pain specialists, or two surgeons.

Your Internet Guide

In addition to talking with your provider and reading any written materials you are given, you might join the millions of people who turn to the Internet every day for medical advice and information. While the Internet is a wonderful resource, it can also be difficult to sort out fact from fiction and to find information you can trust and rely on. Here are a few guidelines. For more detailed Internet advice, see the *painACTION* article, *"The Internet made easy!"*

Check the URL

After you type your question or topic into a search engine, you will see a list of relevant Internet sites. Instead of just clicking, begin by doing

some screening. First, look at the URL, or the web address after the name of the website. Generally, the more reliable sites end with ".gov" (for government agencies), and ".edu" (for academic medical centers). You can also look for national organizations that provide information on the condition you are interested in, which will end with ".org." Just make sure these are nonprofit organizations, such as The American Cancer Society, (*www.cancer.org*).

Other reliable sites

Even if the suffixes "gov", "edu" and "org" don't appear in a URL, the site still might be useful and safe, as *www.painACTION.com* is, for example! Here is a way to evaluate other sites: Is the site easy to navigate? Is the organization reputable? You can often determine this by doing a search on the organization itself to see if there are complaints or lawsuits. Is the site trying to sell you a product to improve your health? If so, warning bells should go off! View with suspicion any site that is trying to sell you something, whether it is a medicine, a food or a health-related device. At a minimum, ask your healthcare provider for advice.

Evaluating Internet information

Once you are satisfied with the site itself, look closely at the information on it:

- Is it current? Always check on the date that the information was posted. This usually appears at the bottom of each screen. If there is no date, beware! This might indicate that there is disproved or outdated information, or a sloppy, untrustworthy website.
- Is the information factual (rather than opinion or ranting), and backed up with references to primary sources, such as research studies?
- Are experts cited? Even if there are no research studies to back up the advice, there should be some other reliable source, such as a reputable expert who is associated with a major academic medical center, or a reliable research organization.

Internet Tips

Want to learn more? Here are some ideas from the *painACTION* article, *"Safe Surfing: finding online pain support."* The guidelines in this article should help you become a smart information-gatherer and a savvy consumer, all of which will increase your chances of dealing successfully with your pain.

Other suggestions:

- The Medical Library Association's User's Guide to Finding and Evaluating Health Information on the Web - *http://www.mlanet.org* (search on "user's guide")
- MEDLINEplus is a consumer-oriented website established by the National Library of Medicine. It includes an online illustrated medical encyclopedia and dictionary. *http://medlineplus.gov/*
- For evidence-based information about complementary and alternative therapies, visit the website of the National Center for Complementary and Alternative Medicine, part of the National Institutes of Health, which also has an excellent consumer health information website. *http://nccam.nih.gov*

In Summary...

- Your medical home should be the first stop on your journey
- It's important to know what questions to ask your healthcare provider
- Second opinions can be helpful
- Choose your Internet resources carefully

Chapter 4
Communication is Key

In your journey to pain management, the healthcare providers you meet along the way can serve as helpful "tour guides." In order to help you, however, they need to know where you are going—your destination: What are the goals of your pain management and what would you like to be able to accomplish? This chapter is about how to help your healthcare provider help you during this important life journey. You might think, as many people do, that your doctor, nurse, physician assistant or other medical professional knows everything about your pain. But this is only partly true. Your healthcare providers may know a great deal about pain in general, and how to treat it. But they probably don't know the details about *your* pain and its effect on your life. So it is important for you to tell them, to *communicate* with them about what your pain is doing to you in your own life. After all, you are the only person in your body, so you are the expert about your own pain! For example, is your pain:

- Making it harder for you to do your job?
- Preventing you from enjoying your favorite activities?
- Interfering with your sleep or your relationships?
- Affecting your ability to take care of your children or other family members?
- Causing you to become depressed or anxious?

No two people will answer these questions in exactly the same way, so that is why it is a good idea to share this information with your healthcare provider. Why is this so important? Because, as discussed earlier in this book, one key to successful pain management is *shared decision-making* between you and your healthcare provider about the course of treatment. Part of shared decision-making is *setting realistic goals and expectations*. If your provider does not know how your pain is preventing you from reaching your goals, how can he or she give you a good idea of what the treatment should be and what kind of relief you can expect? And later on, how can you together decide if the treatment is working? If you want to take a journey, you need to know

where you would like to end up! For tips about starting that conversation, you might want to look at this *painACTION* article, *"Are they listening?: talking about your pain."*

Pain is Not a Score; It is an Experience

As they evaluate your pain, many providers will ask you to rate it on a scale of 0 to 10, "0" being no pain, and "10" being the worst pain imaginable. This is important information, but it is not enough, because *pain is not a score; it is an experience*. For example, if you have back pain, it is not enough for your provider to know that the treatment brought it down from a "9" to a "6". Your provider also has to know if your goal was to be able to play 18 holes of golf, (or repair a transmission, sit at a desk for 8 hours or pick up your grandchildren). Have you reached your goals? If not, the treatment has not been successful and you and your provider need to re-evaluate and come up with a different plan.

What You Can Say

There is an old saying that if a healthcare provider simply listens and gives the patient enough time to talk about his or her problem, the diagnosis will become clear, even without a lot of expensive tests. But what if your provider is not a good listener, or doesn't give you enough time to talk? Here are some things you can say:

- "I know you are in a rush, but I would really like to tell you how this pain is making it hard for me in my life right now. Do you have a few minutes to listen?"
- "Thank you for this pill prescription, but what else can I do to help this pain go away?"
- "How long before I can realistically expect to feel better?"
- "I really don't like taking pain pills if I don't have to. Is there some kind of exercise program, like 'back pain boot camp', that I can do to see if it helps instead? Are there any other non-pill treatments

like acupuncture or biofeedback?" (These are all described on *painACTION*.)

- "Here is what I'd like to be able to do in a few weeks; is this realistic? How about in a few months? [insert your goal here] For example: take a dance or yoga class; do weight training at the gym; start jogging; go hiking; take a car trip."
- "It has been two months, and my pain is really not going away. I am getting discouraged and frustrated. Can we talk about a new plan?"

Communicating With Family and Friends

In addition to communicating with your healthcare provider, there are other people in your life: family, co-workers and friends. Often, these people might not realize how pain is affecting your life. Perhaps you even feel that pain is in control of your life, but people don't see this. They also may not understand that you are on a personal journey to control and manage your pain. It can be very difficult for many people suffering from chronic pain to communicate with others about their experiences. People in acute pain, such as from a sprain or fracture, often show visible signs of their distress: You might look upset or moan and groan, or always be trying to find a comfortable position. Healthcare providers might measure a fast pulse or heart rate, high blood pressure or other obvious physical signs of discomfort and discuss these findings with family members so that they understand the pain more clearly.

People with chronic pain don't usually show such obvious signs, however, which may lead an inexperienced observer, such as a friend or family member, to think that the problem "really isn't that bad". It is helpful to explain to your friends and family members that people with chronic pain—even if it is severe—may not show it. But you don't want to overdo these explanations either, or some people might say that you are "always complaining". So it is a good idea to ask your healthcare provider, or a psychologist, to help you communicate in a positive way with your loved ones so that they understand about your pain and the ways in which they can be supportive to you in your "journey."

Sometimes the biggest causes of frustration, anxiety or depression are what you *don't* know, rather than what you do know. That is why communication is so important. If, for example, you thought your sprained ankle would get better in a week, but the pain is dragging on for a month, wouldn't it have been helpful to know from your healthcare provider that ankles can take three months to heal? The only way to know this kind of information is to ask outright, since many providers might not want to give you discouraging news. But once you do have the facts, you can take steps to cope with them, and that is what the next chapter is about.

An Expert Opinion

Communicating with your healthcare provider

Here are some examples of questions you might want to ask your provider, and some possible answers. Try these questions and see what answers *you* get!

Q Why can't my healthcare provider give me complete pain relief when there are so many "miracles" that medicine can provide, like organ transplants?

A This is an excellent question, and a source of distress for many patients, who see live photographs of Mars on their TV set, yet can hardly walk because of their aching back. The simple truth is that despite all available medical technologies we are often not able to control chronic pain, and are almost never able to get completely rid of a chronic pain problem. In fact, the patients who succeed most in benefiting from pain management techniques are the ones who accept that they will not be able to get rid of their pain problem, and seek help to reduce their level of pain and improve their level of functioning. Why have we not done better? This is a matter for speculation, and people will have different opinions. One important reason is that very little funding has gone to improving the understanding and

treatment of chronic pain: for example, only a tiny fraction of federal funding for medical research goes to pain research.

Q My healthcare provider just prescribed an antidepressant for me. Why? I'm not depressed, I have pain!

A Many medicines have benefits for more than one condition. Antidepressants have effects in depression, of course, but also have effects on certain types of chronic pain. For example, many antidepressants are effective for neuropathic pain (i.e. pain resulting from nerve injuries); antidepressants can be effective for other types of pain as well. On the other hand, patients with chronic pain do in fact frequently suffer from depression as well. So a pain patient who does have depression also may be prescribed an antidepressant. The bottom line is that there are many good reasons for a patient with chronic pain to be prescribed an antidepressant, and it certainly does not mean your healthcare provider thinks you are crazy, or your pain is all "in your head."

Q I've been told to exercise, but every time I do, my pain increases. Doesn't my healthcare provider understand I can't exercise?

A It would be very helpful for you to communicate to your provider about your difficulty with exercising, if you haven't done so already. Healthcare providers tend to encourage their patients to exercise because exercise can help patients with chronic pain in many ways: exercise can increase your ability to function in your day to day life, can help reduce pain, can improve mood, improve sleep, etc. Of course, if you can't exercise because it increases your pain, you will not be able to reap these benefits. The good news is that there are a variety of things you can do to get around this problem. Some examples

are to begin with exercises that you can do before moving onto the more difficult ones; use ice or heat before, during, or after the exercise; take a pain medication an hour before you plan to exercise. A good physical therapist and an attentive healthcare provider should be able to guide you through this problem.

In Summary...

- Pain is not a score, it is an experience
- Try to think about what you want to say to your healthcare provider
- Communication is key
  - › With your healthcare provider
  - › With your family and friends

Chapter 5
Coping with Your Feelings

Before you set off on a car trip, you might consult a travel agent or seek advice from friends and family about where to go and what to see. But, in the end, you have to take the wheel. This is your journey, and *you* are in charge of both your final destination and your route. The same is true of pain management. You can and should seek help from a number of sources, but you do have to direct your own path. You are the only one inside your body, so trust your instincts when something doesn't feel right. From time to time, you may have to redesign your itinerary or travel plans—feeling a sense of control will actually help you to cope emotionally with the difficult moments. This chapter will give you the tools you need to plan a successful emotional journey to managing your pain. You will learn about stress, anxiety and depression and discover tips on how to develop more positive feelings, even when you are coping with pain.

First, a little background on the connections between emotions and pain: Does your body know what is going on in your mind? Surprising as this may sound, the answer is "yes." When you are feeling stressed or anxious, for example, your brain triggers the release of chemicals called "stress hormones" in your body. These include *adrenalin* and *cortisol*, and they can have powerful effects on your pain. You may be feeling stressed or anxious as the result of your pain itself, or the reactions of those around you to your pain, or because of things—such as work or family troubles—that have nothing to do with your pain. But whatever the cause, the result is the same: it can make it harder for you to cope with your pain. Feeling sad and depressed can also make your pain worse.

What is Stress and How Can it Make Pain Worse?

Stress is the response we have to situations that demand that we focus our minds and bodies in some way. Some stress can be thrilling, such as the exhilaration of skiing down a steep mountain or holding

on during a roller coaster ride. Other stress can be unpleasant, such as the anxiety of being late for a presentation at work, or the frustrations of a family disagreement. No matter where it comes from, stress generally creates a "fight, flight or freeze" response, as stress hormones flood our bodies to help us meet the challenge. In response to these hormones our muscles tighten, we breathe faster and we take smaller, shallower breaths, and our hearts speed up. If the stress is "acute," meaning it does not last long, these effects soon disappear. But if you are feeling stress every day, for weeks or months at a time, this is called "chronic."

Chronic stress or anxiety can make pain worse. It can cause your body to continue to hold muscles tighter than they need to be. At the same time, your shallow breaths bring less fresh oxygen to those overworked muscles. As you know if you clench your fist or hunch your shoulders for any length of time, tight muscles contribute to pain. Not only can stress and anxiety make back pain worse, it can also contribute to migraine pain, as the *painACTION* article, *"The link between stress and migraine"* describes.

Coping With Stress and Anxiety

If you've ever experienced significant stress while on vacation, you know that it can make it much harder to enjoy a trip. Chronic stress or anxiety will have a similar negative effect on your journey to pain management, so it's important to learn how to control these feelings. There are several ways to manage stress and anxiety: Identify the causes; talk about it; take ownership of your situation; and use proven stress reduction techniques. The tips in the rest of this chapter will help you reduce your stress, allowing you to continue your journey more comfortably. Your healthcare providers can give you a great deal of helpful guidance, but always remember that you are in charge of mapping out your voyage.

Identify the Causes

The first step in lowering your stress and anxiety levels is to figure out where they are coming from. You can think about this on your own or

ask your healthcare provider to help you. As pointed out in the last chapter, sometimes the unknown is more difficult than the known, so the more reliable information you can find out, the better. You would not simply head to an unfamiliar country without learning something about your destination (talk about stressful!), so take the same proactive steps when it comes to this journey. If you have some realistic information about your path to pain management, you may be less stressed or anxious about it. If your stress is coming from feeling that your pain is lasting too long, for example, ask some frank questions of your provider: "How long can I expect this to go on?" "Will my pain ever completely go away?"

Talk About It

If your stress is coming from your family relationships, it might be a good idea to figure out what people can do to help you and then brainstorm with them about ideas that might help: "At the end of the day, my back is really sore and it would be really nice if someone else would do the dishes. I can finish cleaning up after I sit down for a few minutes." Even if you don't come up with practical solutions, just talking about your pain with a trusted person helps to ease the burden. Some people have found support groups or advocacy organizations helpful as well. You can find links to such resources on the *painACTION* website.

Take Ownership

Evidence shows a direct link between your mood and your ability to cope with pain. If you are feeling down in the dumps, and like a helpless victim of your pain, you might actually find your pain levels increasing. If, on the other hand, you can feel good about yourself as someone who is taking control of your life and your situation, you will very likely find that you are feeling less pain. Easier said than done? Here's how you can take control of your pain:

- Be creative about changing the sources of your stress. If you are feeling overscheduled, see what can be eliminated. Create a one-night "oasis of calm" each week, when you stay

home and relax. Since sleep has been shown to be important in coping with pain, pick one night a week to go to bed by 10 PM.

- Get the "fight" out
  If you feel that anger is bursting out of you, try to tame it by doing some regular do-able form of exercise every day, such as stretching, walking, jogging, or a spinning, yoga or aerobics class.

- Keep a "travel" journal
  Many people find that keeping a journal while traveling enhances their enjoyment of the trip and allows them to sort through their feelings and experiences. The same is true of emotional coping; writing your worries down has been shown to reduce stress and alleviate some pain.

- Calm your body down
  You can't be anxious and calm at the same time, so try to let the calm feeling take over. Do whatever feels most comfortable to you: Sign up for classes in meditation, yoga, or Tai Chi (also called "moving meditation"), or find a trained biofeedback therapist. Read the *painACTION* article, *"Using biofeedback to manage migraines"*. Practice deep, slow breathing, or go for a long walk or bike ride in nature.

The *painACTION* website has several tools you can use to feel calmer, less stressed and more relaxed. These kinds of feelings have been shown to make pain more bearable. The *painACTION "Relaxation Response Tool"*, for example, teaches a proven meditation method, called the relaxation response that is used in medical centers throughout the country to help people cope with pain and discomfort. You can also use *painACTION's "Guided Imagery Tool"*, to take your body on a "mini vacation."

What About Depression?

It's common for people with chronic pain to have depression. Depression can worsen and prolong the pain. Pain and depression can take over a person's thoughts and feelings with more pain leading to more

depression, creating a cycle that is difficult to break. Pain and depression can take over a person's thoughts and feelings with more pain leading to more depression, creating a cycle that is difficult to break. In the *painACTION* article, *"Depression and pain: break the cycle"*, you can learn more details about this. The lesson, "How to deal with depression" gives tips on dealing with depression.

These are just suggestions for ways that others have successfully reduced their stress, anxiety and depression on their journeys to better pain management. You are a unique individual, however, so it is important to find what works best for you. One way to do this is by looking back at your life to find out how you have successfully coped with emotional problems in the past. A mental health provider can also be helpful in figuring out the best ways for you to feel better. In the meantime, the following lessons and tools on the *painACTION* website will be helpful:

- *"How to develop a positive frame of mind"* (Lesson)
- *"How to handle stress in your life"* (Lesson)
- *"How to face the challenges of living with pain"* (Lesson)
- *"My Coping"* (Self-check)

An Expert Opinion

Coping with emotions

Q My pain specialist says I have to see a psychologist before he will take me on as a patient. I am not crazy. Do you think I should have to do this?

A Chronic pain causes major problems for many patients, in addition to pain itself, which is bad enough. Patients with pain that lasts for a long time may get depressed, develop anxiety, have trouble sleeping, or may have trouble in relationships with spouses, friends, and employers. Recognizing this, many

healthcare providers suggest that patients see a psychologist to help with any emotional problems while the pain itself is being worked on. In addition, there are a number of techniques that a psychologist can help you learn to do for yourself, to help reduce the pain, such as relaxation exercises, biofeedback, and self-hypnosis. So being referred to a psychologist doesn't mean that anyone thinks you are crazy – it usually means that your healthcare provider is trying to find every possible way to help you.

Q I'm told that I need to reduce the stress in my life to help with my pain management. How can that help?

A Stress is a part of life, and cannot be completely escaped. This is even more the case when you have chronic pain. As you have seen in this chapter, stress, and the anxiety and irritability it may lead to, may make pain more intense, and may also make it harder to cope with the pain you have. There are many different ways to cope with stress, and learning healthy ways to manage stress can decrease the impact that stress has on managing your pain. This chapter and its links to the *painACTION* tools and lessons will give you useful stress management techniques.

In Summary...

- Chronic stress or anxiety can worsen pain
- Managing stress is important to successful pain management
- Take ownership of your mood and ability to cope with pain
- Depression may occur with chronic pain
  - › Talking about depression with a mental healthcare provider can help

Chapter 6

Your Medication: Staying Safe

When you are traveling in unfamiliar territory, you take a number of precautions to ensure your safety and the safety of the people with you. When you drive a car, you follow the rules of the road. It is important to bring that same caution and respect for safety rules to your pain management journey. The prescription pain pills in that little bottle may look innocent, but they can be as dangerous as a car accident if used improperly. In this chapter, you will learn some important—and possibly surprising—facts about pain medication, particularly opioids, which will help ensure your safety.

Prescription Medications Safety Guidelines

The information in this chapter can be summarized in a few important "rules of the road" about prescription medicine, especially pain medicine:

- Follow the dosage and frequency instructions EXACTLY.
  Never change your medication schedule or dosage (even if you think it is not working) without consulting with your healthcare provider.

- Contact your healthcare provider if you experience troubling medication side effects.
  Read the *painACTION "Medication Side Effects Tool"* to find out the possible side effects of different medications.

- NEVER give your medication to anyone else
  Under any circumstance, and keep it concealed in a safe place where casual visitors are unlikely to see it.

- NEVER keep the medication after you no longer take it
  Discard it safely. The *painACTION* article, *"Getting rid of unneeded medications: Out of sight is not out of mind"* will give you specific suggestions.

What are Opioids?

If you have pain that is not responding to other medicine, your healthcare provider may prescribe opioids for you. Opioids—among the oldest medicines in the world—belong to a group of medications called *analgesics*, which give relief from pain. Opioid is a medical term that describes what are commonly referred to as "narcotics." The natural opioid, morphine, which comes from the opium poppy plant, has been used as a pain reliever for centuries. Other opioids, such as codeine, fentanyl and oxycodone, are manufactured synthetically.

Opioids are prescribed by healthcare providers to treat pain, control coughs, and treat diarrhea. Some are taken by mouth in pill form, while others are given transdermally (skin patches), intranasally (nose spray), or by injection. In the thousands of years that opioids have been used to treat pain, no other pain medication has been found that is as effective. This is because our bodies have natural "receptors" in our cells that respond to them. It is as if the opioid medicine is the "key" that fits perfectly in the "lock" of our cells, to open the door to pain management. So far, so good, but there are some problems with opioids, if they are used in ways that are not prescribed. As we've talked about in previous chapters, good information is a key to travel safety. Here are some definitions to help understand the potential problems with opioids.

Tolerance

This can happen naturally when your body gets used to a particular medication. As a result, the medication does not work as well as it used to and you might feel that you need to take more of it to get the same relief. *You should never make your own decision about this however*, but always discuss the situation with your healthcare provider. (**Tolerance** is very different from addiction, which is discussed below.) Sometimes the solution is simply to change medications or add a new medication.

Dependence

This is another naturally occurring state that happens when your mind *and* body get used to a medication, but in a different way from tolerance. When you become physically **dependent** on a medication, your body actually needs this medication in order to continue working properly. This means that *you should never suddenly stop taking any medication* without first talking to your healthcare provider.

Misuse

This refers to taking a medication in a way that it was not prescribed, or for a condition other than the one for which it was prescribed. If you have medication for your back pain but decide to take it to help you sleep, for example, that is **misusing** it. *This is something you should never do because it is unsafe.*

Abuse

If you use a prescription pain medicine to get a result that has nothing to do with the pain it was intended to treat, this is **abuse**. You are abusing your pain medicine, for example, if you take it to feel better, or get "high." *Like medication misuse, abuse is very dangerous.* You are not trained to understand the ways in which medications interact with anything else you are taking or with your physical condition. Abusing your medication is just as dangerous as driving recklessly or ignoring safety warnings while traveling. Respect the rules laid out by your healthcare provider, and protect the safety and health of your body.

Addiction

People who become addicted to a prescription pain medication are **abusing the drug uncontrollably**, to the point where it is causing physical harm. Unlike **tolerance** and **dependence**, **addiction** is an unnatural state. *If you feel you are becoming addicted to your medication, meaning that you feel the need to take more and more of it and cannot control yourself, seek immediate medical help.*

Diversion

You wouldn't hand your car keys to an unlicensed driver, and you wouldn't send a friend into a dangerous or unfamiliar city alone. Use these instincts about safety when it comes to your prescription pain medication. *Your medication is meant only for you. You should never give it to anyone else, either for money or because you think it might help him or her.* You are not a trained pharmacist, so you can't possibly know which medications work safely for each person. There is much more information about medication safety on the *painACTION* website, including articles, tools, and lessons. Here are some suggestions:

- *"Opioid medication basics"* (Lesson)
- *"How to start an opioid safely"* (Lesson)
- *"How to discuss opioids with your doctor"* (Lesson)
- *"How to travel with opioids"* (Lesson)

Safe Storage and Disposal

When you are behind the wheel, you are not only responsible for your own safety, but also for the safety of the other people in your car. If you took your friends or family on a trip, you would do your best to keep them as safe as possible. Accidents happen, but taking the right safety precautions reduces the risk. When it comes to pain medication, these precautions are not just limited to proper usage: Not only is important to *use* your prescription pain medication safely, you must also know what to do when you are *not* using it. These are powerful drugs and if they fall into the wrong hands they can cause severe physical damage and even death.

Abuse of prescription pain medications is reaching almost epidemic levels in this country, especially among people between ages 18 and 33. Most of these young people get the medications from their friends or family. In 2007 in Utah, of 467 drug-related overdoses, 317 were attributed to legal drugs and 261 of them involved prescription pain medications. So if you have these powerful prescription pain medicines in your possession, you have a responsibility to prevent

anyone else from finding and using them. You can do this by storing them in a hiding place that only you know about, and disposing of any leftover medications in a way that makes sure no one will get them. The *painACTION* article. *"Leftover medications: is out of sight, out of mind?"* has some useful suggestions for how to do this.

An Expert Opinion

Medication safety

Q If I take this medication you are prescribing for me, will I become addicted?

A If you follow the medication guidelines, the risk of addiction is very low. You might, however, become *dependent* on the medication, which means you should never stop taking it suddenly; you also might become *tolerant*, which means we might need to change your prescription. It is important to use the drug ONLY as it is prescribed, without *misusing* or *abusing* it. If you feel you are becoming *addicted*, tell your healthcare provider so you can get the help you need. And certainly remember never to *divert* this medication to anyone else because you would be giving them a very powerful substance that could do harm.

Q Are there limitations on my ability to travel outside of the United States if I am taking prescribed opioid medication?

A When traveling abroad with prescribed controlled substances like opioids it is important to consider two sets of laws; the laws of the home country, and those of the countries to which you will be traveling. The United States Code of Federal Regulations allows an individual to have in his/her possession a controlled substance if it was lawfully obtained for personal medical use. This can be shown by having the medication

in the original container in which it was dispensed to the individual. The container should have the trade or chemical name of the substance or the name and prescription number of the pharmacy that dispensed it. The traveler should make a declaration of this possession to a US Customs Official when leaving the United States. Upon return to the United States the traveler can bring in the remainder of the medication they had when they left the country. There is a 50-dosage unit limitation on bringing into the U.S. controlled substances that were acquired abroad for personal medical use. The International Narcotics Control Board has published guidelines concerning travel with internationally controlled drugs. The laws in individual countries vary widely so the traveler should obtain the specific information about their destinations. Usually they must have in their possession the documents required by that country demonstrating that the medications are for personal medical use and have been appropriately prescribed.

For more information on this topic, go to the University of Wisconsin Pain & Policy Unit website at *http://www.painpolicy.wisc.edu/*

Q The last time I took a narcotic, I was constipated for a month. Is there anything I can take or do after my upcoming surgery to prevent that?

A All narcotics (the correct medical terms are "opioids" or "opioid analgesics") can cause constipation. In fact, it is the most common side effect of these medicines. This side effect is more of a problem for some people than others. Uncontrolled constipation is a leading reason that patients don't take their pain medicines as instructed. The first thing to do is to it tell your healthcare provider that opioid-related constipation is a big problem for you, and ask that a stimulant laxative be prescribed along with the pain medicine. Most laxatives are

taken by mouth and some can also be taken as a suppository. The usual advice about preventing constipation—increasing fluids and fiber in the diet—are probably not helpful for opioid-related constipation. Some laxatives, known as stool softeners, may be helpful, but are not enough. Opioid-related constipation requires a stimulant laxative that encourages the bowel to move the stool along and makes it easier to have a normal bowel movement. Most laxatives are available without a prescription—ask your doctor and pharmacist for specific recommendations. It is very important to prevent and treat constipation. If it becomes a problem for you, let your healthcare provider know so the treatment plan can be changed.

Q I've been on the same opioid now for a year, and it seems that my pain is worsening. Is it possible that the medication is no longer working for me?

A There are many things that can affect how well a medication is working to control the pain. If you have been on the same drug and dose for a long time and notice a change that lasts more than a few days, here are some things to discuss with your healthcare provider: Have you changed your diet or changed other medicines recently—including herbals and natural products? Have you changed brands of pain medicine? Have you had unusual stress? Have you been sick? If there is a known cause for your pain, when was the last time you had a checkup? It is possible that the underlying condition that caused the pain has worsened. In the case of cancer, for example, this could be a warning that the cancer treatment needs to be changed. (See also the definition of "tolerance" in the article, since this could be a factor as well.)

Another possibility is that there has been a buildup of "metabolites," which can actually increase pain. Almost all drugs are processed in the body and changed in some way as they move

through the liver. Sometimes this processing creates byproducts or metabolites. For most patients this is not a problem, because the byproducts are removed by the kidneys and leave the body in the urine. If the kidneys do not remove enough of the metabolites, they can build up and make the nerves more sensitive to things that wouldn't normally cause pain. Changing to a different opioid usually takes care of the problem, and your pain will be under better control again.

In Summary...

- Tolerance, dependence, misuse, abuse, addiction, diversion have different meanings
- Opioids can be very effective to treat some types of pain, and it is important for them to be taken as directed
- Follow medication instructions exactly
- Contact your healthcare provider if you have side effects
- NEVER give medication to anyone else
- ALWAYS store your medication in a concealed, safe place
- Discard unused medication safely

Part II

Your Personal Pain Profile

This part of the book is where our "travel guide" gets more specific. If you are dealing with back pain, migraine or cancer-related pain, refer to the appropriate chapter or chapters in this part. First, however, please take a moment to read this overview, since it will help you take better advantage of the information in the chapters.

The three types of chronic pain discussed in this section are, of course, quite different, but they also have several common features. Each of them can be with you for many years. However, like any long journey, the more you travel, the easier it gets. Each of these types of pain requires "baggage," but the type of load you are carrying may be different. If you have back pain, for example, you probably feel as if you are carrying some sort of burden every day, because your back never gets a day off! It must work all day long, and even when you lie down, to support your body. With back pain, the only difference from day-to-day is, "how much pain will I be in today? Will I be able to do the things I want and need to do?" So in the back pain chapter, we discuss how to modify your life to minimize and manage the pain you might be dealing with every day.

By contrast, migraine pain may leave you free of baggage for days or weeks at a time. The question here is "Will I get a migraine today?" The uncertainty is of course a difficult burden to carry, but you can be sure that if you do ***not*** *get a migraine, you will be able to have a normal day. So the challenge here is what can be done to* ***prevent*** *the headache from beginning, and how to* ***minimize*** *the pain if you do get one; these are the questions we focus on in the chapter about migraine pain.*

Cancer-related pain is quite different from the other two types of chronic pain. Because of advances in cancer treatment, people are living longer and many achieve remission or cure from the disease. Rather than worrying about survival, many cancer patients now are shifting their attention to the pain that results from either the treatment or the long-term effects of the disease itself. In the cancer chapter, therefore, we focus on the causes and types of cancer-related pain and the most effective ways to manage them.

To sum up the chapters in this section, there are three different ways you might wake up in the morning: If you have back pain (Chapter 7), you might be thinking, "How bad is today going to be?" If you have migraines (Chapter 8), your question might be, "Is today going to be a good day or a bad day?" And if you have cancer-related pain (Chapter 9), your feelings might be mixed: "I'm happy to be alive and cancer-free today, but how do I cope with the long-term pain that remains?"

Chapter 7

Back Pain: Finding Support

If you are on a journey to manage your back pain, you have plenty of traveling companions. Government surveys report that back pain is the second most common neurological ailment in the United States—only headache is more common. Nearly everyone at some point has back pain that interferes with work, routine daily activities, or recreation. And back pain is expensive: it is estimated that Americans spend at least $50 billion each year on low back pain, which is *the most common* cause of job-related disability and a leading contributor to missed work. Other research has found that one quarter of Americans report that they suffer from back pain, especially low back pain that lasted at least a whole day, and almost 14 percent report neck pain.

So now that you know you are not alone, what is this problem all about? This chapter tells you some of the main causes of back pain, as well as where you can go to find more information about prevention and treatment on the *painACTION* website.

Your back extends from the top of your neck down to your tailbone, and you can have pain anywhere along that long stretch of spine. Sometimes, the pain might even radiate into your arms and legs. The spine is a collection of bony rings, called *vertebrae,* whose major function is to provide support for the body and protection for the spinal cord—a kind of "scaffolding" for your body. The vertebrae are stacked on one another, separated by firm, pliable "cushions" called *discs*. The stack of bones and discs is held together by ligaments and moved by muscles. The vertebrae form a kind of "tunnel" that houses the spinal cord—a collection of nerves that form a "communications center," sending and receiving messages from your brain, and branching off to the rest of your body. The *"Anatomy of the Back"* tool from *painACTION* has helpful diagrams and explanations.

The back never gets a moment off, even when you are sleeping! The muscles attached to the spine must always be working to keep it in alignment. So if you have back pain, you probably feel as if you are always carrying some form of "baggage" on your journey to pain management. Some days your burden might be lighter; some days heavier, but you are probably always aware of at least the potential for pain. In this chapter, you will learn the most common causes and types of back pain, as well as suggestions for how to manage it. For more details, please consult the Back Pain sections on *painACTION*.

Categories of Back Pain

Most common types of back pain originate in one or more of three places in the back:

- The bones of the spine, the vertebrae
- The muscles, tendons and ligaments attached to these bones
- The nerves that come from the spinal cord that weave in and out of the spine

Structural changes in bones or soft tissue can press on nerves, which results in pain. In some conditions, the nerves themselves become inflamed, and this causes the pain. The conditions and symptoms described below fall into one or more of these three categories.

Muscle Strain or Sprain

This is the most common cause of back pain, since no matter what your position, your muscles are always working to hold your spine in alignment. The muscles of your neck—work particularly hard, since they must hold up your head, which weighs between 8 and 12 pounds. Muscle injury causes inflammation and swelling of the soft tissue, which may press on nearby nerves, resulting in pain. With common-sense treatments, including rest, mild stretching, ice and/or heat, most muscle strains and sprains resolve on their own.

Wear and Tear

As we get older, the bones, muscles and ligaments of the spine are subjected to wear and tear, especially if you participate (or have participated in younger years) in contact sports or other activities that subject the spine to impact. By contrast, moderate exercise—such as walking, jogging, or stretching—is actually beneficial, because it promotes blood flow to the spine.

Wear and tear cause symptoms in the bones and nerves of the spine. These include arthritis of the spine, which is called *spondylosis. [Pronounced 'spondi – lo- sis'] Spinal stenosis*, is one form of arthritis where there is narrowing of the space within the spinal canal. Both of these conditions can cause pain by compressing or "pinching" spinal nerves.

Osteoporosis

As the body ages, bones tend to become thinner and more brittle, especially in women after menopause. Osteoporosis can be treated by diet, weight-bearing exercise and medications, but still has the potential to cause pain. Thinner, more fragile vertebrae weaken the strength of the spine, and may fracture, either because of activity or simply due to the effects of gravity on the spine.

Herniated (slipped) Disc

Discogenic back pain occurs when the cushioning, shock-absorbing discs between the vertebrae malfunction or break, slipping out of position and pinching spinal nerves.

Spondylolisthesis

This condition occurs when one vertebra in the spinal column slips forward over another. This disrupts the whole integrity of the spine, destabilizing it. When the spine is destabilized, the vertebrae pull on muscles, ligaments and other discs, compressing nerves and causing pain.

Sciatica

The sciatic nerve is actually a collection of spinal nerves joined together at the lower part of the spine. At the end of the spine, the sciatic nerve splits in two, sending branches through the buttocks and down the back of each leg all the way to the feet. When any one nerve in this group gets irritated or compressed, it sends pain signals to all of the other nerves, and this pain can extend all the way down the leg.

Back Pain Management

The conditions described above can cause pain that can be described as aching, stiffness, burning, "crackling", shooting, stabbing or throbbing. The different experiences of pain mean that it is very important to describe the pain accurately to your healthcare provider, including its location. Back pain is not only felt in the back, but may radiate outward to arms and legs, and appropriate treatment depends on a correct diagnosis.

Now that you understand the sources of back pain, you can take advantage of the pain management skills described in Part 1 of this book. You will also find the tools, lessons and articles on *painACTION* useful. Here are a few suggestions to get you started:

- *"Back pain treatment: myths and realities"* (Article)
- *"Back spasms: what they are, what to do"* (Article)
- *"Back Pain Circle of Care"* (Tool)
- *"How to save your back doing everyday tasks"* (Lesson)

In Summary...

- If you suffer from back pain, you are not alone. Back pain is the most common cause of job-related disability
- The back never gets a moment off, even when you are sleeping, it is working
- There are many parts of the back and spine, and any of them can cause pain
- Back pain is not only felt in the back, but may radiate outward to arms and legs, and appropriate treatment depends on a correct diagnosis

Chapter 8

Migraine Pain: You in the Driver's Seat

Your interest in this chapter probably means that you don't need to be told what a migraine headache feels like: The throbbing or pulsating pain in your head, accompanied by nausea or vomiting and a sensitivity to light and noise are all too familiar. What you may not know, however, is that while nearly half of the 29.5 million Americans with migraines could benefit from preventive therapies, **only 1 in 5** currently take advantage of them, according to the *National Headache Foundation*. Preventive therapies can decrease the occurrence of migraine by 50 to 80 percent, as well as reduce the severity and duration of migraines that do occur, yet many migraine sufferers are not incorporating these into their treatments.

Migraines are sometimes set off by a combination of causes—also called "triggers", and these may be different for each person. These may include some combination of eating and sleeping habits, certain foods, muscle tension, stress, medications, hormone changes and even the weather. While you can stay away from some migraine triggers—such as certain foods—and reduce others—such as stress or muscle tension—it is impossible to avoid all stress, changes in your hormone levels, and, of course, the weather. So it is important, as you launch your pain management journey, to have a complete diagnosis and assessment of what is causing *your* migraines so you can arrive at an effective treatment plan. In order to do this, you need to be in partnership with a knowledgeable healthcare provider—a travel guide on your journey to migraine prevention and treatment. If you and your provider can identify and then reduce or eliminate your migraine triggers, your journey will be that much smoother and the burden of "pain baggage" that you carry will be lightened!

Did you know that half of the people with migraine headaches choose to "travel alone," by treating themselves and not seeking medical help? Traveling alone on this journey to migraine management is *never a good idea*: The problem with trying to treat your migraines by yourself

is that you may not have the correct diagnosis, and you will also be missing out on a professional, personalized, systematic approach to pain relief.

While medications can be successful in preventing migraines (and you should discuss these with your healthcare provider), a big focus of this book is self-management of pain: What can you change about your lifestyle, coping mechanisms and diet that will reduce your migraine triggers? Read the *painACTION* lesson, *"How to recognize headache triggers"*

As is true for most types of chronic pain, there is usually not one single solution: Your migraine relief will depend on putting together a "package" of treatments—including medication—that responds to your own migraine triggers. And for this, you need a healthcare provider who will become your long-term partner in finding the collection of treatments that are right for you. (Refer back to the chapters in Part I about communication and creating partnerships with your healthcare provider.) The *painACTION* article, *"How to understand migraine treatments"* summarizes and explains various migraine treatment options.

Preventing Migraine: You in the Driver's Seat

While there is much about migraine causes that is not understood, we do know that there are lifestyle, food and preventive measures that you can take to prevent the headache or at least reduce its power. Rather than feeling the helpless victim of your headaches, you can be in the driver's seat and take some control. Here are several suggestions to discuss with your healthcare provider, and you can find many more, in the articles, lessons and tools found on the Migraine Section of *painACTION*.

Traveling Food

As you travel toward your destination of migraine management, consider the food that you take along on your journey. Many foods

and beverages, including cheese, chocolate and caffeine, have been shown to trigger migraines in certain people, although in some cases, caffeine is also used to *control* migraines. These *painACTION* sources discuss the relationship between what you eat and drink and migraine headache in more detail:

- *"Understanding migraine triggers"* (Article)
- *"Caffeine and migraine"* (Article)
- *"Can drinking alcohol cause migraines?"* (Article)
- *"Hypoglycemia and migraine"* (Article)

Lower the Stress

Your levels of stress, anxiety and depression can trigger migraines, so experts recommend that you incorporate stress-reduction techniques into your life. Here are a few ways to do this. There are many more on the *painACTION* website:

- *"How to cope with emotional distress"* (Lesson)
- *"Depression and pain: breaking the cycle"* (Article)
- *"How to use relaxing images to reduce pain"* (Lesson)
- *"Six ways to reduce anxiety"* (Article)

Broaden Your Options

If you are getting frustrated because your migraine headaches have not responded to treatment, you are not alone. Half of all people with migraines decide to stop seeking care for their headaches partly because they are dissatisfied with the treatment. But before you go that route and decide to simply live with the pain, consider broadening your options. Research shows that combining treatments from several different medical specialties—called a "multidisciplinary" approach—can be helpful in the treatment of migraine. The *painACTION* article *"Holistic migraine treatment"*, describes a holistic, multidisciplinary approach to migraine treatment, including biofeedback, relaxation training, herbs and botanicals, cranio-sacral therapy, yoga and Tai Chi.

Other *painACTION* resources:

- *"Positive Frame of Mind"* (Tool)
- *"Relaxation Response"* (Tool)
- *"Using biofeedback to manage migraines"* (Article)

In Summary...

- Migraines are sometimes set off by a combination of causes—also called "triggers", and these may be different for each person
- It is important to have a complete diagnosis and assessment of what is causing your migraines so you can arrive at an effective treatment plan
- As is true for most types of chronic pain, when it comes to migraines, there is usually not one single solution, but a group of strategies – Don't give up!

Chapter 9

Cancer Pain: Changing Your Destination

If you are a cancer survivor, your pain management journey is unique: You most likely began your travels with the goal of simply surviving the disease. Pain was probably not uppermost in your mind when you first received your cancer diagnosis. Now that treatments are better at battling your disease, or maybe have put it into remission, you may find yourself revising your travel destination: You would now like to live more comfortably, with less pain.[1] In this chapter we will talk about the major sources and types of pain for people with cancer as well as treatment options for each. The *painACTION* section on cancer has additional information about coping with cancer pain, and also has expert advice about the effects of cancer on your family.

Cancer isn't always painful. But if you do have pain, it is important to tell your healthcare providers and to expect to work in partnership with them to manage it. *You have the right to pain treatment, so do not be shy about expressing your need for help*. At the same time, you must do your part by sharing the details of your pain experiences with your providers. Everyone's pain is different, so no one but you knows when there's pain and exactly how it feels. Also, everyone responds differently to pain and pain treatment, so what works for one person may not work for another. Chapter 1, on partnerships with your providers, as well as Chapter 4, on communication are particularly relevant if you are dealing with cancer-related pain.

Where Does Cancer Pain Come From?

Cancer-related pain usually comes from one or both of these sources:

- Pain due to the cancer itself, such as a tumor pressing on a nerve or organ

1. The discussion of cancer related pain assumes that your cancer is controlled or in remission

- Pain due to cancer treatments:
  - *Chemotherapy* side effects may include mouth sores, pain and tingling in the fingertips, pains in your bones or joints when you walk or move.
  - *Radiation* side effects can include skin reactions and localized pain. For example, radiation to the head or neck may cause a sore throat.
  - *Surgery and/or other procedures* can cause pain to incisions and during recovery. In addition to being painful, cancer surgery is scary: You might worry about what will happen during the operation. You may wonder what the surgeon will find, and whether you'll be in pain afterwards. It's common to feel alone at this time, and to be anxious about the future. The *"Coping with pain after cancer surgery" painACTION* article describes the physical and emotional effects of surgery and its after-effects, including pain.

Two Kinds of Pain

No matter where your cancer-related pain is coming from, it usually falls into one or both of these two categories:

- *Nociceptive pain* is pain caused by stretching, pressure, or injury to tissues, muscles or organs anywhere in the body and includes aches or pains deep within the body.
- *Neuropathic pain* is caused by pressure, injury or irritation of nerves. People usually describe it as burning, stabbing, shooting, or electric-shock like pain. Neuropathic pain can come on without warning and persist, on and off, for weeks or months.

While there are specific things to do for pain associated with radiation, chemotherapy and surgery (and these are described in the article), treatment depends on the *type* of pain you are having, and whether it is mild, moderate or severe. As described in earlier chapters, it is the *quality* of the pain—and your own experience of it, including how

it is affecting your life—that is most important. This is why **it is critical to communicate and work in partnership with your healthcare providers**—your travel guides in your journey to manage cancer-related pain. Common cancer-related pain problems, discussed in more detail in the article *"Pain treatment options for cancer"*, include skin reactions to radiation, mouth sores due to chemotherapy, as well as swelling and pain (lymphedema) after cancer surgery.

As with other types of chronic pain, it is very important that you seek professional help in managing cancer-related pain. Be sure to tell your healthcare provider everything you are doing or taking—including herbs, dietary supplements and over-the-counter medicines—for your pain, since there can be dangerous interactions.

Emotional Pain

When coping with cancer, the physical pain you might have is only part of the experience. You are also dealing with a serious, frightening, unpredictable disease. It is only natural for you to have some emotional discomfort as well, especially when it comes to your children and other family members. The *painACTION* cancer site has several articles, lessons and tools to help you cope with the physical and emotional pain that cancer brings. Here are just a few examples of the advice you will find there:

- Realize that you are more than your body
  You are still "you," even if your body has changed, or parts of your body don't work like they did before
- Ask for help
  Reach out to get help from your caregiver, partner, friend, or another family member
- Recognize the healing power of time
  As you recover from surgery and/or cancer treatments, you will be able to move on with your life, even if it doesn't feel that way right away

Share your wide range of feelings

Communicate with a professional, a cancer support group, or by writing in a journal. Even if your cancer has been found and treated, you may still feel grief, anger, shock, or resentment that this illness happened to you in the first place. All of these feelings are normal

Seek spiritual support

Spiritual and religious practices and beliefs may help you to cope with the pain of cancer and with the uncertainty and fear of a cancer diagnosis. Many people rely on faith to make sense of their lives and to feel connected to others—but you may also be looking for a connection to something larger: This could be some form of higher power or "god;" or maybe the worlds of nature, music or art; or even a deep attachment to the people you love. For some people, spirituality comes in the form of organized religion, but this certainly is not necessary. Spirituality is found in all cultures and, for many people, it also includes a search for the meaning of life. If you are interested in reading more, go to the *painACTION* article *"Coping with cancer through spirituality"*

In Summary...

- You have the right to pain treatment, so do not be shy about expressing your need for help
- Cancer pain may be related to the cancer itself, or as a result of its treatment
- It is critical to communicate and work in partnership with your healthcare providers to manage cancer pain
- When coping with cancer, the physical pain you might have may only be part of the experience. There could be emotional aspects of your pain that need to be addressed

In Closing

You are now at the end of your journey through this book, but that does not mean your travels have stopped. Managing pain, whatever its origin, for some, can be a lifelong journey. The message of this book is that *you* can be in control of this journey, accompanied by healthcare professionals as your "travel guides," as well as resources like this book (your "road map"), and the *painACTION* website.

While you would like to be completely free of pain (who wouldn't?), your key to successful pain management is to recognize that the most realistic goal is to improve the quality of your life and be able to achieve your goals in work, relationships and the activities you enjoy.

There is a Buddhist saying: "Pain is inevitable; suffering is optional." We all have pain, to one degree or another; what makes the difference in life is how we choose to understand and manage it. With this attitude, you will be able to have the quality of life that you want with the type of pain that you have.

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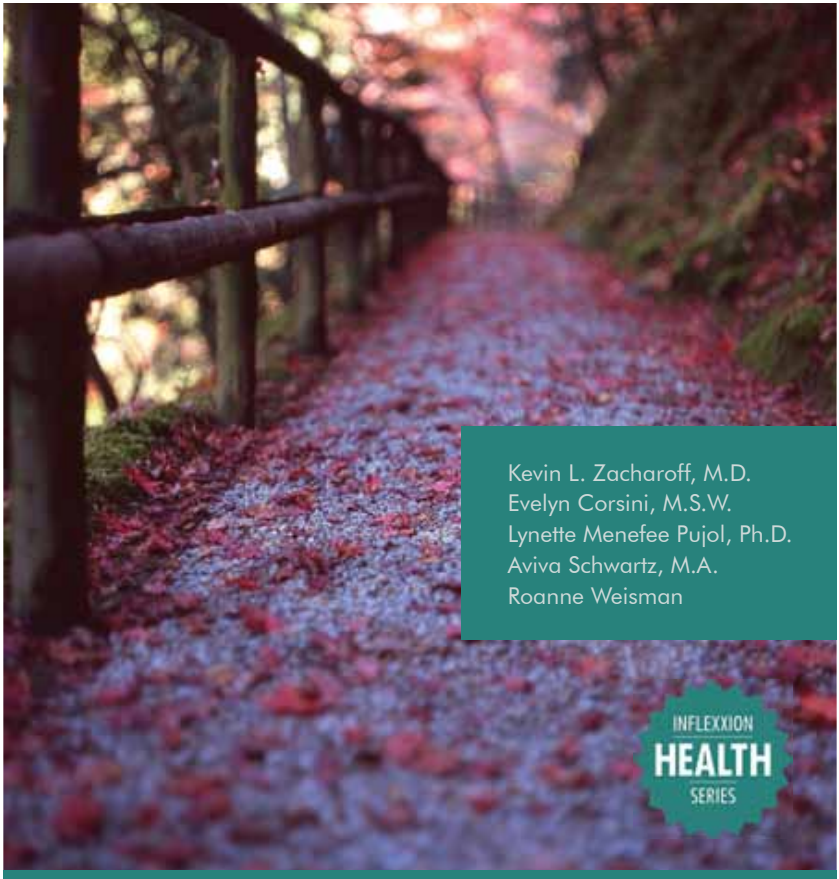
Your Guide to Pain Management

A Road Map for painACTION.com

2nd Edition



Kevin L. Zacharoff, M.D.
Evelyn Corsini, M.S.W.
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Kevin L. Zacharoff, M.D.
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Roanne Weisman

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320 Needham Street, Suite 100 • Newton, MA 02464

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Preface

When you are in pain, nothing else seems to matter. All of your attention is focused with a laser-like intensity on the sensations within your body. Whether your pain comes from an aching back, throbbing in your head, the total body discomfort of cancer and its treatment, or any other pain condition, you feel as though your world revolves around your pain. Because of your pain, you may not be able to go to work or participate in the relationships and activities you enjoy. As a result, you may find yourself feeling depressed or hopeless because you see no end to your suffering.

Do not despair! Help is at hand. *Your Guide to Pain Management* along with the *painACTION* website, on which it is based, will give you the information and unique tools you need to understand your pain, choose the best treatments, adopt effective lifestyle changes, and find a supportive, informed community to help you.

Your Road Map to Pain Management

At times, you might feel as though you are the helpless victim of your pain. We at *painACTION* want to help you change that perspective. With the information and tools available to you in this *Guide* and on the website you can take control of your chronic pain. Think of yourself as an explorer in search of the best ways to manage your pain and live a full, satisfying life. This journey may lead you to new places that are unfamiliar to you, but you can use this book as your "road map" and travel guide. It will direct you to resources and information you need on your journey, while helping you avoid pitfalls.

In particular, this *Guide* will give you detailed information about building a productive partnership with your healthcare provider, and help you develop effective skills for self-management, communication, and coping. You will also learn about the safe use of pain medications. While there are many kinds of pain, our focus here is specifically on back pain, migraine pain, cancer-related pain, neuropathic pain,

arthritis pain, and the pain experienced by returning military service members. You may also find that the information is useful if you are dealing with other kinds of pain.

Are you ready to set off on your journey to effective pain management? If so, read on to learn more about the *painACTION* website and this companion book, *Your Guide to Pain Management*.

painACTION: Helping You Take Control

The *painACTION* website is a useful online resource that helps people with chronic pain take control of their pain and live fulfilling, satisfying lives. Together with this companion *Guide*, *painACTION* will provide you with the tools and resources you need to help manage back pain, migraine pain, cancer-related pain, neuropathic pain, arthritis pain, and pain experienced by returning military service members. The website and this *Guide* provide:

- The latest, scientifically proven pain treatment strategies, including complementary/alternative methods
- Expert advice tailored to *your* personal needs
- Informative articles, comprehensive lessons, interactive self-assessment, and self-help tools, to use in your journey toward effective pain management
- Inspiring stories of people who are successfully managing their chronic pain
- A supportive community of fellow "travelers" and renowned pain experts to call upon whenever you need them

Turn the page to learn more about chronic pain and the effective techniques that will help you take control of your pain!

Introduction

Not all pain is bad. In fact, in some situations, pain can actually be helpful. It can warn you that a stove is too hot or be an early warning sign of a potentially serious illness or a tumor. Chronic pain however, usually serves no useful purpose. The International Association for the Study of Pain defines pain as, "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage... *Pain is subjective.*" What does this mean? It means that *your pain is real*, and you have the right to treatment, even if your healthcare provider can't find a physical cause for your discomfort. In the year 2000, pain was categorized as "the fifth vital sign," meaning that during every medical encounter, health care professionals should ask if you are in pain, in addition to checking your pulse, temperature, blood pressure, and respiratory rate.

Chronic pain—pain that persists for three months or longer, even after the original cause has healed—can itself become a major focus of disability or dysfunction. Chronic pain can evoke emotions like fear, depression, and hopelessness (because we can see no end in sight), despair, and isolation. These emotions may be coupled with the feeling of being out of control and the victim of your body. Because of this complex interplay of emotions, the effective treatment of chronic pain requires a holistic, multi-dimensional approach—focusing not only on the physical cause, but also on your feelings, beliefs, and life-coping skills. This approach is precisely what the *painACTION* website and this *Guide* offer you. Before we begin, however, let's take a closer look at chronic pain.[1]

1. Acute pain, which generally has a specific cause, such as injury, disease, or surgery, and lasts for less than 3 months, is not the focus of this book or *painACTION*.com.

All About Chronic Pain

You are probably reading this book because you are experiencing some form of chronic pain. If so, you are not alone. An *Institute of Medicine* report from 2011 states that chronic pain affects at least 100 million American adults; more than the total affected by heart disease, cancer, and diabetes combined. The report describes that chronic pain represents a national challenge. About one-third of people who report pain indicate that their pain is "disabling," defined as both severe and having a high impact on functions of daily life.

There are many causes of chronic pain. If you are experiencing back pain or migraine pain, you have plenty of company. These are the two most common forms of pain. In addition, based on 2003-2005 data from the National Health Interview survey, 46 million American adults reported doctor-diagnosed arthritis, which represents a considerable cause of chronic pain as well. Among people undergoing active treatments for cancer, an estimated 30 to 50 percent of them experience significant levels of pain. This rises to 70 percent for those with advanced stages of the disease, according to the National Cancer Institute. Because neuropathic pain may be sometimes harder to diagnose and categorize, how often it occurs is unknown.

This is why the *painACTION* website focuses on these five main causes of pain (back, migraine, cancer, arthritic, and neuropathic pain). In addition, the number of military service members coping with chronic pain continues to rise. The annual cost of all kinds of pain in the United States, including healthcare expenses, lost income, and lost productivity is estimated to be $635 billion. Of course, this does not include the additional toll that pain may be taking on family life, social relationships, self-esteem, and happiness. In fact, the psychological component of chronic pain is so important that it is featured in an article on the *painACTION* website, titled "*Pain and the brain"* by psychologist Robert N. Jamison, Ph.D. We are including a summary below, but recommend reading the entire article, when you have the time.

You will find many articles that are equally informative on the website, so be sure to take time to explore *painACTION* as you read this book.

Pain and the Brain

"Pain is complicated. It is a result of much more than the initial disease or injury that sets it off," writes Dr. Jamison. In the past, explains Jamison, people believed that pain signals traveled only one way—from a nerve injury up to the brain. Scientists have now learned that the brain has the ability to act like a "gate," controlling the pain messages that are received and sent out from it. They call this the "Gate Control Theory" of pain. An important part of this theory is that in addition to *receiving* pain signals from the body, the brain can also send messages that block painful sensations to different parts of the body.

The power of the brain to block painful sensations is one of the reasons why pain is such a deeply personal experience, so the more you understand about your pain and its particular "triggers," the more you can play a role in blocking them. And the more active a role you can take in managing your pain, the better your chance of success. Research, for example, tells us that people who feel a sense of control—of ownership—of their health actually do better clinically than those who feel that they are helpless victims of their illness.

One way to take control of your pain, Dr. Jamison says, is to use physical, mental, and emotional gatekeepers to "close the gate," thus reducing pain sensations. Read the *painACTION* article, "*Pain and the brain"* to see several examples of these pain "gatekeepers;" and the rest of this *Guide* as well as the website will tell you how to use them.

Physical gatekeepers include:

- Medications
- Surgery
- Stimulation by heat, massage, or acupuncture
- Techniques to reduce muscle tension

Emotional gatekeepers include:

- Your optimistic feeling that things will get better
- Social support from family, friends, co-workers, and healthcare providers
- A healthy mental attitude
- A lowered level of anxiety
- Management of depression

Mental gatekeepers include:

- Distraction (taking your mind off the pain)
- Humor
- Actively taking charge, rather than passively waiting to see what happens
- Having feelings of control over the pain

An important goal of the *painACTION* program is to help you break the vicious cycle of chronic pain. The pain makes you feel anxious or depressed, which then contributes to more pain, which then causes more anxiety and depression...

Dr. Jamison's article shows how you can break the cycle. The article provides you with information on how to take control of your pain. And by using the *painACTION* program, you can gain a better understanding of your pain and control of how you perceive pain. You will also identify how your personality, family history, and level of emotional distress contribute to your pain. Pain experts have discovered that people who are not too anxious, worried, or depressed; have strong social support; and a generally optimistic outlook; are better able to be distracted from their pain, keep a more objective, realistic outlook, and find good ways to actively cope with their pain.

Part I

Your Pain Management Journey: Starting Off

Your Pain Management Journey: Starting Off

No matter what your chronic pain experience is, the chapters in this section will help with several aspects of your journey to pain management. The skills and ideas in this section apply to all forms of chronic pain. Topics include working with your healthcare team, finding reliable information, taking responsibility for your pain, dealing with your emotions, and understanding your medications.

Part II of this book gets more specific, with chapters that focus specifically on back pain, migraine pain, cancer-related pain, neuropathic pain, arthritis pain, and the pain experienced by military service members. Before you go into the chapters most relevant to you, however, it is a good idea to read the *Introduction* to that section. It will help you understand what the various kinds of pain have in common and how they are different, and will give you a better understanding of your own personal journey to pain management.

Chapter 1

Productive Partnerships: Working With Your Healthcare Providers

When it comes to pain, you don't have to go it alone. It may not take a village, but it certainly does take a team to manage pain—and *you* are a very important member of this team! This chapter is about working as a partner with your doctors, nurses, and other healthcare providers, to control and manage your pain. Along your journey to managing your pain these people will be your "tour guides." But, in order to guide you properly they need to know: Where do you want to go and what is pain stopping you from doing? Perhaps you want to be able to:

- Have more fun with your children
- Sleep more comfortably
- Play golf or tennis with your friends
- Travel
- Spend more time at work
- Walk with less pain
- Perform daily tasks easily

Whatever your goals are, it is important that you talk with your healthcare providers about them, along with the best ways to achieve them. Some of your goals may not be realistic, at least for now. For example, if you have severe pain, you may not be able to train for a five-mile run. However, you may be able to use a guided weight-training program and exercises to build up to a couple of miles of brisk walking. After that, who knows what your limits will be?

To begin, make two lists on a sheet of paper about who is on your healthcare team. In one column, write down the names of your healthcare providers. This might include:

- Your primary care doctor
- Nurse or nurse practitioner
- Pain specialist
- Physical therapist
- Bodywork or massage therapist
- Physician assistant
- Alternative practitioners, such as an acupuncturist
- Psychologist or social worker

The second column should include your own name, as well as any family members or friends who are helping you. These columns form the two sides of your "partnership team." This chapter will describe the roles and responsibilities for individuals on each side of this team to help you create the kinds of healthcare partnerships that will help you manage and control your pain.

Ideally, each side of the team should have *equal responsibility* – split 50-50 between you and your family or friends on one side and all of your healthcare providers on the other. *This means that you should have a say in every decision that is made about your pain, such as:*

- Medications
- Exercise plan
- Special procedures and other treatments
- Surgery

One way to think about your partnership with your provider is to imagine that you are working together to fight a forest fire. Even if you can't completely put out the fire, you can stop it from burning out of control, or at least you can slow it down so that it only flares up once in a while. In working with your provider to control your pain, you will always be balancing two goals:

1. What you would *like* to do for work, family life, and recreation
2. What you *need* to do for your pain, including medication, exercise, diet, and activities (for example, you may need to cut down on some of them).

The trick is to find the *best balance for you* at any given time.

Creating a Medical Home

Once you've completed your list of providers, choose either your primary care physician or nurse practitioner as the one who will oversee the "big picture" of your care to address all of your healthcare needs. This person and his or her team will become your "Medical Home." This term refers to a team-based approach to healthcare, the team being *you* and your healthcare provider. As a partner, your healthcare provider can guide you throughout your pain control journey by helping you navigate through all of your medical care (visits, prescription medications, and referrals to specialty care, like a rheumatologist if you have arthritis). They can also help to coordinate ongoing services that you may need like physical therapy, home health care, complementary and alternative medicine treatments, exercise programs, and family and support services. For more information, read the article, *"Your primary care provider: The center of your treatment"* on the *painACTION* website.

Your primary care provider will always be there to give you trusted medical advice, since he or she knows you best and understands your needs and concerns as well as the details of your home and work life. For your treatment to proceed safely, be sure to share all information about your diet and any over-the-counter medications you may be taking, including herbal supplements. Your medical home is also a source you can rely on to help you sort through all the information you may be hearing on television or reading in the news or on the Internet. For details on how to find trustworthy medical information, please see Chapter 3 on knowledge-based skills.

What to Expect From Your Medical Home

The provider you choose to coordinate your care has several responsibilities. Here are some ideas of what you can expect. You should feel free to discuss with this provider how you would like to work together to:

☑ Figure out what is causing your pain

When you have unexplained chronic pain, it is a good idea to make your *first visit* to the person you have chosen as your medical home provider, such as your primary care doctor or nurse practitioner. By listening and talking with you, this provider will have the best chance of determining the source of your pain and in helping you choose the best combination of ways you can help yourself, along with medicine or treatments. For more information about taking control of your pain, see Chapter 2. Whenever you talk to your medical home provider, it is very important that you *freely ask every question that occurs to you, as well as share details about your life, your diet—including supplements and over-the-counter medicines—and your regular activities.* This is the kind of information that will help your provider make an accurate diagnosis about the cause of your pain.

☑ Help you decide on realistic treatment goals

As mentioned earlier in this book, it may be difficult to eliminate your pain completely. However, it is the responsibility of your provider, always in consultation with you, to recommend the best ways to *at least reduce* the pain and improve your ability to live a satisfying life. In order to do this, your provider needs to know what your goals are and the ways in which the pain is preventing you from reaching those goals. The "destination" of your pain management journey may change over time, so it is important for you and your provider to keep talking and listening to each other. There are several articles and lessons on the *painACTION* website that can help you communicate with your provider. Examples are the lesson, *"How to set reachable goals"* and the article, *"Your pain goals: Fantasy or reality?"*

Create a Treatment Plan

Your medical home provider will also assist you in creating a customized treatment plan. Your plan will consider the source of your pain and available treatments, your physical abilities, and the lifestyle and behavior modification skills that are right for you. Your treatment plan should also include all the team members involved in your care in addition to your medical home (for example, social workers, physical therapists, and any other specialists), so that your treatment plan reflects a smooth course of care among all the members of your team.

The goal of your treatment plan is to reduce and manage your pain, improve your physical activity, restore and maintain daily functioning, and identify other issues that also need treatment, such as depression, anxiety, insomnia, and fatigue. So, it's important to stick to the plan. You can read the articles, *"Why it's important to follow your treatment plan"* and *"How to stick to your medical plan"* on *painACTION*.

Personal Perspective: Your Half of the Partnership

You, as the patient, have as much responsibility as your healthcare team for managing your pain. No one else is inside of your body, and no one else knows exactly how you are feeling. Even if you share this responsibility with a family member, friend, spouse, or other non-medical person, you should have the "big picture" view, just like your medical home provider. This is especially important in the treatment of pain, *since pain is the only medical condition in which the patient has the final say in how successful the treatment is*. Here are some ways you can take charge of your pain treatment:

☑ Coordinate your team

You may decide, in the course of your treatment, that you wish to add another provider to your "team," such as a chiropractor, a massage therapist, an acupuncturist, psychologist or other mental health professional. This is fine, as long as you keep your medical home provider informed of what you are doing and whom you are seeing and make those decisions together.

Keep it going

No matter who you bring onto your team, the key to successful pain management is a *long-term relationship with your medical home provider*. Ideally, this person has known you for some time and understands your life goals, treatment preferences, stresses, relationships, and medical/personal history. You trust and respect each other and feel comfortable challenging and raising questions in an open discussion of treatment options.

An Expert Opinion

Some examples of productive partnerships

Here are examples of some questions you might ask your healthcare provider as part of a "productive partnership" discussion about your pain:

Q Why can't my healthcare providers relieve my pain completely when there are so many "miracles" that medicine can provide?

A This is an excellent question, and a source of distress for many patients, who see medical advances on TV every day, yet can hardly walk because they cannot find adequate relief for their aching backs. The simple truth is contained in your question: the fact is that despite all available medical technologies we are often able to *control* chronic pain, but we are almost never able to completely get rid of a chronic pain problem, unless the reason behind it is easily correctable. In fact, the patients who succeed most in benefiting from pain management techniques are the ones who accept that they will not be able to get rid of their pain problem, and seek help to reduce their level of pain and improve their level of functioning. Why have we not done better? This is a matter for speculation, and people will have different opinions. One important reason is that very little funding has gone into improving the understanding and

treatment of chronic pain. For example, only a tiny fraction of federal funding for medical research goes to pain research.

Q I've been told to exercise, but every time I do, my pain increases. Doesn't my healthcare provider understand I can't exercise?

A Talk with your healthcare provider about your difficulty exercising, if you haven't done so already. Pain experts tend to encourage their patients to exercise because exercise can help patients with chronic pain in many ways. Exercise can increase your ability to function in your day-to-day life, can help reduce pain, can improve mood, and improve sleep. Of course, if you can't exercise because it increases your pain, you will not be able to reap these benefits. The good news is that there are a variety of things you can do to get around this problem. First thing is to "take baby steps" and begin with exercises that you *can* do before moving onto the more difficult ones. Next, use ice or heat before, during, or after the exercise; take a pain medication an hour before you plan to exercise. A good physical therapist, and an attentive healthcare provider, should be able to guide you through this problem.

In Summary...

- Identify your "destination" – with regard to your goals and what you want to achieve when managing your pain
- Construct a list of your healthcare providers, and their role in managing your pain
- Find a "Medical Home" that can coordinate all of your care and understand all of the pieces of the puzzle
- Understand your responsibility in managing your pain
- Become a partner in your pain management, not a "passenger"

Chapter 2

Take Control of Your Pain

When you are in pain, do you sometimes feel like a helpless victim, just waiting for it to go away? Many people have this experience. It is easy to become overwhelmed and hopeless when it seems like pain has taken over your body.

This chapter is about a new way to deal with your pain, by *taking control* and directing your own journey to pain management. While you may not be able to eliminate your pain entirely, you can, with the *self-management skills* you will learn in this chapter, manage it and feel less helpless.

What Are Self-Management Skills and How Will They Help Me?

The painACTION lesson *"How to take control: self-management and pain"* explains it this way: *"Self-management means taking care of yourself and your needs, in a healthy way. A person with self-management skills understands how to keep track of his/her symptoms and treatments. He/she also knows that his/her thoughts and actions can change how his/her illness behaves on any given day."*

Self-management skills can be learned. They are not based on who you are, but on what you are able to do for yourself. Self-management does *not* mean taking over from your healthcare providers. It means working as an equal partner with them to manage your pain. After all, you only see your healthcare provider for about fifteen minutes or half an hour at a time. What about the hours, days, and weeks between your appointments? During these times, you need to be able to take care of yourself, just as a "savvy traveler" may head off to a destination without a tour guide for parts of the trip. Yes, you need to take the prescribed medication and follow the advice you are given, but there is much more you can do as well. Here are some examples:

Notice How You Are Thinking About Your Pain

What you believe really does make a difference in how you feel. For example, do you believe the following facts about pain? (Hint: they are all true.)

- Successful pain management usually takes several different approaches, rather than one "magic bullet."
- Studies show that *passive* methods–using only rest, hot/cold packs, and medications to treat pain – are less effective and are linked to more chronic pain and disability than *active* treatments (exercise, for example).
- Confident people usually have better results with pain management.
- Getting more control over your stress and feelings like depression and anxiety can help to manage your pain.

If you would like help with changing the way you think about your pain, talk to your healthcare provider or ask for a consultation with a social worker or a psychologist.

Keep Track Of Your Pain

In order to help you, your providers must learn how, when, and where you're hurting, and *you* are the only one who can tell them. The ***"Daily Tracker"*** tool, which can be found on the *painACTION* ***My Page***, will help you prepare the information you need to bring up during your medical appointments. This includes:

- The intensity of the pain
- How well your medications work
- Your ability to manage the pain
- How the pain interferes with your daily routines, sleep, mood, and relationships.

The *Daily Tracker* will also teach you accurate ways to describe your pain, because some days it may be worse than others. You can think of this as your "travel journal."

Take an Active Role

There are many ways to be active in your pain management program. Here are just three of them:

☑ Become physically active by exercising

Exercise is truly the most active part of self-management, although it works best when it's started gradually and properly paced. Exercise builds strength and flexibility and causes a natural "antidepressant" effect–which is important as many people with chronic pain become depressed. Need more motivation? If you *don't* exercise, you can experience stiffer joints, weak muscles, less stamina or "staying power," and lower pain tolerance.

☑ Become an active learner

Find out everything you can from your providers and the sources they recommend about your diagnosis and your medications (including side effects and the dangers of missed doses).

☑ Become a problem solver

Problems are inevitable. These might include pain flare-ups, medication that no longer works, or difficult life events. How are you going to deal with them? First, take a deep breath, and then consider the following steps:

- Clearly identify the problem. This may take some time, as the actual problem may not be immediately obvious.
- Decide on your goals. What do you want to accomplish in this situation?
- Figure out your options. What are the possible solutions?
- Pick the most likely solution.
- Take action.

Be Your Own Advocate

Advocates are those who fight for the rights of others. You, as the person who knows your pain best, are your own best advocate. So don't be shy! Ask questions. State your preferences and let your voice be heard. If, for example, you prefer not to take pain medications ask if there are alternatives. Sometimes exercise programs, such as "back pain boot camp," or changes in your diet to control migraines, can help avoid or limit the need for pain medications. Other options, described on *painACTION*, include biofeedback and alternative treatments, such as massage and acupuncture.

Another important way in which you can be your own advocate is to participate fully in your visit to your healthcare provider. An article from *painACTION, "Medical appointments: Making the most of your visit"* lists ways you can do this, including: transferring your records, collecting and bringing important information, making a list of questions, bringing someone with you to take notes and remember what was said, scheduling enough time, repeating back what you hear in summary at the end of the visit, and requesting a copy of any important materials. The article also discusses ways to make important decisions about your treatment and management, keeping a pain diary, and making follow-up plans.

Even as you advocate for yourself, there is always a community of others to support you. This can be your personal relationships including, family, friends, or clergy, or it can be pain organizations and support groups, such as those listed on *painACTION*. If you join the website, you will also find a ready-made community of professionals and other patients who are always available for questions, guidance, and support.

Taking Control of Pain

Here are examples of questions from patients who are taking control of their pain. These questions show patients how to follow some of the advice in this chapter by acting as advocates for themselves, becoming active learners, and making their preferences known.

An Expert Opinion

Q My pain keeps me from sleeping. What can I do to help me get at least one good night of sleep?

A Difficulty sleeping is one of the main problems experienced by patients with chronic pain. Sleeplessness in turn seems to make pain worse, causes anxiety, irritability, depression, and daytime fatigue, and makes it much more difficult to cope with the pain. Therefore, getting a decent night's sleep every night is a critical necessity for patients with chronic pain. There are many ways to approach this problem, and your healthcare provider should be able to provide you with advice about how to get proper sleep.

The basic approaches, called "sleep hygiene," are those followed by any person with insomnia. Such approaches include avoiding napping during the day, avoiding caffeine, exercising during the day (but not close to bedtime), avoiding stimulating activities (such as TV) in bed, and reserving the bed for sleeping. A nighttime snack or glass of milk or tea may also help.

For patients with chronic pain, other techniques may be needed. First, it is worthwhile to remember that many medications and some medical problems may cause insomnia as a side effect. When it is the pain itself keeping you awake, changing your sleep surface (e.g. a different mattress) may help. Finally, a number of medications may help with this problem. Taking an extra dose of a pain medication at bedtime (with your healthcare provider's approval) may help, although it's worth remembering that short-acting medications may wear off in the middle of the night, and some may even cause a "rebound effect," leaving you with more insomnia when they wear off. For that reason, long-acting pain medications are better for maintaining sleep than short-acting ones.

Finally, there are a number of "sleeping pills" that can be used to help with this problem. It is important to remember that none of these strategies are intended for you to try on your own. These are issues you need to discuss with your healthcare provider and decide to try *together*.

Q Ever since my pain began I have been steadily gaining weight. What can I do to lose weight? Is there a special diet I can follow?

A First remember that there are many reasons a person with chronic pain may gain weight, and it is important to figure out the correct reason. Weight gain can be caused by a variety of medical problems, such as hypothyroidism or edema (swelling), so you need a thorough medical evaluation, including blood tests, if you are starting to have unexplained weight gain.

Second, some medications can cause weight gain as a side effect. People who develop mood disturbances, such as anxiety or depression, can have changes in their weight. Finally, the most common reason for weight gain in a patient with chronic pain is that they are eating more, exercising less, or both. This can be caused by a change in daily routine, such as not working any more, or not sleeping as well, which creates more opportunities to eat. There are many ways to deal with this that your healthcare provider can direct you to. Finding a good nutritionist to help on the eating side, and a physical therapist to help on the exercise side, may be useful.

Q Physical therapy only makes my pain worse, but doctors often prescribe physical therapy. Why do they keep prescribing treatments that don't work?

A You may have a legitimate complaint, in that healthcare providers who are not as aware of all the options for pain management may continue to prescribe, in vain, the only treatments

they know about, including physical therapy. But there may be another explanation: healthcare providers know that exercise is critical for the recovery of most patients with chronic pain. A good physical therapist will try to help you gradually increase the amount and type of exercise that you do, and will give you specific advice on tricks you can use to tolerate increasing your level of exercise (such as ice, heat, massage, exercising in water, and pacing yourself).

Many patients fear exercise because they are concerned about harming themselves; it is critical to get a clear statement from your healthcare provider that even though you may feel increased pain while you exercise, that does not mean you will harm yourself. Finally, your healthcare provider may be able to work with your physical therapist to find medical strategies (such as taking your pain medication an hour before exercise) that allow you to tolerate your increasing level of exercise.

In Summary...

- Notice how you are thinking about your pain
- Keep track of your pain
- Take an active role in managing your pain
- Be your own advocate
- Take control of the situation; don't let it control you

Chapter 3

Knowledge is Power

With pain, as with travel, what you don't know *can* hurt you. It is important to know where the pitfalls are and what to trust. This chapter tells you why it is important to seek out reliable information about your pain and its treatment. It also tells you how to find out what you need to know as you begin your pain management journey, and how to figure out the sources of information that you can safely rely on. When you are in pain, it is important to learn about your condition and the various possible treatments. Why? Then you will be able to work in partnership with your healthcare provider to make the best choices. As you embark on your "search and discover" fact-finding mission, there are two main ways to find out what you need to know:

- From your healthcare provider
- On your own

This chapter tells you how to make the best use of both sources.

Your Medical Home: The First Stop On Your Journey

In Chapter 1, you learned about the idea of a "medical home." This is the provider and clinical team overseeing your care, where you can feel as if you are "at home." Your medical home is also your best source for trustworthy advice and information. Often, the person you have the most contact with in your medical home is your primary care doctor, but it can also be a nurse or other healthcare provider. The key is that the medical home has all of the information about you, your pain condition, your other health conditions, your activities, your life situation, your family, any treatments you are having—including "alternative" therapies, and all medications you are taking, including herbal remedies and all over-the-counter medicine or supplements.

Your medical home provider is an excellent first stop on your fact-finding journey, since this provider knows enough about you to be

able to direct you to information that is relevant to your pain, your preferences, and your treatment. *It is important to realize, however, that this is not a one-way flow of knowledge—from provider to you. It is also important for knowledge to flow in the other direction—from you to your provider, especially about any treatments you are having (such as chiropractic, massage, or acupuncture), and any over-the-counter supplements or medications you are taking.* You can also ask for clarification about information you received from another source, for example, "my massage therapist thinks that I would benefit from a yoga class. What do you think?"

Questions to Ask

Now that you know where to begin your fact-finding journey, what other kinds of questions should you ask? Here are a few examples. The answers may be spoken during a conversation, or your provider may give you written materials or direct you to a reputable website for more information:

- What is my exact diagnosis?
- What are the likely causes of my pain?
- What can I do on my own, including diet, exercise, and stress reduction? (See Chapter 5, "Coping with Your Feelings")
- What tests do you recommend (e.g. MRI, CT scan)? Can you explain how they are done?
- What procedures do you recommend? Can you explain them?
- What medications do you recommend? What are the side effects?
- Would surgery be indicated, and what kind? (You would also want to talk to a surgeon in this situation.)
- What can I expect, realistically, in terms of feeling better?
- What websites do you recommend?

Second Opinions

If you are not satisfied with the answers to these questions—or even if you are—you might want to hear from another healthcare provider. This is a good idea because it gives you different perspectives on the same problem. You don't have to worry about hurting someone's feelings by asking for a second opinion. Any reputable healthcare provider would welcome your right to talk to another provider, and would not be threatened or insulted in any way. After all, you are the "boss" of your own body and you need to be completely comfortable about any treatments.

A few guidelines about second opinions however:

- *Do* make sure that any second opinion that you seek is from another provider of the same type as your first one.

- *Don't,* for example, seek a second opinion from a chiropractor and try to compare that to the opinion you received from a primary care doctor. These people have different types of training, so it would be like trying to compare apples and oranges. If you are comparing opinions from specialists, make sure they are of the same kind: For example, two neurologists, two pain specialists, or two surgeons.

Your Internet Guide

In addition to talking with your provider and reading any written materials you are given, you might join the millions of people who turn to the Internet every day for medical advice and information. While the Internet is a wonderful resource, it can also be difficult to sort out fact from fiction and to find information you can trust and rely on. Here are a few guidelines. For more Internet advice, see the *painACTION* article, *"Caught in the Net? Online health information you can trust."*

Check the URL

After you type your question or topic into a search engine, you will see a list of relevant Internet sites. Instead of just clicking, begin by doing some screening. First, look at the URL, the web address after the name of the website. Generally the most reliable sites end with ".gov" (for government agencies), and ".edu" (for academic centers). You can also look for national organizations that provide information on the condition you are interested in, which will end with ".org." Just make sure these are nonprofit organizations, such as The American Cancer Society, *www.cancer.org.*

Other reliable sites

Even if the suffixes "gov," "edu," and "org" don't appear in a URL, the site still might be useful and safe, as *painACTION.com* is, for example. Here is a way to evaluate other sites: Is the site easy to navigate? Is the organization reputable? You can often determine this by doing a search on the organization itself to see if there are complaints or lawsuits. Is the site trying to sell you a product to improve your health? If so, warning bells should go off! View with suspicion any site that is trying to sell you something, whether it is a medicine, a food, or a health-related device. At a minimum, ask your health care provider for advice.

Evaluating Internet information

Once you are satisfied with the site itself, look closely at the information on it:

- Is it current? Always check the date that the information was posted. This usually appears at the bottom of each screen. If there is no date, beware! This might indicate that there is disproved or outdated information, or a sloppy, untrustworthy website.
- Is the information factual (rather than opinion or ranting) and backed up with references to primary sources, such as research studies?

- ☑ Are experts cited? Even if there are no research studies to back up the advice, there should be some other reliable source, such as a reputable expert who is associated with a major academic medical center, or a reliable research organization.

The guidelines in this article should help you become a smart information-gatherer and a savvy consumer, all of which will increase your chances of dealing successfully with your pain.

Want to learn more? Read the *painACTION* article, *"Online support groups: Getting connected."*

Other suggestions:

- The Medical Library Association's User's Guide to Finding and Evaluating Health Information on the Web - *http://www.mlanet.org* (search on "user's guide")
- MEDLINEplus is a consumer-oriented website licensed by the National Library of Medicine. It includes an online illustrated medical encyclopedia and dictionary. *http://medlineplus.gov*
- For evidence-based information about complementary and alternative therapies, visit the website of the National Center for Complementary and Alternative Medicine, part of the National Institutes of Health, which is an excellent consumer health information website. *http://nccam.nih.gov*

In Summary...

- Your medical home should be the first stop on your journey
- It's important to know what questions to ask your healthcare provider
- Second opinions can be helpful
- Choose your Internet resources carefully

Chapter 4

Communication is Key

In your journey to pain management, the healthcare providers you meet along the way can serve as helpful "tour guides." In order to help you, however, they need to know where you are going—your destination: What are the goals of your pain management and what would you like to be able to accomplish? This chapter is about how to help your healthcare provider help you during this important life journey. You might think, as many people do, that your doctor, nurse, physician assistant, or other medical professional knows everything about your pain. But this is only partly true. Your healthcare providers may know a great deal about pain in general, and how to treat it. But they probably don't know the details about *your* pain and its effect on your life. So it is important for you to tell them, to *communicate* with them about what your pain is doing to you in your own life. After all, you are the only person in your body, so you are the expert about your own pain! For example, is your pain:

- Making it harder for you to do your job?
- Preventing you from enjoying your favorite activities?
- Interfering with your sleep or your relationships?
- Affecting your ability to take care of your children or other family members?
- Causing you to become depressed or anxious?

No two people will answer these questions in exactly the same way, so that is why it is a good idea to share this information with your healthcare provider. Why is this so important? Because, as discussed earlier in this book, one key to successful pain management is *shared decision-making* between you and your healthcare provider about the course of treatment. Part of shared decision-making is *setting realistic goals and expectations.* If your provider does not know how your pain is preventing you from reaching your goals, how can he or she

give you a good idea of what the treatment should be and what kind of relief you can expect? And later on, how can you together decide if the treatment is working? If you want to take a journey, you need to know where you would like to end up. For tips about starting that conversation, you might want to look at the *painACTION* lesson, *"How to set realistic goals when you have chronic pain."*

Pain is Not a Score; It is an Experience

As they evaluate your pain, many providers will ask you to rate it on a scale of 0 to 10, "0" being no pain, and "10" being the worst pain imaginable. This is important information, but it is not enough, because *pain is not a score; it is an experience.* For example, if you have back pain, it is not enough for your provider to know that the treatment brought it down from a "9" to a "6." Your provider also has to know if your goal was to be able to play 18 holes of golf (or repair a transmission, sit at a desk for 8 hours, or pick up your grandchildren). Have you reached your goals? If not, the treatment has not been successful and you and your provider need to re-evaluate and come up with a different plan.

There is an old saying that if a healthcare provider simply listens and gives the patient enough time to talk about his or her problem, the diagnosis will become clear, even without a lot of expensive tests. But what if your provider is not a good listener, or doesn't give you enough time to talk? Here are some things you can say:

- "I know you are in a rush, but I would really like to tell you how this pain is making it hard for me in my life right now. Do you have a few minutes to listen?"
- "Thank you for this pill prescription, but what else can I do to help this pain go away?"
- "How long before I can realistically expect to feel better?"
- "I really don't like taking pain pills if I don't have to, is there some kind of exercise program, like 'back pain boot camp,' that I can do to see if it helps instead? Any other non-pill treatments like acupuncture or biofeedback?" These are all described in *painACTION*.

- "Here is what I'd like to be able to do in a few weeks; is this realistic? How about in a few months [insert your goals here]?" For example: take a dance or yoga class, do weight training at the gym, start jogging, go hiking, and take a car trip.
- "It has been two months, and my pain is really not going away. I am getting discouraged and frustrated. Can we talk about a new plan?"

Communicating With Family and Friends

In addition to communicating with your healthcare provider, there are other people in your life: family, co-workers, and friends. Often, these people might not realize how pain is affecting your life. Perhaps you even feel that pain is in control of your life, but people don't see this. They also may not understand that you are on a personal journey to control and manage your pain. It can be very difficult for many people suffering from chronic pain to communicate with others about their experiences. People in acute pain, such as from a sprain or fracture, often show visible signs of their distress. You might look upset or moan and groan, or always be trying to find a comfortable position. Healthcare providers might measure a fast pulse or heart rate, high blood pressure, or other obvious physical signs of discomfort and discuss these findings with family members so that they understand the pain more clearly.

People with chronic pain don't usually show such obvious signs, however, which may lead an inexperienced observer, such as a friend or family member, to think that the problem "really isn't that bad." It is helpful to explain to your friends and family members that people with chronic pain—even if it is severe—may not show it. But you don't want to overdo these explanations either, or some people might say that you are "always complaining." You may want to read the *painACTION* article, *"Are they listening: Talking about your pain."* That is why it may be a good idea to ask your healthcare provider, or a psychologist, to help you communicate in a positive way with your loved ones, so that they understand your pain and the ways in which they can be supportive to you in your "journey."

Sometimes the most common causes of frustration, anxiety, or depression are what you *don't* know, rather than what you do know. That is why communication is so important. If, for example, you thought your sprained ankle would get better in a week, but the pain is dragging on for a month, wouldn't it have been helpful to know from your healthcare provider that ankles can take three months to heal? The only way to know this kind of information is to ask outright, since many providers might not want to give you discouraging news. But once you do have the facts, you can take steps to cope with them, and that is what the next chapter is about.

An Expert Opinion

Communicating with your healthcare provider

Here is an example of a question you might want to ask your provider, and a possible answer. Try this question and see what answer *you* get!

Q My healthcare provider just prescribed an antidepressant for me. Why? I'm not depressed, I have pain!

A Many medicines have benefits for more than one condition. Antidepressants have effects on depression, of course, but may also have effects on certain types of chronic pain. For example, many antidepressants are effective for neuropathic pain (i.e. pain resulting from nerve injuries); antidepressants can be effective for other types of pain as well.

On the other hand, patients with chronic pain do in fact frequently suffer from depression as well. So a person with pain who does have depression also may be prescribed an antidepressant. The bottom line is that there are many good reasons for a patient with chronic pain to be prescribed an antidepressant, and it certainly does not mean your healthcare provider thinks you are crazy, or your pain is all "in your head."

In Summary...

- Pain is not a score, it is an experience
- Try to think about what you want to say to your healthcare provider
- Communication is key
  - › With your healthcare provider
  - › With your family and friends

Chapter 5

Coping With Your Feelings

Before you set off on a car trip, you might consult a travel agent or seek advice from friends and family about where to go and what to see. But, in the end, only you can take the wheel. This is your journey, and *you* are in charge of both your final destination and your route. The same is true of pain management. You can and should seek help from a number of sources, but you have to direct your own path. So trust your instincts when something doesn't feel right. From time to time, you may have to redesign your itinerary or travel plans—feeling a sense of control will actually help you emotionally cope with the difficult moments. This chapter will give you the tools you need to plan a successful emotional journey as you manage your pain. You will learn about stress, anxiety, and depression, and discover tips on how to develop more positive feelings, even when you are coping with pain.

First, here's a little background about the connection between emotions and pain. Does your body know what is going on in your mind? Surprising as this may sound, the answer is "yes." When you are feeling stressed or anxious, for example, your brain triggers the release of chemicals called stress hormones in your body. These include *adrenalin* and *cortisol*, and they can have powerful effects on your pain. You may be feeling stressed or anxious as the result of the pain itself, because of the reactions of those around you to your pain, or because of things—such as work or family troubles—that have nothing to do with your pain. But whatever the cause, the result is the same: it can make it harder for you to cope with your pain. Feeling sad and depressed can also make your pain worse.

What is Stress and How Can it Make Pain Worse?

Stress is the response we have to situations that demand that we focus our minds and bodies in some way. Some stress can be thrilling, such as the exhilaration of skiing a steep mountain or holding on during a

roller coaster ride. Other stress can be unpleasant, such as the anxiety of being late for a presentation at work, or the frustrations of a family disagreement. No matter where it comes from, stress generally creates a "fight, flight, or freeze" response as stress hormones flood our bodies to help us meet the challenge. In response to these hormones our muscles tighten, we breathe faster, we take smaller, shallower breaths, and our hearts speed up. If the stress is "acute," meaning it does not last long, these effects soon disappear. But if you are feeling stress every day, for weeks or months at a time, this is called "chronic." The *painACTION* Tool, *"Stages of Stress: Fight or Flight"* may help you understand how stress can affect your body.

Chronic stress or anxiety can make pain worse. It can cause your body to continue to hold muscles tighter than they need to be. At the same time, your shallow breaths bring less fresh oxygen to those overworked muscles. As you know if you clench your fist or hunch your shoulders for any length of time, tight muscles contribute to pain. Not only can stress and anxiety make back pain worse, it can also contribute to migraine pain, as the *painACTION* article *"The link between stress and migraine"*describes.

Coping With Stress and Anxiety

If you've ever experienced significant stress while on vacation, you know that it can make it much harder to enjoy a trip. Chronic stress or anxiety will have a similar negative effect on your journey of pain management, so it's important to learn how to control these feelings. There are several ways to manage stress and anxiety. Identify the causes, talk about it, take ownership of your situation, and use proven stress reduction techniques. The tips in the rest of this chapter will help you reduce your stress, allowing you to continue your journey more comfortably. Your healthcare providers can give you a great deal of helpful guidance, but always remember that you are in charge of mapping out your voyage.

Identify the Causes

The first step in lowering your stress and anxiety levels is to figure out the source. You can think about this on your own or ask your healthcare provider to help you. You would not simply head to an unfamiliar country without learning something about your destination (talk about stressful!), so take the same proactive steps when it comes to this journey. If you have some realistic information about your path to pain management, you may be less stressed or anxious about it. If your stress is coming from feeling that your pain is lasting too long, for example, ask some frank questions of your healthcare provider: "How long can I expect this to go on?" "Will my pain ever completely go away?"

Talk About It

If your stress is coming from your family relationships, it might be a good idea to figure out what your family can do to help you, and then brainstorm with them about ideas that might help. For example, you could share the following: "At the end of the day, my back is really sore and it would be really nice if someone else would do the dishes. I can finish cleaning up after I sit down for a few minutes." Even if you don't come up with practical solutions, just talking about your pain with a trusted person helps to ease the burden. Some people have found support groups or advocacy organizations helpful as well. You can find links to such resources on the *painACTION* website.

Take Ownership

Evidence shows a direct link between your mood and your ability to cope with pain. If you are feeling down in the dumps, and like a helpless victim of your pain, you might actually find your pain levels increasing. If, on the other hand, you can feel good about yourself as someone who is taking control of your life and your situation, you will very likely find that you are feeling less pain. Easier said than done? Here's how you can take control of your pain:

Be creative about changing the sources of your stress
If you are feeling overscheduled, see what can be eliminated. Create a one-night "oasis of calm" each week, when you stay home and relax. Since sleep has been shown to be important in coping with pain, pick one night a week to go to bed by 10:00 p.m.

Get the "fight" out
If you feel that anger is bursting out of you, tame it by doing some regular, vigorous exercise every day, such as brisk walking, jogging, or a spinning or aerobics class.

Keep a "travel" journal
Many people find that keeping a journal while traveling enhances their enjoyment of the trip and allows them to sort through their feelings and experiences. The same is true of emotional coping; writing your worries down has been shown to reduce stress and alleviate some pain.

Calm your body down
There are a number of techniques that you can learn to do for yourself to help reduce the pain, which will make you less anxious, such as relaxation exercises, biofeedback, and self-hypnosis. Do whatever feels most comfortable to you. Sign up for classes in meditation, yoga, or tai chi (also called "moving meditation"), or find a trained biofeedback therapist. Practice deep, slow breathing, or go for a long walk or bike ride. Learn more about these techniques from the *painACTION* Tool, *"Complementary and Alternative Medicine (CAM)."*

The *painACTION* website also has several tools you can use to feel calmer, less stressed, and more relaxed -- feelings which have been shown to make pain more bearable. The *painACTION "Relaxation Response Tool"* for example, teaches a proven meditation method called the *relaxation response* that is used in medical centers throughout the country to help people cope with pain and discomfort. You can also use *painACTION's "Guided Imagery Tool"* to take your body on a "mini vacation."

What About Depression?

It's common for people with chronic pain to have depression. Depression can worsen and prolong the pain. Pain and depression can take over a person's thoughts and feelings with more pain leading to more depression, creating a cycle that is difficult to break. In the *painACTION* article, *"Depression and pain: Break the cycle"* you can learn more details about this. The lesson *"How to deal with depression"* gives more tips.

These are just some suggestions for ways that others have successfully reduced their stress, anxiety, and depression on their journeys to better pain management. You are a unique individual, however, so it is important to find what works best for *you*. One way to do this is by looking back at your life to find out how you have successfully coped with emotional problems in the past. A mental health provider can also be helpful in figuring out the best ways for you to feel better. In the meantime, the following lessons on the *painACTION* website will be helpful:

- *"How to develop a positive frame of mind"*
- *"How to handle stress in your life"*
- *"How to face the challenges of living with pain"*
- *"Taking things one day at a time"*

An Expert Opinion

Coping with emotions

Q My pain specialist says I have to see a psychologist before he will take me on as a patient. I am not crazy. Do you think I should have to do this?

A Chronic pain causes major problems for many patients, in addition to pain itself, which is bad enough. Patients with pain that lasts for a long time may get depressed, develop anxiety, have

trouble sleeping, or may have trouble in relationships with spouses, friends, and employers. Recognizing this, many healthcare providers suggest that patients see a psychologist to help with any emotional problems while the pain itself is being worked on. So being referred to a psychologist doesn't mean that anyone thinks you are crazy – it usually means that your healthcare provider is trying to find every possible way to help you.

Q I'm told that I need to reduce the stress in my life to help with my pain management. How can that help?

A Stress is a part of life, and cannot be completely escaped. This is even more the case when you have chronic pain. As you have seen in this chapter, stress and the anxiety and irritability it may lead to, may make pain more intense, and may also make it harder to cope with your pain. There are many different ways to cope with stress, and learning healthy ways to manage stress can decrease the impact that stress has on managing your pain. Throughout this chapter, there are links to the *painACTION* tools and lessons that give you useful stress management techniques.

In Summary...

- Chronic stress or anxiety can worsen the experience of pain
- Managing stress is important to successful pain management
- Take ownership of your mood and ability to cope with pain
- Depression may occur with chronic pain
  - › Talking about depression with a mental healthcare provider can help

Chapter 6

Your Medication: Staying Safe

When you are traveling in unfamiliar territory, you take a number of precautions to ensure your safety and the safety of the people with you. When you drive a car, you follow the rules of the road. It is important to bring that same caution and respect for safety rules when you use medicine that helps you on your pain management journey.

Using medicine *safely* applies to *all* of the medicines you take. This includes those over-the-counter pain relievers or cough syrups you get at the local drug store, as well as the vitamins and herbal supplements you may pick up at a health food store. Sometimes the safety concern is not one specific medicine, but the *combination* of medicines you take. The best way to know you are using a medicine safely is to be sure that your healthcare provider and your pharmacist know about *everything* you take. The *painACTION* website has several articles with good information about this subject, including:

- *"Your pain medication: Don't mix and match"*
- *"Over-the-counter pain relief: Part of your plan?"*
- *"What you should know about acetaminophen"*

Prescription Medications Safety Guidelines

The prescription pain pills in that little bottle may look innocent, but they can be as dangerous as a car accident if used improperly. In this section, you will learn some important—and possibly surprising—facts about pain medication, particularly opioids, facts that will help to ensure your safety. There are a few important "rules of the road" about prescription pain medicine:

- **Follow the dosage and frequency instructions EXACTLY**
  Never change your medication schedule or dosage (even if you think it is not working) without consulting with your healthcare provider.

- **Contact your healthcare provider if you experience troubling medication side effects**
  Use the *painACTION "Medication Side Effects Tool"* to find out the possible side effects of different medications, and read the lesson *"How to manage opioid side effects."*

- **NEVER give your medication to anyone else**
  Under any circumstances, it is never safe to share your prescription pain medication with someone else.

- **Always keep medicine locked up and concealed in a safe place where casual visitors are unlikely to see it or have access to it**
  You can't always predict who will be coming to your home; better safe than sorry.

- **NEVER keep the medication after you no longer need to take it**
  Discard it safely. The *painACTION* article, *"Getting rid of unneeded medications: Out of sight is not out of mind"* will give you specific suggestions.

What are Opioids?

If you have pain that is not responding to other medicine, your healthcare provider may prescribe opioids for you. Opioids—among the oldest medicines in the world—belong to a group of medications called *analgesics*, which give relief from pain. Opioid is a medical term that describes what are commonly referred to as "narcotics." The natural opioid, morphine, which comes from the opium poppy plant, has been used as a pain reliever for centuries. Other opioids, such as codeine, fentanyl and oxycodone, are manufactured synthetically.

Opioids are prescribed by healthcare providers to treat pain, control coughs, and treat diarrhea. Some are taken by mouth in pill form, while others are given transdermally (skin patches), intranasally (nose spray), or by injection. In the thousands of years that opioids

have been used to treat pain, no other pain medication has been found that is as effective. This is because our bodies have natural "receptors" in our cells that respond to them. It is as if the opioid medicine is the "key" that fits perfectly in the "lock" of our cells, to open the door to pain management. So far, so good. But there are some problems with opioids if they are used in ways that are not prescribed. As we've talked about in previous chapters, good information is a key to travel safety. Here are some definitions to help understand the potential problems with opioids.

Tolerance

This can happen naturally when your body gets used to a particular medication. As a result, the medication does not work as well as it used to and you might feel that you need to take more of it to get the same relief. *You should never make your own decision about this.* Always discuss the situation with your healthcare provider (**tolerance** is very different from addiction, which is discussed below). Sometimes the solution is simply to change medications or add a new medication.

Dependence

This is another naturally occurring state that happens when your mind *and* body get used to a medication, but in a different way than tolerance. When you become physically **dependent** on a medication, your body actually needs this medication in order to continue working properly. This means that *you should never suddenly stop taking any medication* without first talking to your healthcare provider.

Misuse

This refers to taking a medication in a way that it was not prescribed, or for a condition other than the one for which it was prescribed. If you have medication for your back pain but decide to take it to help you sleep, for example, that is **misusing** it. *This is something you should never do because it is unsafe.*

Abuse

If you use a prescription pain medicine to get a result that has nothing to do with the pain it was intended to treat, this is **abuse**. You are abusing your pain medicine, for example, if you take it to feel better, or get "high." *Like medication misuse, abuse is very dangerous.* You are not trained to understand the ways in which medications interact with anything else you are taking or with your physical condition. Abusing your medication is just as dangerous as driving recklessly or ignoring safety warnings while traveling. Respect the rules laid out by your healthcare provider, and protect the safety and health of your body.

Addiction

People who become addicted to a prescription pain medication **are abusing the drug uncontrollably**, to the point where it is causing physical harm. Unlike **tolerance** and **dependence**, **addiction** is an unnatural state. *If you feel you are becoming addicted to your medication, meaning that you feel the need to take more and more of it and cannot control yourself, seek immediate medical help.*

Diversion

You wouldn't hand your car keys to an unlicensed driver, and you wouldn't send a friend into a dangerous or unfamiliar city alone. Use these instincts about safety when it comes to your prescription pain medication. *Your medication is meant only for you. You should never give it anyone else, either for money or because you think it might help him or her.* You are not a trained pharmacist, so you can't possibly know which medications work safely for each person.

There is much more information about medication safety on the *painACTION* website, including articles, tools, and lessons. Here are some suggestions:

- *"Opioid medication basics"*
- *"How to start an opioid safely"*
- *"How to discuss opioids with your healthcare provider"*

- *"How to travel with opioids"*
- *"Caution: More websites selling drugs"*

Safe Storage and Disposal

When you are behind the wheel, you are not only responsible for your own safety, but also for the safety of the other people in your car. If you took your friends or family on a trip, you would do your best to keep them as safe as possible. Accidents happen, but taking the right safety precautions reduces the risk. When it comes to pain medication, these precautions are not just limited to proper usage. Not only is it important to *use* your prescription pain medication safely, you must also know what to do when you are *not* using it. These are powerful drugs and if they fall into the wrong hands they can cause severe consequences, and even death.

Abuse of prescription pain medications is reaching epidemic levels in this country, especially among people between ages 18 and 33. Most of these young people get the medications from their friends or family. In 2007, of the 467 drug-related overdoses leading to death in the state of Utah, 317 were attributed to legal drugs and 261 of them involved prescription pain medications. So if you have these powerful prescription pain medicines in your possession, *you have a responsibility to prevent anyone else from finding and using them.* You can do this by locking and storing them in a hiding place that only you know about, and disposing of any leftover medications in a way that makes sure no one will get them. The *painACTION* lesson *"How to take, store, and dispose of opioids,"* has some useful suggestions.

An Expert Opinion

Medication Safety

Q If I take an opioid pain medication you are prescribing for me, will I become addicted?

A There is a chance you may become addicted. The risk of addiction may not be high, although some experts state that it can range from 3-20%. You might, however, become *dependent* on the medication, which means you should never stop taking it suddenly; you also might become *tolerant*, which means your healthcare provider might need to increase the dosage of your prescription. It is important to use the medicine ONLY as it is prescribed, without *misusing* or *abusing* it. If you feel you are becoming *addicted*, tell your healthcare provider so you can get the help you need. And certainly remember never to *divert* this medication to anyone else because you would be giving them a very powerful substance that could do harm.

Q The last time I took an opioid, I was constipated for a month. Is there anything I can take or do after my upcoming surgery to prevent that?

A All opioids may cause constipation. In fact, it is the most common side effect of these medicines. This side effect is more of a problem for some people than others. Uncontrolled constipation is a leading reason that patients don't take their pain medicines as instructed. The first thing to do is to it tell your healthcare provider that opioid-related constipation is a big problem for you, and ask that a stimulant and/or laxative be prescribed along with the pain medicine. Most laxatives are taken by mouth and some can be taken as a suppository.

The usual advice about preventing constipation—increasing fluids and fiber in the diet—are probably not helpful for opioid-related constipation. Some laxatives, known as stool softeners, may be helpful, but are not enough. Opioid-related constipation requires a stimulant laxative that encourages the bowel to move the stool along and makes it easier to have a normal bowel movement. Most laxatives are available without a prescription—ask your doctor and pharmacist for specific recommendations. It is very important to prevent and treat

constipation. If it becomes a problem for you, let your healthcare provider know so the treatment plan can be changed.

Q I've been on the same pain medicine now for a year, and it seems that my pain is worsening. Is it possible that the medicine is no longer working for me?

A There are many things that can affect how well a medication is working to control the pain. If you have been on the same medicine and dose for a long time and notice a change that lasts more than a few days, here are some things to discuss with your healthcare provider.

- Have you changed your diet or changed other medicines recently—including herbals and natural products?
- Has the brand of pain medicine changed?
- Have you had unusual stress?
- Have you been sick?
- If there is a known cause for your pain, when was the last time you had a checkup? It is possible that the underlying condition that caused the pain has worsened. See also the definition of "tolerance" above, since this could be a factor as well.

Another possibility is that there has been a buildup of "metabolites," which can actually increase pain, called *hyperalgesia*. Almost all drugs are processed in the body and changed in some way as they move through the liver. Sometimes this processing creates by-products or metabolites. For most patients this is not a problem, because the by-products are removed by the kidneys and leave the body in the urine. If the kidneys do not remove enough of the metabolites, they can build up and make the nerves more sensitive to things that wouldn't normally cause pain. Sometimes, changing to a different pain medication takes care of the problem, and your pain will be under better control again.

In Summary...

- Tolerance, dependence, misuse, abuse, addiction, and diversion have different meanings
- Medications can be a very effective way to treat some types of pain, but it is important for them to be taken *exactly* as directed
- Contact your healthcare provider if you have medication side effects
- NEVER give prescription pain medicine to anyone else
- ALWAYS store your medicine in a concealed, secure, safe place
- Discard unused medicine safely (you may get information about this from your pharmacy)

Part I I

Your Personal Pain Profile

Your Personal Pain Profile

In this part of the book our "travel guide" gets more specific. If you are dealing with back pain, migraine, cancer-related pain, neuropathic pain, arthritis pain, or experiencing post-deployment pain as a returning military service member, refer to the appropriate chapter or chapters in this part. First, however, please take a moment to read this overview, since it will help you take better advantage of the information in the upcoming chapters.

The six types of chronic pain discussed in this section are, of course, quite different from each other, but they also have several common features. Each of them can be with you for many years. However, like any long journey, the more you travel, the easier it gets. Each of these types of pain requires "baggage," but the type of load you are carrying may be different. If you have back pain, for example, you probably feel as if you are carrying some sort of burden every day, because your back never gets a day off! It must work all day long, even when you lie down, to support your body. With back pain, the only difference from day-to-day is, "how much pain will I be in today? Will I be able to do the things I want and need to do?" So, in the back pain chapter we discuss how to modify your

life to minimize and manage the pain you might be dealing with every day.

By contrast, migraine pain may leave you free of baggage for days or weeks at a time. The question here is "Will I get a migraine today?" The uncertainty is of course a difficult burden to carry, but you can be sure that if you do not get a migraine, you will be able to have a normal day. So, the challenge here is what can be done to prevent the headache from beginning, and how to minimize the pain if you do get one. These are the questions we focus on in the chapter about migraine pain.

Cancer-related pain is quite different from other types of chronic pain. Because of advances in cancer treatment, people are living longer and many achieve remission from the disease. Rather than worrying about survival, many cancer patients now are shifting their attention to the pain that results from either the treatment or the long-term effects of the disease itself. In the cancer chapter, therefore, we focus on the causes and types of cancer-related pain and the most effective ways to manage them.

Neuropathic pain can develop suddenly or over time, and your baggage may be "what is going to happen next" since its course and response to treatment can sometimes be

unpredictable. At the same time, by speaking up about your pain, by continuing to search for better treatment and a better quality of life, you are helping healthcare professionals become better at identifying neuropathic pain, and encouraging them to work to develop better treatments.

While there are many kinds of arthritis, osteoarthritis, which is primarily a result of the long-term "wear and tear" on your joints, is the most common. Since everyone is on the journey through life, and the expectation for longevity in the United States continues to increase, managing the pain and potential disability of osteoarthritis has become a national priority.

Returning military service members with chronic pain may find that their "baggage" results from the increased likelihood of surviving an injury that may have been physical, emotional, or both, and may have resulted in continued chronic pain. Unfortunately, feeling alone and uncared for is often a common experience for service members, and great efforts are being made to right that wrong.

To sum up the chapters in this section, there are different ways you might wake up in the morning: If you have

back pain, arthritis pain, or neuropathic pain (Chapter 7, 10, 11), you might be thinking, "How bad is today going to be?" If you have migraines (Chapter 8), your question might be, "Is today going to be a good day or a bad day?" If you have cancer-related pain (Chapter 9), your feelings might be mixed: "I'm happy to be alive and cancer-free today, but how do I cope with the long-term pain that remains?" And as a returning military service member (Chapter 12) you may be thinking, "Does anybody care about my pain?"

Chapter 7

Back Pain: Finding Support

If you are on a journey to manage your back pain, you have plenty of traveling companions. Government surveys report that back pain is the second most common neurological ailment in the United States (headache is the most common). At some point, nearly everyone has back pain that interferes with work, routine daily activities, or recreation. Low back pain is *the most common* cause of job-related disability and is a leading contributor to missed work. Other research has found that one quarter of Americans report that they suffer from back pain, particularly low back pain that lasted a whole day, and almost 14% of Americans report neck pain. Back pain is also very expensive. It is estimated that Americans spend about $50 billion each year on low back pain treatment.

So now that you know you are not alone, what is this problem all about? This chapter talks about some of the main causes of back pain, and will direct you to more information about prevention and treatment on the *painACTION* website.

Your back extends from the top of your neck down to your tailbone, and you can have pain anywhere along that long stretch of spine. Sometimes, the pain might even radiate to your arms and legs. The spine is a collection of bony rings called *vertebrae*. Their major function is to provide support for the body and protect the spinal cord—a kind of "scaffolding" for your body. The vertebrae are stacked on one another, and are separated by firm, pliable "cushions" called *discs*. The stack of bones and discs is held together by ligaments and moved by muscles. The vertebrae form a kind of "tunnel" that houses the spinal cord -- a collection of nerves that form a "communications center", sending and receiving messages from your brain, and branching off to the rest of your body. The *"Anatomy of the Back"* tool from *painACTION* has helpful diagrams and explanations.

The back never gets a moment off, even when you are sleeping! The muscles attached to the spine must always be working to keep it in alignment. So if you have back pain, you probably feel as if you are always carrying some form of "baggage" on your journey to pain management. Some days your burden might be lighter, and some days it will be heavier – but you are probably always aware of the potential for pain. In this chapter, you will learn the most common causes and types of back pain, as well as suggestions for how to manage it. For more details, please consult the Back Pain section on *painACTION*.

Categories of Back Pain

The most common types of back pain originate in one or more of three places in the back:

- The bones of the spine, the vertebrae
- The muscles, tendons, and ligaments attached to these bones
- The nerves that come from the spinal cord that weave in and out of the spine

Structural changes in bones or soft tissue can press on nerves, which results in pain. In some conditions, the nerves themselves become inflamed, and this causes pain. The conditions and symptoms described below fall into one or more of these three categories.

Muscle Strain or Sprain

This is the most common cause of back pain, since no matter what your position, your muscles are always working to hold your spine in alignment. The muscles of your neck work especially hard since they hold up your head, which weighs between 8 and 12 pounds. Muscle injury causes inflammation and swelling of the soft tissue, which may press on nearby nerves, resulting in pain. With commonsense treatments including rest, mild stretching, ice, and/or heat, most muscle strains and sprains resolve on their own.

Wear and Tear

As we get older, the bones, muscles, and ligaments of the spine are exposed to wear and tear, especially if you participate (or have par-

ticipated in younger years) in contact sports or other activities that subject the spine to impact. By contrast, moderate exercise, such as walking, jogging, or stretching, is actually beneficial because it promotes blood flow to the spine.

Wear and tear cause symptoms in the bones and nerves of the spine. These include arthritis of the spine, which is called *spondylosis [pronounced 'spondi – lo-sis']. Spinal stenosis* is one form of arthritis where there is narrowing of the space within the spinal canal. Both of these conditions can cause pain by compressing or "pinching" spinal nerves.

Osteoporosis

As the body ages, bones often become thinner and more brittle, especially in post-menopausal women. Osteoporosis can be treated by diet, weight-bearing exercise, and medications, but it still has the potential to cause pain. Thinner vertebrae can also fracture, either due to physical activity or simply because of the effects of gravity on the spine.

Herniated (slipped) Disc

Discogenic back pain occurs when the cushioning, shock-absorbing discs between the vertebrae malfunction or break, slipping out of position and pinching spinal nerves.

Spondylolisthesis

Spondylolisthesis [pronounced 'spondi –lo-lis –thesis'] occurs when one vertebra in the spinal column slips forward over another. This disrupts the whole integrity of the pine, destabilizing it. When the spine is destabilized, the vertebrae pull on muscles, ligaments, and other discs, compressing nerves and causing pain.

Sciatica

The sciatic nerve is actually a collection of spinal nerves joined together at the lower part of the spine. At the end of the spine, the sciatic nerve splits in two, sending branches through the buttocks and down the back of each leg all the way to the feet. When any one nerve in this group gets irritated or compressed, it sends pain signals to all of the other nerves, and this pain can extend all the way down the leg.

Back Pain Management

The conditions above can cause pain that can be described as aching, stiffness, burning, "crackling", shooting, stabbing, or throbbing. The different experiences of pain mean that it is very important to describe the pain accurately to your healthcare provider, including its location. Back pain is not only felt in the back, but may radiate outward to arms and legs, and appropriate treatment depends on a correct diagnosis.

Now that you understand the common sources of back pain, you can take advantage of the pain management skills described in Part 1 of this book. You may also find the tools, lessons, and articles on *painACTION* useful. Here are a few suggestions to get you started:

- *"Back pain treatment: Myths and realities" (Article)*
- *"Back spasms: What they are, what to do" (Article)*
- *"Back Pain Circle of Care" (Tool)*
- *"How to save your back doing everyday tasks" (Lesson)*

In Summary...

- If you suffer from back pain, you're not alone. Back pain is the most common cause of job-related disability
- The back never gets a moment off; it's working even when you're sleeping
- Any part of the back and spine can cause pain
- Back pain is not only felt in the back – sometimes it may radiate outward to arms and legs, and appropriate treatment depends on a correct diagnosis

Chapter 8

Migraine Pain: You in the Driver's Seat

Your interest in this chapter probably means that you don't need to be told what a migraine headache feels like. The throbbing or pulsating pain in your head, accompanied by nausea or vomiting, and a sensitivity to light and noise, are all too familiar. What you may not know however, is that while nearly half of the 30 million Americans with migraines could benefit from preventive therapies, **only 1 in 5** currently take advantage of them, according to the *National Headache Foundation.* Preventive therapies can decrease the occurrence of migraine by 50 to 80 percent, as well as reduce the severity and duration of migraines that do occur. Yet many migraine sufferers are not incorporating these into their treatments.

Migraines are sometimes set off by a combination of causes, also called "triggers", and these may be different for each person. They may include some combinations of eating and sleeping habits, certain foods, muscle tension, stress, medications, hormone changes, and even the weather. While you can stay away from some migraine triggers, such as certain foods, and reduce others, such as stress or muscle tension, it is impossible to avoid all stress, changes in your hormone levels, and of course, the weather. So it is important as you begin your pain management journey to have a complete diagnosis and assessment of what is causing *your* migraines, so that you can arrive at an effective treatment plan. In order to do this, you'll need to be in partnership with a knowledgeable healthcare provider – a travel guide on your journey to migraine prevention and treatment. If you and your provider can identify and then reduce or eliminate your migraine triggers, your journey will be that much smoother and the burden of "pain baggage" that you carry will be lightened!

Did you know that half of the people with migraine headaches choose to "travel alone" by treating themselves and not seeking medical help? Traveling alone on the journey to migraine management is *never* a

good idea. The problem with trying to treat your migraines by yourself is that you may not have the correct diagnosis, and you will also be missing out on a professional, personalized, and systematic approach to pain relief.

While medications can be successful in preventing migraines (and you should discuss these with your healthcare provider), a big focus of this book is the self-management of pain. What can *you* change about your lifestyle, coping mechanisms, and diet that can reduce your migraine triggers? Read the *painACTION* lesson *"How to recognize headache triggers"* for more information.

As is true for most types of chronic pain, there is usually not one single solution: Your migraine relief will depend on putting together a "package" of treatments, including medication, that responds to your own migraine triggers. And for this, you need a healthcare provider who will become your long-term partner in finding the right collection of treatments for you. (Refer back to the chapters in Part I about communication and creating partnerships with your healthcare provider.) The *painACTION* lesson *"How to understand migraine treatments"* summarizes and explains various migraine treatment options.

Preventing Migraine: You in the Driver's Seat

While there is much about migraine causes that is not understood, we do know that lifestyle, food, and other measures that you can take, can prevent the headache, or at least reduce its power. Rather than feeling like a helpless victim of your headaches, you can be in the driver's seat and take some control. Here are several suggestions to discuss with your healthcare provider. You can find many more, in the articles, lessons, and tools in the Migraine section of *painACTION*.

Traveling Food

As you travel toward your destination of migraine management, consider the food that you take along on your journey. Many foods and beverages, including cheese, chocolate, and caffeine, have been

shown to trigger migraines in certain people – although in some cases, caffeine is also used to *control* migraines. These *painACTION* articles discuss the relationship between what you eat and drink and migraine headache:

- *"Understanding migraine triggers"*
- *"Caffeine and migraine"*
- *"Can drinking alcohol cause migraines?"*
- *"Hypoglycemia and migraine"*

Lower the Stress

Your levels of stress, anxiety, and depression, can also trigger migraines, so experts recommend that you incorporate stress-reduction techniques into your life. You can find stress-management information on the *painACTION* website:

- *"How to cope with emotional distress" (Lesson)*
- *"Depression and pain: Breaking the cycle" (Article)*
- *"How to use relaxing images to reduce pain" (Lesson)*
- *"Six ways to reduce anxiety" (Article)*

Broaden Your Options

If you're frustrated because your migraine headaches have not responded to treatment, you are not alone. Half of all people with migraines stop seeking care for their headaches partly because they are dissatisfied with their treatment. Before you go that route and decide to simply live with pain, consider broadening your options. Research shows that combining treatments from several different medical specialties—called a "multidisciplinary" approach—can be helpful in the treatment of migraine. The *painACTION* article *"Holistic migraine treatment"* describes a holistic, multidisciplinary approach to migraine treatment, including biofeedback, relaxation training, herbs and botanicals, craniosacral therapy, yoga, and Tai chi.

Other *painACTION* resources to review include:

- *"Positive Frame of Mind" (Tool)*
- *"Relaxation Response" (Tool)*
- *"Using biofeedback to manage migraines" (Article)*

In Summary...

- Migraines are sometimes set off by a combination of causes – also called "triggers"; and these may be different for each person
- It's important to have a complete diagnosis and assessment of what's causing your migraines so you can arrive at an effective treatment plan
- As is true for most types of chronic pain, when it comes to migraines, there is usually not one single solution, but a group of strategies. Don't give up!

Chapter 9

Cancer Pain: Changing Your Destination

If you are a cancer survivor, your pain management journey is unique: You most likely began your travels with the goal of simply surviving the disease. Pain was probably not uppermost in your mind when you first received your cancer diagnosis. Now that treatments are better at battling your disease, or maybe have put it into remission, you may find yourself revising your travel destination: You would now like to live more comfortably, with less pain. In this chapter we will talk about the major sources and types of pain for people with cancer as well as treatment options for each. The *painACTION* section on cancer has additional information about coping with cancer pain, and also has expert advice about the effects of cancer on your family.

Cancer isn't always painful. But if you do have pain, it is important to tell your healthcare providers and to expect to work in partnership with them to manage it. *You have the right to pain treatment, so do not be shy about expressing your need for help.* At the same time, you must do your part by sharing the details of your pain experiences with your providers. Everyone's pain is different, so no one but you knows when there's pain and exactly how it feels. Also, everyone responds differently to pain and pain treatment, so what works for one person may not work for another. Both Chapter 1, on partnerships with your providers, and Chapter 4, on communication, are particularly relevant if you are dealing with cancer-related pain.

Where Does Cancer Pain Come From?

Cancer-related pain usually comes from one or both of these sources:

- Pain due to the cancer itself, such as a tumor pressing on a nerve or organ
- Pain due to cancer treatments:
  - *Chemotherapy* side effects may include mouth sores, pain and tingling in the fingertips and or toes, pains in your bones or joints when you walk or move.

- *Radiation* side effects can include skin reactions and localized pain. For example, radiation to the head or neck may cause a sore throat.
- *Surgery and/or procedures* can cause pain to incisions and during recovery. In addition to being painful, cancer surgery can be scary: You might worry about what will happen during the operation. You may wonder what the surgeon will find, and whether you'll be in pain afterwards. It's common to feel alone at this time, and to be anxious about the future. The *painACTION* article, *"Coping with pain after cancer surgery"* describes the physical and emotional effects of surgery, and its after-effects, including pain.

Two Kinds of Pain

No matter where your cancer-related pain is coming from, it usually falls into one or both of these two categories:

- *Nociceptive pain* is pain caused by stretching, pressure, or injury to tissues, muscles, or organs anywhere in the body and includes aches or pains deep within the body.
- *Neuropathic pain* is caused by pressure, injury, or irritation of nerves. People usually describe it as burning, stabbing, shooting, or electric-shock like pain. Neuropathic pain can come on without warning and persist, on and off, for weeks, months, or longer.

While there are specific things to do for pain associated with radiation, chemotherapy, and surgery described in several articles in the *painACTION* cancer section, treatment depends on the *type* of pain you are having, and whether it is mild, moderate, or severe. As described in earlier chapters, it is the *quality* of the pain—and your own experience of it, including how it is affecting your life —that is most important. This is why **it is critical to communicate and work in partnership with your healthcare providers** – your travel guides in your journey to manage cancer-related pain. Common cancer-related pain problems, discussed in more detail in the articles, include skin reactions to radiation, mouth sores due to chemotherapy, as well as swelling and pain (lymphedema) after cancer surgery.

As with other types of chronic pain, it is very important that you seek professional help in managing cancer-related pain. Be sure to tell your healthcare provider everything you are doing or taking—including herbs, dietary supplements, and over-the-counter medicines—for your pain, since there can be dangerous interactions.

Emotional Pain

When coping with cancer, the physical pain you might have is only part of the experience. You are also dealing with a serious, frightening, unpredictable disease. It is only natural for you to have some emotional discomfort as well, especially when it comes to your children and other family members. The *painACTION* cancer section has several articles, lessons, and tools to help you cope with the physical and emotional pain that cancer brings. Here are just a few examples of the advice you will find there:

- **Realize that you are more than your body**
  You are still "you," even if your body has changed, or parts of your body don't work like they did before
- **Ask for help**
  Reach out to get help from your caregiver, partner, friend, or another family member
- **Recognize the healing power of time**
  As you recover from surgery and/or cancer treatments, you will be able to move on with your life, even if it doesn't feel that way right away
- **Share your wide range of feelings**
  Communicate with a professional, a cancer support group, or by writing in a journal. Even if your cancer has been found and treated, you may still feel grief, anger, shock, or resentment that this illness happened to you in the first place. All of these feelings are normal.

Seek spiritual support

Spiritual and religious practices and beliefs may help you to cope with the pain of cancer and with the uncertainty and fear of a cancer diagnosis. Many people rely on faith to make sense of their lives and to feel connected to others—but you may also be looking for a connection to something larger: This could be some form of higher power or "god," or maybe the worlds of nature, music or art; or even a deep attachment to the people you love. For some people, spirituality comes in the form of organized religion, but this certainly is not necessary. Spirituality is found in all cultures and, for many people, it also includes a search for the meaning of life. If you are interested in reading more, go to the *painACTION* article *"Coping with cancer through spirituality."*

In Summary...

- You have the right to pain treatment, so do not be shy about expressing your need for help
- Cancer pain may be related to the cancer itself, or as a result of its treatment
- It is critical to communicate and work in partnership with your healthcare providers to manage cancer pain
- When coping with cancer, the physical pain you might have may only be part of the experience. There could be emotional aspects of your pain that need to be addressed.

Chapter 10

Neuropathic pain: Finding Your Way

Imagine that you wake up to the sound of a smoke detector going off in your house. You remember that you burned something while cooking the other day, but the smoke has cleared out since then – so why is the smoke detector still setting off the alarm? Neuropathic pain is very similar to a malfunctioning smoke detector because what set it off may be a mystery.

What is neuropathic pain?

Neuropathic pain affects nearly 20 million people in the U.S. It can be hard to diagnose, difficult to understand, extremely painful, and for some people, very disabling. People with neuropathic pain may have one or more of a variety of different symptoms. For example, they may feel sensations of sharp pain, dull pain, tingling pain, and even burning pain. Neuropathic pain may change the route of your life's journey. But with appropriate management techniques, understanding, and knowledgeable "tour guides," you can find your way to your destination, although it may be different than your original plan.

Because neuropathic pain can be hard to understand, hard to diagnose, and sometimes is invisible, it is very important to learn as much as you can about it to understand the "territory." Sometimes this can be a lot of work.

To better understand neuropathic pain, it's helpful to know how your nerves work. Nerves act as messengers between your body and your brain. When you injure yourself, your nerves send a message to your brain, causing you to feel pain. This is actually protective as it is a warning, not unlike the red light on your car's dashboard that tells you something is wrong and needs attention. Usually, after you've injured yourself and feel pain, the injury heals and the pain goes away, just like when you fix the car problem. This is called *nociceptive* pain.

With *neuropathic* (nerve) pain, the source or site of the pain isn't always clear. In neuropathic pain, the nervous system can malfunction and fire off pain messages to your brain repeatedly, creating an endless cycle. The pain signals continue to travel back and forth between your brain and body. As a result, you may feel pain for what seems to be no obvious reason. The "faulty smoke detector" might sound the alarm for months, or even years, making it hard to work, sleep, or even perform daily tasks. To better understand this cycle, see the *"Neuropathic Pain Cycle Tool"* on *painACTION*.

What causes neuropathic pain?

The cause of neuropathic pain may not always be completely clear, even to your healthcare provider. Sometimes it's the result of an injury or chronic disease, and sometimes it's the result of the treatment for certain diseases.

Examples of different causes of neuropathic pain include:

- Diabetes
- Post-herpetic neuralgia resulting from a shingles attack
- Phantom limb pain after a limb amputation
- Cancer surgery
- Chemotherapy or radiation treatment for cancer
- Complex Regional Pain Syndrome

Diabetic neuropathy is a common disorder that affects people with long-standing or poorly controlled diabetes. Symptoms typically include tingling, burning, and/or numbness in the lower legs and feet, but pain may radiate to other body parts as well. The National Institutes of Health estimate that between 60% and 70% of people with diabetes also have neuropathy.

Shingles is the acute outbreak of a blistering and extremely painful rash along neural pathways in certain areas of your body, often your back or the side of your chest. The pain is caused by an inflamma-

tion of nerves affected from the chickenpox virus, which healthcare providers call the "varicella-zoster" virus. It *only* occurs in people who have had chicken pox in the past. If you've had chickenpox, the virus stays "sleeping" in your body and may reappear as shingles in adulthood, for no apparent reason. Shingles-related pain can last for an indefinite amount of time even after the rash has healed. When this happens it is called *post-herpetic neuralgia (PHN)*. PHN is one of the more common types of neuropathic pain, usually occurring in older people.

Phantom limb pain is a type of neuropathic pain that may often occur when a person has a limb amputated. Although the limb is no longer there, the nerves from the remaining part of the limb still send pain signals to the brain that appear to be coming from the limb. This is because the "wiring" in the nervous system is not working properly, sending messages that can feel like itching, burning, shooting, or throbbing, from the "missing limb." This can have a devastating effect on a person's quality of life.

Pain after cancer surgery is a growing concern, especially after breast cancer surgery, as the number of people surviving cancer grows. Researchers are paying attention to this problem and are developing recommendations for surgical techniques that will lower the risk of this happening.

Chemotherapy or radiation for cancer can also lead to neuropathic pain because they may have caused a nerve injury or inflammation of nerves. These are sometimes known to be possible side effects of these treatments, so understanding this in advance may help the patient and healthcare provider plan ways to lessen the likelihood that this will happen. Sometimes treatment is adjusted, depending on the severity of the pain.

Complex regional pain syndrome (CRPS), formerly known as *reflex sympathetic dystrophy (RSD)*, is characterized by severe pain that lasts long after an injury has happened and appears to have healed,

usually affecting the area where the injury occurred. The injury may have been as minor as a sprained ankle, or as severe as a fracture. Symptoms include excruciating pain that can also feel like burning, sensitivity to even the lightest touch, such as clothing or a sheet, and swelling and redness in the affected area. It is important to seek medical attention to try to diagnose CRPS early. Because it may be hard to recognize and should be treated aggressively once it is identified, finding a knowledgeable health care provider is *very* important.

There are many articles on *painACTION* that provide more information about different types of neuropathic pain.

- *"Diabetic neuropathy: Prevention and treatment"*
- *"Postherpetic neuralgia: Shingles pain that doesn't stop"*
- *"Cancer and neuropathic pain: Tingling, numbness, and sensitive nerves"*
- *"Pain that continues after breast cancer surgery"*
- *"Understanding phantom limb pain"*
- *"Trigeminal neuralgia: When your face is on fire"*

Managing Neuropathic Pain

Because neuropathic pain is seemingly "invisible" it may be difficult to talk about it and to find ways to manage it. It can be very discouraging to feel like you've steered off course during your journey, but there are roads that may be manageable. Below, you'll find some information to help you with this type of pain. You can find more articles, lessons, and tools about living with neuropathic pain on *painACTION*.

☑ Learn the language of neuropathic pain

It might be hard to describe your pain. Both words and actions can help your healthcare providers better understand the source of your pain and try to figure out the diagnosis. Point out the exact areas where the pain strikes, and don't be afraid to use descriptions such as "on fire" "excruciating" or "throbbing." The more specific you are the better. When it comes to your pain, especially neuropathic pain, every detail matters!

Understand that pain management is not the same thing as a cure

Unfortunately, there isn't often a one-size-fits-all treatment that works over the long-term for people with neuropathic pain. A lot of patience is going to be required for the diagnosis to be determined, and even more patience for treatment approaches to have an effect. It can take months. Most people who have neuropathic pain will tell you that the path from identification to effective treatment is a long and winding, and sometimes quite a "rough road."

It's important that you don't confuse a long-standing treatment plan with a "cure." For most people, there may be no permanent or complete solution to neuropathic pain. It may come down to a matter of coping and getting support from others. Support from others is often a critical piece of the road map when it comes to neuropathic pain. Certainly realistic goals and expectations are going to be important.

Realize that research is ongoing – and that you can be a part of it

Research about neuropathic pain management continues to grow. There are many reasons to be optimistic about the increased ability to diagnose it sooner and treat it more effectively. In the year 2011 there were 170 research studies in the works relating to neuropathic pain treatment. Many studies often actively look for participants with neuropathic pain. If you are interested in learning more about up-and-coming research and/or clinical trials, you can read the *painACTION* article, *"Thinking of joining a clinical trial"* and search for a trial on the National Institutes of Health website *www.clinicaltrials.gov.*

Neuropathic pain will define the course of your journey, possibly more than any other type of pain. The *painACTION* website has much more information about neuropathic pain management, including:

- *"The Neuropathic Pain Cycle" (Tool)*
- *"The language of neuropathic pain"(Lesson)*
- *"What makes neuropathic pain different from other pain" (Article)*
- *"Why aren't there better treatments for neuropathic pain?" (Article)*

In Summary...

- Neuropathic pain reveals itself in different ways and affects people differently
- The cause of neuropathic pain may not always be clear; although this type of pain is often associated with certain situations or health conditions, such as an injury or diabetes
- To ensure appropriate diagnosis and treatment, it is important to use your own words to explain your symptoms to your healthcare provider
- There is no standard treatment for neuropathic pain, so it will require you to be patient
- Research about new management techniques for neuropathic is ongoing, so don't lose hope

Chapter 11

Arthritis Pain: Keep Moving

If you have arthritis, pain may be a part of your journey from time to time. But you're not making the trip alone since arthritis is one of the most common health problems in the U.S. In a recent government survey, nearly 50 million people reported that they had been diagnosed with some form of arthritis. In addition, 21 million people can't perform some daily activities because of their arthritis condition.

Pain is one of the hallmark symptoms of arthritis. Arthritis-related pain occurs because the supporting structures of your body – your bones and joints – become damaged or swollen. And unlike other kinds of pain, it may feel worse after periods of rest rather than after activity.

Contrary to popular belief, arthritis doesn't just affect the elderly (usually defined as age 65 or older) as many Americans younger than age 65 have some form of arthritis, too. Since many "baby boomers" are now reaching the age of 65 that may not seem very old. "Baby boomers" have been more actively involved with sports and exercise than previous generations, and may actually be even more at risk of developing degenerative osteoarthritis because of the increased wear and tear to their joints. As the population continues to age, the number of people living with arthritis will continue to rise as well. With an annual healthcare cost of more than $80 billion, arthritis is also one of the most expensive health conditions and is likely to become even more expensive.

To better understand how to manage arthritis-related pain, it's helpful to know a little bit about the condition. First of all, "arthritis" isn't just one disease. There are more than 100 different types of arthritis conditions, all of which may include *joint inflammation*, which is the basic definition of arthritis. A joint can be thought of as a "meeting point" between two bones. Without joints, you wouldn't be able to

move or bend. Inflamed joints often cause pain, swelling, and stiffness, and can seriously limit the ability to get around and do every day activities. Different types of arthritis affect different numbers of joints, so your symptoms may vary depending on what type of arthritis you have. Osteoarthritis, rheumatoid arthritis, and gout, are among the most common types of arthritis.

Osteoarthritis

Osteoarthritis (OA) is the most widespread type of arthritis in the U.S. It is referred to as a *degenerative joint disease* because this type of arthritis typically results from "wear and tear." The most common cause of OA is aging. Over time, the smooth surfaces of a joint may wear away or become irregular and roughened. Along with the roughness often comes irritation (inflammation) of the joint surfaces, which can be painful. Just like the brake pads on your car, joints can wear out. A joint may also be more likely to become "arthritic" if there was a past injury, such as a fracture or torn cartilage, when you were younger. OA pain may be accompanied by stiffness, "cracking," or creaking in the affected joint. OA usually worsens over time.

Rheumatoid Arthritis

Rheumatoid arthritis (RA) is the most common arthritis-related *autoimmune disease.* With an autoimmune disease, the body's immune system attacks healthy tissue as though it was a foreign invader, like a bacteria or a virus. RA can affect many joints in the body at the same time, while OA is usually limited to one or two joints. Unlike OA, RA typically affects people at an earlier age, and may even occur in children; it is usually a progressive disease. Much like OA, RA usually causes some limitation of physical activity and pain. People with RA often have other symptoms besides pain and joint involvement. The table below summarizes the differences between OA and RA.

	Osteoarthritis	Rheumatoid Arthritis
Age of onset	Usually affects people over age 60	Can strike at any age, but generally affects 20 to 50 year olds
Cause	"Wear and tear" of the joints over time, previous injury	Autoimmune disease
Joint involvement	Can affect one joint	Usually affects many joints throughout the body
Stiffness	Stiffness usually occurs for a short period of time in the morning	Stiffness can last for hours or for a whole day
Gender	Common in men and women	Affects more women than men
Diagnosis	X-rays are helpful	Lab tests can identify the problem along with x-rays
Other symptoms	Pain and swelling in the affected joint(s)	Pain, chronic fatigue, fever, weight loss, along with swelling of the joints
Treatment options	Pain relievers (over-the-counter or prescription), physical therapy, mobility aids, surgery when necessary	Pain-relieving medications along with "disease-modifying" medications to halt the progression of disease, mobility aids, surgery when necessary

Gout

Gout is another common form of arthritis that can cause excruciating pain, tenderness, and swelling of certain joints. It is triggered by a buildup of uric acid in the body, which deposits as crystals within the joint(s). Gout pain can occur suddenly and usually affects a single joint when it strikes. Although it often starts at the base of the big toe, it can affect other joints in the body, such as ankles, knees, wrists, and hands. A "gouty attack" can come on suddenly, and be so painful that it might wake you from sleep. The condition is more common in men, but women are increasingly prone to gout after menopause. Other risk factors include being overweight or having a history of eating rich foods and drinking alcohol. Gout may also run in families.

Arthritis Pain Management

There are many possible treatments for arthritis-related pain. While the specific type of arthritis usually plays an important role in choosing a treatment plan, some forms of treatment are commonly used for all types of arthritis. Many people with will use a combination of ways to deal with their pain on their journey to pain management.

- **Medications to reduce pain**
  There are many medicines available to treat the pain of arthritis. Some can be purchased at a drug store without a prescription, and some require a healthcare provider to prescribe them. Medicines can come in a variety of forms, including creams, pills, and injections into the joint itself. Since many of these medicines can be purchased without a prescription it is important to keep your healthcare provider informed about everything you use to treat your arthritis pain, to avoid problems than can result from taking more than one medicine at a time.

- **Medications to treat the cause of the arthritis condition**
  Both rheumatoid arthritis and gout are examples of medical conditions that may be treated with prescription medicines meant to change the underlying disease that is causing the pain. Making the decision about which medicines to use, and

when, can be complicated; your healthcare provider will weigh the benefits and risks of each option available to you. Treatment with medicines may need to be repeated over time, as the disease may occasionally "flare-up" and become more active.

Non-medication ways to reduce pain

There are many ways to reduce arthritis pain without using medicine, including the use of heat or cold, physical therapy, massage, and acupuncture. Because osteoarthritis is such a common health problem, it is important to be aware of the "too good to be true" miracle cures that are frequently advertised, and may be just a waste of money. It's always a good idea to discuss all treatments you are considering with your healthcare provider to make sure that you don't do more harm than good.

Life-style changes

Life-style changes are often recommended to reduce pain from arthritis conditions, especially osteoarthritis. Common recommendations include a weight loss program (when excess weight is an issue) to lessen the "wear and tear" on weight-bearing joints; learning proper body mechanics, such as the right way lift, or sit, or get up from a chair; and exercises to strengthen muscles that can help support the joints. With low risk and low cost, life-style changes may be the most cost-effective way to treat arthritis pain, and you play a major role in these solutions.

Adaptive equipment

Adaptive equipment, such as braces, canes, or walkers can help reduce pain by reducing the amount of stress on the joints by helping to bear some of the weight. In addition, they can help keep people active and mobile.

Surgery

Joint replacement is an option for some arthritic joints, most often the weight-bearing joints, the hips, and the knees. While this kind of surgery is becoming more common, there is a lot to

be learned about joint replacement surgery if you think it may be in your future. The *painACTION* article *"What to consider when making decisions about joint replacement surgery"* may help.

These *painACTION* lessons and articles may be useful on your arthritis pain management journey:

- *"Arthritis tips and tools for easier living" (Lesson)*
- *"Staying socially connected when living with chronic pain" (Lesson)*
- *"Arthritis and nutrition" (Article)*
- *"Bolstering your resiliency" (Article)*
- *"Fun ways to be physically active when you have arthritis" (Article)*
- *"Chair yoga" (Lesson)*

In Summary...

- Arthritis is one of the most common health problems in the U.S. and stands to increase as the population gets older
- There are over 100 types of arthritis, but osteoarthritis, rheumatoid arthritis, and gout are among the most common
- Your healthcare provider or medical home can help you develop a pain management plan that fits best with your condition and lifestyle
- There are many strategies to help relieve arthritis pain. Keep an open mind!

Chapter 12

Wounded Warriors: Coming Home

As a current or former military service member, you have probably experienced a lot during your tour of duty, including deployment to a war zone. If your service in the military was recent, you were likely deployed to a war zone multiple times. Your pain may have come from a combat injury, an accident while on duty, or from overuse of your joints and muscles in a physically demanding job. Regardless of how your pain began, coming home to begin a pain management journey was probably the last thing you envisioned when you joined the Armed Forces.

You should know that you are not alone in this journey. Due to better body armor and improved delivery of medical care down range, soldiers are living through wounds that would have killed them in the past, so the number of Wounded Warriors coming home has increased. Although these numbers constantly change, the U.S. Casualty Report for April 13, 2012 listed 47,818 individuals wounded in action while serving in Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), and Operation New Dawn (OND). And thousands more are treated in the Veteran's Health Administration (VHA) system for injuries sustained in military duty prior to these operations. Many of these injuries result in chronic pain, medical discharge from the military, and changes in the quality of daily and family life.

Your treatment is a matter of concern for the United States Department of Defense (DOD) and the VHA. A taskforce organized by the Office of the Army Surgeon General has published a guide to pain management that focuses on comprehensive and standardized care for all military members *(See the Additional Resources page at the back of the book)*. This care is to focus on using multiple treatments and specialists, including complementary and alternative treatments like acupuncture, to improve your functioning and your life.

Warriors' Pain

The type of pain you have depends on your experiences and injury. Back pain is the most common pain symptom for deployed service members. Some other common types of pain from military experience are listed below:

Acute pain
This is the type of pain that occurs immediately after an injury or tissue damage such as a surgical procedure, and is usually sharp and sudden

Neuropathic pain
This type of pain comes from pressure, injury, or irritation to nerves, and is often described as 'burning' or 'shooting'

Phantom pain
Phantom pain is the pain felt in an absent limb following an amputation

Nociceptive pain
This kind of pain is caused by stretching, pressure, or injury to tissue, muscles, or organs anywhere in the body, and includes deep aching

Central Pain
Central pain is caused by damage to or dysfunction of the brain, brainstem, or spinal cord, which are parts of the central nervous system

Headache pain
Headaches can result from many types of injuries, including injuries to the neck, head, and brain

Burn pain
Burns can result in different types of pain, depending on the kind of burn (e.g., chemical, electrical, fire), and the depth of the tissue damage

Otalgia
This is ear pain that can result from exposure to blasts or loud noises

You may have experienced polytrauma, or multiple combat blast injuries and traumas, including post-concussive syndrome (also called shell shock, in which symptoms of a mild head injury like headache,

confusion, or irritability continue over days or weeks). This may make your pain problem more complex. Added to your pain may be *traumatic brain injury (TBI), post-traumatic stress disorder (PTSD)* or *mild TBI along with substance abuse.*

Pain Management for Warriors

Here's the good news: Military service has prepared you well to steer a course through the obstacles presented by chronic pain. Below are some suggestions.

- **Don't delay your treatment**
  Warriors are used to a tough, no-nonsense, "no pain, no gain" way of living. *You must do the opposite for pain treatment to work.* The longer you tough it out with no treatment, the harder your pain will be to treat.

- **Build a supportive team**
  As a member of the military, *you know the value of a team. And you know what qualities you need to make a team work.* So use these skills to build a pain management treatment team that can give you good directions and guide your path. *Include former service members in your support team as well,* since they will share your experiences.

- **Be willing to try new things**
  Relaxation, meditation, medical massage, or acupuncture can be helpful if suggested by your healthcare provider

- **Conquer the emotional obstacles**
  Combat-related stress, difficult memories, loss of friends, and the family costs of multiple deployments, may affect your thoughts and emotions and make your pain experience worse. It takes courage to steer around these emotional obstacles, but *it can be done and there are people willing to help you.* Although the memories of what happened in those difficult times may not go away completely, the emotional intensity of re-experiencing them will diminish with treatment and can stop interrupting your life.

Develop a new mission

Embarking on a pain management journey means selecting an initial destination. That may mean a new mission for your life. Use your resilience and strength to redefine your mission. You are still able to live a life of service by finding a way to contribute to the lives of others. *Find a cause bigger than yourself and make a first step, even if it's a small one.*

In Summary...

- There are many types of pain, including pain associated with head trauma, that may be part of a Warrior's pain management journey
- The most courageous thing you can do is to get help for physical and emotional wounds
- You are still resilient and strong and can use these qualities for good, no matter how your body is affected by pain
- You can live a life of selfless service as a Warrior or civilian

In Closing

You are now at the end of your journey through this book, but that does not mean your travels have stopped. Managing pain, whatever its origin, for some, can be a lifelong journey. The message of this book is that *you* can be in control of this journey, accompanied by healthcare professionals as your "travel guides," as well as resources like this book (your "road map"), and the *painACTION* website.

While you would like to be completely free of pain (who wouldn't?), your key to successful pain management is to recognize that the most realistic goal is to improve the quality of your life and be able to achieve your goals in work, relationships, and the activities you enjoy.

There is a Buddhist saying: "Pain is inevitable; suffering is optional." We all have pain, to one degree or another; what makes the difference in life is how we choose to understand and manage it. With this attitude, you will be able to have the quality of life that you want with the type of pain that you have.

Additional Resources

Afterdeployment.org:
A website providing wellness resources for the military community. *afterdeployment.org*

Arthritis Foundation:
A national nonprofit organization. *arthritis.org*

National Center for Alternative and Complementary Medicine:
A part of the National Institutes of Health. *nccam.nih.gov*

National Headache Foundation:
A national nonprofit organization. *headaches.org*

National Institute of Arthritis and Musculoskeletal and Skin Diseases:
A part of the U.S. National Institutes of Health. *niams.nih.gov*

National Institute of Neurological Disorders and Stroke:
A part of the National Institutes of Health *ninds.nih.gov*

National Cancer Institute:
A part of the National Institutes of Health. *cancer.gov*

Pain Management Task Force, Final Report, May 2010, Office of the Army Surgeon General:
Available at *amedd.army.mil/reports/Pain_Management_Task_Force*

The Neuropathy Association:
A national nonprofit organization: *neuropathy.org*

U.S. National Library of Medicine, National Institutes of Health:
A free resource provided by the National Institutes of Health. *nlm.nih.gov*

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Notes

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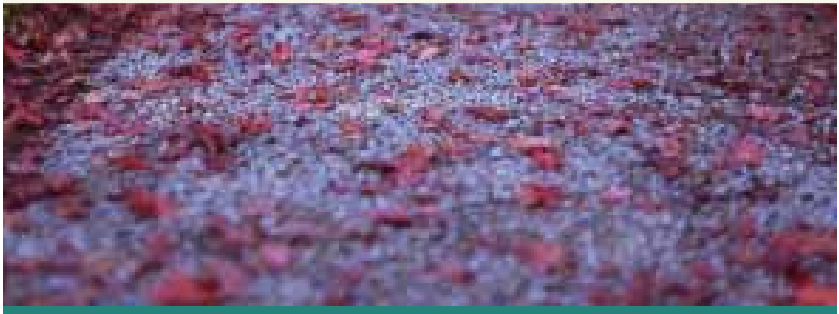

INFLEXXION HEALTH SERIES

Also in the Inflexxion Health Series:

- **PainEDU.org Manual**
  A Pocket Guide to Pain Management
- **Managing Chronic Pain with Opioids in Primary Care**
- **Cross-Cultural Pain Management**
  Effective Treatment of Pain in the Hispanic Population

http://web.archive.org/web/20101007082841/http://painknowledge.org/patiented/pdf/B712_PF_PE_FINAL%20070809.pdf

PERSISTENT PAIN | In Older People

How Pain Can Affect Your Life

Pain can affect all parts of your life. It can:

- Make it difficult to work
- Decrease your ability to perform "activities of daily living," such as cleaning, traveling, and cooking
- Be associated with depression and anxiety
- Cause stress in family relationships
- Cause you to avoid contact with people that you care about

It is important to talk with your healthcare provider about your pain so that you can develop a treatment plan

Pain: Know the Signs

Pain can be a problem for people of all ages, but it may be especially difficult to diagnose and treat in older adults who may have dementia or other medical conditions. It is important to be able to recognize signs of pain in someone that you care about who may not be able to describe pain to her healthcare provider. Here are some signs of pain to look out for:

- ✓ Grimacing
- ✓ Fidgeting
- ✓ Rocking
- ✓ Tension or irritability
- ✓ Crying

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The NIPC is supported by an educational grant from Endo Pharmaceuticals Inc.

This handout will discuss some of the reasons that persistent pain is an issue for older adults, and ways that persistent pain can be assessed and treated.

What is persistent pain?

Persistent, or *chronic*, pain is pain that lasts for longer than 3 months. It can be caused by an injury or surgery, or it may not have a known cause. Persistent pain affects 25% to 50% of older adults, and is often associated with medical conditions that are more common in older people. Some examples include:

- Problems with bones and muscles, such as a strain or sprain.
- *Arthritis*—swelling of the joints, which commonly occurs in the knees or fingers.
- Osteoarthritis—a breakdown of *cartilage* in the joints. Cartilage is the connective tissue found on bones. When this tissue breaks down, joints and bones rub against one another, causing pain.
- Cancer pain—caused by the cancer itself and/or the chemotherapy and radiation used to treat the cancer.
- *Neuropathic pain*, or pain in the nerves. One type, *diabetic peripheral neuropathy*, feels like electricity or "pins-and-needles" in the hands and feet, and is associated with nerve damage caused by diabetes. The second type, *postherpetic neuralgia*, is a burning/tingling under the skin that is caused by shingles. *Shingles* is a painful rash that occurs when the virus that causes chickenpox becomes active again. Postherpetic neuralgia occurs when the shingles heals but the pain remains. It is more common in older adults or those with weak immune systems.

Why is persistent pain a problem in older adults?

Because persistent pain has many different causes, it can be difficult to diagnose and treat in older people. This is especially true if someone has problems with memory, attention, language, and problem-solving that make it hard for them to do their normal, everyday activities. These problems may be signs of a condition called *dementia*. Older adults with dementia may find it difficult to describe pain to their healthcare provider or rate their pain on a pain scale. Depression is common in older people, as well, and can make pain worse; persistent pain can also cause depression.

How is persistent pain assessed?

Your healthcare provider will measure your pain with a pain scale that describes how severe your pain is. Some scales range from 0 to 10, where a score of 0 is no pain and 10 is the worst pain. Your healthcare provider may also ask you about the type of pain you are experiencing. For example, is your pain sharp, dull, or aching? Where does it hurt? What time of day do you feel the most pain? The answers to these questions will help your healthcare provider work with you in developing a treatment plan.

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How is persistent pain treated?

There are many treatments available for persistent pain. Talk with your healthcare provider about any medications that you may be taking or any health conditions that you may have before starting any pain treatment. You should also let your healthcare provider know as soon as possible if you have any side effects from your pain medication.

Some drug treatments can be useful for different types of persistent pain:

- Nonsteroidal anti-inflammatory drugs (NSAIDs), such as *aspirin*, *naproxen*, and *diclofenac*, block chemicals in your body that cause pain. Some NSAIDs are available as pills or tablets, and others are available in topical forms that can be applied to the skin.
- *Acetaminophen* is a medication that is commonly used to relieve different types of pain.
- Topical analgesics, such as *lidocaine patches*, work by stopping the nerves from sending pain signals.
- Opioids block pain messages that your body sends from reaching the brain. Some types of opioids include *hydrocodone*, *morphine*, *codeine*, *oxycodone*, *methadone*, *fentanyl*, and *oxymorphone*.
- Antidepressants such as *duloxetine* can be used to treat both pain and depression associated with pain.
- Anticonvulsants, such as *gabapentin* and *pregabalin*, work by changing the way that the body senses pain.

Non-drug treatments can also be helpful for persistent pain:

- Physical therapy and/or exercise to reduce pain and increase mobility.
- Transcutaneous electrical nerve stimulation (TENS), for sore joints and muscles. TENS is a type of therapy that uses low-voltage electrical currents to decrease pain. The electrical currents flow through wires that are applied to the skin over the muscle that hurts.
- Cognitive/behavioral therapy helps people learn how to think differently about their pain, and learn new ways of understanding and controlling their pain, such as deep breathing, relaxation, or distraction.
- Acupuncture involves the placement of small needles into specific parts of the body to ease pain.
- Over-the-counter topical creams, gels, rubs, or sprays, which can be applied to the skin for muscle and bone problems.

Your healthcare provider will know which treatment approach is best for you.

FOR MORE INFORMATION:

Talk to Your Healthcare Provider.

Persistent Pain: MYTHS AND FACTS

- **MYTH:** Pain is a normal part of aging, so I should just "deal with it."
- **FACT:** It is true that pain is more common as we get older, but it is not a normal part of aging; it is a sign that something is wrong. All pain should be taken seriously and treated.
- **MYTH:** I will become addicted to my pain medicine if I have to take it every day.
- **FACT:** Medicines that are used to treat pain usually do not cause addiction if they are prescribed and taken correctly.
- **MYTH:** I don't know what is causing my pain, so my healthcare provider will not believe me.
- **FACT:** Persistent pain often has no known cause. Your healthcare provider will work with you to understand your pain and what might be causing it. He should perform a thorough examination and discuss with you the appropriate treatment for your pain.

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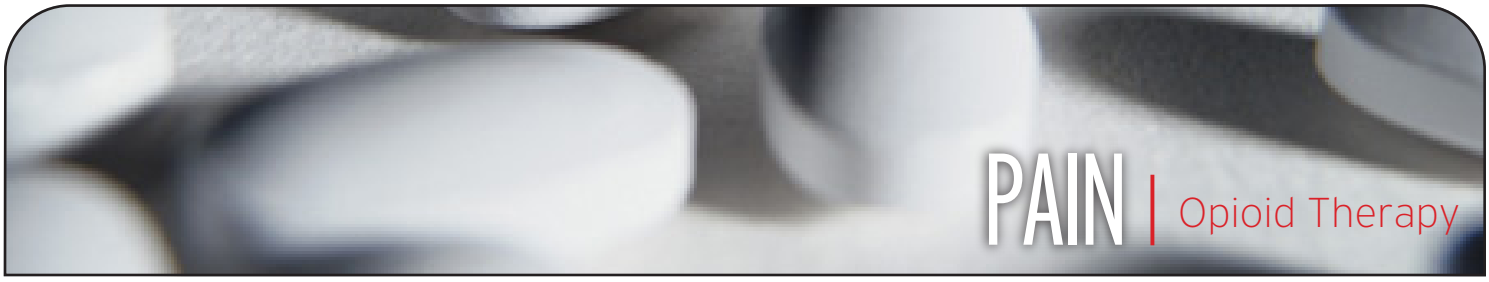

PAIN | Opioid Therapy

SHORT- VS LONG-ACTING OPIOIDS: WHAT'S THE DIFFERENCE?

Short-acting opioids

- Work more quickly
- Treat pain for a short period
- Taken as needed when you first start to feel pain

Long-acting opioids

- Are released in the body over a longer period of time so pain relief lasts for several hours
- Treat persistent pain
- Taken on a regular schedule (every 8–12 hours) at the same time every day

EXPLAIN YOUR PAIN

ONLY YOU KNOW HOW MUCH PAIN YOU ARE IN.

Be sure to tell your healthcare provider the following information about your pain to help him best treat it:

- ✓ When it starts
- ✓ Where it occurs
- ✓ How long it lasts
- ✓ Any "triggers" that cause you pain

Remember, having pain is *not* a way of life—all types of pain can be treated, and be controlled or decreased as the result of treatment.

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The NIPC is supported by an educational grant from Endo Pharmaceuticals Inc.

Opioids can be taken safely for pain relief. This handout will review some of the risks and benefits of opioid therapy, and what you can expect once you start taking an opioid medication.

Opioids are used to treat moderate-to-severe pain (pain that is greater than 4 on a pain scale where 0 is no pain and 10 is the worst possible pain). They work like natural substances found in the body (known as *endorphins*) that are produced to control pain. *Hydrocodone* (Vicodin), *morphine* (Avinza, Kadian, MS Contin, Oramorph), *codeine* (Tylenol with Codeine, Empirin with Codeine), *oxycodone* (OxyContin, Percocet), *methadone* (Dolophine, Methadose), *fentanyl* (Actiq, Fentora, Duragesic), and *oxymorphone* (Opana) are the names of commonly prescribed opioids.

Opioids are either *short-* or *long-acting* (*see "Short- vs Long-Acting Opioids" box*), and can be used to treat *chronic* and *acute* pain. *Chronic* (or *persistent*) pain is present over a long period of time. Some examples include pain that is associated with a long-term illness or condition, such as arthritis, low back pain, or cancer. *Acute* pain is short-term and may be severe, for example, pain that is caused by an injury.

It is important to talk with your healthcare provider about the type of pain that you are experiencing. See the checklist on the left (*Explain Your Pain*) for some tips about communicating your pain level to your healthcare provider.

What are some of the benefits of opioid therapy?

Opioids can be very beneficial for treatment of both acute and chronic pain. Opioid therapy can:

- Reduce pain
- Improve pain-related dysfunction (that is, when your pain stops you from doing your normal activities of daily living)
- Improve quality of life

As with any medication, there are some side effects that are associated with opioid therapy. The most common side effects that occur with opioid use include the following:

- Constipation
- Drowsiness
- Confusion
- Nausea
- Itching
- Dizziness
- Shortness of breath

Your healthcare provider can help to address and, in some cases, prevent side effects that may occur as a result of opioid treatment. Less severe side effects, including nausea, itching, or drowsiness, typically go away within a few days without the need for further treatment. If you experience any side effects, you should let your healthcare provider know immediately.

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Your healthcare provider will work with you to ensure that you are taking your opioids safely. As with all prescription medications, some risks are associated with opioid therapy. These include *tolerance, physical dependence, withdrawal,* and *addiction.*

When patients become *tolerant* to a medication, it means that they need increasing amounts of the medication to give the same effect that occurred when they first started taking it. Once you are on the right dose of medication for your pain, tolerance usually does not occur. Unless your pain worsens, you will most likely remain on the same opioid dose throughout your treatment. Just because you are tolerant and need more medication does not mean that you are addicted.

Physical dependence means that you may experience symptoms of *withdrawal* if you stop taking regular doses of your opioid too quickly. Common symptoms of withdrawal include restlessness, insomnia, sweating, or nausea/vomiting. These symptoms can be avoided by slowly decreasing the opioid dose. You should not change your dose on your own; speak with your healthcare provider if you feel that you need to have your medication adjusted. Just because you develop withdrawal symptoms if you miss a dose does not mean that you are addicted.

Addiction is excessive use of a medication or drug even though it may be harmful to the user. People who take opioids as prescribed usually do not become addicted. It is important to keep up an ongoing dialogue with your healthcare provider and let him know if you feel that you are using your medications for reasons other than pain control or if you feel unable to control how often and how much of your medication you are taking.

What can you expect in terms of pain relief and improvements in your quality of life?

After starting opioid therapy, you may see the following positive improvements:

- Your pain level may decrease
- Your level of function should improve: you may find you are now able to participate in activities of daily living, such as work and hobbies, that you were not able to enjoy when your pain was worse
- Your sleep may improve

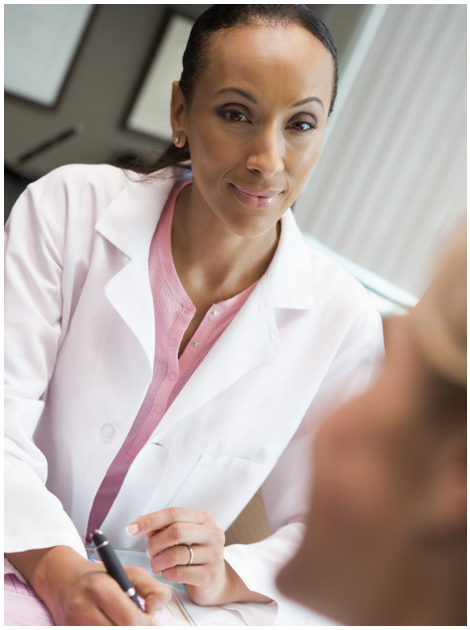
What if opioid treatment doesn't work?

If opioid treatment is not appropriate for you, or if you are experiencing side effects, talk with your healthcare provider. She can help to decide on the next best course of action, which may include switching to a different opioid or to a new pain medication. Do not stop taking your opioid medication on your own; make sure to discuss stopping medication with your healthcare provider first.

Opioids are just one part of your pain treatment. Your healthcare provider will partner with you to help reduce your pain, and may also recommend other medications, lifestyle changes, or non-drug treatments that can be used with opioid treatment to obtain the best results.

FOR MORE INFORMATION:

Talk to Your Healthcare Professional



TIPS for Using Opioids to Treat Pain

- Take your medication *exactly* as it is prescribed.
- Discuss any concerns that you have regarding opioid therapy with your healthcare provider.
- Let your healthcare provider know if you are experiencing any side effects. She can modify your dose or change your medication.
- Tell your healthcare provider about any other medication(s) that you may be taking.
- Keep all of your appointments with your healthcare provider.
- Keep track of the time when you took your pain medication and the activity that you were doing when your pain occurred.

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PERSISTENT PAIN TREATMENT | The Team Approach

What are the Goals of a Team Approach to Pain Management?

The team approach can help you to take control of your pain and regain a normal and active lifestyle. During and after your treatment, you will

- Be better able to exercise, walk, and return to your daily activities with decreased pain.
- Be more aware of pain triggers (depression, anger) and be better able to relax your mind and thoughts.
- Understand more about treatments and medications and how they help your pain.
- See an improvement in your social relationships and your communication with family and friends.
- Be able to return to your job with confidence, increased self-esteem, and decreased pain.

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What is a team approach to pain management?

A team approach to pain management is a type of treatment plan that combines the knowledge and skills of several healthcare professionals who work with your primary healthcare provider to help manage your pain.

How does this approach work?

Your primary healthcare provider will perform a detailed physical examination to discover the main cause(s) of your pain. During the examination, you may be asked about the history and location of your pain, any previous pain treatments and medications that you have taken, how well you cope with pain, and any current stress or factors that may be affecting your pain. Then, depending on the severity of your pain, your healthcare provider may consult with other specialists to discuss the best treatment plan for you based on the results of your exam. Once you begin treatment, the team of specialists will follow-up with you regularly to see how your pain level and daily activities have improved.

What types of specialists might be involved in this approach?

Here are some specialists who may be a part of your pain management team:

- *Pain specialist:* A pain specialist treats patients who experience pain related to a specific cause (for example, pain from an injury) and those who suffer from pain as a condition (for example, headaches). Pain specialists diagnose conditions, provide treatment, and counsel patients and their families.
- *Neurologist*: A neurologist may be a pain specialist and will examine the nerves in your neck and spinal cord, muscle movement and strength, balance, and reflexes, to help determine the cause of your pain, and determine treatment.
- *Orthopedist*: An orthopedist will make sure that your bones and muscles are not injured. He or she will also test the movement of your head, shoulders, back, arms, and legs to determine the cause(s) of your pain.
- *Psychologist*: Pain can have deep psychological effects on the mind, including feelings of hopelessness, anger, and despair. These feelings can affect your ability to engage in normal daily activities. A *psychologist* will conduct an interview with you to learn more about your pain experience (for example, pain history, medications, and mood changes).
- *Physical therapist*: A physical therapist will use exercises, stretches, and other techniques to help you improve mobility, decrease pain, and reduce any disability related to illness or injury. Physical therapy may also include an education program (understanding pain), or manual therapy (help balance muscle and stretch tight skin).

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PERSISTENT PAIN TREATMENT | The Team Approach

- *Occupational therapist*: An occupational therapist will assess the way pain affects your ability to perform job duties and help you develop, recover, and/or maintain your work skills. They will talk with you and/or your employer to find and remove anything that can cause accidents or injury in your work space (for example, correct how you sit and type in front of a computer or add more lighting).
- *Pharmacist*: Together with other healthcare providers, a *pharmacist* helps to manage pain by educating you about your medications, identifying side effects that may arise with certain medications, regularly reviewing medications to make sure that there are no safety issues, and monitoring whether you are following your treatment plan.
- *Social worker*: A social worker uses strategies, such as relaxation training and goal setting, to help you and your family cope with your pain. He or she works with the multidisciplinary pain management team to address barriers to treatment, including fear of drug addiction, insurance issues, child/family care, or transportation. The social worker also provides information on community resources, such as support groups.
- *Nurse*: A nurse will assist in providing care and helping you follow your treatment plan. He or she can help to make communication easier between the members of your multidisciplinary treatment team, as well as between you and the specialists who are treating you.

What else should I know about this approach?

The team approach to pain management can place you on the right track by providing you with the necessary skills and medical treatments for managing your pain.

- Among the therapists already mentioned, you may also meet with a family counselor, massage therapist, psychiatrist, or other healthcare provider trained to manage pain.
- Treatment should fit with your lifestyle, whether it is inpatient care (treatment that is provided in a hospital or other location and requires an overnight stay), outpatient care (treatment that does not require an overnight stay), or both.
- Treatment programs may include group therapy, relaxation and stress management, and educational programs, among others.

FOR MORE INFORMATION:

Talk to Your Healthcare Provider.

HELPFUL RESOURCES

The following organizations have information regarding pain management programs and healthcare providers:

- American Academy of Pain Management
  www.aapainmanage.org
- American Pain Foundation
  www.painfoundation.org
- American Pain Society
  www.ampainsoc.org
- Commission on Accreditation of Rehabilitation Facilities
  www.carf.org

REFERENCES ACT Myalgic Encephalomyelitis/Chronic Fatigue Syndrome Society. Multidisciplinary pain management. Available at: www.mecfscanberra.org/au/pain/mdpc.htm • Booker C, Nicol M. *Nursing adults: the practice of caring*. St Louis, MO: Mosby; 2003. • Chen PP. Multidisciplinary approach to chronic pain management. *HKMJ*. 1996;2(4):401-404. • Golden BA. A multidisciplinary approach to nonpharmacologic pain management. *JAOA*. 2002;102 (suppl 3):S1-S5. • International Association of the Study of Pain. Outline curriculum on pain for schools of occupational therapy and physical therapy. Available at: http://www.iasp-pain.org/AM/Template.cfm?Section=Home&Template=/CM/HTMLDisplay.cfm&ContentID=1806 • International Association of the Study of Pain. Pain clinic guidelines. Available at: http://www.iasp-pain.org/AM/Template.cfm?Section=Pain_Treatment_Facilities&Template=/CM/HTMLDisplay.cfm&ContentID=9106 • Smiles SS. A team approach to pain management: A conversation with Demaceo Howard, MD, and W. Keith Barnhill, PhD. Available at: http://www.iasp-pain.org/AM/Template.cfm?Section=Home&Template=/CM/HTMLDisplay.cfm&ContentID=1806 • Stanford School of Medicine. Psychological therapy. Available at: www.paincenter.stanford.edu/patient_care/therapy.html • UWHealth. Physical and occupational therapy. Available at: http://www.uwhealth.org/chronicpain/physicalandoccupationaltherapy/12056. All websites accessed July 9, 2009.

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http://web.archive.org/web/20101007071117/http://painknowledge.org/patiented/pdf/B712_PF_PE_Managing%20Persistent_FINAL%20060509.pdf

MANAGING PERSISTENT PAIN in OLDER PEOPLE | Tips for the Caregiver

Many older adults are affected by *chronic*, or *persistent*, pain, which is pain that lasts longer than 3 months. Older people with persistent pain often need help from family and friends to perform normal, everyday activities, including walking, bathing, or dressing. As a *caregiver*, you have an important role in providing physical care and emotional support for your loved one(s). This handout offers tips for recognizing signs of pain, reducing pain and discomfort, and speaking with healthcare providers.

How can you tell when your loved one is in pain?

It can be upsetting to see someone you care about in pain. As the caregiver, you are in the best position to recognize signs of pain. Here are a few rules of thumb:

- **Trust is key.** If older adults think that no one believes they are having pain, they may become upset and stop reporting their pain accurately.
- **Know what "normal" behavior is.** Keep close watch for changes in appetite and sleep, and be aware of increased wandering.
- **Pay attention to body language.** Older adults may not want to report pain or may be unable to express their pain in words, so it is important to be aware of their body language. Body language includes facial expressions (for example, frowning, frightened face), wrinkling the forehead, closing the eyes tightly, rapid blinking, tears, or clenched fists.
- **Listen for words other than "pain."** Different words such as "ache" or "sore" may be used to describe pain.
- **Listen for sounds.** Moaning, groaning, or sighing may be a sign that the person is uncomfortable or in pain.
- **Watch for any body movements that might be signs of pain.** These can include twitching, rocking, or a stiff upper or lower body that is rigid and is moved slowly.
- **Note mental changes.** Pain can sometimes cause stressful emotions such as crying, confusion, or annoyance.

What to do if you notice these signs:

As the caregiver, it is important for you to recognize and report these changes to the healthcare provider. Make sure you know the following information about your loved one's pain:

- Location of the pain (for example, head or leg), what the pain feels like (for example, sharp or thumping), how long the pain lasts, and when the pain occurs (for example, after a meal or in the morning)
- Mention any actions that cause the pain, such as body movement
- Any mental or behavioral changes, including depression or anger
- Types of medications the person is taking and any side effects that the medications may be causing

Also be sure to:

- Be clear when talking with the healthcare provider and stay calm.
- Follow the healthcare provider's suggestions and directions carefully. If your loved one is still in pain, follow up with the healthcare provider immediately so that treatment can be adjusted. Continue seeing the healthcare provider until the pain has improved.

Professional Postgraduate Services®

The National Initiative on Pain Control® (NIPC®) is sponsored by Professional Postgraduate Services®, Secaucus, NJ.

The NIPC is supported by an educational grant from Endo Pharmaceuticals Inc.

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Tools for Measuring Pain in Older Adults

Because older adults may have difficulty talking and clearly expressing what they feel to their healthcare providers, several tools have been created to help measure pain and identify daily activities that cause pain.

- FACES Pain Rating Scale–A visual tool for those who might have difficulty using words to explain how their painful symptoms make them feel. It shows faces that are scored from 0 to 10, where a score of 0 is a smiley face (no pain) and 10 is a crying face (worst pain).
- Pain Thermometer–A visual tool that looks like a thermometer and can be used for people who have difficulty explaining their pain in words. The top of the thermometer is "pain as bad as could be" and the bottom is "no pain."
- Daily pain diary–This can be used everyday to record pain and what steps were taken to reduce pain. One way to record pain is to rate it on a scale of 0 to 10, where 0 is no pain and 10 is severe pain. You can also record simple things that can affect pain, such as weather or any worries. Bring this diary to each appointment with the healthcare provider.

FACES Pain Rating Scale

Each face is for a person who feels happy because she has no pain (hurt) or sad because she has some or a lot of pain. Choose the face that best describes your own pain.

0–5 coding	0	1	2	3	4	5
0–10 coding	0	2	4	6	6	10
	No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

From Hockenberry MJ, Wilson D, Winkelstein ML: Wong's Essentials of Pediatric Nursing, ed. 7, St. Louis, 2005, p. 1259. Used with permission. Copyright, Mosby.

REFERENCES American Geriatrics Society Foundation for Health in Aging. Assessing pain in loved ones with dementia: a guide for family and caregivers. Available at: http://www.healthinaging.org/public_education/pain. • American Geriatrics Society Foundation for Health in Aging. Pain. In: *Eldercare at home. A comprehensive online guide for family caregivers.* Available at: http://www.healthinaging.org/public_education/eldercare. • National Family of Caregivers. Advocating for a loved one in pain: presented by the American Academy of Pain Management. Available at: http://www.thefamilycaregiver.org/caregiving_resources/aapm.cfm. • Sharp E. For the caregiver: recognizing and responding to pain in loved ones with dementia. In: *Dimensions.* 2008. Available at: http://depts.washington.edu/adrcweb/DIMENSIONS.shtml. • World Health Organization Regional Office for the Western Pacific. Care for the patients in pain. In: *Nursing care of the sick: A guide for nurses working in small rural hospitals.* Manila, Philippines: World Health Organization;1998:chap 13. Available at: http://www.wpro.who.int/NR/rdonlyres/8AD3E358-AD6C-46CA-9E27-0664E59E161F/0/Nursing_Care_of_the_Sick.pdf. • All websites accessed May 14, 2009.

FOR MORE INFORMATION:

Talk to Your Healthcare Provider

What are some other ways to reduce my loved one's pain and discomfort?

- ✓ Show that you recognize the pain and respond with a caring attitude
- ✓ Talk slowly and quietly
- ✓ A soothing massage and/or comforting touch can sometimes help to ease the pain
- ✓ Help her change the way that she is sitting or lying down to make her more comfortable
- ✓ Invite visitors to comfort him with friendly conversation
- ✓ Play her favorite music quietly

Helpful Websites

The Following Websites Offer Information And Resources For People Who Are Affected By Persistent Pain And Their Caregivers:

- **American Pain Foundation**
  www.painfoundation.org
- **American Academy of Pain Management**
  www.aapainmanage.org
- **American Chronic Pain Association**
  www.theacpa.org
- **National Pain Foundation**
  www.nationalpainfoundation.org
- **Pain Connection**
  www.painconnection.org

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http://web.archive.org/web/20120206114904/http://www.painfoundation.org/learn/publications/files/cot-dos-donts.pdf

Chronic Opioid Therapy
Dos and Don'ts to Help Avoid Problems

Using Opioids Safely & Responsibly

Although opioids help many people with moderate to severe pain function and regain their quality of life, these strong pain medications are also highly sought after by people who are looking to misuse or abuse them.

The risk for abuse and diversion is why opioids are considered "controlled substances." It's also why your provider might use certain risk management strategies – for example, treatment agreements, pill counts and urine testing – to document that you are taking your medication as prescribed. Remember, your health care team is on your side to help you get the pain relief you need.

DO	DON'T
Follow your health care provider's instructions. Ask questions if you don't understand how to properly take, store or get rid of unused or expired opioid medications. **Read the information sheet and/or medication guide** that comes with your prescription. **Report all side effects** to your health care provider. **Tell your health care provider if you or someone in your family has a history of mental illness or substance abuse** (for example, alcoholism, abusing illicit drugs or being prone to other compulsive behaviors). **Understand the difference between tolerance, physical dependence and addiction**; they aren't the same. **Use a pain diary** to record your pain and how your treatment is working in between medical visits. *APF's Targeting Chronic Pain: Your Personal Notebook* is a great tool. **Use one pharmacy for your opioid and other medications**, if possible. **Safely store and dispose of opioids and other medications** to be sure that children, pets and others don't intentionally or accidentally take them. Put medicines in a locked cabinet and not in locations easily accessed by others (medicine cabinets, nightstands, purses or kitchen counters). Keep all medications in the original bottle. **Keep careful track of when and how much medication you take**. **File a report with your local police department** if you suspect someone has stolen your prescription. You may save a life.	**Change the dose of your pain medication** – taking more or less or skipping doses – without talking with your health care provider first. Taking a higher dose than is recommended can be dangerous, possibly deadly. Taking too little may result in unnecessary pain and suffering. If you are not getting pain relief or think your dose is too high, talk with your health care provider before making any changes. **Share your medications** with anyone. Only a health care provider can decide whether someone needs pain medication. **Drive or use heavy machinery** when you first start taking this kind of medication until your health care provider says it's alright. **Crush or break pills.** You must never chew, cut, crush, or dissolve opioid tablets or open opioid capsules, unless specifically told to do so. Opioid patches must never be cut or folded and they need to stick to the skin completely. **Use opioids to treat conditions other than pain** (sleep, bad mood, stress, or anxiety). **Mix with alcohol, antihistamines, barbiturates or benzodiazepines.** All of these substances can make someone's breathing slower. When these are taken together, it can be life-threatening. Tell your health care team all of the medications, supplements and herbal products that you take to avoid dangerous interactions. **Take any of your medications in the dark.** Turn on the light. Always double check that you are taking the right medicine at the right dose.

Resources to Help

APF has a number of tools to help you. Visit www.painfoundation.org and check out:

- *Targeting Chronic Pain:* Your personal notebook
- *Treatment Options: Your Guide to Pain Management*
- PainSAFE at www.painsafe.org for more information about how to safely use opioids and other pain therapies
- Expert Q&A on risk management strategies for opioid therapy
- PainAid, APF's online support community
- Chronic Opioid Therapy, Preparing for Your Appointments

This educational activity is supported through an educational grant from Endo Pharmaceuticals.

https://web.archive.org/web/20150513234458/http://painmatters.com/docs/TalktoYourDoctor-Downloadable-PDF_02.26.pdf

PAIN MATTERS

A Guide for Talking to Your Doctor About Chronic Pain

You've probably experienced what happens to many people during a visit to your doctor--you know the key reasons for your visit, you've thought through all of the questions you want to ask, and the minute the doctor says hello, it all disappears. This downloadable tool is intended to help you talk to your doctor about your chronic pain and help you work together to find the right pain management plan.

1. What is the main reason for your visit? A first-time meeting to discuss a pain management plan or a repeat visit to track the status of your existing pain management plan?

2. How would you describe the symptoms of pain you're experiencing?

- Is it sharp, throbbing, aching or burning? Is there numbness or tingling associated with the pain?
- Where is it located? Be as specific as possible by pointing to the specific area or region of your body.
- It may help to rate your pain on a scale of 1 to 10, where 1 is no pain and 10 is the worst pain you can imagine. Try tracking your pain for several days or weeks before visiting your doctor, if possible, to see how it changes over time.

3. How often do you experience your pain (daily, several times per week, or weekly)?

4. What time of day is your pain the worst (in the morning or at bedtime)?

5. Does your pain interfere with your regular routine like sleeping, lifting common household objects, bending, walking or sitting?

6. Are you currently doing anything to help manage the pain you're feeling? Do you do yoga, get massages, acupuncture therapy, or take over-the-counter medicines? How often do you do these things?

7. Do you have any known allergies to medicines you've taken?

Getting the Answers You Need

It's important that your doctor has all of the right information to understand your pain and work with you to customize a pain management plan that is right for you. It is also important for you to be well informed about what to expect from a pain care plan. Here are the types of questions you may want to ask your doctor.

1. What should I know before I begin the pain management plan?

2. What are the benefits of the plan you are recommending? What are the risks?

3. How often should I take my medicine?

4. Are there any specific instructions such as taking it with or without food, should I take it morning or night?

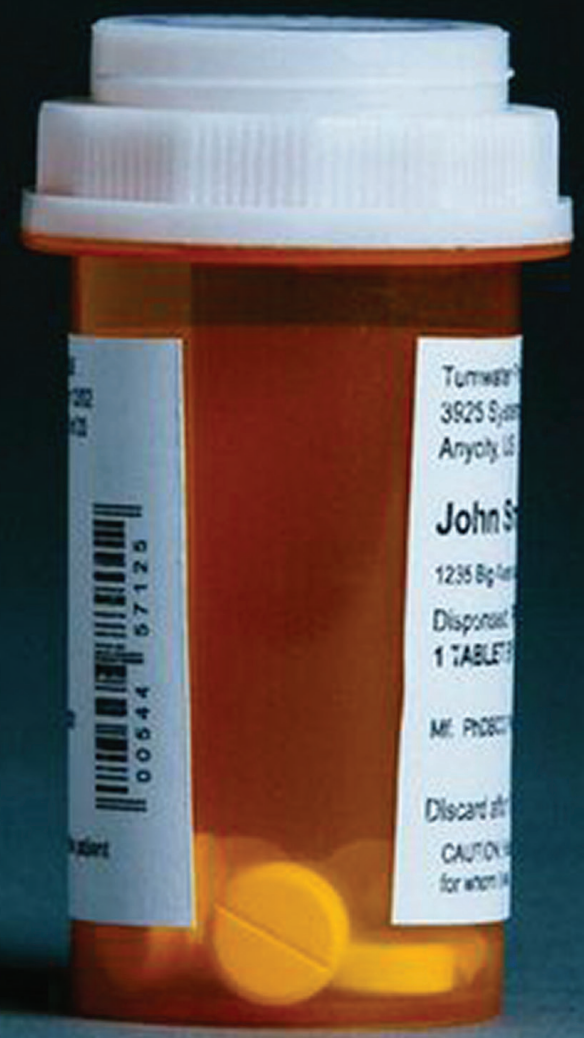
5. What other side effects could I experience with this medicine? What should I do if I experience a side effect?

6. How much will this medicine cost and will my insurance cover the medicine? Are there any support programs available to help supplement the cost?

https://web.archive.org/web/20181011154544/https://www.cdc.gov/rxawareness/pdf/CDC_RxAwareness_Newspaper_ads_12x10.5in.pdf

Prescription opioids can be **addictive** and **dangerous**.

It only takes a little
to lose a lot.



cdc.gov/RxAwareness

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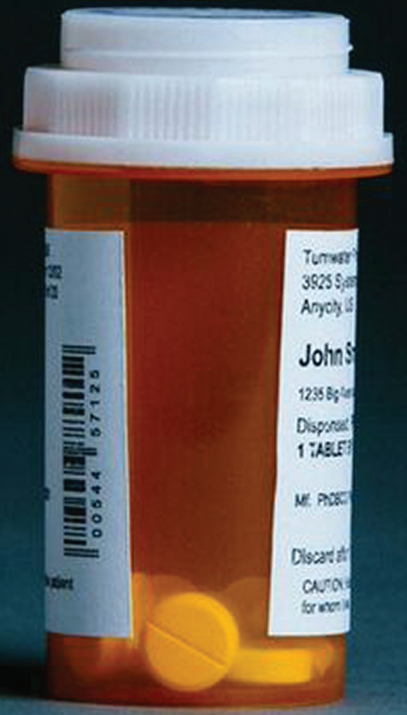
https://web.archive.org/web/20181011154548/https://www.cdc.gov/rxawareness/pdf/9828_CDC_NCIPC_Billboard_v03_RELEASE-Posterflex.pdf

Prescription opioids can be addictive and dangerous.

It only takes a little to lose a lot.



cdc.gov/RxAwareness

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https://web.archive.org/web/20150724081137mp_/http://www.theacpa.org/uploads/Life_Scale_3.pdf

American Chronic Pain Association

Quality Of Life Scale

A Measure Of Function For People With Pain

Non-functioning

0		Stay in bed all day. Feel hopeless and helpless about life.
1		Stay in bed at least half the day. Have no contact with outside world.
2		Get out of bed but don't get dressed. Stay at home all day.
3		Get dressed in the morning. Minimal activities at home. Contact with friends via phone, email.
4		Do simple chores around the house. Minimal activities outside of home two days a week.
5		Struggle but fulfill daily home responsibilities. No outside activity. Not able to work/volunteer.
6		Work/volunteer limited hours. Take part in limited social activities on weekends.
7		Work/volunteer for a few hours daily. Can be active at least five hours a day. Can make plans to do simple activities on weekends.
8		Work/volunteer for at least six hours daily. Have energy to make plans for one evening social activity during the week. Active on weekends.
9		Work/volunteer/be active eight hours daily. Take part in family life. Outside social activities limited.
10		Go to work/volunteer each day. Normal daily activities each day. Have a social life outside of work. Take an active part in family life

Normal Quality of Life

American Chronic Pain Association

Quality Of Life Scale

A Measure Of Function For People With Pain

Pain is a highly personal experience. The degree to which pain interferes with the quality of a person's life is also highly personal.

The American Chronic Pain Association Quality of Life Scale looks at ability to function, rather than at pain alone. It can help people with pain and their health care team to evaluate and communicate the impact of pain on the basic activities of daily life. This information can provide a basis for more effective treatment and help to measure progress over time.

The scale is meant to help individuals measure activity levels. We recognize that homemakers, parents and retirees often don't work outside the home, but activity can still be measured in the amount of time one is able to "work" at fulfilling daily responsibilities be that in a paid job, as a volunteer, or within the home.

With a combination of sound medical treatment, good coping skills, and peer support, people with pain can lead more productive, satisfying lives. The American Chronic Pain Association can help.

For more information, contact the ACPA:

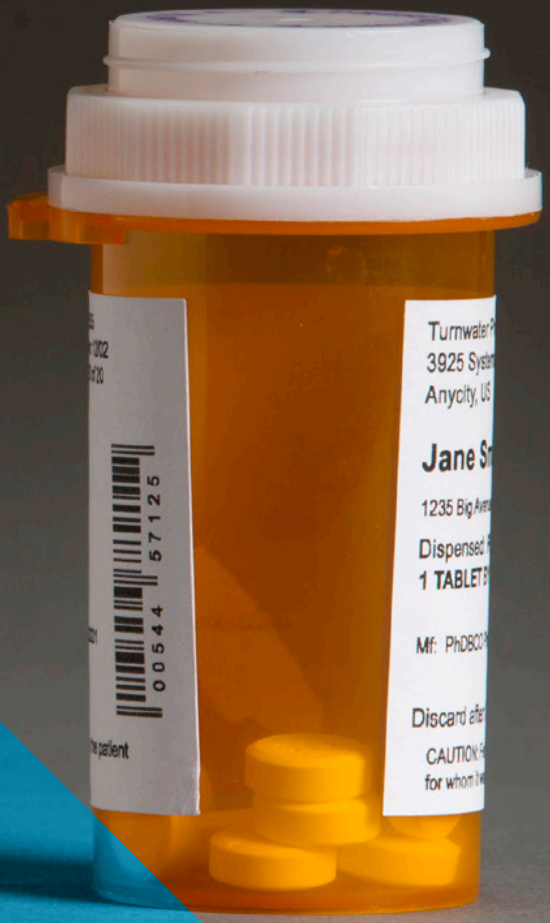
Post Office Box 850
Rocklin, CA 95677
916.632-0922
800.533.3231
Fax: 916.632.3208
E-mail: acpa@pacbell.net
Web Page: www.theacpa.org

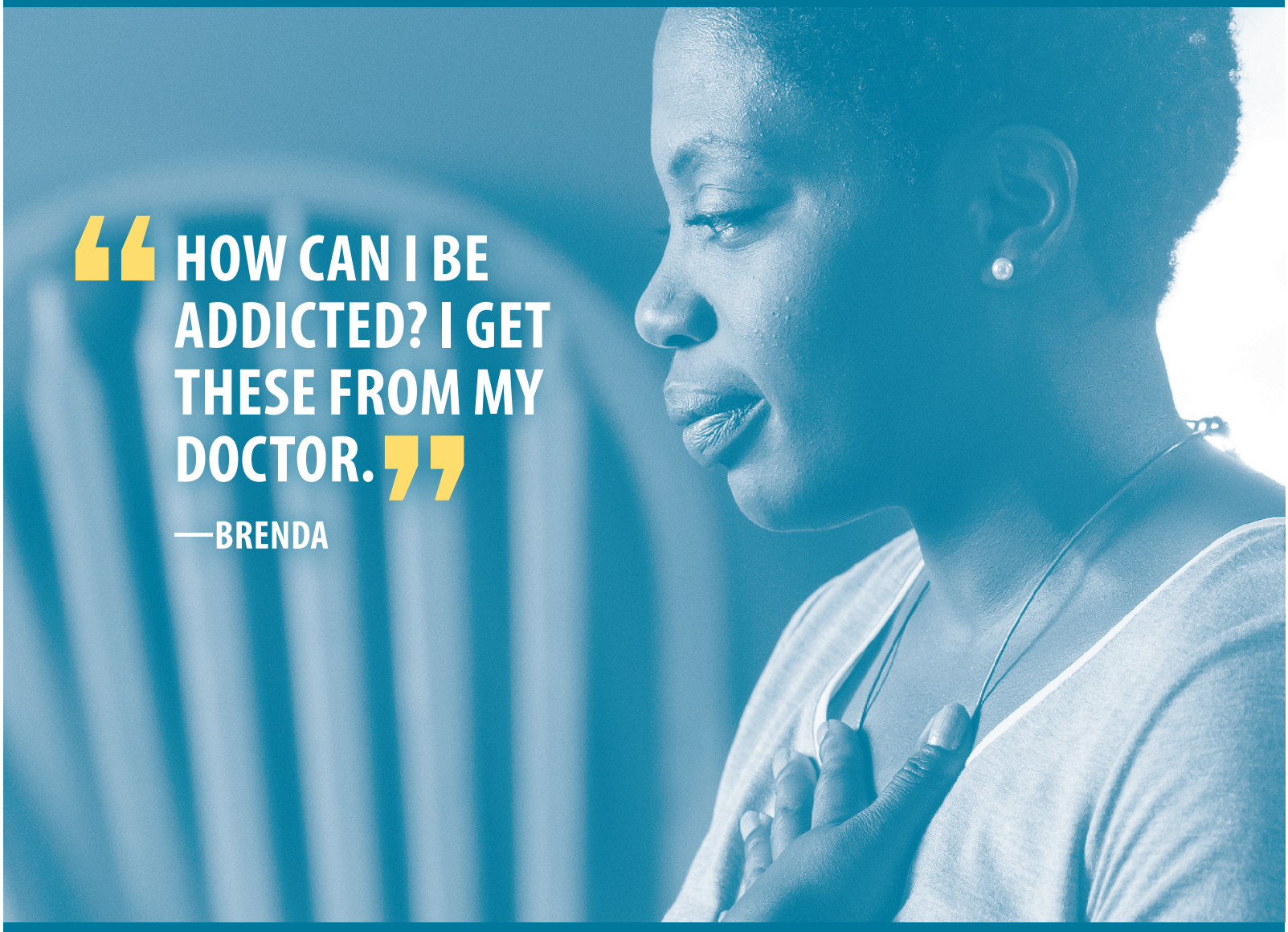
https://web.archive.org/web/20180627135807/https://www.cdc.gov/rxawareness/pdf/Overview-Rx-Awareness-Resources.pdf

2017

ADDRESSING THE PRESCRIPTION OPIOID CRISIS

CDC Rx AWARENESS CAMPAIGN OVERVIEW




“HOW CAN I BE ADDICTED? I GET THESE FROM MY DOCTOR.”
—BRENDA

Contents


“IT’S LIKELY THAT EVERYBODY KNOWS SOMEBODY WHO IS STRUGGLING WITH THIS VERY PROBLEM.”
—NOAH

Addressing the Prescription Opioid Crisis

Prescription Opioid Abuse Is a Critical Public Health Issue

Every day, more than 1,000 people are treated in emergency departments for misusing prescription opioids, and more than 40 people die from prescription opioid overdoses.[1,2] From 1999 to 2015, more than 183,000 people died in the United States from overdoses related to prescription opioids.[3] Prescription opioids are often prescribed following surgery or injury to treat moderate-to-severe pain, or for health conditions such as cancer. In recent years, there has been a dramatic increase in the use of prescription opioids for the treatment of chronic pain unrelated to cancer, despite serious risks and a lack of evidence about their long-term effectiveness.

Overdoses from opioids are on the rise and killing Americans of all races and ages. Families and communities across the country are coping with the health, emotional, and economic effects of this epidemic.

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[1] Substance Abuse and Mental Health Services Administration. *Highlights of the 2011 Drug Abuse Warning Network (DAWN) findings on drug-related emergency department visits. The DAWN Report*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration; 2013. ***http://www.samhsa.gov/data/2k13/DAWN127/sr127-DAWN-highlights.htm.*** Accessed December 2016.

[2] U.S. Department of Health and Human Services, Office of the Surgeon General. *Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health*. Washington, DC: U.S. Department of Health and Human Services; November 2016.

[3] Centers for Disease Control and Prevention. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: National Center for Health Statistics; 2016. ***http://wonder.cdc.gov***. Accessed December 2016.


“ONE PRESCRIPTION CAN BE ALL IT TAKES TO LOSE EVERYTHING.”
—MIKE

Rx Awareness Campaign Description

To raise awareness of prescription opioid abuse and overdose, in 2017 the Centers for Disease Control and Prevention (CDC) launched Rx Awareness, its first prescription opioid overdose prevention campaign. The Rx Awareness campaign is evidence-driven and tells the real stories of people whose lives were torn apart by opioid use and abuse.

The Rx Awareness campaign focuses on adults ages 25–54 who have taken opioids at least once for medical or nonmedical (recreational) use, and it highlights the importance of reducing opioid abuse to prevent overdoses. The goals of the campaign are to:

- Increase awareness that opioids can be addictive and dangerous; and
- Increase the number of individuals who avoid using opioids nonmedically (recreationally) or who choose options other than opioids for safe and effective pain management.

CDC incorporated first-person stories into the campaign based on past effective use of testimonials to communicate about complex and sensitive health behaviors. The cornerstone of the campaign is a series of videos that feature individuals who are either living in recovery from opioid use disorder, or who are family members who lost someone to a prescription opioid overdose.

Rx Awareness Campaign Materials

- Digital
  - 30-second testimonial videos
  - Web banner ads
  - Online search ads
  - 5-second bumper digital video ads
- Campaign website (cdc.gov/RxAwareness)
- Radio
  - 30-second ads
- Out-of-home
  - Billboards
  - Newspaper ads

In addition to video advertisements, the campaign includes radio advertisements; digital materials, such as web banner advertisements; and materials for out-of-home spaces, such as billboards and newspaper advertisements.

Rx Awareness Campaign Target Audience

CDC selected the target audience for the Rx Awareness campaign after conducting a series of background and formative research activities to deepen its understanding of communication needs about the opioid epidemic. We learned that adults between the ages of 45 and 54 had not yet been targeted by a broad-reaching campaign. This information was reinforced by surveillance data indicating that the population with the highest fatality rate from opioid overdoses was non-Hispanic white adults ages 45–54. We also found a need for communication efforts to deliver primary prevention messages to younger audiences ages 25–35, who are less likely to experience chronic pain but may be exposed to opioids for other reasons, such as having a sports injury or undergoing a dental procedure. Ultimately, we combined these audiences for the Rx Awareness campaign to include all adults ages 25–54.

Campaign Approach and Messaging

Early campaign research included an environmental scan, literature review, social media assessment, focus groups, and in-depth interviews. These activities sought to answer the following questions:

- What communication campaigns exist to prevent prescription opioid use and abuse?
- Have these programs been evaluated?
- Have best practices been identified for creative execution of communication campaigns?
- What influences audiences' behaviors related to prescription opioid use and avoidance?
- What are audiences' information preferences and needs related to prescription opioids?
- What are audiences' preferred formats for receiving information on this topic?
- Who are audiences' trusted sources for health information and guidance?

A key finding of this early research was that personal and emotional messages strongly resonated with audiences, particularly messages that addressed loss, such as the loss of relationships with family and friends and loss of employment. This drove the campaign approach to capture testimonials about negative outcomes and loss.

We also learned about widespread concern in communities across the country about opioid overdoses, and the need for multichannel dissemination strategies to reach the whole community. Billboards are one of the campaign's channels, based on participants' recommendations to use them to place campaign messages.

Findings from the formative research guided the development of the campaign's tagline, "It only takes a little to lose a lot," and the reality statement, "Prescription opioids can be addictive and dangerous." The Rx Awareness campaign used elements and approaches based on the formative research findings.

The Rx Awareness campaign uses the term "prescription opioid" instead of "painkiller." The term "painkiller" is misleading because while opioids relieve pain, they do not eliminate pain.

The campaign does not include messages about heroin. Specificity is a best practice in communication, and the Rx Awareness campaign messaging focuses on the critical issue of prescription opioids. Given the broad target audience, focusing on prescription opioids avoids diluting the campaign messaging. Heroin is a related topic that also needs formative research and message testing.


“OUR SECRETS KEEP US SICK.”
—DEVIN

Pilot Testing

CDC launched a small-scale pilot that implemented all components of the Rx Awareness campaign and ran for 14 weeks in 9 high-burden counties in 4 states: Ohio, Oregon, Rhode Island, and West Virginia. CDC based this placement on criteria such as reach, participants' readiness to implement a campaign, and level of interest. The pilot presented an important message to these areas—which are highly affected by prescription opioid overdose—while also allowing CDC to test creative campaign materials in the field and obtain valuable input on the ads before launching the campaign. An assessment of the pilot campaign explored target audiences' exposure to and perceptions of a series of campaign messages and materials.

A mixed-method design integrating data from in-depth interviews and a quasi-experimental, one-group retrospective post-then-pretest (RPTP) survey was used to assess target audiences' responses to campaign messages and materials designed to influence their knowledge, awareness, attitudes, and behavioral intentions related to prescription opioid use and misuse.

Key results from the assessment of the Rx Awareness campaign's channel selection, messages, and materials are described in the next section.

In-depth Interviews: Key Findings

- Most participants believed the content on the billboards, videos, and radio ads.
- Participants reported that it would be easy to read the first line of the billboards while driving a car, but that reading the second line would be more difficult.
- Participants reported that the video ads were relatable, and that they could sympathize with the storytellers' situations. The speakers in the videos were thought to be relatable because they looked like people from the participants' communities.
- Most participants said that they would share the video testimonials with others.

Online Survey: Key Findings

- Among survey respondents exposed to the Rx Awareness campaign (see Figure 1):
  - 70 percent saw campaign billboards;
  - 71 percent saw online or digital media (this included any campaign content a participant saw online);
  - 65 percent heard a radio ad;
  - 39 percent saw an online bumper; and
  - 36 percent saw an online video.
- Most people exposed to the campaign reported that the overall campaign was attention-grabbing (76 percent), believable (81 percent), and meaningful to them (77 percent) (see Figure 2).
- 74 percent of participants reported that the campaign message ("Prescription opioids can be addictive and dangerous") was effective or very effective at improving knowledge that prescription opioids can be addictive and dangerous, and 63 percent said that the campaign message was effective or very effective at making people aware of the risks of prescription opioids.

Figure 1. Participants' Exposure to Rx Awareness Campaign

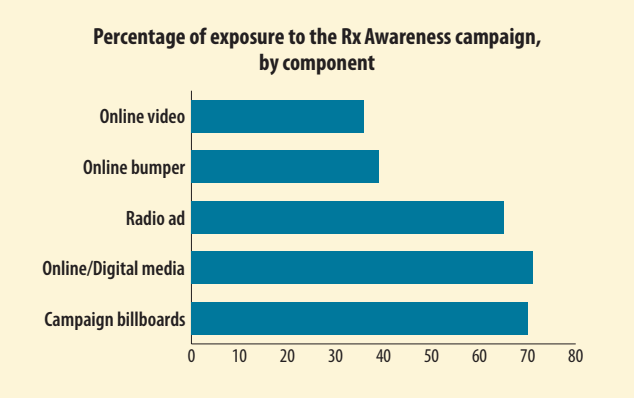
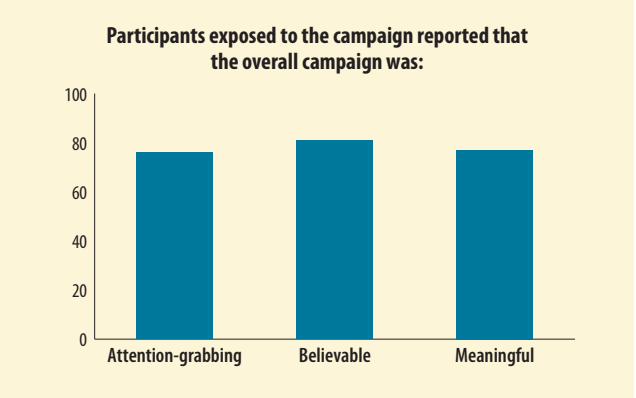


Figure 2. Participants' Experience with the Rx Awareness Campaign



- Almost 70 percent of participants thought that the campaign message ("Prescription opioids can be addictive and dangerous") was effective or very effective at helping people understand that using prescription opioids the wrong way can lead to overdose.
- Most people exposed to the campaign reported that they intend to ask healthcare providers for alternatives to prescription opioids (71 percent), or they intend to avoid using prescription opioids recreationally or medically (73 percent).

Digital Analytics: Key Findings

The pilot Rx Awareness campaign delivered search and display ads, testimonial videos, and a bumper video that gained 141 million impressions, 5.47 million interactions, and 360,294 click-throughs to the *cdc.gov/drugoverdose* website. The breakdown of these results is included in Table 1.

Table 1. Digital Metrics Summary

Campaign	Impressions	Completed Views or Interactions	Interaction Rate or VTR	Clicks to Website
Search	1,081,145	13,298	1.23%	13,298
Display	125,694,669	312,397	0.25%	312,397
YouTube without bumper	12,150,225	3,092,502	25.45%	29,773
Bumper, Dec. 19, 2016–Jan 11, 2017	1,455,921	1,289,218	88.55%	3,807
Bumper, March 10–17, 2017[1]	899,351	765,528	85.12%	1,019
Total	141,281,311	5,472,943	3.87%	360,294

[1] March 10–17, 2017: During this time, the bumper was shown only to those who had already seen a testimonial video.

Additional highlights from the pilot campaign include the following:

- Testimonial videos reached 80 percent of the campaign target audience.
- The testimonials had a view-through-rate (or VTR, which is the rate at which an audience member viewed the video from beginning to end) of 25 percent, above the government benchmark of 20–22 percent.
- Display ads, which included the static and animated banner ads, performed throughout the campaign at a higher click-through rate (or CTR, which is the rate at which a viewer clicks on the banner to go to the website advertised in the ad) than the government benchmark, with the static banners consistently performing better than the animated banners.
- The search ads also had a higher CTR than the government benchmark throughout the campaign, except for the last 2-week reporting period, which may be an indication of market saturation.

Overall Findings

The findings support the continued use of video testimonials featuring messages and stories from those who have experienced prescription opioid addiction or those who have lost someone due to addiction. The data collected from the pilot campaign indicate that these stories are a powerful and effective way to raise awareness and increase knowledge about the dangers of prescription opioid use and misuse.

For people exposed to the campaign, regardless of which campaign materials they saw or heard (billboards, radio ads, online bumpers, or online videos), most (over 70 percent) accurately thought that the purpose of the message in the campaign materials was "preventing misuse of prescription opioid pain medications." Further, over 50 percent reported that the purpose of the messages from CDC about prescription opioids was "preventing deaths from prescription opioid pain medication overdoses." These findings suggest that campaign exposure may contribute to awareness and knowledge that prescription opioids are addictive and dangerous. This belief may foster understanding that there is a need to prevent misuse of prescription opioids, which is an important expected outcome of the Rx Awareness campaign.

When asked what would motivate them to talk to others about prescription opioids, interview respondents commonly stated that while billboards helped raise awareness (and most survey respondents reported seeing billboards), this channel would not motivate them to talk to others about this issue. This suggests that although people may frequently see campaign billboards, this channel is not central to facilitating discussion with others about prescription opioids. The results show that audiences prefer awareness-building messages in materials that contain personal narratives. The use of personal narratives in audio and video appears to be far more effective than other channels at motivating people to talk with others.

Campaign messages can often help individuals recognize problems in their community. Our survey found, however, that many respondents are aware that prescription opioid misuse is a "big problem" in the United States but are less aware of the problem in their communities. For example, although CDC implemented the campaign in high-burden communities, roughly 80–88 percent of people exposed to the campaign noted awareness of prescription opioid overdose as a problem in the United States, compared with 67–74 percent who said it was a problem in their community. Even more telling is that among people unexposed to the campaign, only 55 percent report being aware that overdose is a problem in their community. The differences between exposed and unexposed groups regarding opioid overdose awareness are important; however, the most dramatic differences in responses between those exposed to the campaign and those unexposed were related to intention items, such as intention to talk with their health care provider about prescription opioids, which had differences ranging from approximately 10 to 30 percent.

Overall, the campaign messages and materials show evidence of contributing to increased awareness, knowledge, and intentions. Findings also suggest that campaign messages have the potential to not only affect awareness and knowledge, but also influence actions.

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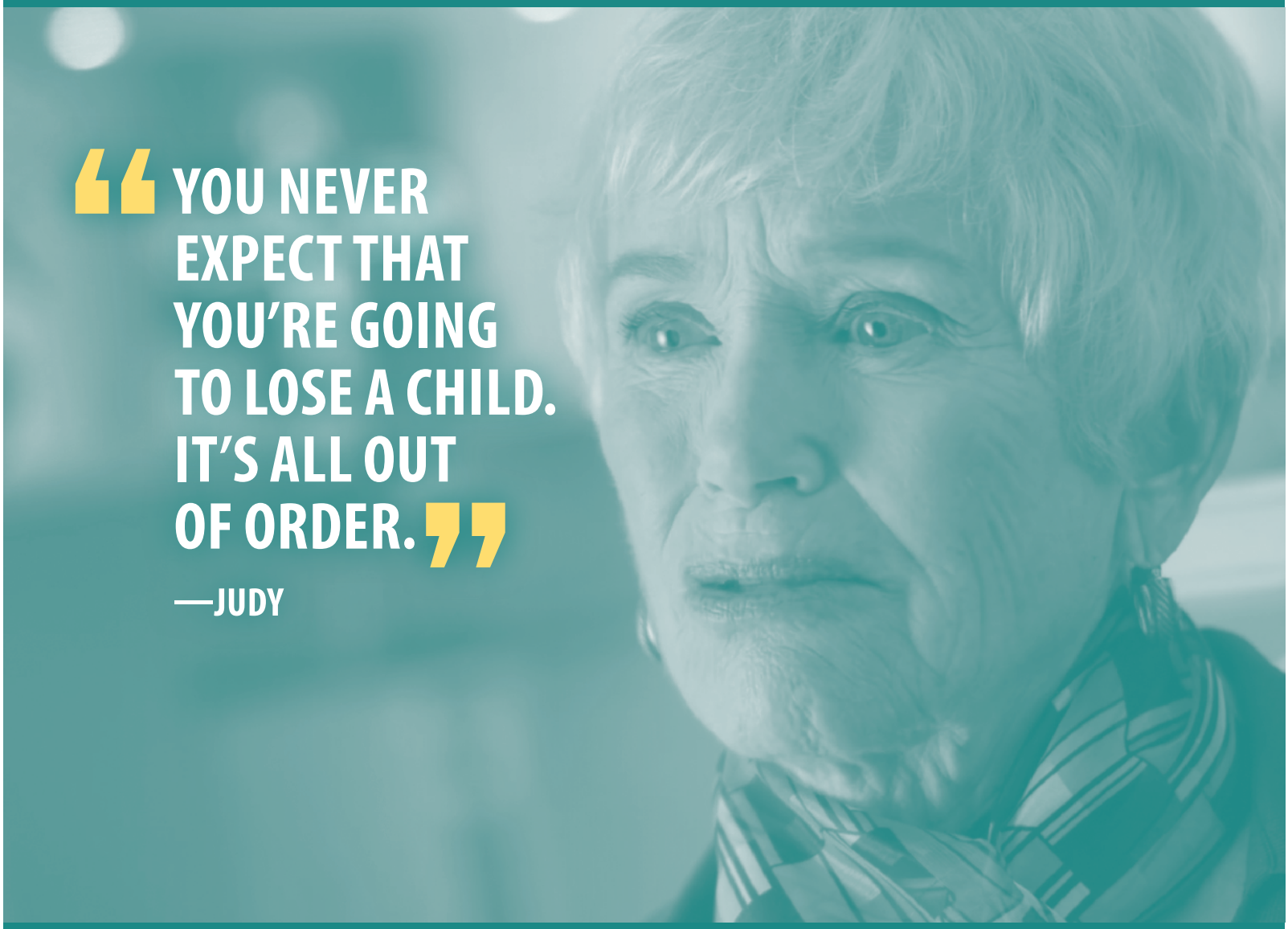
“I’M NOT SUPPOSED TO BE THE ONE TO PICK WHICH SNEAKERS I’M GOING TO BURY HIM IN.”
—ANN MARIE

Overview of the Rx Awareness Campaign Elements

The campaign materials include eight testimonial videos, as well as seven radio, two digital, and two out-of-home advertisements. Additional testimonial videos will be added to the campaign in the future. For biographies about the individuals currently featured in the testimonial advertisements, please see the appendix.

Name	Format	Length/Size	Language	Description
Ann Marie	Video and radio	30 seconds	English	This ad features Ann Marie, a mother who lost her 22-year-old son, Chris, to a prescription opioid overdose.
Brenda	Video and radio	30 seconds	English	This ad features Brenda, who shares her experiences with addiction to prescription opioids and the toll they took on her life.
Devin	Video and radio	30 seconds	English	This ad features Devin, who began using prescription opioids after a minor surgery as a teenager.
Judy	Video and radio	30 seconds	English	This ad features Judy, a mother who lost her son, Steve, age 43, to a prescription opioid overdose.
Mike	Video and radio	30 seconds	English	This ad features Mike, who became addicted to prescription opioids and ended his college sports career.
Noah	Video and radio	30 seconds	English	This ad features Noah, who shares his experience with losing his father at age 58 to prescription opioid addiction.
Tamera	Video and radio	30 seconds	English	This ad features Tamera, who shares her experience with losing almost everything she had to prescription opioid addiction.
Teresa	Video	30 seconds	English	This ad features Teresa, who lost her brother RJ at age 32 to a prescription opioid overdose.
CDC bumper ad	Web	5 seconds	English	This animated ad features a prescription medicine bottle and the phrase "It only takes a little to lose a lot."
CDC banner ad	Web	N/A	English	This digital banner ad features a prescription medicine bottle and the phrase "It only takes a little to lose a lot." The ad is available in four sizes, in both static and animated versions.
CDC billboard/ poster	Billboard/ poster	12′ x 24′	English	This ad features a prescription medicine bottle and the phrase "It only takes a little to lose a lot."
CDC newspaper ad	Newspaper	⅙-page ad: 7.98″ x 5.25″ ¼-page ad: 10″ x 7″ ½-page ad: 12″ x 10.5″	English	These ads state that prescription opioids can be addictive and dangerous. They feature a prescription medicine bottle and the phrase "It only takes a little to lose a lot."


“YOU NEVER EXPECT THAT YOU’RE GOING TO LOSE A CHILD. IT’S ALL OUT OF ORDER.”
—JUDY

Campaign Launch and Rollout

CDC created the Rx Awareness campaign for states, coalitions, and communities to implement in their jurisdictions across the country. These groups can use all the Rx Awareness campaign materials and tag them for local use. States can access tools and resources to support their use of the campaign materials and develop their capacity to design, frame, and implement the Rx Awareness campaign. The campaign materials are available to CDC-funded states and will be publicly available in the future through an online resource center.

The success of the Rx Awareness campaign relies on efforts by states, communities, local agencies, and organizations across the country to share the campaign materials and broaden the reach of this critical and urgent public health message.

This CDC public health effort is accompanied by numerous other materials, including a new campaign website (*cdc.gov/RxAwareness*), patient-centered resources, and provider clinical tools (*cdc.gov/drugoverdose/training*).

P-29829 _ 00777


“NOTHING MATTERED MORE THAN GETTING MY FIX.”
—TAMERA

Appendix

Bios

ANN MARIE

Ann Marie's son, Christopher, was a good student and a gifted baseball player and had close relationships with his mother and sister. When he was 20 years old, Christopher was in a minor car accident, and afterward was prescribed opioids for minor back pain. Ann Marie believes Christopher's tolerance to opioids grew quickly, perhaps within just days. As his addiction grew, she says he sought out several doctors who would prescribe him opioids. He increased his intake from one pill to more than 20 pills a day. When he could no longer get prescriptions from doctors, he began buying pills on the street. Ann Marie described how these pills and his addiction completely changed her son. Everything he had worked for no longer mattered to him. He had trouble sleeping, often did not come home at night, and became defensive and combative toward the people he loved. Ann Marie tried admitting him to various detox centers and treatment facilities, but he was either rejected or kicked out for poor behavior. Without help, his addiction persisted and intensified. Within roughly two years of beginning to use prescription opioids, Christopher overdosed and died at just 22 years old.

Ann Marie has been passionate about sharing her loss in the hopes of saving others from this tragedy. She started *Christopher's Reason*, a place where people suffering from opioid addiction can be directed to the treatment they need.

BRENDA

When she was 25, Brenda was in a car crash on her way to the grocery store. After the incident she needed to see numerous doctors and neurologists, and one of them gave her a prescription for opioid pain medication. Brenda doesn't remember being warned about the risks of taking prescription opioids or the dangers of misuse. One day after she filled the prescription, she doubled her dose and, from that moment on, she never again took the medication as it was prescribed. She began going to multiple doctors for pills and eventually was buying and selling them in her community. She felt lonely and isolated, and was suffering. Everything else took a backseat in her life, including her friends and family. Brenda became addicted to heroin, a point that she never thought she would reach.

When Brenda discovered she was four weeks pregnant, "Part of me wanted to keep using, but more of me wanted to stop," she said. Thanks to the help of her family, especially her stepfather, she was able to get into a treatment program for pregnant women and to detox. She entered a transitional living program and delivered a healthy baby. She has been in recovery for two years.

DEVIN

Devin had his wisdom teeth removed when he was 16. After the surgery, he received a 30-day prescription for opioid pain medication and liked the way the pills made him feel. After three days, he had used the entire prescription. He soon realized it was easy to obtain prescription opioids from people's bathrooms, from friends, or from people on the street. Throughout college, he used prescription opioids and heroin. He woke up one day, at age 24, and found himself in a hospital with his mother and a drug counselor at his side. They said to him, "Devin, you overdosed. You need to get help." It was then that he realized he was on his way to losing everything and needed to make a change.

With the support of his family, he started rehabilitation at a treatment center for 90 days. After successfully completing treatment, he entered a transitional living house.

Today, Devin has been in recovery for 10 years. He has a wife, a daughter, a home, a master's degree, and a career that he has dedicated to helping others recover from substance use. Devin reminds his clients that opioid use disorder is a brain disease, not a moral failing. When he goes to the doctor or dentist now, he always talks with them about his history of substance use and makes it clear that he does not want an opioid prescription. He wants to work closely with medical professionals to train them how to support patients in recovery from substance use disorders.

JUDY

Judy's son, Steve, was a loving son, fiancé, brother, uncle, cousin, nephew, and friend. He was a gifted musician and athlete. He earned Dean's List status in college and a degree in economics that led to a successful career as a financial advisor. Steve suffered a back injury as an adult that left him with severe constant pain that doctors were unable to successfully treat. He became depressed due to the impact of the pain on his way of life. He was prescribed antidepressants, which helped but did not eliminate his symptoms. Steve was then given a prescription for opioids and became addicted. Within three years, he was seeking multiple doctors to fill duplicate prescriptions. Steve eventually acknowledged his addiction and enrolled in rehabilitation and treatment programs, but the grip of his addiction had taken an incredibly strong hold. Following completion of a 28-day addiction treatment program, Steve relapsed and died of an overdose at the age of 43.

After the loss of her son, Judy found a note he had written about his experience with prescription opioids: "At first they were a lifeline. Now they are a noose around my neck." Since his passing, Judy founded the *Steve Rummler Hope Network* to heighten awareness of the dilemma of chronic pain and the disease of addiction, and to improve the associated care process.

MIKE

Mike grew up in a blue-collar family, playing street hockey and pickup football in local parks. He was a good student and excelled as a three-sport varsity athlete in high school. During his senior year, he had surgery to repair a broken wrist from a hockey injury. Following his surgery, he was prescribed an opioid pain medication. Shortly after, his wisdom teeth were removed, and he was given another prescription for opioids. Mike believes he became addicted within three to six months of starting the second prescription. He did not realize his prescription opioid use had progressed to the point of addiction until he became sick from withdrawal after forgetting to bring his prescription on a family vacation. From then on, he continued taking prescription opioids, not to treat pain, but to avoid the symptoms of withdrawal. He recalls that during this time, he completely lost sight of his goals and the things he once loved.

After multiple detox attempts, Mike overcame his addiction and is now thriving in recovery. He returned to school, earned his bachelor's degree, and is currently pursuing a graduate degree. Mike is a certified intervention professional and the founder of *Wicked Sober*. His business is a Recovery Centers of America Company that assists those struggling with drug and alcohol dependency with achieving recovery.

NOAH

Noah has fond memories of his childhood and the close relationship he shared with his father, Rick. Noah recalls that his dad lived life to the fullest. He worked hard and enjoyed entertaining his colleagues and friends. Noah was aware that his father's social lifestyle involved drinking and smoking cigarettes, but it never seemed to be in excess. Noah and his brother felt no cause for concern at first, but then began to notice that pills were missing from their own prescriptions for opioid pain medications received for back pain and dental work. Still, Noah says he and his brother didn't address this with their father, as he wasn't showing signs of drug misuse or addiction.

Suffering from other health issues, Rick was hospitalized in his mid-50s after suffering minor strokes, and although the doctors weren't sure what had caused his stroke and collapse, opioids were found in his system while at the hospital. Afterward, Noah tells of his father adopting a healthier lifestyle, however, two years later, Rick was found unconscious in his home with prescription opioids in his system. Rick died in the hospital at age 58.

TAMERA

Tamera believes she became addicted to opioid pain medications within a year of being prescribed them to manage chronic severe headaches. She began requiring stronger and larger doses to experience the same effects the opioids once provided. She sought out prescriptions from multiple doctors before resorting to purchasing pills on the street. Her career, her home, and a significant amount of retirement savings were all lost to her addiction. Tamera was eventually forced to give up custody of her son, who went to live with his father, so that she could attend detox and fight for her recovery.

After a number of years, Tamera was able to overcome her addiction. She still experiences residual health problems due to prescription opioid abuse, including hearing loss, digestive issues, and throat damage that has affected her voice. Tamera works at *Hope House*, and she recently became a Certified Addiction Recovery Empowerment Specialist (CARES) through the Georgia Council on Substance Abuse, so she can help others overcome their struggles with addiction.

TERESA

Teresa describes her brother RJ as an incredibly bright, creative, and talented writer. She and RJ were especially close growing up and as young adults, until RJ's prescription opioid addiction took hold and eventually took his life at the age of 32. As a teen, Teresa says RJ would often host parties when their mother was away, relying on Teresa to keep it a secret. Not wanting to betray her big brother's trust, she kept his secrets safe, and continued to do so even after RJ began using prescription opioids nonmedically.

RJ's addiction led to car accidents, an arrest, and multiple failed attempts at treatment facilities. He eventually enlisted in the military in an effort to get himself back on track. He served in Iraq in 2006, and returned home still struggling with his addiction. He remained sober for six months before his final relapse and the overdose that caused his death. Following his passing, Teresa found RJ's diary, which was her first true look at his suffering and struggle. Teresa has become an advocate for drug use awareness and policy change. She is the co-founder of *Speak Up Florida* and is an ambassador for *Shatterproof*.

https://web.archive.org/web/20180130112352/https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

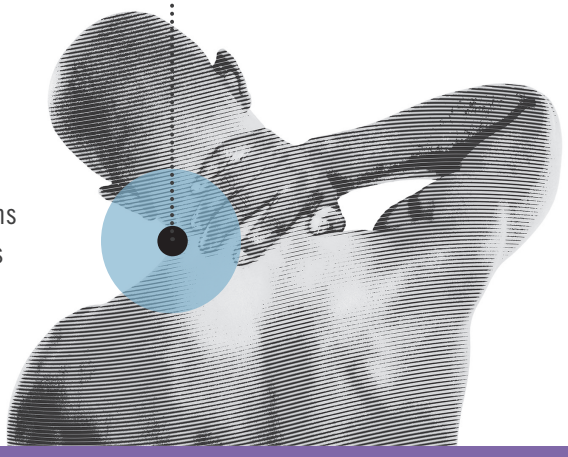
1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- **Opioids are not first-line or routine therapy for chronic pain**
- **Establish and measure goals for pain and function**
- **Discuss benefits and risks and availability of nonopioid therapies with patient**



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

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OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

4 When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5 When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6 Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, 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.

7 Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8 Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9 Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10 When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11 Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12 Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

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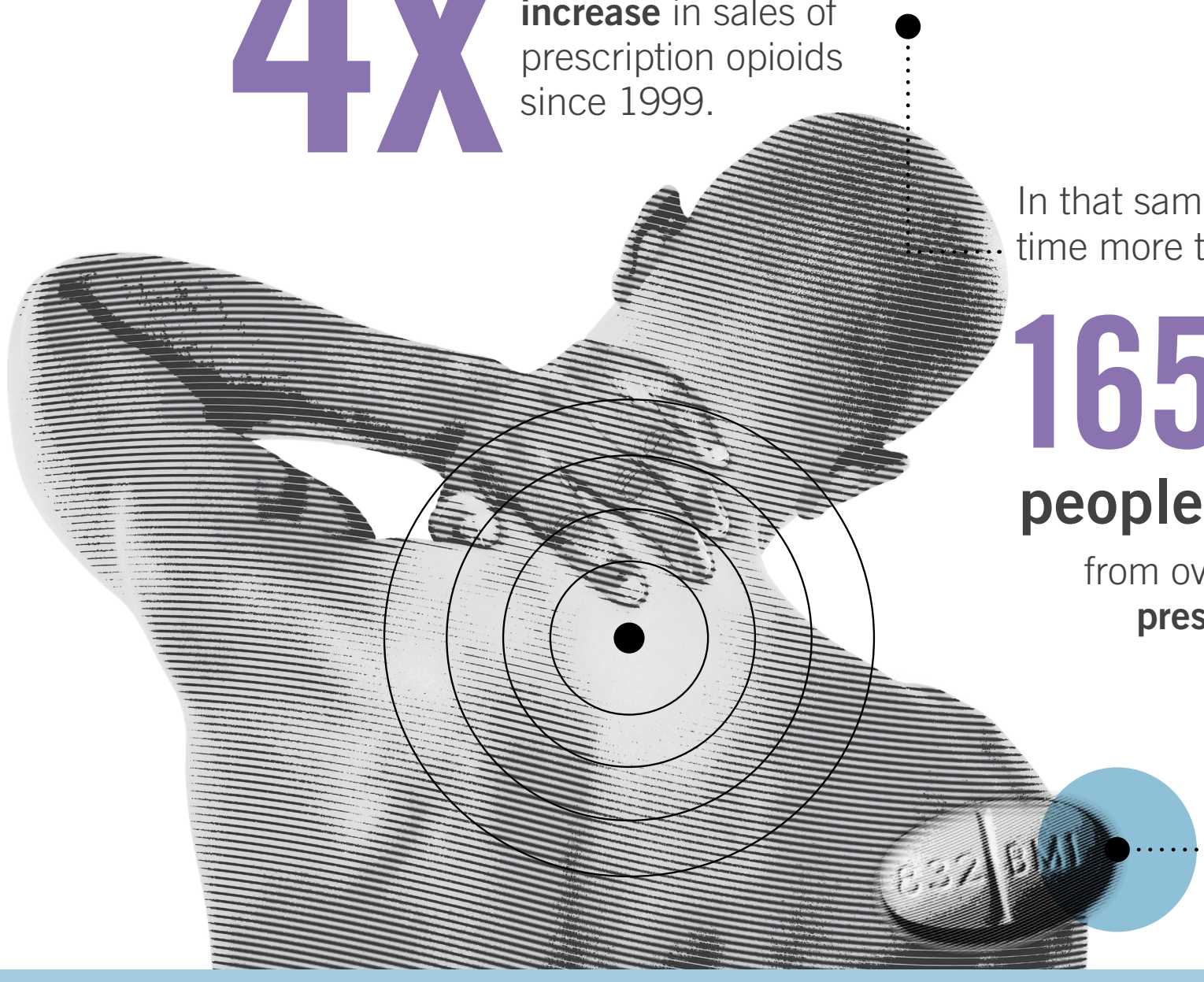
https://web.archive.org/web/20180130112404/https://www.cdc.gov/drugoverdose/pdf/Guidelines_Providers_Poster-a.pdf

REDUCE OVERDOSE. PRESCRIBE RESPONSIBLY.

OVERPRESCRIBING LEADS TO MORE ABUSE AND MORE OVERDOSE DEATHS.

4x **increase** in sales of prescription opioids since 1999.



In that same time more than

165,000

people have died

from overdose related to **prescription opioids.**

REFER TO THE *CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN* FOR RESPONSIBLE PRESCRIBING OF THESE DRUGS[1].

1 USE NONOPIOID THERAPIES
Don't use opioids routinely for chronic pain. Use nonopioid therapies alone or in combination with opioids. Only consider opioid therapy if you expect benefits for pain and function to outweigh risks.

2 START LOW AND GO SLOW
When opioids are used, start with the lowest effective dosage and short-acting opioids instead of extended-release/long-acting opioids.

3 FOLLOW-UP
Regularly assess whether opioids are improving pain and function without causing harm. If benefits do not outweigh harms, optimize other therapies and work with patients to taper opioids.

[1]Recommendations do not apply to pain management in the context of active cancer treatment, palliative care, and end-of-life care

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

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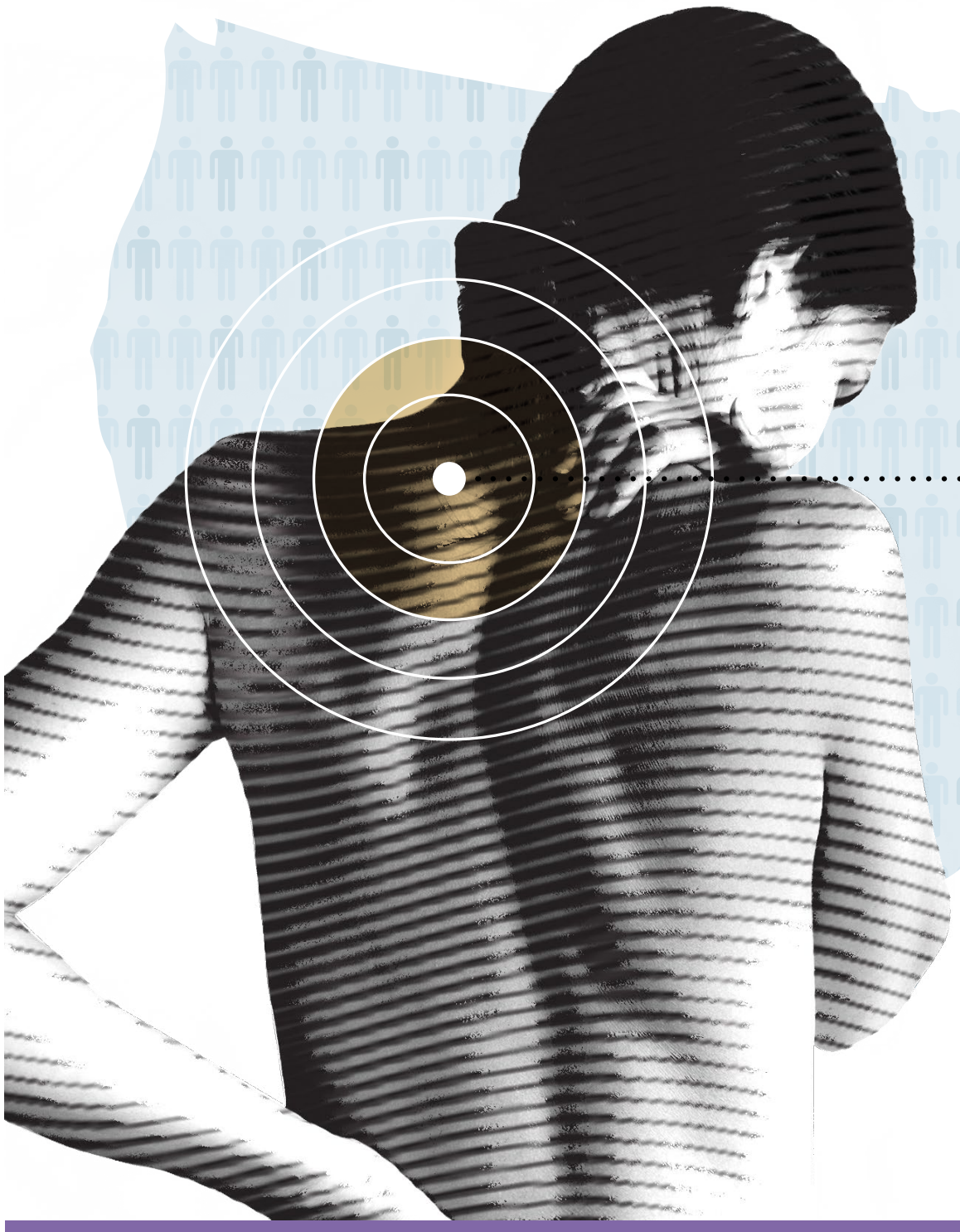
https://web.archive.org/web/20180130112244/https://www.cdc.gov/drugoverdose/pdf/guidelines_patients_poster-a.pdf

KNOW THE RISKS



AS MANY AS

1 IN 4

PEOPLE

receiving **prescription opioids** long term in a primary care setting struggles with opioid addiction.

MANAGE YOUR PAIN, MINIMIZE YOUR RISK.

Chronic pain can be devastating, and effective pain management is essential to get your life back. Talk to your doctor about ways to manage your pain that don't involve prescription opioids, such as:

- Non-opioid pain relievers, such as acetaminophen (Tylenol®), ibuprofen (Advil®), or naproxen (Aleve®)
- Physical therapy and exercise
- Cognitive behavioral therapy
- Certain antidepressants and anticonvulsants

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

LEARN MORE | www.cdc.gov/drugoverdose/prescribing.guideline.html

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https://web.archive.org/web/20180130112248/https://www.cdc.gov/drugoverdose/pdf/Original-PatientPoster-Digital.pdf

OUR COMMITMENT

Safer, More Effective Pain Management

Your health and safety are important to us.

Opioid pain medications like oxycodone or hydrocodone can help with severe, acute pain or pain from illnesses like cancer. Taking opioids, especially for longer periods of time, can often do more harm than good. Many non-opioid treatments have been shown to control pain effectively with fewer side effects.

How you can help:

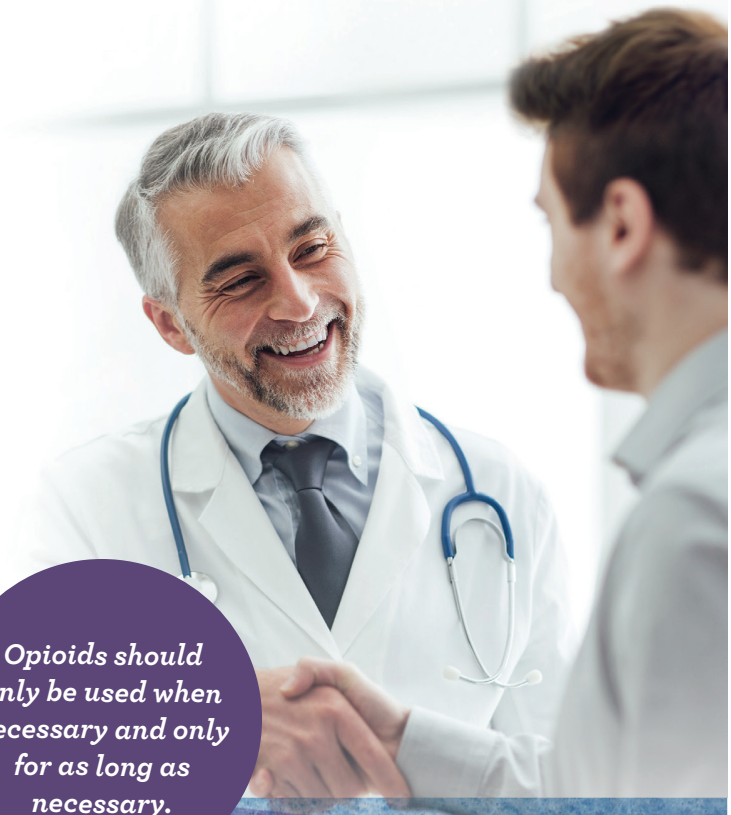
1. When you have pain, let us know your treatment preferences.
2. Whether or not you are prescribed opioids, ask what else you can do to feel better and get relief from your symptoms.
3. If you are prescribed opioids, ask how long you will need to take them, and how we will work with you to stop taking them.

As your healthcare providers, we promise to:

MANAGE: Provide the best possible treatment for your condition.

PERSONALIZE: Work closely with you to set pain management goals and develop a treatment plan that will help you achieve your goals.

COLLABORATE: Assess the risks and benefits of prescription opioids together, and prescribe opioids only when their benefits outweigh their risks.



Opioids should only be used when necessary and only for as long as necessary.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

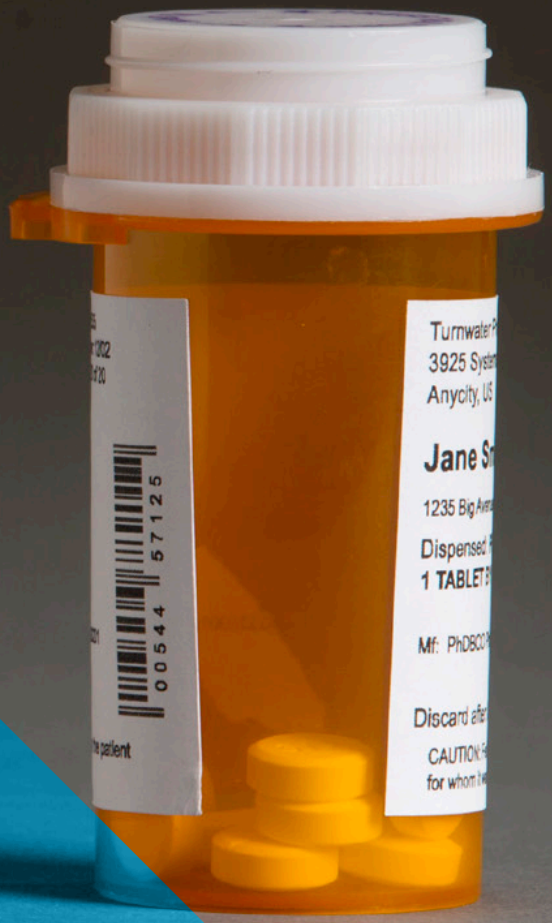
P-29829 _ 00791

https://web.archive.org/web/20210325181046/https://www.cdc.gov/rxawareness/pdf/Overview-Rx-Awareness-Resources.pdf

2017

ADDRESSING THE PRESCRIPTION OPIOID CRISIS

CDC Rx AWARENESS CAMPAIGN OVERVIEW



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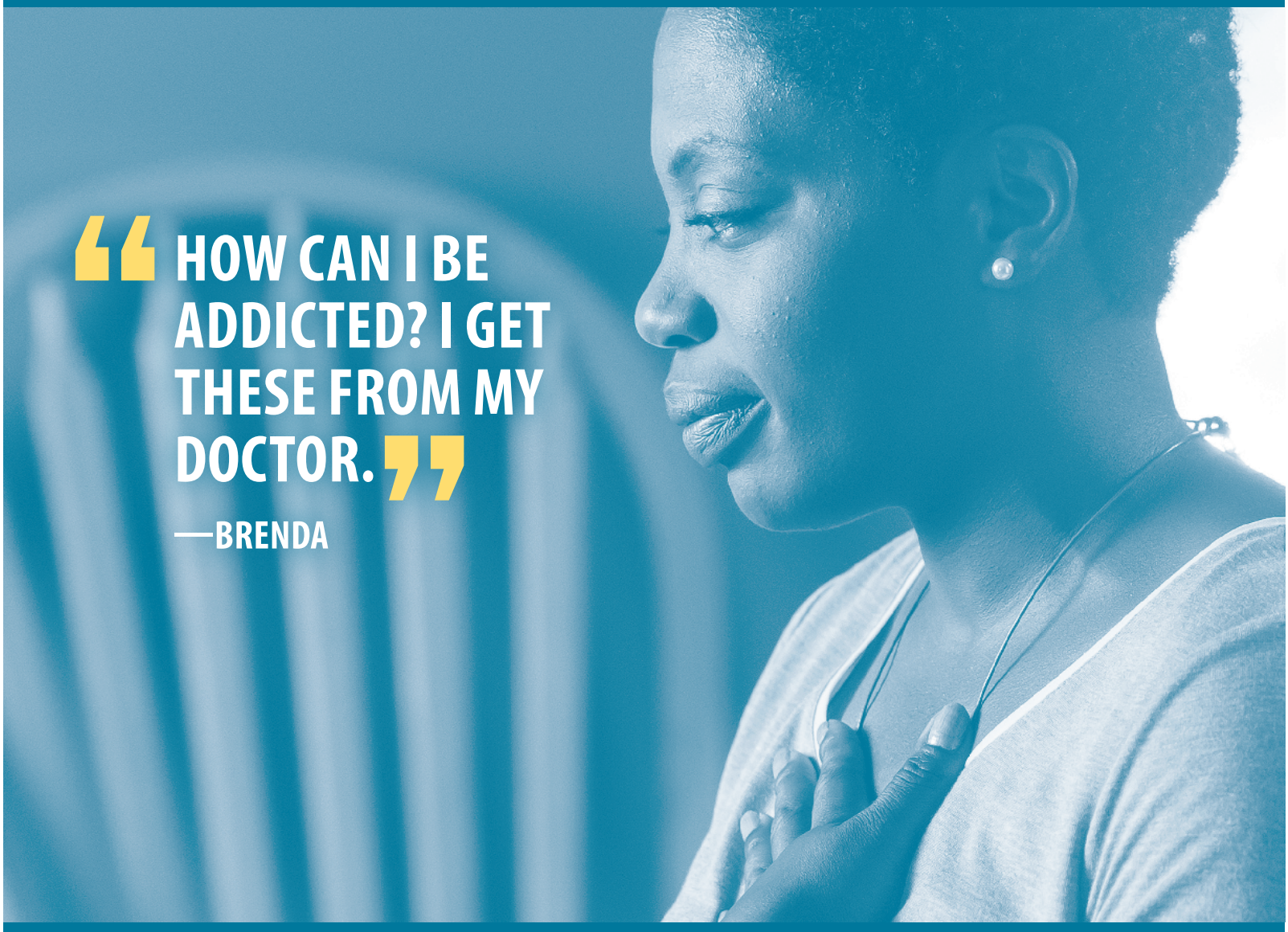
“HOW CAN I BE ADDICTED? I GET THESE FROM MY DOCTOR.”
—BRENDA

Contents


“IT’S LIKELY THAT EVERYBODY KNOWS SOMEBODY WHO IS STRUGGLING WITH THIS VERY PROBLEM.”
—NOAH

Addressing the Prescription Opioid Crisis

Prescription Opioid Abuse Is a Critical Public Health Issue

Every day, more than 1,000 people are treated in emergency departments for misusing prescription opioids, and more than 40 people die from prescription opioid overdoses.[1,2] From 1999 to 2015, more than 183,000 people died in the United States from overdoses related to prescription opioids.[3] Prescription opioids are often prescribed following surgery or injury to treat moderate-to-severe pain, or for health conditions such as cancer. In recent years, there has been a dramatic increase in the use of prescription opioids for the treatment of chronic pain unrelated to cancer, despite serious risks and a lack of evidence about their long-term effectiveness.

Overdoses from opioids are on the rise and killing Americans of all races and ages. Families and communities across the country are coping with the health, emotional, and economic effects of this epidemic.

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[1] Substance Abuse and Mental Health Services Administration. *Highlights of the 2011 Drug Abuse Warning Network (DAWN) findings on drug-related emergency department visits. The DAWN Report*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration; 2013. ***http://www.samhsa.gov/data/2k13/DAWN127/sr127-DAWN-highlights.htm.*** Accessed December 2016.

[2] U.S. Department of Health and Human Services, Office of the Surgeon General. *Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health*. Washington, DC: U.S. Department of Health and Human Services; November 2016.

[3] Centers for Disease Control and Prevention. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: National Center for Health Statistics; 2016. ***http://wonder.cdc.gov***. Accessed December 2016.


“ONE PRESCRIPTION CAN BE ALL IT TAKES TO LOSE EVERYTHING.”
—MIKE

Rx Awareness Campaign Description

To raise awareness of prescription opioid abuse and overdose, in 2017 the Centers for Disease Control and Prevention (CDC) launched Rx Awareness, its first prescription opioid overdose prevention campaign. The Rx Awareness campaign is evidence-driven and tells the real stories of people whose lives were torn apart by opioid use and abuse.

The Rx Awareness campaign focuses on adults ages 25–54 who have taken opioids at least once for medical or nonmedical (recreational) use, and it highlights the importance of reducing opioid abuse to prevent overdoses. The goals of the campaign are to:

- Increase awareness that opioids can be addictive and dangerous; and
- Increase the number of individuals who avoid using opioids nonmedically (recreationally) or who choose options other than opioids for safe and effective pain management.

CDC incorporated first-person stories into the campaign based on past effective use of testimonials to communicate about complex and sensitive health behaviors. The cornerstone of the campaign is a series of videos that feature individuals who are either living in recovery from opioid use disorder, or who are family members who lost someone to a prescription opioid overdose.

Rx Awareness Campaign Materials

- Digital
  - 30-second testimonial videos
  - Web banner ads
  - Online search ads
  - 5-second bumper digital video ads
- Campaign website (cdc.gov/RxAwareness)
- Radio
  - 30-second ads
- Out-of-home
  - Billboards
  - Newspaper ads

In addition to video advertisements, the campaign includes radio advertisements; digital materials, such as web banner advertisements; and materials for out-of-home spaces, such as billboards and newspaper advertisements.

Rx Awareness Campaign Target Audience

CDC selected the target audience for the Rx Awareness campaign after conducting a series of background and formative research activities to deepen its understanding of communication needs about the opioid epidemic. We learned that adults between the ages of 45 and 54 had not yet been targeted by a broad-reaching campaign. This information was reinforced by surveillance data indicating that the population with the highest fatality rate from opioid overdoses was non-Hispanic white adults ages 45–54. We also found a need for communication efforts to deliver primary prevention messages to younger audiences ages 25–35, who are less likely to experience chronic pain but may be exposed to opioids for other reasons, such as having a sports injury or undergoing a dental procedure. Ultimately, we combined these audiences for the Rx Awareness campaign to include all adults ages 25–54.

Campaign Approach and Messaging

Early campaign research included an environmental scan, literature review, social media assessment, focus groups, and in-depth interviews. These activities sought to answer the following questions:

- What communication campaigns exist to prevent prescription opioid use and abuse?
- Have these programs been evaluated?
- Have best practices been identified for creative execution of communication campaigns?
- What influences audiences' behaviors related to prescription opioid use and avoidance?
- What are audiences' information preferences and needs related to prescription opioids?
- What are audiences' preferred formats for receiving information on this topic?
- Who are audiences' trusted sources for health information and guidance?

A key finding of this early research was that personal and emotional messages strongly resonated with audiences, particularly messages that addressed loss, such as the loss of relationships with family and friends and loss of employment. This drove the campaign approach to capture testimonials about negative outcomes and loss.

We also learned about widespread concern in communities across the country about opioid overdoses, and the need for multichannel dissemination strategies to reach the whole community. Billboards are one of the campaign's channels, based on participants' recommendations to use them to place campaign messages.

Findings from the formative research guided the development of the campaign's tagline, "It only takes a little to lose a lot," and the reality statement, "Prescription opioids can be addictive and dangerous." The Rx Awareness campaign used elements and approaches based on the formative research findings.

The Rx Awareness campaign uses the term "prescription opioid" instead of "painkiller." The term "painkiller" is misleading because while opioids relieve pain, they do not eliminate pain.

The campaign does not include messages about heroin. Specificity is a best practice in communication, and the Rx Awareness campaign messaging focuses on the critical issue of prescription opioids. Given the broad target audience, focusing on prescription opioids avoids diluting the campaign messaging. Heroin is a related topic that also needs formative research and message testing.


“OUR SECRETS KEEP US SICK.”
—DEVIN

Pilot Testing

CDC launched a small-scale pilot that implemented all components of the Rx Awareness campaign and ran for 14 weeks in 9 high-burden counties in 4 states: Ohio, Oregon, Rhode Island, and West Virginia. CDC based this placement on criteria such as reach, participants' readiness to implement a campaign, and level of interest. The pilot presented an important message to these areas—which are highly affected by prescription opioid overdose—while also allowing CDC to test creative campaign materials in the field and obtain valuable input on the ads before launching the campaign. An assessment of the pilot campaign explored target audiences' exposure to and perceptions of a series of campaign messages and materials.

A mixed-method design integrating data from in-depth interviews and a quasi-experimental, one-group retrospective post-then-pretest (RPTP) survey was used to assess target audiences' responses to campaign messages and materials designed to influence their knowledge, awareness, attitudes, and behavioral intentions related to prescription opioid use and misuse.

Key results from the assessment of the Rx Awareness campaign's channel selection, messages, and materials are described in the next section.

In-depth Interviews: Key Findings

- Most participants believed the content on the billboards, videos, and radio ads.
- Participants reported that it would be easy to read the first line of the billboards while driving a car, but that reading the second line would be more difficult.
- Participants reported that the video ads were relatable, and that they could sympathize with the storytellers' situations. The speakers in the videos were thought to be relatable because they looked like people from the participants' communities.
- Most participants said that they would share the video testimonials with others.

Online Survey: Key Findings

- Among survey respondents exposed to the Rx Awareness campaign (see Figure 1):
  - 70 percent saw campaign billboards;
  - 71 percent saw online or digital media (this included any campaign content a participant saw online);
  - 65 percent heard a radio ad;
  - 39 percent saw an online bumper; and
  - 36 percent saw an online video.
- Most people exposed to the campaign reported that the overall campaign was attention-grabbing (76 percent), believable (81 percent), and meaningful to them (77 percent) (see Figure 2).
- 74 percent of participants reported that the campaign message ("Prescription opioids can be addictive and dangerous") was effective or very effective at improving knowledge that prescription opioids can be addictive and dangerous, and 63 percent said that the campaign message was effective or very effective at making people aware of the risks of prescription opioids.

Figure 1. Participants' Exposure to Rx Awareness Campaign

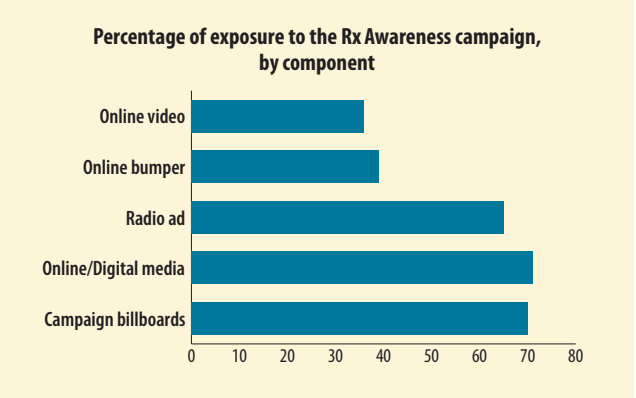
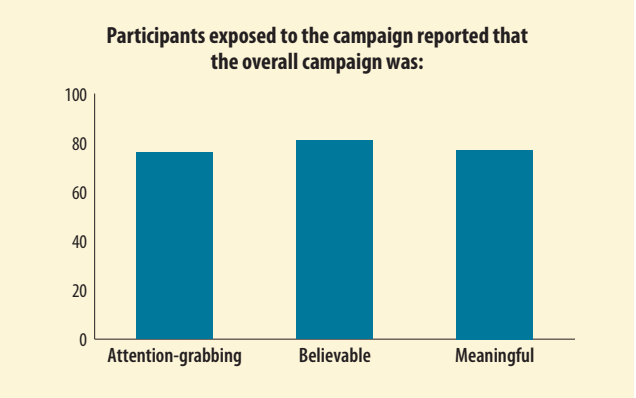


Figure 2. Participants' Experience with the Rx Awareness Campaign



- Almost 70 percent of participants thought that the campaign message ("Prescription opioids can be addictive and dangerous") was effective or very effective at helping people understand that using prescription opioids the wrong way can lead to overdose.
- Most people exposed to the campaign reported that they intend to ask healthcare providers for alternatives to prescription opioids (71 percent), or they intend to avoid using prescription opioids recreationally or medically (73 percent).

Digital Analytics: Key Findings

The pilot Rx Awareness campaign delivered search and display ads, testimonial videos, and a bumper video that gained 141 million impressions, 5.47 million interactions, and 360,294 click-throughs to the *cdc.gov/drugoverdose* website. The breakdown of these results is included in Table 1.

Table 1. Digital Metrics Summary

Campaign	Impressions	Completed Views or Interactions	Interaction Rate or VTR	Clicks to Website
Search	1,081,145	13,298	1.23%	13,298
Display	125,694,669	312,397	0.25%	312,397
YouTube without bumper	12,150,225	3,092,502	25.45%	29,773
Bumper, Dec. 19, 2016–Jan 11, 2017	1,455,921	1,289,218	88.55%	3,807
Bumper, March 10–17, 2017[1]	899,351	765,528	85.12%	1,019
Total	141,281,311	5,472,943	3.87%	360,294

[1] March 10–17, 2017: During this time, the bumper was shown only to those who had already seen a testimonial video.

Additional highlights from the pilot campaign include the following:

- Testimonial videos reached 80 percent of the campaign target audience.
- The testimonials had a view-through-rate (or VTR, which is the rate at which an audience member viewed the video from beginning to end) of 25 percent, above the government benchmark of 20–22 percent.
- Display ads, which included the static and animated banner ads, performed throughout the campaign at a higher click-through rate (or CTR, which is the rate at which a viewer clicks on the banner to go to the website advertised in the ad) than the government benchmark, with the static banners consistently performing better than the animated banners.
- The search ads also had a higher CTR than the government benchmark throughout the campaign, except for the last 2-week reporting period, which may be an indication of market saturation.

Overall Findings

The findings support the continued use of video testimonials featuring messages and stories from those who have experienced prescription opioid addiction or those who have lost someone due to addiction. The data collected from the pilot campaign indicate that these stories are a powerful and effective way to raise awareness and increase knowledge about the dangers of prescription opioid use and misuse.

For people exposed to the campaign, regardless of which campaign materials they saw or heard (billboards, radio ads, online bumpers, or online videos), most (over 70 percent) accurately thought that the purpose of the message in the campaign materials was "preventing misuse of prescription opioid pain medications." Further, over 50 percent reported that the purpose of the messages from CDC about prescription opioids was "preventing deaths from prescription opioid pain medication overdoses." These findings suggest that campaign exposure may contribute to awareness and knowledge that prescription opioids are addictive and dangerous. This belief may foster understanding that there is a need to prevent misuse of prescription opioids, which is an important expected outcome of the Rx Awareness campaign.

When asked what would motivate them to talk to others about prescription opioids, interview respondents commonly stated that while billboards helped raise awareness (and most survey respondents reported seeing billboards), this channel would not motivate them to talk to others about this issue. This suggests that although people may frequently see campaign billboards, this channel is not central to facilitating discussion with others about prescription opioids. The results show that audiences prefer awareness-building messages in materials that contain personal narratives. The use of personal narratives in audio and video appears to be far more effective than other channels at motivating people to talk with others.

Campaign messages can often help individuals recognize problems in their community. Our survey found, however, that many respondents are aware that prescription opioid misuse is a "big problem" in the United States but are less aware of the problem in their communities. For example, although CDC implemented the campaign in high-burden communities, roughly 80–88 percent of people exposed to the campaign noted awareness of prescription opioid overdose as a problem in the United States, compared with 67–74 percent who said it was a problem in their community. Even more telling is that among people unexposed to the campaign, only 55 percent report being aware that overdose is a problem in their community. The differences between exposed and unexposed groups regarding opioid overdose awareness are important; however, the most dramatic differences in responses between those exposed to the campaign and those unexposed were related to intention items, such as intention to talk with their health care provider about prescription opioids, which had differences ranging from approximately 10 to 30 percent.

Overall, the campaign messages and materials show evidence of contributing to increased awareness, knowledge, and intentions. Findings also suggest that campaign messages have the potential to not only affect awareness and knowledge, but also influence actions.

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“I’M NOT SUPPOSED TO BE THE ONE TO PICK WHICH SNEAKERS I’M GOING TO BURY HIM IN.”
—ANN MARIE

Overview of the Rx Awareness Campaign Elements

The campaign materials include eight testimonial videos, as well as seven radio, two digital, and two out-of-home advertisements. Additional testimonial videos will be added to the campaign in the future. For biographies about the individuals currently featured in the testimonial advertisements, please see the appendix.

Name	Format	Length/Size	Language	Description
Ann Marie	Video and radio	30 seconds	English	This ad features Ann Marie, a mother who lost her 22-year-old son, Chris, to a prescription opioid overdose.
Brenda	Video and radio	30 seconds	English	This ad features Brenda, who shares her experiences with addiction to prescription opioids and the toll they took on her life.
Devin	Video and radio	30 seconds	English	This ad features Devin, who began using prescription opioids after a minor surgery as a teenager.
Judy	Video and radio	30 seconds	English	This ad features Judy, a mother who lost her son, Steve, age 43, to a prescription opioid overdose.
Mike	Video and radio	30 seconds	English	This ad features Mike, who became addicted to prescription opioids and ended his college sports career.
Noah	Video and radio	30 seconds	English	This ad features Noah, who shares his experience with losing his father at age 58 to prescription opioid addiction.
Tamera	Video and radio	30 seconds	English	This ad features Tamera, who shares her experience with losing almost everything she had to prescription opioid addiction.
Teresa	Video	30 seconds	English	This ad features Teresa, who lost her brother RJ at age 32 to a prescription opioid overdose.
CDC bumper ad	Web	5 seconds	English	This animated ad features a prescription medicine bottle and the phrase "It only takes a little to lose a lot."
CDC banner ad	Web	N/A	English	This digital banner ad features a prescription medicine bottle and the phrase "It only takes a little to lose a lot." The ad is available in four sizes, in both static and animated versions.
CDC billboard/ poster	Billboard/ poster	12′ x 24′	English	This ad features a prescription medicine bottle and the phrase "It only takes a little to lose a lot."
CDC newspaper ad	Newspaper	⅙-page ad: 7.98″ x 5.25″ ¼-page ad: 10″ x 7″ ½-page ad: 12″ x 10.5″	English	These ads state that prescription opioids can be addictive and dangerous. They feature a prescription medicine bottle and the phrase "It only takes a little to lose a lot."

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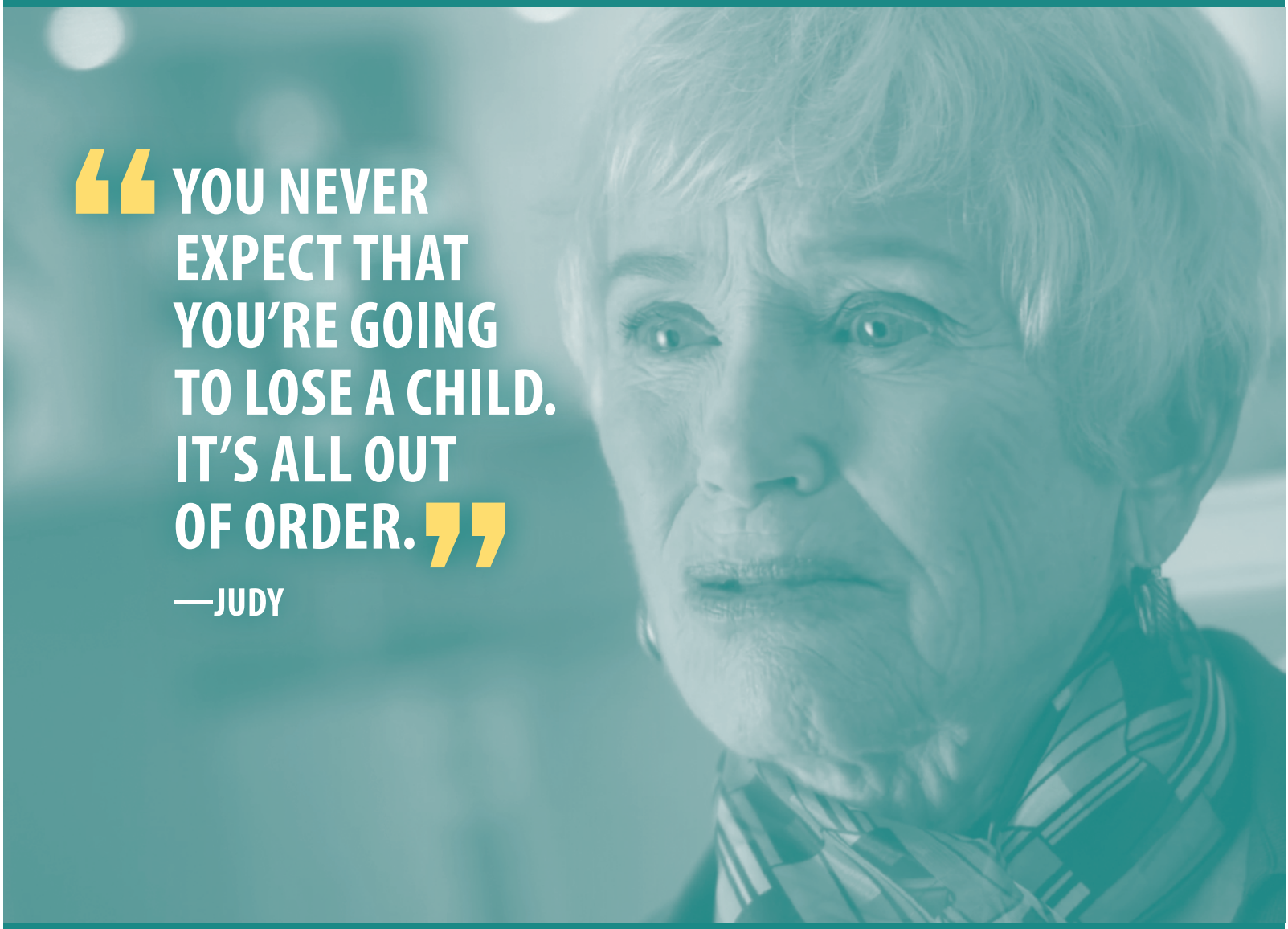
“YOU NEVER EXPECT THAT YOU’RE GOING TO LOSE A CHILD. IT’S ALL OUT OF ORDER.”
—JUDY

Campaign Launch and Rollout

CDC created the Rx Awareness campaign for states, coalitions, and communities to implement in their jurisdictions across the country. These groups can use all the Rx Awareness campaign materials and tag them for local use. States can access tools and resources to support their use of the campaign materials and develop their capacity to design, frame, and implement the Rx Awareness campaign. The campaign materials are available to CDC-funded states and will be publicly available in the future through an online resource center.

The success of the Rx Awareness campaign relies on efforts by states, communities, local agencies, and organizations across the country to share the campaign materials and broaden the reach of this critical and urgent public health message.

This CDC public health effort is accompanied by numerous other materials, including a new campaign website (*cdc.gov/RxAwareness*), patient-centered resources, and provider clinical tools (*cdc.gov/drugoverdose/training*).

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“NOTHING MATTERED MORE THAN GETTING MY FIX.”
—TAMERA

Appendix

Bios

ANN MARIE

Ann Marie's son, Christopher, was a good student and a gifted baseball player and had close relationships with his mother and sister. When he was 20 years old, Christopher was in a minor car accident, and afterward was prescribed opioids for minor back pain. Ann Marie believes Christopher's tolerance to opioids grew quickly, perhaps within just days. As his addiction grew, she says he sought out several doctors who would prescribe him opioids. He increased his intake from one pill to more than 20 pills a day. When he could no longer get prescriptions from doctors, he began buying pills on the street. Ann Marie described how these pills and his addiction completely changed her son. Everything he had worked for no longer mattered to him. He had trouble sleeping, often did not come home at night, and became defensive and combative toward the people he loved. Ann Marie tried admitting him to various detox centers and treatment facilities, but he was either rejected or kicked out for poor behavior. Without help, his addiction persisted and intensified. Within roughly two years of beginning to use prescription opioids, Christopher overdosed and died at just 22 years old.

Ann Marie has been passionate about sharing her loss in the hopes of saving others from this tragedy. She started *Christopher's Reason*, a place where people suffering from opioid addiction can be directed to the treatment they need.

BRENDA

When she was 25, Brenda was in a car crash on her way to the grocery store. After the incident she needed to see numerous doctors and neurologists, and one of them gave her a prescription for opioid pain medication. Brenda doesn't remember being warned about the risks of taking prescription opioids or the dangers of misuse. One day after she filled the prescription, she doubled her dose and, from that moment on, she never again took the medication as it was prescribed. She began going to multiple doctors for pills and eventually was buying and selling them in her community. She felt lonely and isolated, and was suffering. Everything else took a backseat in her life, including her friends and family. Brenda became addicted to heroin, a point that she never thought she would reach.

When Brenda discovered she was four weeks pregnant, "Part of me wanted to keep using, but more of me wanted to stop," she said. Thanks to the help of her family, especially her stepfather, she was able to get into a treatment program for pregnant women and to detox. She entered a transitional living program and delivered a healthy baby. She has been in recovery for two years.

DEVIN

Devin had his wisdom teeth removed when he was 16. After the surgery, he received a 30-day prescription for opioid pain medication and liked the way the pills made him feel. After three days, he had used the entire prescription. He soon realized it was easy to obtain prescription opioids from people's bathrooms, from friends, or from people on the street. Throughout college, he used prescription opioids and heroin. He woke up one day, at age 24, and found himself in a hospital with his mother and a drug counselor at his side. They said to him, "Devin, you overdosed. You need to get help." It was then that he realized he was on his way to losing everything and needed to make a change.

With the support of his family, he started rehabilitation at a treatment center for 90 days. After successfully completing treatment, he entered a transitional living house.

Today, Devin has been in recovery for 10 years. He has a wife, a daughter, a home, a master's degree, and a career that he has dedicated to helping others recover from substance use. Devin reminds his clients that opioid use disorder is a brain disease, not a moral failing. When he goes to the doctor or dentist now, he always talks with them about his history of substance use and makes it clear that he does not want an opioid prescription. He wants to work closely with medical professionals to train them how to support patients in recovery from substance use disorders.

JUDY

Judy's son, Steve, was a loving son, fiancé, brother, uncle, cousin, nephew, and friend. He was a gifted musician and athlete. He earned Dean's List status in college and a degree in economics that led to a successful career as a financial advisor. Steve suffered a back injury as an adult that left him with severe constant pain that doctors were unable to successfully treat. He became depressed due to the impact of the pain on his way of life. He was prescribed antidepressants, which helped but did not eliminate his symptoms. Steve was then given a prescription for opioids and became addicted. Within three years, he was seeking multiple doctors to fill duplicate prescriptions. Steve eventually acknowledged his addiction and enrolled in rehabilitation and treatment programs, but the grip of his addiction had taken an incredibly strong hold. Following completion of a 28-day addiction treatment program, Steve relapsed and died of an overdose at the age of 43.

After the loss of her son, Judy found a note he had written about his experience with prescription opioids: "At first they were a lifeline. Now they are a noose around my neck." Since his passing, Judy founded the *Steve Rummler Hope Network* to heighten awareness of the dilemma of chronic pain and the disease of addiction, and to improve the associated care process.

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MIKE

Mike grew up in a blue-collar family, playing street hockey and pickup football in local parks. He was a good student and excelled as a three-sport varsity athlete in high school. During his senior year, he had surgery to repair a broken wrist from a hockey injury. Following his surgery, he was prescribed an opioid pain medication. Shortly after, his wisdom teeth were removed, and he was given another prescription for opioids. Mike believes he became addicted within three to six months of starting the second prescription. He did not realize his prescription opioid use had progressed to the point of addiction until he became sick from withdrawal after forgetting to bring his prescription on a family vacation. From then on, he continued taking prescription opioids, not to treat pain, but to avoid the symptoms of withdrawal. He recalls that during this time, he completely lost sight of his goals and the things he once loved.

After multiple detox attempts, Mike overcame his addiction and is now thriving in recovery. He returned to school, earned his bachelor's degree, and is currently pursuing a graduate degree. Mike is a certified intervention professional and the founder of *Wicked Sober*. His business is a Recovery Centers of America Company that assists those struggling with drug and alcohol dependency with achieving recovery.

NOAH

Noah has fond memories of his childhood and the close relationship he shared with his father, Rick. Noah recalls that his dad lived life to the fullest. He worked hard and enjoyed entertaining his colleagues and friends. Noah was aware that his father's social lifestyle involved drinking and smoking cigarettes, but it never seemed to be in excess. Noah and his brother felt no cause for concern at first, but then began to notice that pills were missing from their own prescriptions for opioid pain medications received for back pain and dental work. Still, Noah says he and his brother didn't address this with their father, as he wasn't showing signs of drug misuse or addiction.

Suffering from other health issues, Rick was hospitalized in his mid-50s after suffering minor strokes, and although the doctors weren't sure what had caused his stroke and collapse, opioids were found in his system while at the hospital. Afterward, Noah tells of his father adopting a healthier lifestyle, however, two years later, Rick was found unconscious in his home with prescription opioids in his system. Rick died in the hospital at age 58.

TAMERA

Tamera believes she became addicted to opioid pain medications within a year of being prescribed them to manage chronic severe headaches. She began requiring stronger and larger doses to experience the same effects the opioids once provided. She sought out prescriptions from multiple doctors before resorting to purchasing pills on the street. Her career, her home, and a significant amount of retirement savings were all lost to her addiction. Tamera was eventually forced to give up custody of her son, who went to live with his father, so that she could attend detox and fight for her recovery.

After a number of years, Tamera was able to overcome her addiction. She still experiences residual health problems due to prescription opioid abuse, including hearing loss, digestive issues, and throat damage that has affected her voice. Tamera works at *Hope House*, and she recently became a Certified Addiction Recovery Empowerment Specialist (CARES) through the Georgia Council on Substance Abuse, so she can help others overcome their struggles with addiction.

TERESA

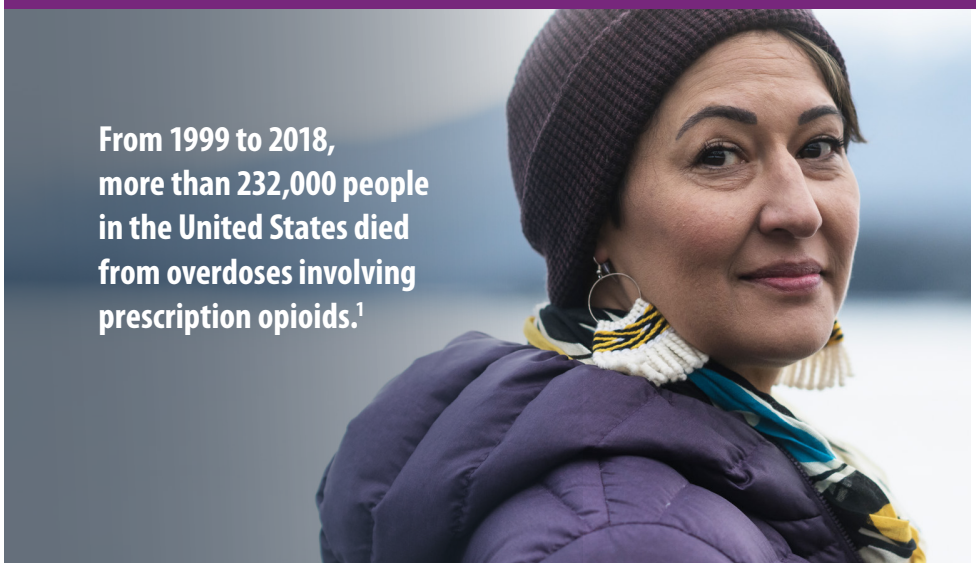
Teresa describes her brother RJ as an incredibly bright, creative, and talented writer. She and RJ were especially close growing up and as young adults, until RJ's prescription opioid addiction took hold and eventually took his life at the age of 32. As a teen, Teresa says RJ would often host parties when their mother was away, relying on Teresa to keep it a secret. Not wanting to betray her big brother's trust, she kept his secrets safe, and continued to do so even after RJ began using prescription opioids nonmedically.

RJ's addiction led to car accidents, an arrest, and multiple failed attempts at treatment facilities. He eventually enlisted in the military in an effort to get himself back on track. He served in Iraq in 2006, and returned home still struggling with his addiction. He remained sober for six months before his final relapse and the overdose that caused his death. Following his passing, Teresa found RJ's diary, which was her first true look at his suffering and struggle. Teresa has become an advocate for drug use awareness and policy change. She is the co-founder of *Speak Up Florida* and is an ambassador for *Shatterproof*.

https://web.archive.org/web/20211204135521/https://www.cdc.gov/rxawareness/pdf/RxAwareness-Campaign-Overview-508.pdf

CDC Rx AWARENESS CAMPAIGN FACTSHEET

Educating Americans About the Risks of Prescription Opioids



The Need

The Centers for Disease Control and Prevention's (CDC) National Center for Injury Prevention and Control, along with other Federal agencies, made it a priority to raise awareness that prescription opioids can be addictive and dangerous. Vital to achieving this goal was the development of an evidence-based, audience-driven communications campaign that could resonate with those at risk for prescription opioid misuse and overdose.

The Approach

CDC's *Rx Awareness* campaign tells the stories of real people whose lives were impacted by prescription opioids. The goals of the campaign are to:

- Increase awareness that prescription opioids can be addictive and dangerous
- Lower prescription opioid misuse
- Increase the number of patients seeking nonopioid pain management options
- Increase awareness about recovery and reduce stigma

CDC developed a series of videos as the cornerstone of the campaign, featuring individuals living in recovery from opioid use disorder as well as family members who have lost someone to prescription opioid overdose. The testimonials provide compelling real-life accounts to help make others aware of the risks and dangers of prescription opioids.

The *Rx Awareness* campaign launched in 2017 with a focus on reaching people between the ages of 25 and 54 who have taken opioids at least once for medical or nonmedical reasons. This audience was determined based on surveillance data indicating that this age range had the highest fatality rate from opioid overdoses. In 2018, based on evaluation findings, the campaign began an effort to expand and include more stories that reflect audience segments within the 25–54 age range, including younger adults (25- to 34-year-olds), older adults (45- to 54-year-olds), pregnant women, veterans, and American Indians/Alaska Natives.

CAMPAIGN MATERIALS

DIGITAL

- **15- and 30-second testimonial videos**
- **Long-form testimonial videos**
- **Web banner ads**
- **Online search ads**
- **6-second bumper video ads**
- **Social media ads**

CAMPAIGN WEBSITE

- **cdc.gov/RxAwareness**

RADIO

- **30-second ads**

OUT-OF-HOME

- **Billboards**
- **Newspaper ads**
- **Postcards**
- **Posters**

cdc.gov/RxAwareness

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

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CDC Rx AWARENESS CAMPAIGN FACTSHEET

If you're struggling with prescription opioids, there is hope. Recovery is possible.

Research showed that campaign messages should evolve to be positive, empowering, and to instill hope. For this reason, new campaign materials were developed to include the message that recovery is possible.

Campaign Reach

In December 2016, CDC conducted a pilot that implemented the *Rx Awareness* campaign for 14 weeks in nine high-burden counties across four States. CDC based this placement on criteria such as reach, participants' readiness to implement a campaign, and level of interest. In 2017, the campaign launched in 16 additional counties across 4 States. During the summer of 2020, a new suite of campaign materials launched in select markets within Utah, West Virginia, New Mexico, and Alaska that include stories of people who reflect the priority audience segments.

The success of *Rx Awareness* depends on the efforts of State, local, and Tribal organizations that extend the reach of the campaign as part of their drug overdose prevention efforts. *Rx Awareness* was designed with these organizations in mind and includes ready-made and tested materials that CDC-funded partners can customize for local use.

Overall Findings

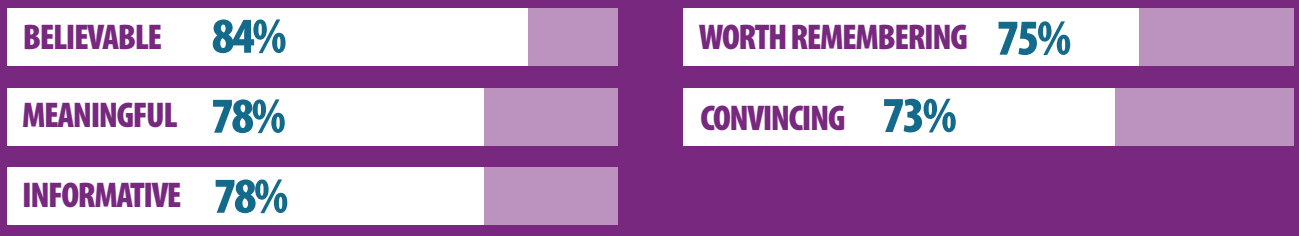
The *Rx Awareness* campaign has reached hundreds of millions of people across the country. Evaluation efforts showed that after seeing or hearing the campaign messages:

- Sixty-eight percent of people reported that they intend to ask their doctor for alternatives to prescription opioids, if needed
- Seventy-four percent of people reported that they plan to avoid prescription opioids medically and/or recreationally

Findings across these research efforts suggest that campaign messages have the potential to not only affect awareness and knowledge but also to influence actions.

MESSAGES WITH IMPACT

CDC surveyed audiences exposed to campaign messages; 83 to 89 percent found the ads effective. Audiences also thought the campaign was:



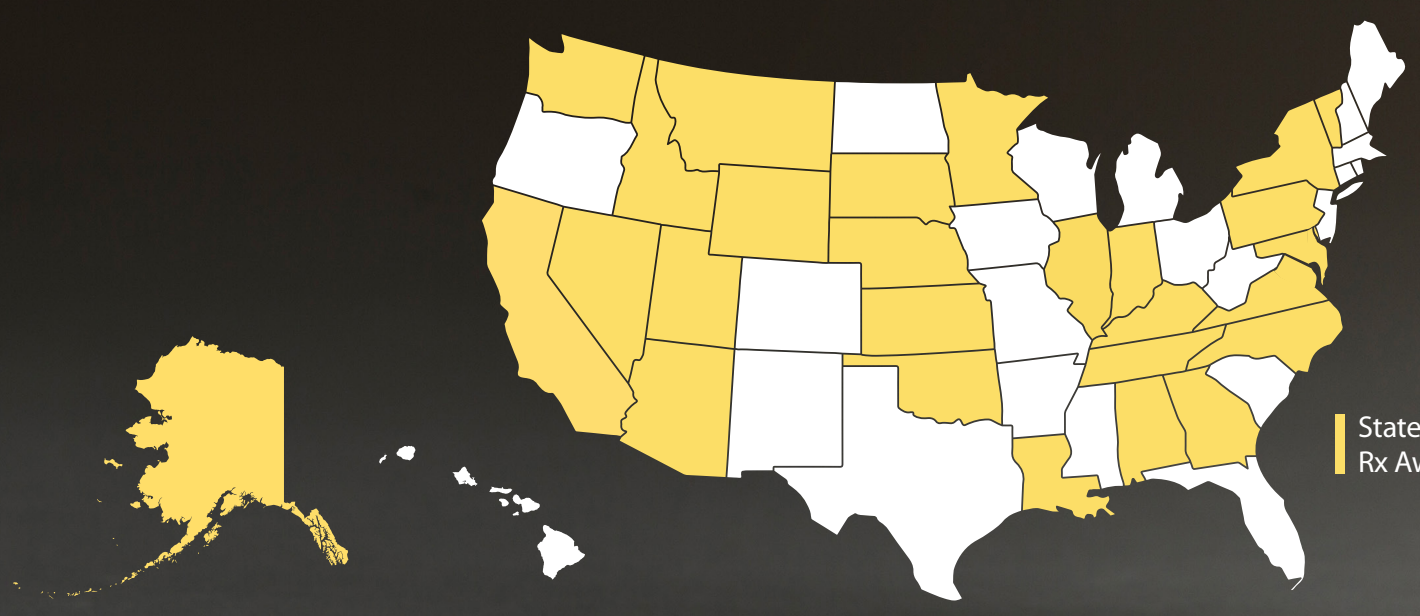
This CDC public health effort includes many other materials, such as a campaign website, patient-centered resources, and provider tools available at cdc.gov/RxAwareness.

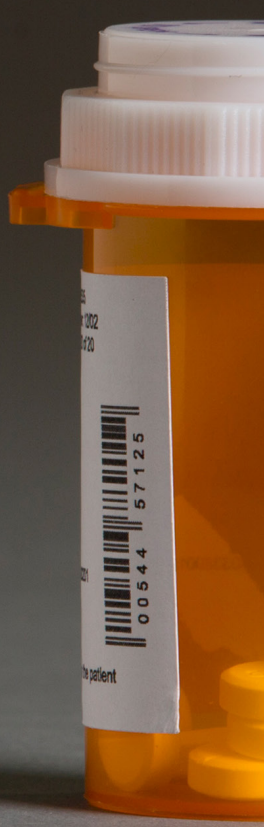
[1] Wide-ranging Online Data for Epidemiologic Research (WONDER). Centers for Disease Control and Prevention; 2020. Reviewed February 26, 2020. Accessed July 15, 2020. http://wonder.cdc.gov

https://web.archive.org/web/20211204135519/https://www.cdc.gov/rxawareness/pdf/CDC-RxAwareness-Infographic-Launch-508.pdf

CDC'S Rx AWARENESS CAMPAIGN

Working to protect Americans and end the opioid overdose crisis, CDC launched the evidence-based Rx Awareness campaign in 2017.





To date, the campaign is expected to run in some capacity in 27 states and the District of Columbia, reaching Americans across the country with real stories of people whose lives have been negatively affected by prescription opioids.

ABOUT Rx AWARENESS

CAMPAIGN GOALS:

- Increase awareness that opioids can be addictive and dangerous
- Lower non-medical, or recreational, opioid use
- Increase the number of patients seeking nonopiod options for pain management

TARGET AUDIENCE:

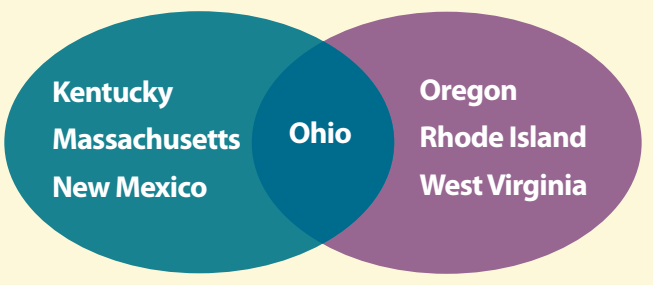
- Adults, ages 25–54, who have taken opioids at least once

MATERIALS:

- Testimonial Videos
- Billboards & Print Ads
- Radio PSAs
- Digital Ads
- Website

OVERVIEW OF THE CAMPAIGN LAUNCH

In 2016, CDC ran a 14-week campaign pilot in Ohio, Oregon, Rhode Island, and West Virginia. In September 2017, after the successful pilot, CDC officially launched the Rx Awareness campaign in 16 high-burden counties in 4 states, Kentucky, Ohio, Massachusetts, and New Mexico. These counties were chosen based on level of interest and readiness to run a campaign.



IMPLEMENTING PILOT FEEDBACK

Following a pilot evaluation, CDC modified the Rx Awareness campaign to include:

New testimonials with added demographics (Brenda and Devin)

Updated visuals to increase overall appeal and make the tagline more prominent

Brenda and Devin's testimonials had the highest click-through rates to the website (20%–30%), proving to be a powerful contribution to the series.

A POWERFUL MESSAGE FOR MILLIONS OF AMERICANS

Rx Awareness campaign materials reached hundreds of millions of people across the country.

DIGITAL	RADIO	BILLBOARDS	SEARCH	SOCIAL MEDIA
112M impressions	**21.8M** impressions	**36M** impressions	**14.5%** increase in likelihood to search "opioids" in markets running digital ads versus in other CDC-funded states	**28M** impressions
5.95M interactions	**5,868** spots	**31%** of people who saw a billboard were motivated to search for more information	**138%** increase in online searches for "opioid abuse" after seeing a testimonial video	**1,855** posts
370,000 clicks to website	**16%** increase in awareness of Rx opioid dangers			
5.6M video views				

M = millions

Ann Marie's heart-breaking story of losing her son was the top performer and was viewed to completion more than 40% of the time.

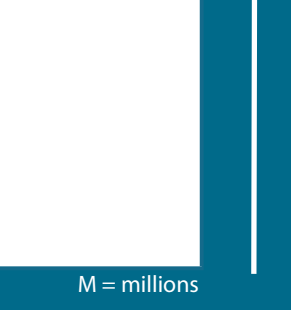
Rx AWARENESS HAS AN IMPACT

CDC surveyed audiences who were exposed to campaign messages, and 83%-89% found the ads effective. Audiences also thought the campaign was:

- BELIEVABLE 84%
- MEANINGFUL 78%
- INFORMATIVE 78%
- WORTH REMEMBERING 75%
- CONVINCING 73%

ENCOURAGING PEOPLE TO ACT

68% Plan to ask a doctor for alternatives to prescription opioids, if needed.



74% Plan to avoid prescription opioids medically and/or recreationally.

For more information about launching Rx Awareness in your state email **duipinquiries@cdc.gov**.
To learn more about prescription opioid misuse and abuse, visit **www.cdc.gov/RxAwareness**.

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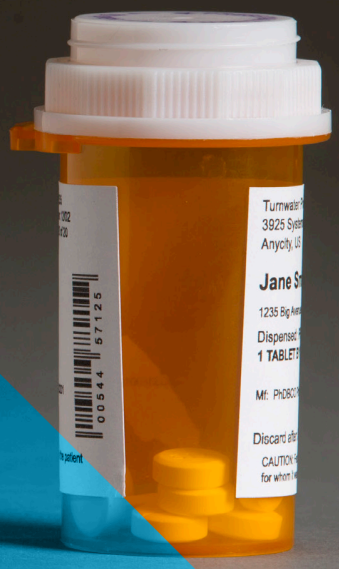
https://web.archive.org/web/20211016091143/https://www.cdc.gov/drugoverdose/pdf/Prevent-Addiction-Fact-Sheet.pdf

Take Action to Prevent Addiction

Learn how to reduce risk.



Know the Facts About Opioids

41 PEOPLE DIE EVERY DAY

Every day in the United States, 41 people lose their lives to prescription opioid overdose.

Prescription opioids—like hydrocodone, oxycodone, and morphine—can be prescribed by doctors to treat moderate to severe pain but can have serious risks and side effects.

ANYONE CAN BECOME ADDICTED

Opioids are highly addictive. Research shows that if you use opioids regularly, you may become dependent on them.

That's because opioids change how the brain and nervous system function. **You can't know how your brain will react to opioids before taking them.**

Talk With Your Doctor

Your doctor may talk to you about prescription opioids for pain treatment. Ask about the risks and benefits so that you can work together to decide what is best. You can also ask your doctor to help you find other safer ways to manage pain.

It Only Takes a Little to Lose a Lot

Opioids can be addictive and dangerous.

Risks include misuse, addiction, and overdose.

Opioids affect the part of the brain that controls breathing.

If you take too high a dose, it can slow your breathing and cause death.

Combining opioids with alcohol and other drugs—

like sleeping pills or cough medication **—increases your chances of death.**[1]

[1] fda.gov/Drugs/DrugSafety/ucm518473.htm

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Start the Conversation

Protect yourself and others by talking about your questions and concerns.

Talk with your doctor.	Ask about nonopioid pain management options, addiction, and overdose risks.
Talk with your loved ones if you're concerned about opioid misuse or addiction.	Let them know that you care about them, and be patient and open when listening so that they feel heard and valued.
Encourage your loved ones to get help if they need it.	Help them look for treatment, and offer to go with them to their first appointment. Your support can make a difference.

Tips to Reduce Risk

Follow these tips to protect yourself and those you care about.

Only take prescription medication that is prescribed to you. **Don't share medication with others.**

Take the medicine as prescribed. Don't use medications in greater amounts, more often, or longer than directed by your doctor.

Keep medicines in a safe place. It's best to store prescription opioids in a place that can be locked—like a keyed medicine cabinet—to keep them secure from children and visitors.

Dispose of expired or unused prescription opioids. Remove them from your home as soon as possible to reduce the chance that others will misuse them. To get rid of prescription opioids and other medications safely:

- Check with your pharmacist to see if you can return them to the pharmacy.
- Find a medicine take-back option near you at **takebackday.dea.gov**.

Treatment Support

For those who might have an opioid use disorder, call SAMHSA's National Helpline at **1-800-662-HELP**.

Find opioid treatment options in your state at **goo.gl/Gtkv9C**.

Learn the signs of a quality treatment center at **goo.gl/X1FCGW**.

Hear real stories about recovery from prescription opioids at **cdc.gov/RxAwareness**.

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https://web.archive.org/web/20210506043126/https://www.cdc.gov/rxawareness/pdf/CDC_RxAwareness_SocialMediaKit_Final.pdf

CDC Rx AWARENESS CAMPAIGN SOCIAL MEDIA KIT

Introduction

Overdoses from opioids are on the rise and killing Americans of all races and ages. Families and communities across the country are coping with the health, emotional, and economic effects of this epidemic. The CDC Rx Awareness Campaign Social Media Kit was created to help CDC's partners share the Rx Awareness campaign messages with their networks and communities. Together, we can reach a broad audience to raise awareness about the campaign and the risks of opioid overdose.

About the Rx Awareness Campaign

In 2017, the Centers for Disease Control and Prevention (CDC) launched Rx Awareness, its first prescription opioid overdose prevention campaign to raise awareness of prescription opioid abuse and overdose. The Rx Awareness campaign is evidence-driven and tells the real stories of people whose lives were torn apart by opioid use and abuse.

The Rx Awareness campaign focuses on adults ages 25–54 who have taken opioids at least once for medical or nonmedical (recreational) use, and it highlights the importance of reducing prescription opioid misuse and abuse to prevent overdoses. The goals of the campaign are to:

- Increase awareness that opioids can be addictive and dangerous; and
- Increase the number of individuals who avoid using opioids nonmedically (recreationally) or who choose options other than opioids for safe and effective pain management.

CDC incorporated first-person stories into the campaign based on past effective use of testimonials to communicate about complex and sensitive health behaviors. The cornerstone of the campaign is a series of videos that feature individuals who are living in recovery from opioid use disorder, or who are family members who lost someone to a prescription opioid overdose. In addition to videos, the campaign includes radio advertisements; digital materials, such as web banners; and materials for out-of-home spaces, such as billboards and newspaper advertisements.

ENGAGING THROUGH SOCIAL MEDIA

The Rx Awareness Campaign Social Media Kit provides graphics from the campaign and tailored posts that you can use to share and promote the Rx Awareness campaign on your social media channels, including Facebook, Instagram, and Twitter.

Rx Awareness Campaign Materials

- **Digital**
  - 30-second testimonial videos
  - Web banner ads
  - Online search ads
  - 5-second bumper digital video ads
  - Social media ads
- **Campaign Website**
  - cdc.gov/RxAwareness
- **Radio**
  - 30-second ads
- **Out-of-Home**
  - Billboards
  - Newspaper ads

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FACEBOOK AND INSTAGRAM POSTS

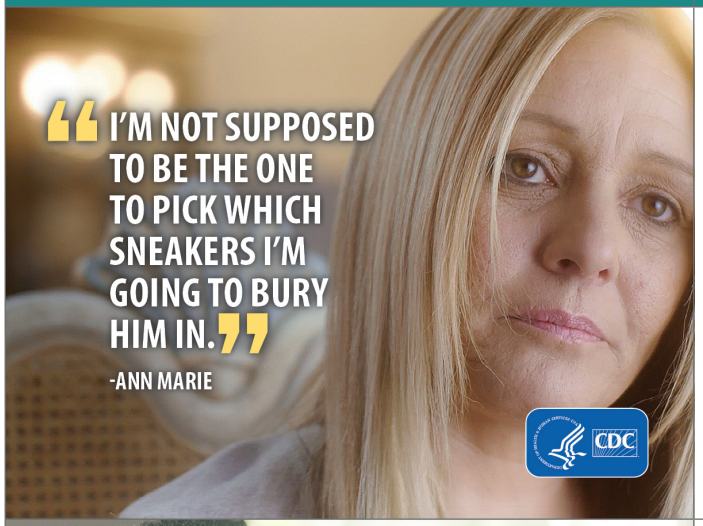
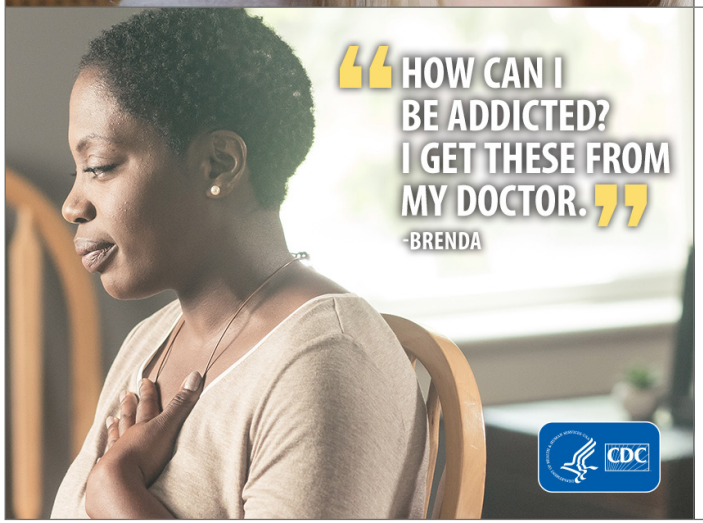
The following chart provides ready-to-use Facebook and Instagram content and images that your organization can post online to spread the word about the Rx Awareness campaign.

Instructions:

1. Use the images in the chart below (also attached as image files).
2. Use the post suggestions provided, or simply use them as inspiration to create your own posts.
3. Always include the **#RxAwareness** hashtag – this ensures we'll all be part of the same social conversation!

IMAGE	FACEBOOK TEXT	INSTAGRAM TEXT
	• Prescription #opioids have serious risks of abuse and overdose. Learn what [YOUR ORGANIZATION'S NAME] is doing to help reduce these risks in our communities. [LINK TO YOUR ORGANIZATION'S SITE] #RxAwareness • In 2016, prescription #opioids killed [NUMBER AND NAME OF STATE RESIDENTS; for example, 225 Marylanders]. Together, we can stop this growing trend of prescription opioid abuse and overdose. Learn how. [LINK TO YOUR ORGANIZATION'S SITE] #RxAwareness • #RxAwareness starts with you. Tell others how prescription #opioids have affected you. Learn more at cdc.gov/RxAwareness.	Prescription #opioids have serious risks of abuse and overdose. Learn more at the link in our bio. #RxAwareness [LINK TO cdc.gov/RxAwareness IN INSTAGRAM BIO]

FACEBOOK AND INSTAGRAM POSTS

IMAGE	FACEBOOK TEXT	INSTAGRAM TEXT
	She never expected she’d lose her son to prescription #opioid overdose. Hear Ann Marie’s story at cdc.gov/RxAwareness. #RxAwareness	She never expected she’d lose her son to prescription #opioid overdose. Hear Ann Marie’s story at the link in our bio. #RxAwareness [LINK TO cdc.gov/RxAwareness IN INSTAGRAM BIO]
	Brenda never knew about the risks of addiction to prescription #opioids. Learn more at cdc.gov/RxAwareness. #RxAwareness	Brenda never knew about the risks of addiction to prescription #opioids. Learn more at the link in our bio. #RxAwareness [LINK TO cdc.gov/RxAwareness IN INSTAGRAM BIO]

FACEBOOK AND INSTAGRAM POSTS

IMAGE	FACEBOOK TEXT	INSTAGRAM TEXT
	Devin’s addiction to prescription #opioids began with a minor surgery at age 16. Learn more about the dangers of prescription opioids at cdc.gov/RxAwareness. #RxAwareness	Devin’s addiction to prescription #opioids began with a minor surgery at age 16. Learn more at the link in our bio. #RxAwareness [LINK TO cdc.gov/RxAwareness IN INSTAGRAM BIO]
	Judy shares her son’s prescription #opioid overdose story at cdc.gov/RxAwareness. #RxAwareness	Judy shares the story of her son’s death from prescription #opioid overdose. Learn more at the link in our bio. #RxAwareness [LINK TO cdc.gov/RxAwareness IN INSTAGRAM BIO]

FACEBOOK AND INSTAGRAM POSTS

IMAGE	FACEBOOK TEXT	INSTAGRAM TEXT
	Mike started to watch his life slip away from addiction to prescription #opioids. Hear more from Mike at cdc.gov/RxAwareness. #RxAwareness	He started to watch his life slip away. Hear Mike's prescription #opioid story at the link in our bio. #RxAwareness [LINK TO cdc.gov/RxAwareness IN INSTAGRAM BIO]
	Real stories. Real people. Noah lost his dad from prescription #opioid overdose. Hear more at cdc.gov/RxAwareness. #RxAwareness	Real stories. Real people. Noah lost his dad from prescription #opioid overdose. #RxAwareness See more in the link in our bio. [LINK TO cdc.gov/RxAwareness IN INSTAGRAM BIO]

FACEBOOK AND INSTAGRAM POSTS

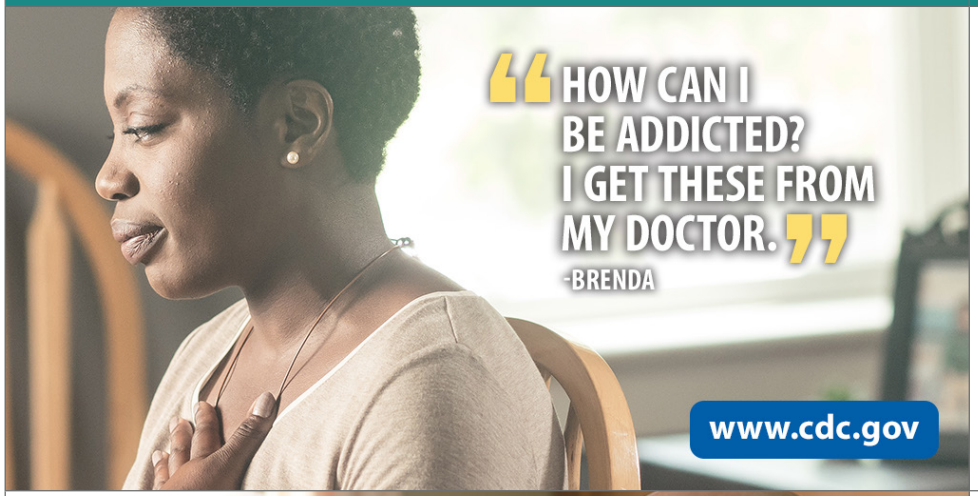
IMAGE	FACEBOOK TEXT	INSTAGRAM TEXT
	Listen to Tamera's story about prescription #opioids at cdc.gov/RxAwareness. #RxAwareness	Listen to Tamera's story about prescription #opioids at the link in our bio. #RxAwareness [LINK TO cdc.gov/RxAwareness IN INSTAGRAM BIO]
	She lost her brother at age 32 to a prescription #opioid overdose. To hear more of Teresa's story, visit cdc.gov/RxAwareness. #RxAwareness	Teresa's brother was only 32 when he overdosed on prescription #opioids. Hear her story at the link in our bio. #RxAwareness [LINK TO cdc.gov/RxAwareness IN INSTAGRAM BIO]

TWITTER POSTS

The chart below provides ready-to-use Twitter content and images that your organization can post online to spread the word about the Rx Awareness campaign.

IMAGE	TWITTER TEXT
	• It only takes a little to lose a lot. What's your prescription #opioid story? #RxAwareness cdc.gov/RxAwareness • #RxAwareness starts with you. Tell others how prescription #opioids have affected you. cdc.gov/RxAwareness • Prescription #opioids can be addictive and dangerous. Learn more at cdc.gov/RxAwareness. #RxAwareness • Know the risks associated with prescription #opioids. Talk to your doctor for #RxAwareness. cdc.gov/RxAwareness • Prescription #opioids can help manage pain but have a serious risk of abuse & overdose. cdc.gov/RxAwareness #RxAwareness [LINK TO YOUR ORGANIZATION'S SITE]
	Ann Marie shares her son's prescription #opioid story at cdc.gov/RxAwareness. #RxAwareness

TWITTER POSTS

IMAGE	TWITTER TEXT
	Brenda never knew about the risks of addiction to prescription #opioids. Learn more at cdc.gov/RxAwareness. #RxAwareness
	Devin’s addiction to prescription #opioids began with a minor surgery. Learn more at cdc.gov/RxAwareness. #RxAwareness

TWITTER POSTS

IMAGE	TWITTER TEXT
	To hear Judy’s #RxAwareness story about losing her son to #opioids, visit cdc.gov/RxAwareness.
	“Within a few months, I was completely addicted.” Listen as Mike tells his prescription #opioid story at cdc.gov/RxAwareness. #RxAwareness

TWITTER POSTS

IMAGE	TWITTER TEXT
	Real stories. Real people. Noah lost his dad to #opioids. Hear more at cdc.gov/RxAwareness. #RxAwareness
	To hear Tamera’s prescription #opioid survivor story, go to cdc.gov/RxAwareness. #RxAwareness

TWITTER POSTS

IMAGE	TWITTER TEXT
	Teresa lost her brother to prescription #opioids. Hear more about #RxAwareness at cdc.gov/RxAwareness.

Tips for Dissemination

Below are a few quick tips to help you make the most of your social media posts to promote the Rx Awareness campaign on Facebook, Twitter, and Instagram.

- Be sure to keep your posts brief. People are more likely to read short posts than lengthy ones.
- Connect with partners. Ask them to share the posts or promote the content.
- Use the campaign hashtag on Twitter and Instagram to label your message: **#RxAwareness**, which allows people to group and sort posts with that hashtag.
- Engage with our social media handles through likes, mentions, and shares:
  - Twitter: @CDCInjury and @DebHouryCDC
  - Facebook: https://www.facebook.com/CDC

For more information and materials, refer to the cdc.gov/RxAwareness website.

https://web.archive.org/web/20210421011251/https://www.cdc.gov/drugoverdose/pdf/patients/preventing-an-opioid-overdose-tip-card-a.pdf

Know the Signs. *Save a Life.*

Opioid Overdose Basics

Prescription opioids (like hydrocodone, oxycodone, and morphine) and illicit opioids (like heroin and illegally made fentanyl) are powerful drugs that have a risk of a potentially fatal overdose. Anyone who uses opioids can experience an overdose, but certain factors may increase risk including but not limited to:

- Combining opioids with alcohol or certain other drugs
- Taking high daily dosages of prescription opioids
- Taking more opioids than prescribed
- Taking illicit or illegal opioids, like heroin or illicitly-manufactured fentanyl, that could could possibly contain unknown or harmful substances
- Certain medical conditions, such as sleep apnea, or reduced kidney or liver function
- Age greater than 65 years old

Death from an opioid overdose happens when too much of the drug overwhelms the brain and interrupts the body's natural drive to breathe.

Learn more about opioids to protect yourself and your loved ones from opioid abuse, addiction, and overdose: www.cdc.gov/drugoverdose

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

PREVENTING AN OPIOID OVERDOSE

Signs and Symptoms of an Opioid Overdose

During an overdose, breathing can be dangerously slowed or stopped, causing brain damage or death. It's important to recognize the signs and act fast. Signs include:

- Small, constricted "pinpoint pupils"
- Falling asleep or loss of consciousness
- Slow, shallow breathing
- Choking or gurgling sounds
- Limp body
- Pale, blue, or cold skin

What To Do If You Think Someone Is Overdosing

It may be hard to tell if a person is high or experiencing an overdose. If you aren't sure, it's best to treat it like an overdose– you could save a life.

1. Call 911 immediately.
2. Administer naloxone, if available.
3. Try to keep the person awake and breathing.
4. Lay the person on their side to prevent choking.
5. Stay with him or her until emergency workers arrive.

Ask your doctor about naloxone - a safe medication that can quickly stop an opioid overdose. It can be injected into the muscle or sprayed into the nose to rapidly block the effects of the opioid on the body.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

https://web.archive.org/web/20210318031433/https://www.cdc.gov/drugoverdose/pdf/patients/ConversationStarter_AvoidAddiction-508.pdf

CONVERSATION STARTERS

If You Are Prescribed Opioids, Learn How to Reduce the Risk of Addiction

Prescription opioids (like oxycodone, hydrocodone, and morphine) are chemicals that bind to receptors in your brain and body to help reduce pain. They can be effective for severe pain, but come with risks for misuse, addiction, and overdose.

Ask your doctor these questions to fully understand the risks of prescription opioids and make sure you're getting care that is safe, effective, and right for you.

1 What is opioid use disorder (opioid addiction)?

Anyone can become addicted to prescription opioids. Physical dependence, when unpleasant symptoms occur when medication is stopped ("withdrawal"), is expected after using opioids for more than a few days. Opioid use disorder (OUD), often referred to as "opioid addiction," occurs when attempts to cut down or control opioid use are unsuccessful, or when use results in social problems and a failure to fulfill obligations at work, school, and home.

> **Talk to your doctor about your medical and mental health history, any medications you are taking, and if you or anyone in your family has a history of substance misuse or addiction. Never take opioids in higher amounts or more often than prescribed.**

Opioids: *natural or manufactured chemicals that bind to receptors in your brain and body to reduce pain. Common prescription opioids include oxycodone, hydrocodone, and morphine.*

Drug Misuse: *the use of prescription drugs without a prescription, or in a different way than prescribed.*

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Learn More: www.cdc.gov/drugoverdose

Reduce the Risk of Opioid Addiction

2 What increases my risk of overdose and death?

Risk of overdose and death becomes greater when opioids are taken:

- At higher dosages
- For longer periods of time
- More often than prescribed
- Combined with benzodiazepines (also known as "benzos" and include diazepam and alprazolam), other sedatives, or alcohol
- Combined with other opioids, including illicit opioids like heroin

> **Talk to your doctor about any other medications you are using. Ask about the serious side effects (like excessive sleepiness or craving more of the medication) so you and your family know when to call a doctor or go to the hospital.**

3 What can I expect while I am taking prescription opioids?

To help ensure the safest, most effective use of opioids, your doctor may:

- Prescribe the lowest effective dose of immediate-release opioids
- Check your state's prescription drug monitoring program information
- Conduct urine drug testing during the course of your therapy, which is increasingly becoming a routine part of care
- Prescribe naloxone, which can reverse an overdose
- Follow up within the first few days after starting a new opioid or when changing your dose
- Follow up at least every 3 months if you are on a stable dose, to ensure benefits continue to outweigh risks

> **Always let your doctor know about any concerns you may have about taking prescription medicines. Tell your doctor if you continue to experience pain while taking opioids to discuss other ways to reduce your pain.**

If you or someone close to you needs help for a substance use disorder, talk to your doctor or call SAMHSA's National Helpline at 1-800-662-HELP or go to SAMHSA's Behavioral Health Treatment Services Locator (http://findtreatment.samhsa.gov)

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https://web.archive.org/web/20210318155343/https://www.cdc.gov/drugoverdose/pdf/patients/ConversationStarter_ChronicPain-508.pdf

CONVERSATION STARTERS

If You Have Chronic Pain

Chronic pain can be overwhelming and frustrating. You and your doctor can work together to improve your daily life and manage your pain. There are many hopeful solutions. Prescription opioids are one option for helping to reduce pain but come with some risks. It is important to understand all of your options and the risks and benefits of each.

Take control of how you manage your pain and ask your doctor about different options. Work with your doctor to find safe and effective care to help you reach your goals.

1 What are the treatment options that don't involve opioids?

Chronic pain can often be managed without opioids, and many other options have been shown to work better with fewer side effects.

Examples include:

- Over-the-counter medications like acetaminophen, ibuprofen, and naproxen
- Physical therapy and exercise
- Cognitive behavioral therapy (CBT)
- Certain antidepressants and anticonvulsants

> **Keep in mind that sometimes you may feel worse before you feel better when starting a new treatment program.**

Chronic pain: *pain lasting 3 months or more that can be caused by a disease or condition, injury, medical treatment, or even an unknown reason.*

Opioids: *natural or manufactured chemicals that bind to receptors in your brain and body to reduce pain. Common prescription opioids include oxycodone, hydrocodone, and morphine.*

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

Learn More: www.cdc.gov/drugoverdose

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CONVERSATION STARTERS

If You Have Chronic Pain

2 What can I expect if I am prescribed opioids to reduce my pain?

It's important to understand that opioids can reduce pain in the short-term, but will not likely relieve all of your pain. The goal of any pain management is to increase your ability to do everyday activities.

> **Follow up with your doctor within the first few days of starting your prescription to ensure opioids are helping. You should also discuss what kind of pain relief and improvement you can expect overall.**

Prescription opioids may have side effects like sleepiness and dizziness. Even when taken as directed there is a risk of tolerance (needing more of the drug to produce the same effects) and physical dependence (experiencing withdrawal when the drug is stopped).

3 What else can I do to manage my chronic pain?

Develop your personal pain management plan with your doctor which may include:

- Your personal treatment goals, which describe what you may achieve as you make progress
- Information about treatment options
- Referral to specialists as needed

Learn More: www.cdc.gov/drugoverdose

https://web.archive.org/web/20210318024446/https://www.cdc.gov/drugoverdose/pdf/prescribing/Guidelines_Factsheet-a.pdf

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

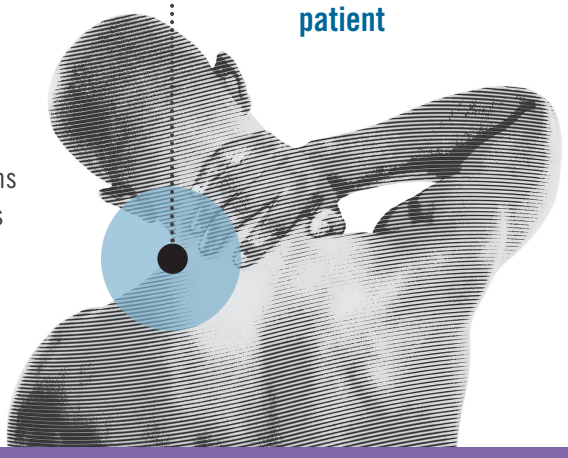
1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- **Opioids are not first-line or routine therapy for chronic pain**
- **Establish and measure goals for pain and function**
- **Discuss benefits and risks and availability of nonopioid therapies with patient**



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

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OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are needed for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed

4 When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5 When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6 Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, 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.

7 Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8 Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9 Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10 When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11 Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12 Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

- Evaluate risk factors for opioid-related harms
- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for opioid use disorder if needed

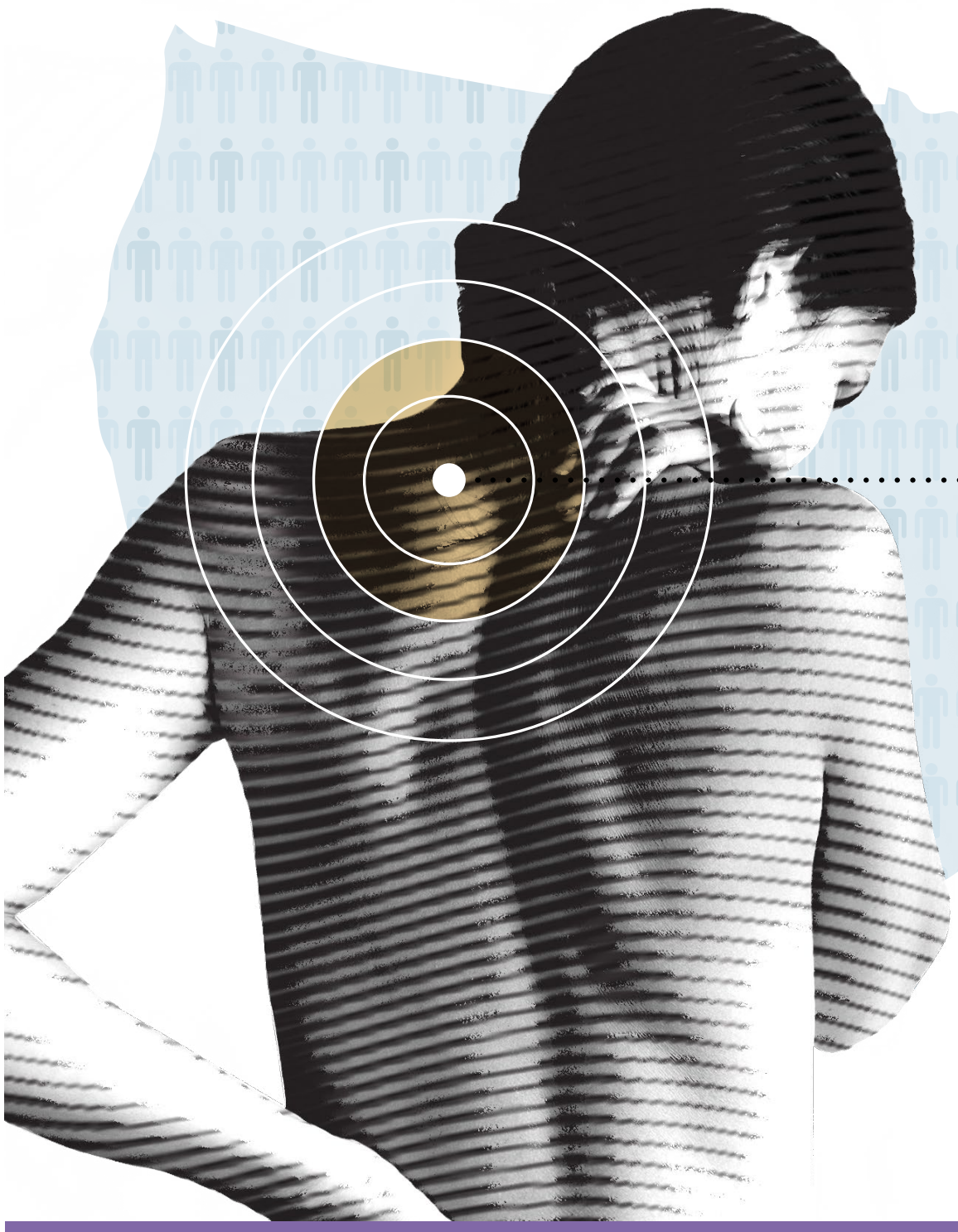
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

P-29829 _ 00848

https://web.archive.org/web/20210505230307/https://www.cdc.gov/drugoverdose/pdf/guidelines_patients_poster-a.pdf

KNOW THE RISKS



AS MANY AS

1 IN 4

PEOPLE

receiving **prescription opioids** long term in a primary care setting struggles with opioid addiction.

MANAGE YOUR PAIN, MINIMIZE YOUR RISK.

Chronic pain can be devastating, and effective pain management is essential to get your life back. Talk to your doctor about ways to manage your pain that don't involve prescription opioids, such as:

- Non-opioid pain relievers, such as acetaminophen (Tylenol®), ibuprofen (Advil®), or naproxen (Aleve®)
- Physical therapy and exercise
- Cognitive behavioral therapy
- Certain antidepressants and anticonvulsants

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

LEARN MORE | www.cdc.gov/drugoverdose/prescribing.guideline.html

P-29829 _ 00850

https://web.archive.org/web/20210318002820/https://www.cdc.gov/drugoverdose/pdf/Original-PatientPoster-Digital.pdf

OUR COMMITMENT

Safer, More Effective Pain Management

Your health and safety are important to us.

Opioid pain medications like oxycodone or hydrocodone can help with severe, acute pain or pain from illnesses like cancer. Taking opioids, especially for longer periods of time, can often do more harm than good. Many non-opioid treatments have been shown to control pain effectively with fewer side effects.

How you can help:

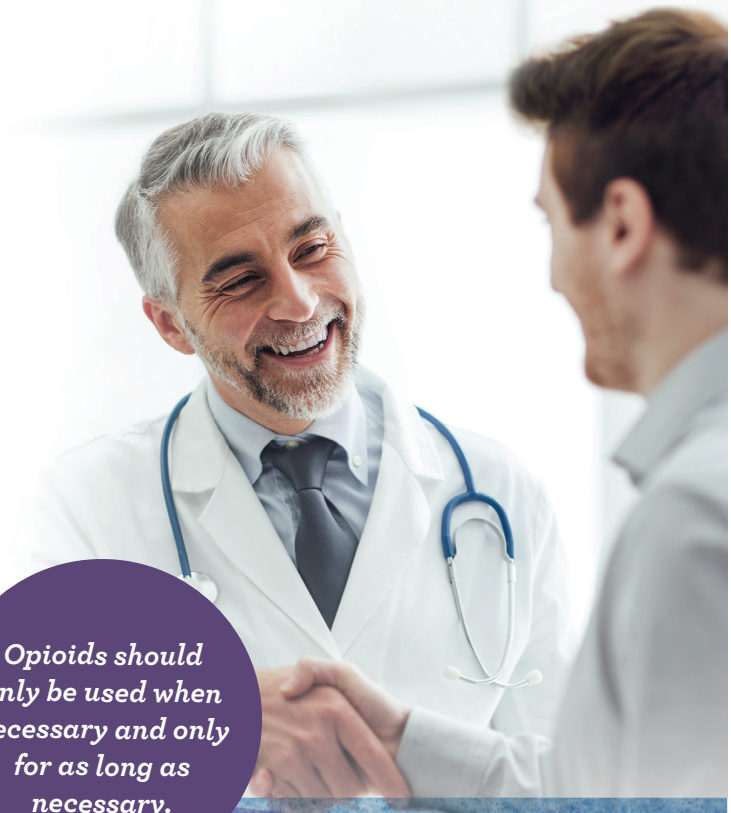
1. When you have pain, let us know your treatment preferences.
2. Whether or not you are prescribed opioids, ask what else you can do to feel better and get relief from your symptoms.
3. If you are prescribed opioids, ask how long you will need to take them, and how we will work with you to stop taking them.

As your healthcare providers, we promise to:

MANAGE: Provide the best possible treatment for your condition.

PERSONALIZE: Work closely with you to set pain management goals and develop a treatment plan that will help you achieve your goals.

COLLABORATE: Assess the risks and benefits of prescription opioids together, and prescribe opioids only when their benefits outweigh their risks.



Opioids should only be used when necessary and only for as long as necessary.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

P-29829 _ 00852

https://web.archive.org/web/20150212020801/http://fentora.com/pdfs/FENTORA_PatientBrochure.pdf

FENTORA®
(fentanyl buccal tablet) C-II

About breakthrough cancer pain and *FENTORA*

FENTORA is a prescription medicine used to manage breakthrough cancer pain in adults with cancer who are already routinely taking other opioid pain medicines around-the-clock for cancer pain.

FENTORA is started only after you have been taking other opioid medicines and your body has become used to them (you are opioid tolerant). Do not use *FENTORA* if you are not opioid tolerant.

FENTORA is only available through the TIRF REMS Access program. Talk to your doctor.

Please see pages 12-17 for Important Safety Information.
Please see Medication Guide within the accompanying Full Prescribing Information inside pocket.

P-29829 _ 00854

Q What is breakthrough pain?

A In patients with cancer, it is common to experience pain that lasts all day. This type of persistent pain can be controlled with daily around-the-clock pain medications. However, this pain relief can be interrupted by breakthrough pain: an intense "flare" of pain that "breaks through" around-the-clock pain medications.[1,2]

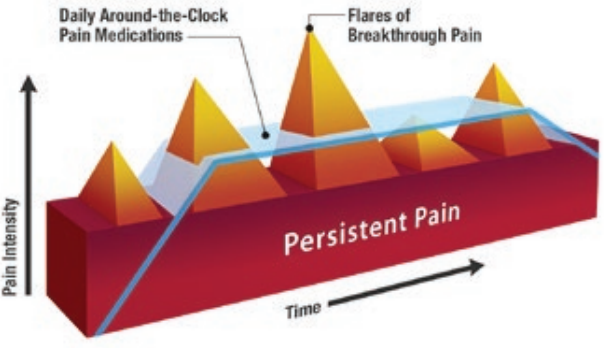
Please see pages 12-17 for Important Safety Information.
Please see Medication Guide within the accompanying Full Prescribing Information inside pocket.

P-29829 _ 00855

Q What makes breakthrough pain different?

A Breakthrough pain has unique characteristics that differentiate it from persistent pain.

- Breakthrough pain comes on rapidly[1,2]
- It is often unpredictable[1,2]
- It usually lasts only for a short period of time[1-3]
- It can happen several times a day[1,2]



P-29829 _ 00856

Q What is *FENTORA*?

A *FENTORA* is a prescription medication that contains the medicine fentanyl. *FENTORA* is a type of short-acting opioid called a Transmucosal Immediate-Release Fentanyl (TIRF). *FENTORA* is used specifically to manage breakthrough pain in opioid-tolerant adult patients with cancer who are already taking around-the-clock medications for their persistent pain.[4]

- *FENTORA* is started only after you have been taking other around-the-clock opioids for persistent pain and your body has become used to them—this means you are opioid tolerant. Do not use *FENTORA* if you are not opioid tolerant
- You can ask your healthcare provider if you are opioid tolerant
- You must stay under your healthcare provider's care while using *FENTORA*
- *FENTORA* is only:
  - Available through the TIRF Risk Evaluation and Mitigation Strategy (REMS) Access program
  - Given to patients who are opioid tolerant

It is not known if *FENTORA* is safe and effective in children under 18 years of age. **Keep *FENTORA* in a safe place away from children.**

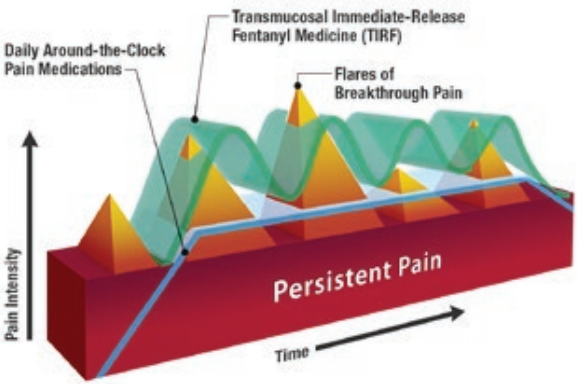
Please see pages 12-17 for Important Safety Information.
Please see Medication Guide within the accompanying Full Prescribing Information inside pocket.

P-29829 _ 00857

Q How does *FENTORA* help treat breakthrough pain?

A *FENTORA* provides relief that generally matches the pattern of individual breakthrough pain episodes in opioid-tolerant adult patients with cancer.[4,5]

- *FENTORA* is designed to begin working as soon as 15 minutes in some patients, and provides relief for about 1 hour in most patients



P-29829 _ 00858

Q What important information should I know about *FENTORA*?

A *FENTORA* can cause life-threatening breathing problems.

- **Use *FENTORA* exactly as prescribed by your healthcare provider**
  - DO NOT use more than 2 doses of *FENTORA* for each episode of breakthrough cancer pain
  - Wait at least 4 hours before treating a new episode of breakthrough cancer pain with *FENTORA*
- **Do not switch from *FENTORA* to other medicines that contain fentanyl or change your *FENTORA* dose without talking with your healthcare provider**
- **Never give *FENTORA* to anyone else,** even if they have the same symptoms you have. It may harm them or even cause death and is against the law. Keep *FENTORA* in a safe place

FENTORA is available only through a program called the Transmucosal Immediate-Release Fentanyl (TIRF) Risk Evaluation and Mitigation Strategy (REMS) Access program. To receive *FENTORA*, you must talk to your healthcare provider about the benefits and risks of *FENTORA*, agree to all of the instructions, and sign the Patient-Prescriber Agreement Form.

Please see pages 12-17 for Important Safety Information.
Please see Medication Guide within the accompanying Full Prescribing Information inside pocket.

P-29829 _ 00859

Q What are possible side effects of *FENTORA*?

A *FENTORA* can cause serious side effects, including breathing problems that can become life-threatening. Other possible serious side effects include:

- Decreased blood pressure
- Physical dependence
- A chance of abuse or addiction
- Pain, irritation, or sores at the application site (on your gum, on the inside of your cheek, or under your tongue)

Common side effects of *FENTORA* are nausea, vomiting, dizziness, low red blood cell count, tiredness, swelling of the arms, hands, legs and feet, and headache.

Constipation is a very common side effect of opioid pain medicines including *FENTORA* and often does not go away without treatment.

These are not all the possible side effects of *FENTORA*. For more information, ask your healthcare provider.

P-29829 _ 00860

Q Who should not use *FENTORA*?

A Do not use *FENTORA*:

- **If you are not opioid tolerant**
- If you are under 18 years of age
- For short-term pain, such as pain after surgery, headaches or migraine, and/or dental pain
- If you are allergic to any of the ingredients in *FENTORA*. Please see the full Medication Guide included within the pocket of this brochure for a complete list of ingredients in *FENTORA*

Please see pages 12-17 for Important Safety Information.
Please see Medication Guide within the accompanying Full Prescribing Information inside pocket.

Additional important information I should know about *FENTORA*

Do not switch from *FENTORA* to other medications that contain fentanyl without talking to your healthcare provider. The amount of fentanyl in a dose of *FENTORA* is not the same as the amount of fentanyl in other medications that contain fentanyl. Your healthcare provider will provide a starting dose of *FENTORA* that may be different from other fentanyl-containing medications you have been taking.

Never give *FENTORA* to anyone else, even if they have the same symptoms as you. *FENTORA* is a federally controlled substance (CII) because it is a strong opioid (narcotic) pain medicine that can be misused by people who abuse prescription medicines or street drugs.

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Q How do I take *FENTORA*?

A Use *FENTORA* exactly as prescribed by your healthcare provider.

- Use **1** dose of *FENTORA* at the beginning of an episode of breakthrough cancer pain
- If your breakthrough cancer pain does not get better 30 minutes after taking the first dose of *FENTORA*, you can use **only 1** more dose of *FENTORA* as instructed by your healthcare provider
- You must not use more than 2 doses of *FENTORA* for each episode of breakthrough cancer pain
- You must wait at least 4 hours before treating a new episode of breakthrough pain with *FENTORA*
- If you stop taking your around-the-clock opioid pain medication for your persistent cancer pain, **you must stop** using *FENTORA*. You are no longer opioid tolerant. Talk to your healthcare provide about how to treat your pain.

Do not take any medications while using *FENTORA* until you have talked to your healthcare provider. Your healthcare provider will tell you if it is okay to take other medicines while you are using *FENTORA*.

Please see pages 12-17 for Important Safety Information.
Please see Medication Guide within the accompanying Full Prescribing Information inside pocket.

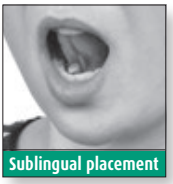
Q How do I administer *FENTORA*?

A *FENTORA* has both buccal and sublingual options for administration.

Your doctor must determine an appropriate dose using buccal administration before you can begin taking *FENTORA* sublingually.

Buccal placement

FENTORA should be placed in the buccal cavity, above the rear molar, between the upper cheek and gum. Switch sides of your mouth for each dose.



Sublingual placement

Place the *FENTORA* tablet under your tongue and let it dissolve.

For both buccal and sublingual administration

- Leave the tablet in place until it dissolves—generally between 14 to 25 minutes
- After 30 minutes, if there is any *FENTORA* left in your mouth, you may drink a glass of water to help you swallow it
- If you cannot use *FENTORA* in this manner, tell your healthcare provider. Your healthcare provider will tell you what to do
- You should not crush, split, suck, or chew *FENTORA* tablets, or swallow tablets whole as this may lessen the relief from breakthrough pain

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FENTORA®
(fentanyl buccal tablet) C II

Important Safety Information

The information listed below is not a complete list. Please read the **full Medication Guide** completely before you start using *FENTORA*® (fentanyl buccal tablet) CII, and each time you get a new prescription. This information does not take the place of talking with your healthcare provider about your medical condition or your treatment. Share this important information with members of your household and other caregivers.

IMPORTANT:

Do not use FENTORA unless you are regularly using another opioid pain medicine around-the-clock for your cancer pain and your body is used to these medicines (this means you are opioid tolerant). You can ask your healthcare provider if you are opioid tolerant.

Keep FENTORA in a safe place away from children.

Get emergency help IMMEDIATELY if:

- **A child takes FENTORA. FENTORA can cause an overdose and death in any child who takes it**
- **An adult who has not been prescribed FENTORA uses it**
- **An adult who is not already taking opioids around-the-clock uses FENTORA**

These are medical emergencies that can cause death. If possible, try to remove FENTORA from the mouth.

Please see Medication Guide within the accompanying Full Prescribing Information inside pocket.

P-29829 _ 00865

What important information should I know about *FENTORA*?

***FENTORA* can cause life-threatening breathing problems.**

- **Use *FENTORA* exactly as prescribed by your healthcare provider**
  - DO NOT use more than 2 doses of *FENTORA* for each episode of breakthrough cancer pain
  - Wait at least 4 hours before treating a new episode of breakthrough cancer pain with *FENTORA*
- **Do not switch from *FENTORA* to other medicines that contain fentanyl or change your *FENTORA* dose without talking with your healthcare provider**
- **Never give *FENTORA* to anyone else,** even if they have the same symptoms you have. It may harm them or even cause death and is against the law. Keep *FENTORA* in a safe place

FENTORA is available only through a program called the Transmucosal Immediate-Release Fentanyl (TIRF) Risk Evaluation and Mitigation Strategy (REMS) Access program. To receive *FENTORA*, you must talk to your healthcare provider about the benefits and risks of *FENTORA*, agree to all of the instructions, and sign the Patient-Prescriber Agreement Form.

P-29829 _ 00866

Who should not use *FENTORA*?

Do not use *FENTORA*:

- **If you are not opioid tolerant. Opioid tolerant means that you are already taking other opioid pain medicines around-the-clock for your cancer pain, and your body is used to these medicines**
- For short-term pain that you would expect to go away in a few days, such as pain after surgery, headaches or migraine, and/or dental pain
- If you are allergic to any of the ingredients in *FENTORA*

What should I tell my healthcare provider before using *FENTORA*?

Tell your healthcare provider about all the medicines you take, including prescription medicines, vitamins, and herbal supplements. Some medicines may cause serious or life-threatening side effects when taken with *FENTORA*.

- **Do not take any medicine while using *FENTORA* until you have talked to your healthcare provider. Your healthcare provider will tell you if it is okay to take other medicines while you are using *FENTORA***
- Be very careful about taking other medicines that may make you sleepy, such as other pain medicines, antidepressant medicines, sleeping pills, anti-anxiety medicines, antihistamines, or tranquilizers

Please see Medication Guide within the accompanying Full Prescribing Information inside pocket.

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What should I avoid while using *FENTORA*?

- **Do not drive, operate heavy machinery, or do other dangerous activities** until you and your healthcare provider know how *FENTORA* affects you
- **Do not drink alcohol while using *FENTORA*.** It can increase the chance of dangerous side effects

What are possible side effects of *FENTORA*?

***FENTORA* can cause serious side effects, including:**

1. **Breathing problems that can become life-threatening.**

   Stop taking *FENTORA* and call your healthcare provider or get emergency medical help IMMEDIATELY if you:

   - Have trouble breathing
   - Have drowsiness with slowed breathing
   - Have slow, shallow breathing (little chest movement with breathing)
   - Feel faint, very dizzy, confused, or have unusual symptoms

   These symptoms can be a sign that you have taken too much *FENTORA* or the dose is too high for you. **These symptoms may lead to serious problems or death if not treated right away.**

2. **Decreased blood pressure.** This can make you feel dizzy or lightheaded when you stand up.

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3. **Physical dependence. Do not stop taking *FENTORA* or taking any other opioid without talking to your healthcare provider.** You could become sick with uncomfortable withdrawal symptoms because your body has become used to these medicines. Physical dependency is not the same as drug addiction.

4. **A chance of abuse or addiction.** This chance is higher if you are or have been addicted to or abused other medicines, street drugs, or alcohol, or have a history of mental health problems.

5. **Pain, irritation, or sores at the application site (on your gum, on the inside of your cheek, or under your tongue).**

The most common side effects of *FENTORA* are:

- Nausea
- Vomiting
- Dizziness
- Low red blood cell count
- Tiredness
- Swelling of the arms, hands, legs and feet
- Headache

Constipation is a very common side effect of opioid pain medicines including *FENTORA* and is unlikely to go away without treatment. Talk to your healthcare provider about prevention or treatment of constipation while taking *FENTORA*.

Please see Medication Guide within the accompanying Full Prescribing Information inside pocket.

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Talk to your healthcare provider if you have any side effects.

These are not all the possible side effects of *FENTORA*. For more information, ask your healthcare provider or pharmacist or call 1-800-896-5855.

You are encouraged to report side effects of prescription drugs to the FDA. Visit www.FDA.gov/medwatch, call 1-800-FDA-1088, or fax to 1-800-FDA-0178.

This information does not take the place of talking with your doctor for medical advice about your condition or treatment.

Please see Medication Guide located at the end of the Full Prescribing Information.

Notes

Notes

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FENTORA®
(fentanyl buccal tablet) C-II

The *FENTORA* Prescription Savings Card may help you save

The *FENTORA* Prescription Savings Card provides:

- First month FREE*†
- $5 copay on future prescriptions*†

*Up to 3 prescriptions in accordance with the Terms and Limitations.
†Limitations apply.

For more information, visit **FENTORA.com**

Please see pages 11-16 for Important Safety Information. Please see Medication Guide within the accompanying Full Prescribing Information inside pocket.

References: 1. Portenoy RK, Hagen NA. Breakthrough pain: definition, prevalence and characteristics. *Pain*. 1990;41(3):273-281. **2.** Portenoy RK, Payne D, Jacobsen P. Breakthrough pain: characteristics and impact in patients with cancer pain. *Pain*. 1999;81(1-2):129-134. **3.** Zeppetella G, O'Doherty CA, Collins S. Prevalence and characteristics of breakthrough pain in cancer patients admitted to a hospice. *J Pain Symptom Manage*. 2000;20(2):87-92. **4.** Fentora [package insert]. Frazer, PA: Cephalon Inc.; 2013. **5.** Portenoy RK, Taylor D, Messina J, Tremmel L. A randomized, placebo-controlled study of fentanyl buccal tablet for breakthrough pain in opioid-treated patients with cancer. *Clin J Pain*. 2006;22(9):805-811.

TEVA CNS

 FEN-40048 May 2013 Printed in USA.

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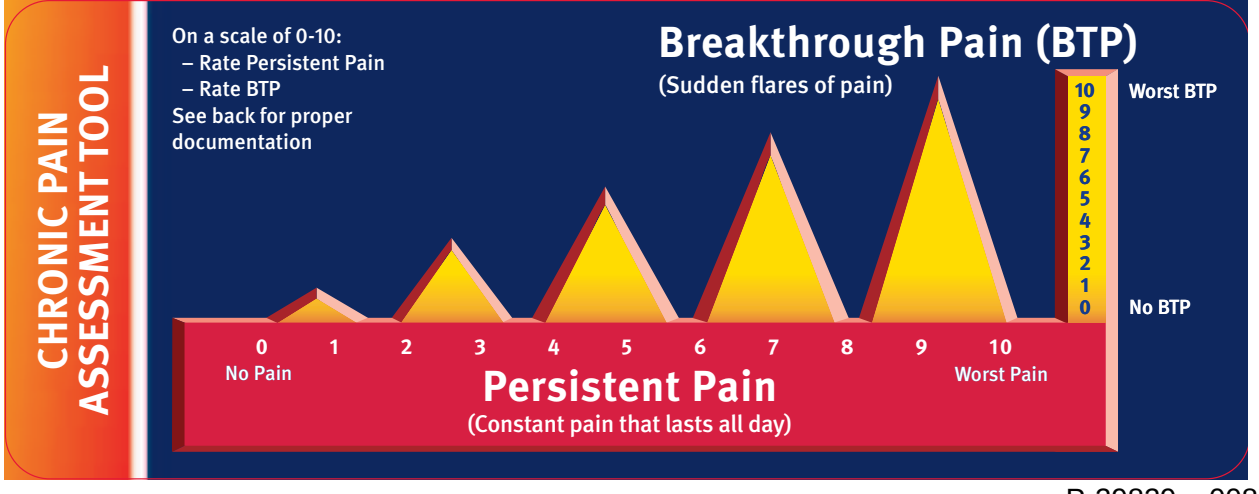
https://web.archive.org/web/20060623000714/http://www.breakthroughpain.com/assets/20051123PainTool.pdf


CHRONIC PAIN ASSESSMENT TOOL
On a scale of 0-10:
– Rate Persistent Pain
– Rate BTP
See back for proper documentation
Breakthrough Pain (BTP)
(Sudden flares of pain)
10
9
8
7
6
5
4
3
2
1
0
Worst BTP
No BTP
0
No Pain
1
2
3
4
5
6
7
8
9
10
Worst Pain
Persistent Pain
(Constant pain that lasts all day)

Ensuring Proper Documentation of Persistent Pain and Breakthrough Pain (BTP)

	Intensity	Variation	Duration	Location	Description	Quality of Life
Persistent Pain	Using the persistent pain scale, ask: "On a scale of 0 to 10 (with 10 being the worst pain imaginable) please rate your persistent pain."	"Does your persistent pain vary throughout the day?"	"Does your pain last all day?" "If not, how long?" "When does it usually occur?"	"Point to where on your body the pain occurs?" "Is it on the surface or deep inside?" "Does it move from one location to another?"	"Which of these words best describes your pain?" "Aching" "Dull" "Numbness" "Sharp" "Shooting" "Tingling"	"Tell me how this pain affects ...your daily life." ...your favorite activities." ...your mood." ...relationship with spouse or family."
Break-through Pain (BTP)	Using the BTP scale, ask: "Do you experience flare-ups of BTP throughout the day?" "Please indicate on a scale of 0 to 10 (with 10 being the worst pain imaginable) ...the intensity of a TYPICAL episode of BTP." ...the intensity of your WORST episode of BTP."	**Onset** "How quickly does your BTP strike?"	"How long does ...a TYPICAL flare of BTP last?" ...your WORST flares of BTP last?"			

Cephalon® deliver more℠

https://web.archive.org/web/20051018164531/http://www.painfoundation.org/downloads/Notebook.pdf

Pain Notebook

NAME

ADDRESS

CITY

STATE, ZIP

EMAIL

PHONE

American Pain Foundation

The Importance of Managing Your Pain

Good pain management starts with good communication between you and your healthcare provider. This notebook will show you how to work together.

Understanding that chronic pain is a disease in itself—and one that is harmful to the body—is a new way of thinking. Until recently, pain was considered only as a symptom of a disease or condition, or just a natural part of aging.

Today, we know that pain should never be ignored. It should be assessed thoroughly and treated aggressively, and in some cases managed as a chronic condition. We've learned that when pain is managed, stress is reduced, and the body heals faster.

When people with pain work together with their healthcare professionals and take an active role in their pain management, they get the best results possible—less pain and more involvement in life.

TYPES OF PAIN

Understanding the different kinds of pain that you may be experiencing—and the terms used to describe them—will help you communicate better with your medical team. Using the right terms (described below) and the Pain Notebook when meeting with your medical team will help them best determine the most specific and effective plan to manage your pain.

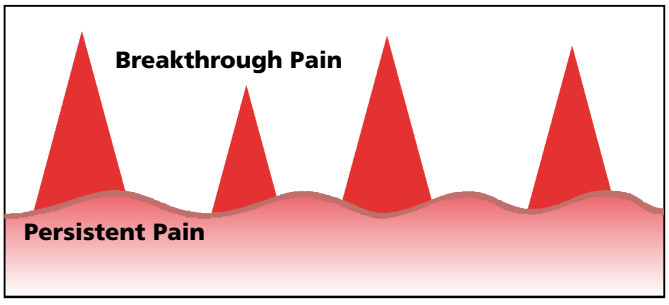
Acute Pain comes on suddenly, usually from an injury or surgery. It can usually be treated and lasts for a short period of time.

Chronic Pain lasts beyond the usual healing time for an illness or injury. It can last from months to years. At times it can go away completely, or it can remain constant. **Types of chronic pain:**

Intermittent Pain is episodic. It may occur in waves or patterns. Intermittent pain is often treated with NSAIDs, adjuvant medicines, and non-drug therapies. Moderate to severe intermittent pain may be treated with short-acting opioids.

Persistent pain lasts 12 or more hours every day for more than three months. It is usually treated with medicine that you take at specific times every day so that you get pain relief throughout the day. Moderate to severe pain may be treated with opioids.

Breakthrough pain comes up quickly or "breaks through" the medicine you are taking to relieve your persistent pain. It can occur many times during the day. This type of pain can be treated with specific medicines used as you need them to get quick pain relief.



The goal of pain management is to treat pain until optimal relief and functional outcomes are reached.

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How can I best communicate with my healthcare team?

You and the members of your healthcare team are partners in managing your pain. Here are some tips to help that partnership work well:

Be prepared and organized:

- Use the Pain Notebook as much as you can. It will give your medical team valuable information about your pain experience between office or clinic visits.
- Write down your questions. List your most important concerns first. Bring them to the healthcare provider's office or the clinic, and check them off as they're answered.

Be honest and open. Don't hold back. Remember:

- You have the information your medical team needs to be able to relieve your pain.
- You have no reason to be embarrassed or afraid to talk to your medical team. They will take the time to listen to your concerns.

Take notes during your visit:

- Include concerns about your pain and other issues related to your care before the visit ends (refer to your list of questions).
- Think about bringing a family member or good friend to take notes. The stress of a medical visit can sometimes make people miss important information.

Make sure you understand all instructions and explanations:

- If something isn't clear, ask your healthcare provider to explain it again in a different way until you're sure you understand.
- Before you leave, repeat what you heard back to the person who gave you the instructions. This is a final check to make sure you understand all the details and that your notes are accurate.

Follow the agreed treatment plan:

- Don't make changes without checking with your healthcare provider.
- If the plan isn't working well, call the office or clinic as soon as possible and explain the problem.

Pain Care Bill of Rights

As a Person with Pain, You Have The Right to:

- Have your report of pain taken seriously and to be treated with dignity and respect by doctors, nurses, pharmacists, and other healthcare professionals.
- Have your pain thoroughly assessed and promptly treated.
- Be informed by your healthcare provider about what may be causing your pain, possible treatments, and the benefits, risks, and costs of each.
- Participate actively in decisions about how to manage your pain.
- Have your pain reassessed regularly and your treatment adjusted if your pain has not been eased.
- Be referred to a pain specialist if your pain persists.
- Get clear and prompt answers to your questions, take time to make decisions, and refuse a particular type of treatment if you choose.

Although not always required by law, these are the rights you should expect for your pain care.

Using Your Pain Notebook

Why Use the Pain Notebook?

You are the expert on your own pain.

You have the right to have your pain treated.

Your Pain Notebook will help you keep a record of your pain experience throughout the day.

Keeping track of what things make your pain better or worse will help your medical team find the best ways to treat your pain.

This is why it is so important to use your Pain Notebook every day—especially on the days you are most in pain.

Your physical and emotional comfort are important parts of treating your pain. Your Pain Notebook has important information that will help your medical team find the most effective ways to treat your pain.

How to Use Your Pain Notebook

Use your Pain Notebook in a way that is most helpful to you. You do not have to fill in all the parts. And if you need additional pages, you can print them from the APF website: www.painfoundation.org.

Keep your Pain Notebook in one particular place—one that is handy and easy to remember.

Find a comfortable place to sit so that you can write down your information.

Write down as much information as you can think of about your pain.

Each two-page daily section of your notebook has three parts.

The first section, the **Daily Pain Chart**, helps you create a visual picture of your daily pain experience. Follow your pain level throughout the day choosing several times that fit your routine, like when you get in or out of bed, eat meals, take medicines, get the mail, or take a walk. Make a mark that corresponds to your pain level at these times. For example, if you wake at 7 am and your pain is a 6, mark where 7 am and 6 on the pain scale intersect.

The second section, the **Daily Pain Log**, is where you can record information about your pain—intermittent, persistent, or breakthrough—treatments, and side effects. Also record days you have no pain. In addition, use this section to look at how you are dealing and coping with pain. What has helped you most? What is not working? Make additional notes in this section to record pain producing activities, as well as times of pain relief. Also keep a record of things you did to relieve your pain.**You can draw lines from the events on the Chart to explanations in the Log to show why pain levels went up or down.**

Then, at the end of the day, come back and use the **Daily Pain Summary** to give an overview of your pain for that day.

Using all sections gives your medical team the best description of how your pain changes throughout the day. If it's easier for you to complete one part only, that's okay. The important thing is to track your pain each day.

If you are not able to complete a page every day, find someone to help you with the task for at least one week. This can still give your medical team an idea of changes in your pain over time.

P-29829 _ 00882

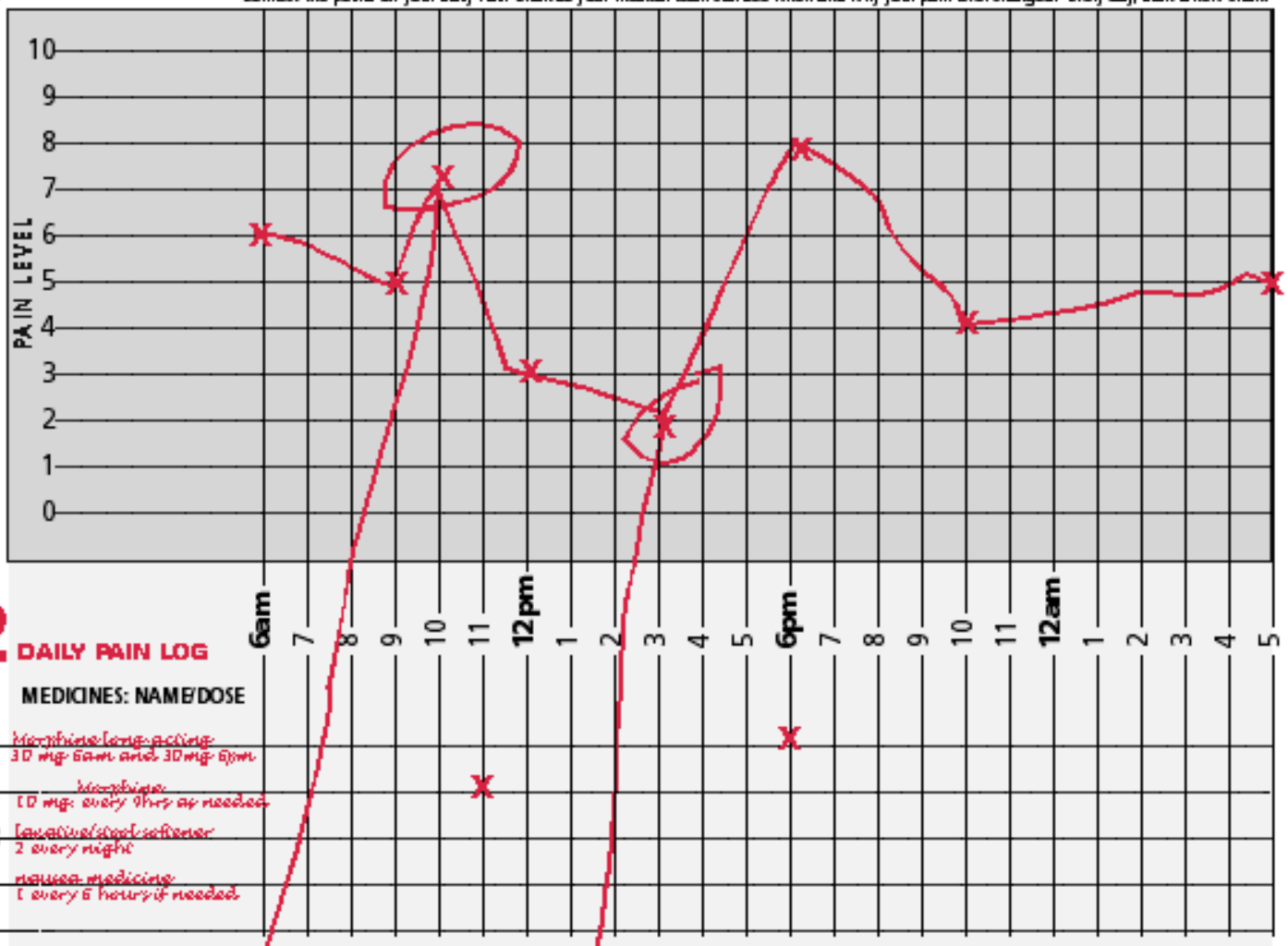
Name Mary Johnson

Day Thursday

Date June 10, 2004

1 DAILY PAIN CHART

Connect the points on your Daily Pain Chart so your medical team can see when and why your pain level changed. Every day, start a new chart.



2 DAILY PAIN LOG

MEDICINES: NAME/DOSE

#1 Morphine long-acting 30 mg 6am and 30mg 6pm

#2 Morphine 10 mg every 4hrs as needed

#3 Laxative/stool softener 2 every night

#4 nausea medicine 1 every 6 hours if needed

#5

NON-MEDICINE THERAPY (other than prescription medicines)

hot bath

ACTIVITIES/EXERCISE

walked dog

COMMENTS AND MORE INFORMATION: Make notes for and about visits with your healthcare provider, side effects from treatments you may be experiencing, and any problems you are having coping with your pain. You may also want to write more about some of your answers on the previous page.

I forgot my morning medicine. I did a little too much yesterday and had to take it easy today. I felt a little sad today, but was able to reach a friend to talk. My pain is pretty well under control, but I need help with my breakthrough pain.

Name Mary Johnson
Day Thursday
Date June 10, 2004

3 DAILY PAIN SUMMARY

Did you have pain today? ___NO _X_YES

Did you avoid or limit any of your activities or cancel plans today because of pain or changes in your pain?

_X_NO ___YES: **What activities?**

Did you take all your pain medicine today according to instructions? _X_NO ___YES

Even though you took your pain medicine for persistent pain on schedule, were there times during the day that you experienced unrelieved breakthrough pain? ___NO _X_YES

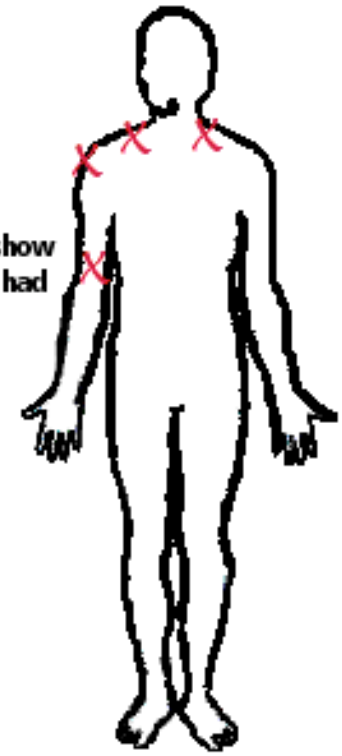
How many times did this happen today?

1 (2) 3 4 5 6 7 8 9 10 more than 10

Did any specific activity start your breakthrough pain? ___NO _X_YES: **What activities?**

walking my dog

Put an "X" on the body diagram to show each place you've had pain today.



What was your average level of pain today?

0 1 2 (3) 4 5 6 7 8 9 10

Other than prescription medicine, did you do anything else today to relieve the pain?
___NO _X_YES **(Check any that you used.)**

_X_ Non-prescription drugs (e.g., acetaminophen, ibuprofen)
___ Herbal remedies
_X_ Hot or cold packs
___ Exercise
___ Changing position (such as lying down or elevating your legs)
___ Physical therapy
___ Massage
___ Acupuncture
___ Rest
___ Psychological counseling
___ Talk to trusted friend, family, clergy
___ Prayer, meditation, guided imagery
___ Relaxation technique (hypnosis, biofeedback)
___ Creative technique (art or music therapy)
_X_ Other (describe):
took a hot bath

Check any of these common side effects that you've noticed after taking your pain medicine.

_X_ Drowsiness, sleepiness
___ Nausea, vomiting, upset stomach
___ Constipation
___ Lack of appetite
___ Other (describe):

Did you skip any of your scheduled pain medicines today? ___NO _X_YES: **Why?**
I forgot

Did you call your doctor's office or clinic between visits because of pain? _X_NO ___YES

Overall, are you satisfied with your pain management? _X_YES ___NO **(Explain what makes you satisfied or not satisfied. Use Log section.)**

What pain level overall would you find acceptable?

0 1 (2) 3 4 5 6 7 8 9 10

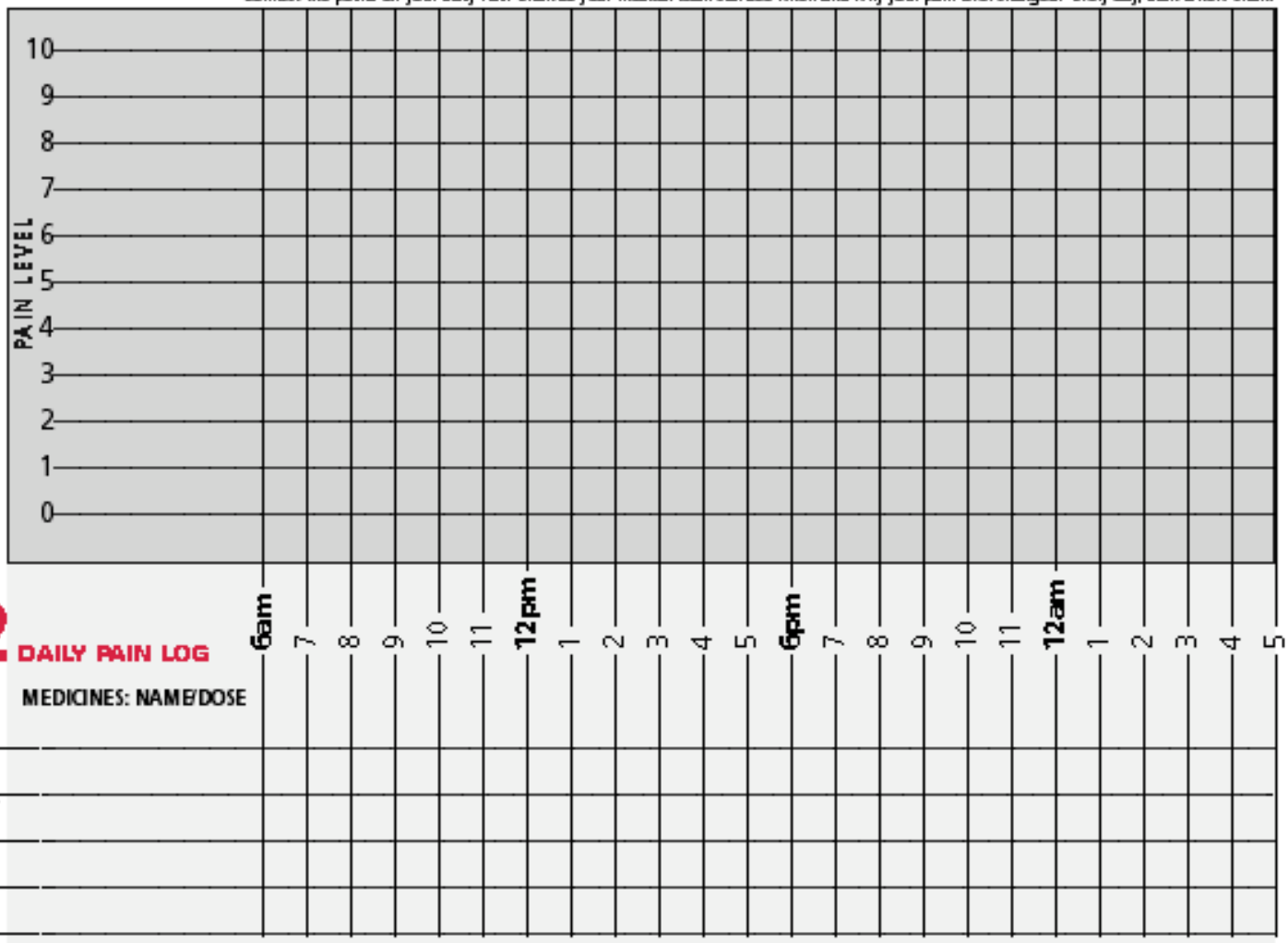
Name _____

Day _____

Date _____

1 DAILY PAIN CHART

Connect the points on your Daily Pain Chart so your medical team can see when and why your pain level changed. Every day, start a new chart.



2 DAILY PAIN LOG

MEDICINES: NAME/DOSE

#1 _____

#2 _____

#3 _____

#4 _____

#5 _____

NON-MEDICINE THERAPY (other than prescription medicines)

ACTIVITIES/EXERCISE

COMMENTS AND MORE INFORMATION: Make notes for and about visits with your healthcare provider, side effects from treatments you may be experiencing, and any problems you are having coping with your pain. You may also want to write more about some of your answers on the previous page.

Name _____

Day _____

Date _____

3 DAILY PAIN SUMMARY

Did you have pain today? ____NO ____YES

Did you avoid or limit any of your activities or cancel plans today because of pain or changes in your pain?

____NO ____YES: **What activities?**

_____

Did you take all your pain medicine today according to instructions? ____NO ____YES

Even though you took your pain medicine for persistent pain on schedule , were there times during the day that you experienced unrelieved breakthrough pain? ____NO ____YES

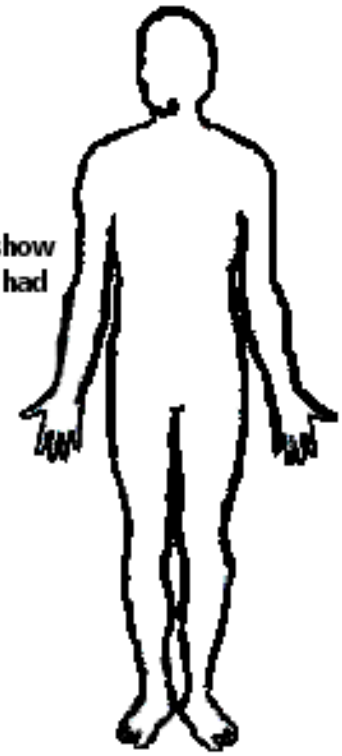
How many times did this happen today?

1 2 3 4 5 6 7 8 9 10 more than 10

Did any specific activity start your breakthrough pain? ____NO ____YES: **What activities?**

_____

Put an "X" on the body diagram to show each place you've had pain today.



What was your average level of pain today?

0 1 2 3 4 5 6 7 8 9 10

Other than prescription medicine, did you do anything else today to relieve the pain?
____NO ____YES **(Check any that you used.)**

____ Non-prescription drugs (e.g., acetaminophen, ibuprofen)
____ Herbal remedies
____ Hot or cold packs
____ Exercise
____ Changing position (such as lying down or elevating your legs)
____ Physical therapy
____ Massage
____ Acupuncture
____ Rest
____ Psychological counseling
____ Talk to trusted friend, family, clergy
____ Prayer, meditation, guided imagery
____ Relaxation technique (hypnosis, biofeedback)
____ Creative technique (art or music therapy)
____ Other (describe):

_____

Check any of these common side effects that you've noticed after taking your pain medicine.

____ Drowsiness, sleepiness
____ Nausea, vomiting, upset stomach
____ Constipation
____ Lack of appetite
____ Other (describe):

_____

Did you skip any of your scheduled pain medicines today? ____NO ____YES: **Why?**

_____

Did you call your doctor's office or clinic between visits because of pain? ____NO ____YES

Overall, are you satisfied with your pain management? ____YES ____NO **(Explain what makes you satisfied or not satisfied. Use Log section.)**

What pain level overall would you find acceptable?

0 1 2 3 4 5 6 7 8 9 10

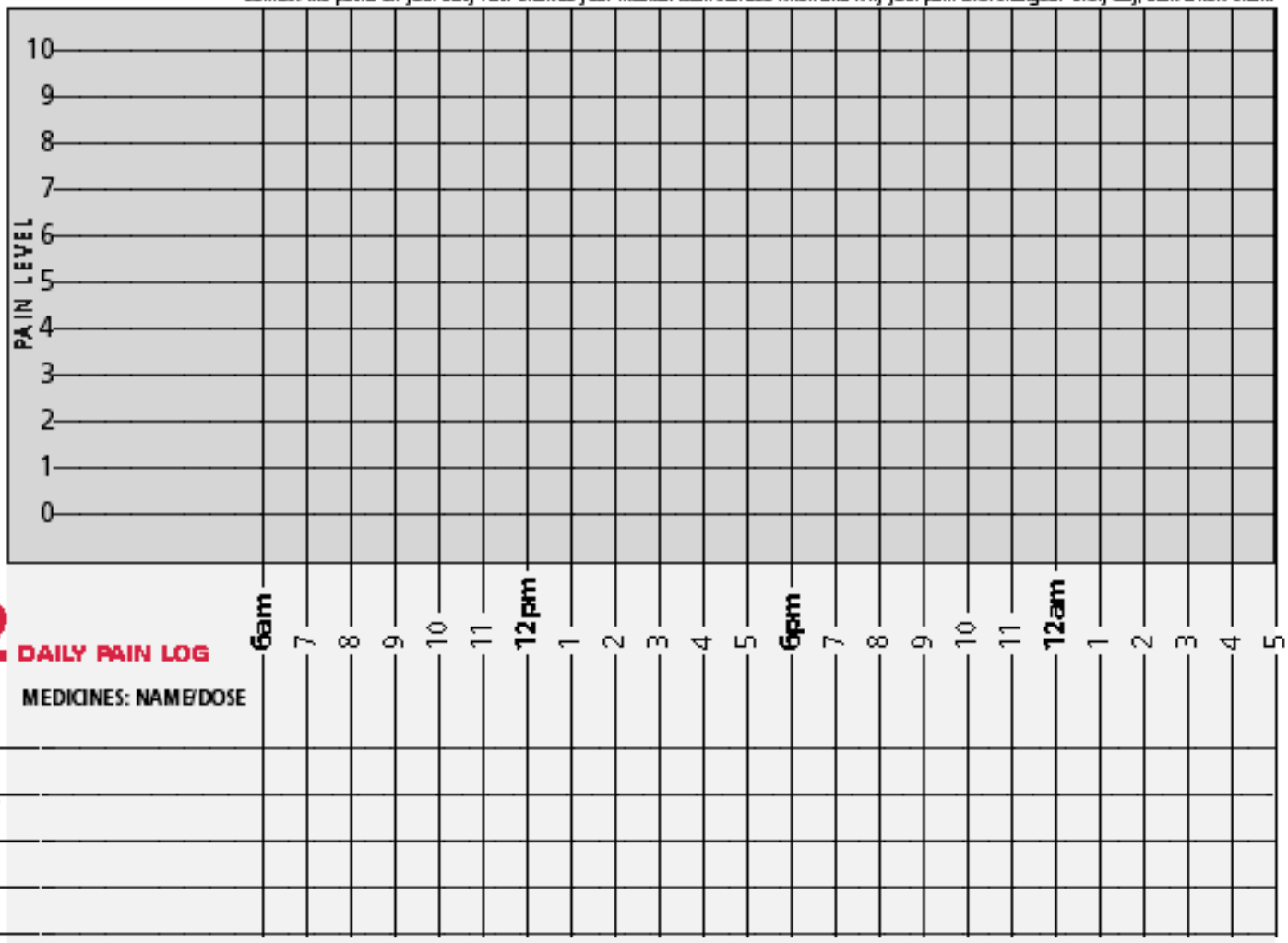
Name _____

Day _____

Date _____

1 DAILY PAIN CHART

Connect the points on your Daily Pain Chart so your medical team can see when and why your pain level changed. Every day, start a new chart.



2 DAILY PAIN LOG

MEDICINES: NAME/DOSE

#1 _____

#2 _____

#3 _____

#4 _____

#5 _____

NON-MEDICINE THERAPY (other than prescription medicines)

ACTIVITIES/EXERCISE

COMMENTS AND MORE INFORMATION: Make notes for and about visits with your healthcare provider, side effects from treatments you may be experiencing, and any problems you are having coping with your pain. You may also want to write more about some of your answers on the previous page.

Name _____

Day _____

Date _____

3 DAILY PAIN SUMMARY

Did you have pain today? ____NO ____YES

Did you avoid or limit any of your activities or cancel plans today because of pain or changes in your pain?

____NO ____YES: **What activities?**

_____

Did you take all your pain medicine today according to instructions? ____NO ____YES

Even though you took your pain medicine for persistent pain on schedule , were there times during the day that you experienced unrelieved breakthrough pain? ____NO ____YES

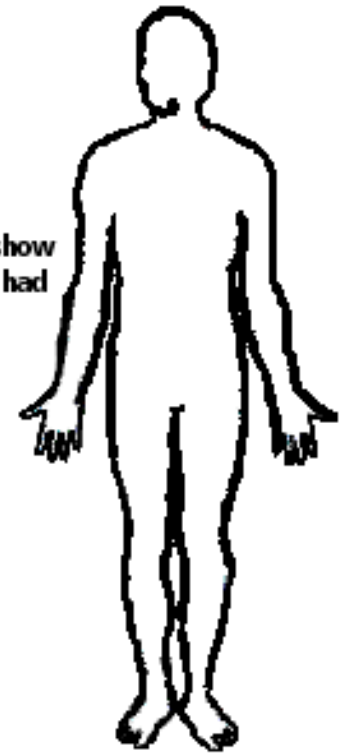
How many times did this happen today?

1 2 3 4 5 6 7 8 9 10 more than 10

Did any specific activity start your breakthrough pain? ____NO ____YES: **What activities?**

_____

Put an "X" on the body diagram to show each place you've had pain today.



What was your average level of pain today?

0 1 2 3 4 5 6 7 8 9 10

Other than prescription medicine, did you do anything else today to relieve the pain?
____NO ____YES **(Check any that you used.)**

____ Non-prescription drugs (e.g., acetaminophen, ibuprofen)
____ Herbal remedies
____ Hot or cold packs
____ Exercise
____ Changing position (such as lying down or elevating your legs)
____ Physical therapy
____ Massage
____ Acupuncture
____ Rest
____ Psychological counseling
____ Talk to trusted friend, family, clergy
____ Prayer, meditation, guided imagery
____ Relaxation technique (hypnosis, biofeedback)
____ Creative technique (art or music therapy)
____ Other (describe):

_____

Check any of these common side effects that you've noticed after taking your pain medicine.

____ Drowsiness, sleepiness
____ Nausea, vomiting, upset stomach
____ Constipation
____ Lack of appetite
____ Other (describe):

_____

Did you skip any of your scheduled pain medicines today? ____NO ____YES: **Why?**

_____

Did you call your doctor's office or clinic between visits because of pain? ____NO ____YES

Overall, are you satisfied with your pain management? ____YES ____NO **(Explain what makes you satisfied or not satisfied. Use Log section.)**

What pain level overall would you find acceptable?

0 1 2 3 4 5 6 7 8 9 10

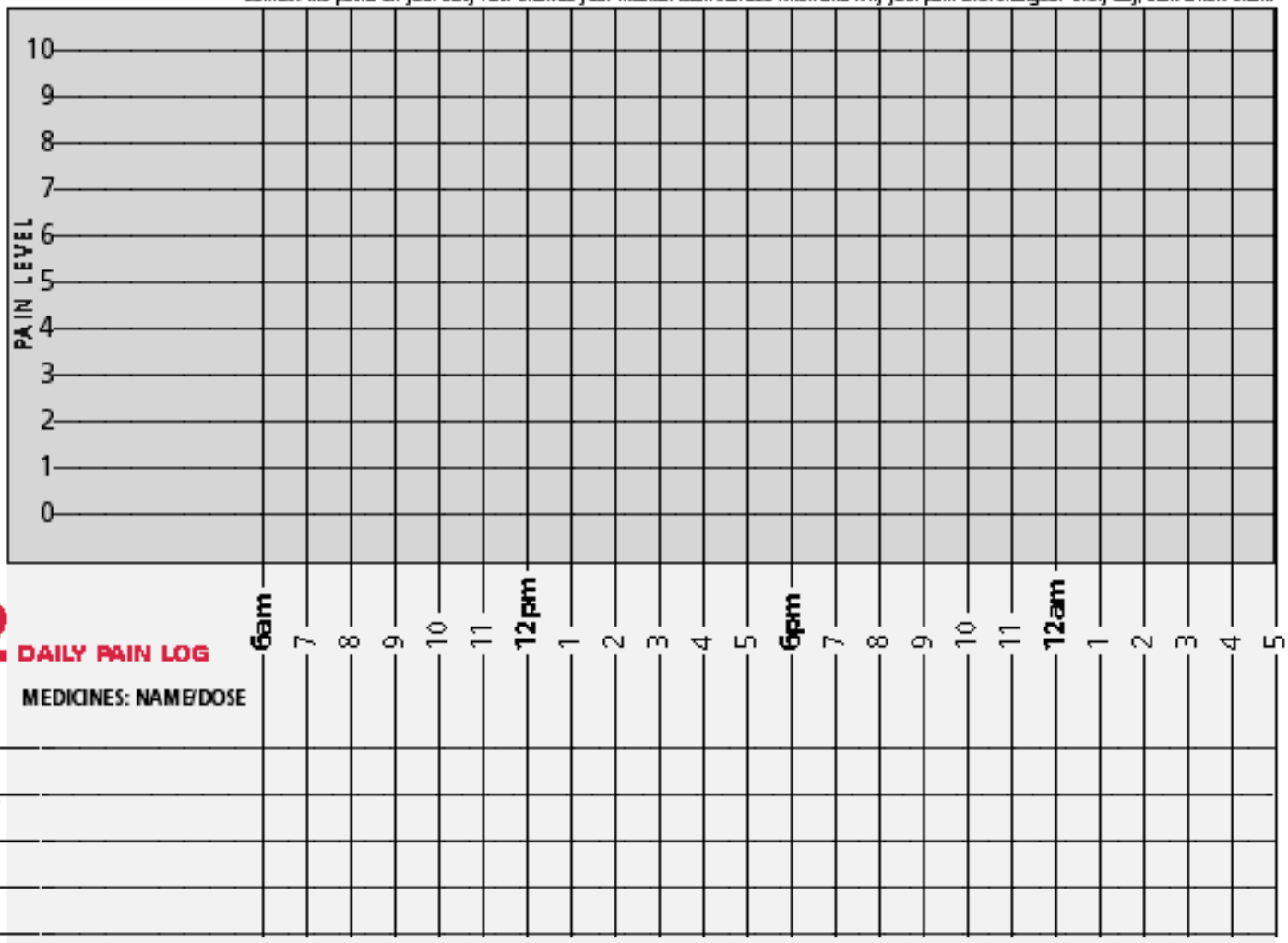
Name _____

Day _____

Date _____

1 DAILY PAIN CHART

Connect the points on your Daily Pain Chart so your medical team can see when and why your pain level changed. Every day, start a new chart.



2 DAILY PAIN LOG

MEDICINES: NAME/DOSE

#1 _____

#2 _____

#3 _____

#4 _____

#5 _____

NON-MEDICINE THERAPY (other than prescription medicines)

ACTIVITIES/EXERCISE

COMMENTS AND MORE INFORMATION: Make notes for and about visits with your healthcare provider, side effects from treatments you may be experiencing, and any problems you are having coping with your pain. You may also want to write more about some of your answers on the previous page.

Name _____

Day _____

Date _____

3 DAILY PAIN SUMMARY

Did you have pain today? ____NO ____YES

Did you avoid or limit any of your activities or cancel plans today because of pain or changes in your pain?

____NO ____YES: **What activities?**

_____

Did you take all your pain medicine today according to instructions? ____NO ____YES

Even though you took your pain medicine for persistent pain on schedule , were there times during the day that you experienced unrelieved breakthrough pain? ____NO ____YES

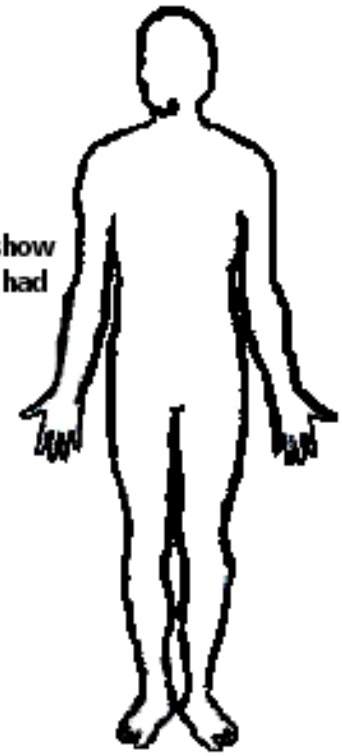
How many times did this happen today?

1 2 3 4 5 6 7 8 9 10 more than 10

Did any specific activity start your breakthrough pain? ____NO ____YES: **What activities?**

_____

Put an "X" on the body diagram to show each place you've had pain today.



What was your average level of pain today?

0 1 2 3 4 5 6 7 8 9 10

Other than prescription medicine, did you do anything else today to relieve the pain?
____NO ____YES **(Check any that you used.)**

____ Non-prescription drugs (e.g., acetaminophen, ibuprofen)
____ Herbal remedies
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____ Massage
____ Acupuncture
____ Rest
____ Psychological counseling
____ Talk to trusted friend, family, clergy
____ Prayer, meditation, guided imagery
____ Relaxation technique (hypnosis, biofeedback)
____ Creative technique (art or music therapy)
____ Other (describe):

_____

Check any of these common side effects that you've noticed after taking your pain medicine.

____ Drowsiness, sleepiness
____ Nausea, vomiting, upset stomach
____ Constipation
____ Lack of appetite
____ Other (describe):

_____

Did you skip any of your scheduled pain medicines today? ____NO ____YES: **Why?**

_____

Did you call your doctor's office or clinic between visits because of pain? ____NO ____YES

Overall, are you satisfied with your pain management? ____YES ____NO **(Explain what makes you satisfied or not satisfied. Use Log section.)**

What pain level overall would you find acceptable?

0 1 2 3 4 5 6 7 8 9 10

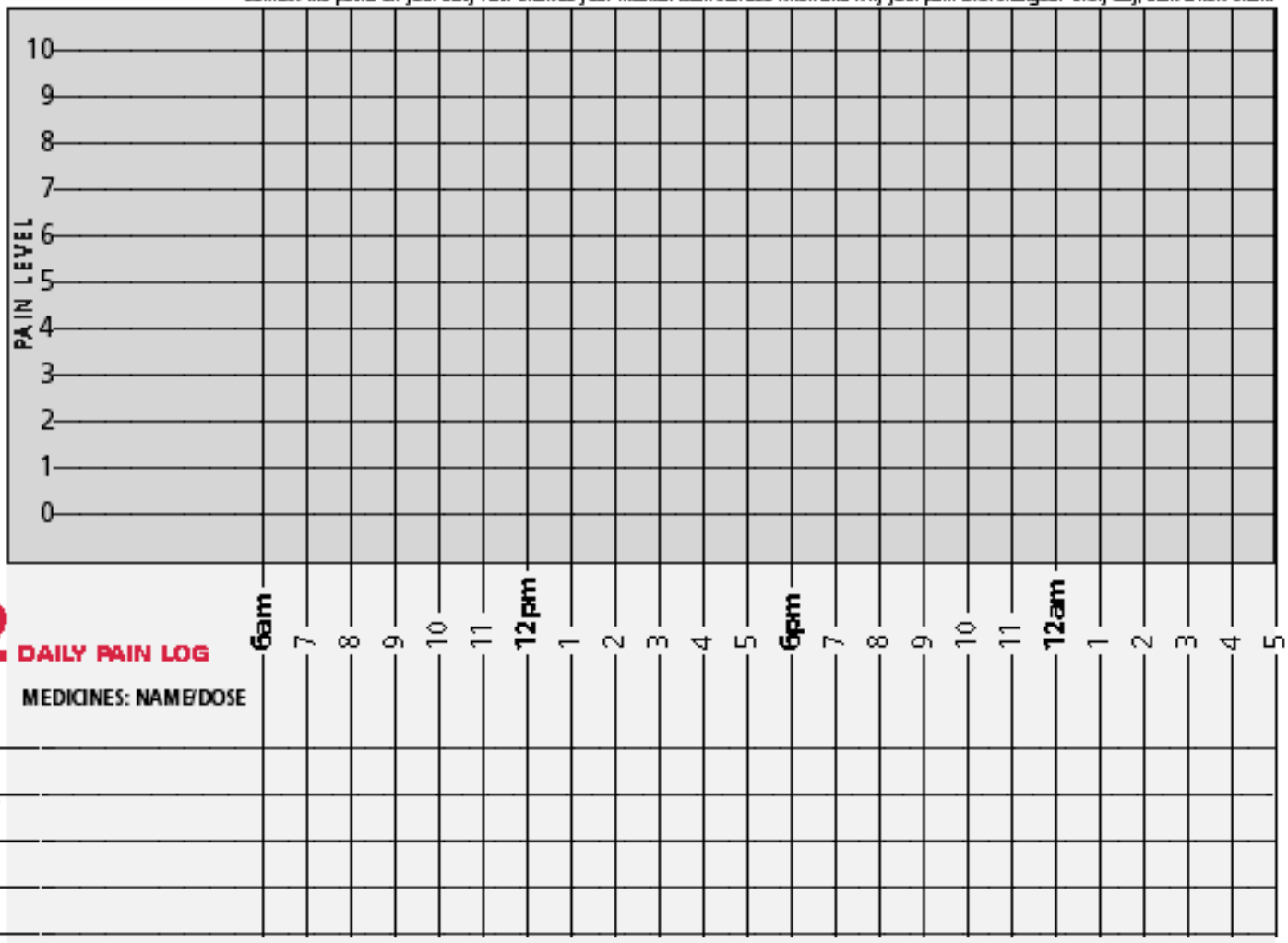
Name _____

Day _____

Date _____

1 DAILY PAIN CHART

Connect the points on your Daily Pain Chart so your medical team can see when and why your pain level changed. Every day, start a new chart.



2 DAILY PAIN LOG

MEDICINES: NAME/DOSE

#1 _____

#2 _____

#3 _____

#4 _____

#5 _____

NON-MEDICINE THERAPY (other than prescription medicines)

ACTIVITIES/EXERCISE

COMMENTS AND MORE INFORMATION: Make notes for and about visits with your healthcare provider, side effects from treatments you may be experiencing, and any problems you are having coping with your pain. You may also want to write more about some of your answers on the previous page.

Name _____

Day _____

Date _____

3 DAILY PAIN SUMMARY

Did you have pain today? ____NO ____YES

Did you avoid or limit any of your activities or cancel plans today because of pain or changes in your pain?

____NO ____YES: **What activities?**

_____

Did you take all your pain medicine today according to instructions? ____NO ____YES

Even though you took your pain medicine for persistent pain on schedule , were there times during the day that you experienced unrelieved breakthrough pain? ____NO ____YES

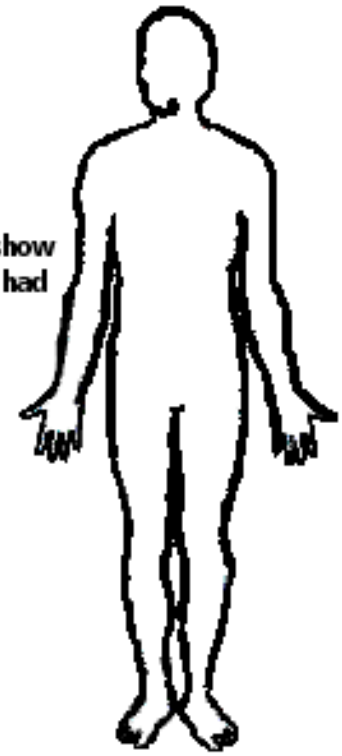
How many times did this happen today?

1 2 3 4 5 6 7 8 9 10 more than 10

Did any specific activity start your breakthrough pain? ____NO ____YES: **What activities?**

_____

Put an "X" on the body diagram to show each place you've had pain today.



What was your average level of pain today?

0 1 2 3 4 5 6 7 8 9 10

Other than prescription medicine, did you do anything else today to relieve the pain?
____NO ____YES **(Check any that you used.)**

____ Non-prescription drugs (e.g., acetaminophen, ibuprofen)
____ Herbal remedies
____ Hot or cold packs
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____ Physical therapy
____ Massage
____ Acupuncture
____ Rest
____ Psychological counseling
____ Talk to trusted friend, family, clergy
____ Prayer, meditation, guided imagery
____ Relaxation technique (hypnosis, biofeedback)
____ Creative technique (art or music therapy)
____ Other (describe):

_____

Check any of these common side effects that you've noticed after taking your pain medicine.

____ Drowsiness, sleepiness
____ Nausea, vomiting, upset stomach
____ Constipation
____ Lack of appetite
____ Other (describe):

_____

Did you skip any of your scheduled pain medicines today? ____NO ____YES: **Why?**

_____

Did you call your doctor's office or clinic between visits because of pain? ____NO ____YES

Overall, are you satisfied with your pain management? ____YES ____NO **(Explain what makes you satisfied or not satisfied. Use Log section.)**

What pain level overall would you find acceptable?

0 1 2 3 4 5 6 7 8 9 10

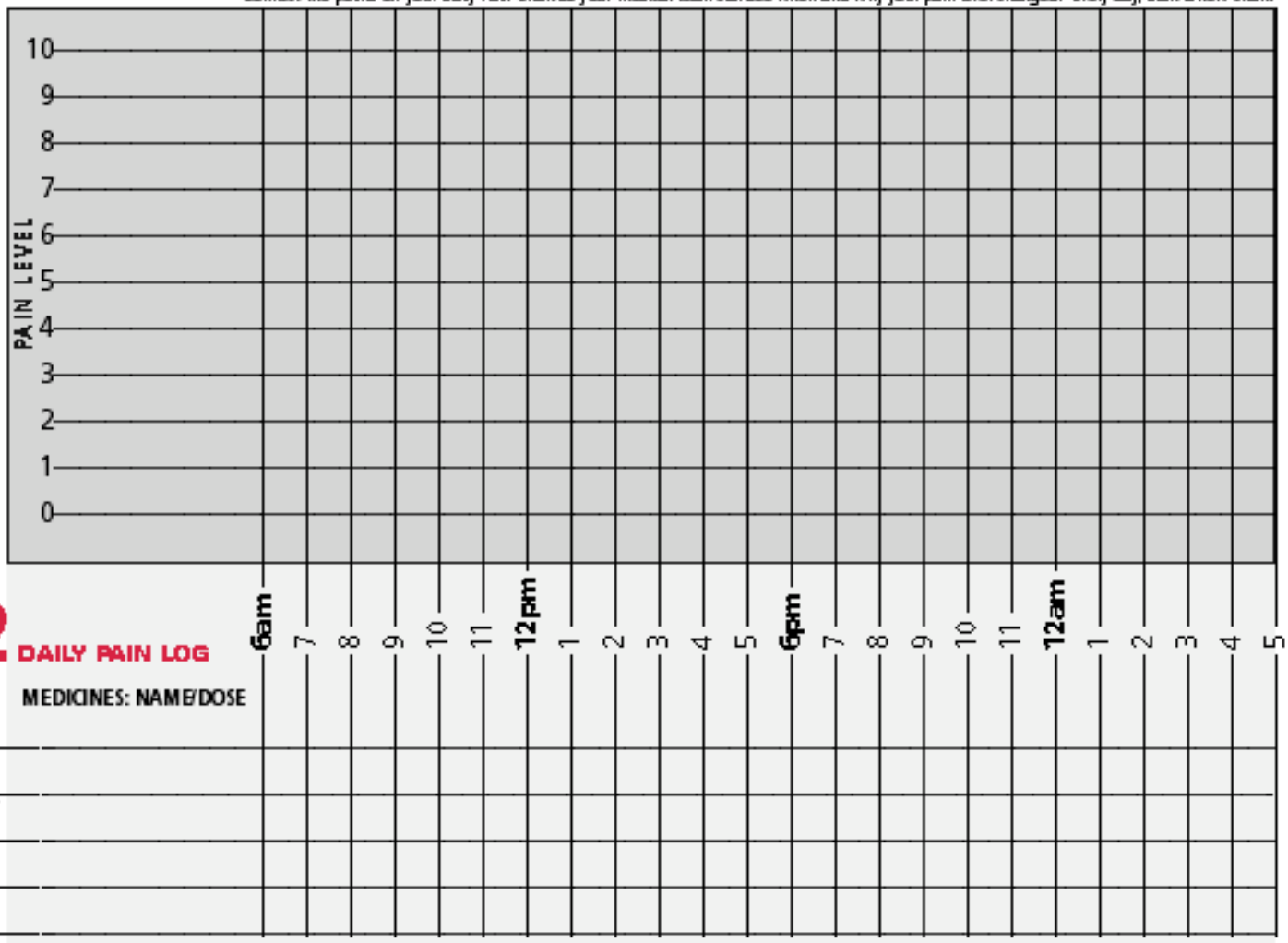
Name _____

Day _____

Date _____

1 DAILY PAIN CHART

Connect the points on your Daily Pain Chart so your medical team can see when and why your pain level changed. Every day, start a new chart.



2 DAILY PAIN LOG

MEDICINES: NAME/DOSE

#1 _____

#2 _____

#3 _____

#4 _____

#5 _____

NON-MEDICINE THERAPY (other than prescription medicines)

ACTIVITIES/EXERCISE

COMMENTS AND MORE INFORMATION: Make notes for and about visits with your healthcare provider, side effects from treatments you may be experiencing, and any problems you are having coping with your pain. You may also want to write more about some of your answers on the previous page.

Name _____

Day _____

Date _____

3 DAILY PAIN SUMMARY

Did you have pain today? ____NO ____YES

Did you avoid or limit any of your activities or cancel plans today because of pain or changes in your pain?

____NO ____YES: **What activities?**

_____

Did you take all your pain medicine today according to instructions? ____NO ____YES

Even though you took your pain medicine for persistent pain on schedule , were there times during the day that you experienced unrelieved breakthrough pain? ____NO ____YES

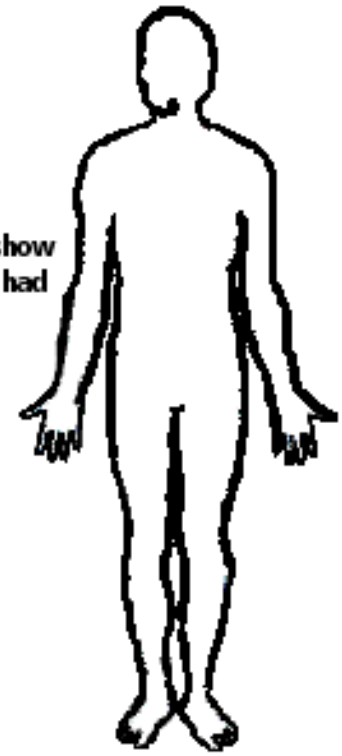
How many times did this happen today?

1 2 3 4 5 6 7 8 9 10 more than 10

Did any specific activity start your breakthrough pain? ____NO ____YES: **What activities?**

_____

Put an "X" on the body diagram to show each place you've had pain today.



What was your average level of pain today?

0 1 2 3 4 5 6 7 8 9 10

Other than prescription medicine, did you do anything else today to relieve the pain?
____NO ____YES **(Check any that you used.)**

____ Non-prescription drugs (e.g., acetaminophen, ibuprofen)
____ Herbal remedies
____ Hot or cold packs
____ Exercise
____ Changing position (such as lying down or elevating your legs)
____ Physical therapy
____ Massage
____ Acupuncture
____ Rest
____ Psychological counseling
____ Talk to trusted friend, family, clergy
____ Prayer, meditation, guided imagery
____ Relaxation technique (hypnosis, biofeedback)
____ Creative technique (art or music therapy)
____ Other (describe):

_____

Check any of these common side effects that you've noticed after taking your pain medicine.

____ Drowsiness, sleepiness
____ Nausea, vomiting, upset stomach
____ Constipation
____ Lack of appetite
____ Other (describe):

_____

Did you skip any of your scheduled pain medicines today? ____NO ____YES: **Why?**

_____

Did you call your doctor's office or clinic between visits because of pain? ____NO ____YES

Overall, are you satisfied with your pain management? ____YES ____NO **(Explain what makes you satisfied or not satisfied. Use Log section.)**

What pain level overall would you find acceptable?

0 1 2 3 4 5 6 7 8 9 10

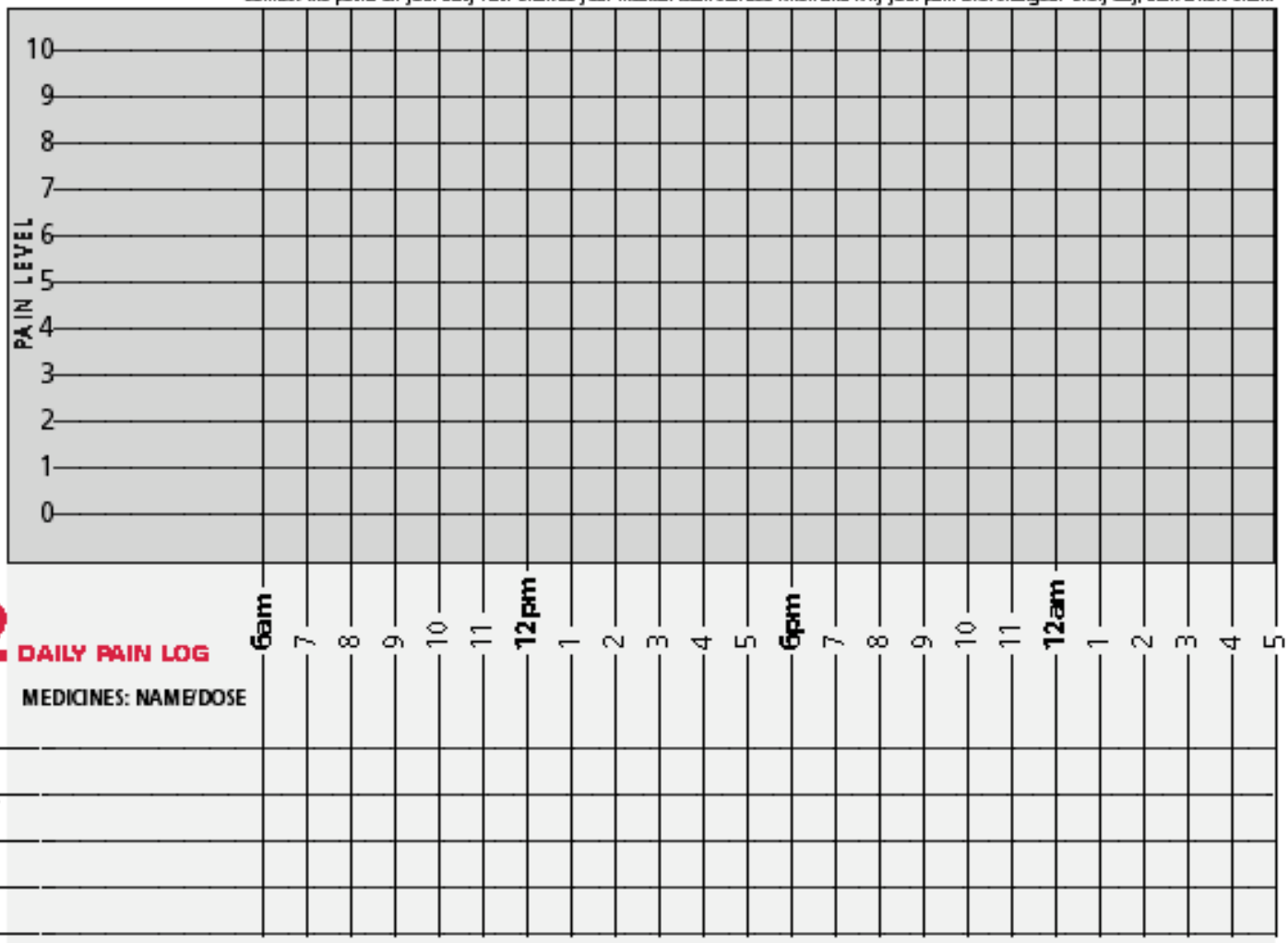
Name _____

Day _____

Date _____

1 DAILY PAIN CHART

Connect the points on your Daily Pain Chart so your medical team can see when and why your pain level changed. Every day, start a new chart.



2 DAILY PAIN LOG

MEDICINES: NAME/DOSE

#1 _____

#2 _____

#3 _____

#4 _____

#5 _____

NON-MEDICINE THERAPY (other than prescription medicines)

ACTIVITIES/EXERCISE

COMMENTS AND MORE INFORMATION: Make notes for and about visits with your healthcare provider, side effects from treatments you may be experiencing, and any problems you are having coping with your pain. You may also want to write more about some of your answers on the previous page.

Name _____

Day _____

Date _____

3 DAILY PAIN SUMMARY

Did you have pain today? ____NO ____YES

Did you avoid or limit any of your activities or cancel plans today because of pain or changes in your pain?

____NO ____YES: **What activities?**

_____

Did you take all your pain medicine today according to instructions? ____NO ____YES

Even though you took your pain medicine for persistent pain on schedule , were there times during the day that you experienced unrelieved breakthrough pain? ____NO ____YES

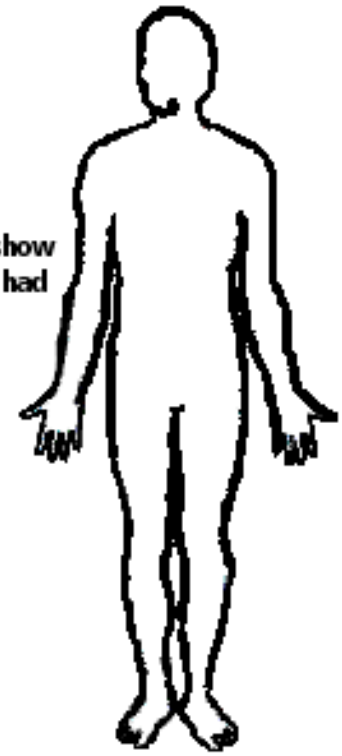
How many times did this happen today?

1 2 3 4 5 6 7 8 9 10 more than 10

Did any specific activity start your breakthrough pain? ____NO ____YES: **What activities?**

_____

Put an "X" on the body diagram to show each place you've had pain today.



What was your average level of pain today?

0 1 2 3 4 5 6 7 8 9 10

Other than prescription medicine, did you do anything else today to relieve the pain?
____NO ____YES **(Check any that you used.)**

____ Non-prescription drugs (e.g., acetaminophen, ibuprofen)
____ Herbal remedies
____ Hot or cold packs
____ Exercise
____ Changing position (such as lying down or elevating your legs)
____ Physical therapy
____ Massage
____ Acupuncture
____ Rest
____ Psychological counseling
____ Talk to trusted friend, family, clergy
____ Prayer, meditation, guided imagery
____ Relaxation technique (hypnosis, biofeedback)
____ Creative technique (art or music therapy)
____ Other (describe):

_____

Check any of these common side effects that you've noticed after taking your pain medicine.

____ Drowsiness, sleepiness
____ Nausea, vomiting, upset stomach
____ Constipation
____ Lack of appetite
____ Other (describe):

_____

Did you skip any of your scheduled pain medicines today? ____NO ____YES: **Why?**

_____

Did you call your doctor's office or clinic between visits because of pain? ____NO ____YES

Overall, are you satisfied with your pain management? ____YES ____NO **(Explain what makes you satisfied or not satisfied. Use Log section.)**

What pain level overall would you find acceptable?

0 1 2 3 4 5 6 7 8 9 10

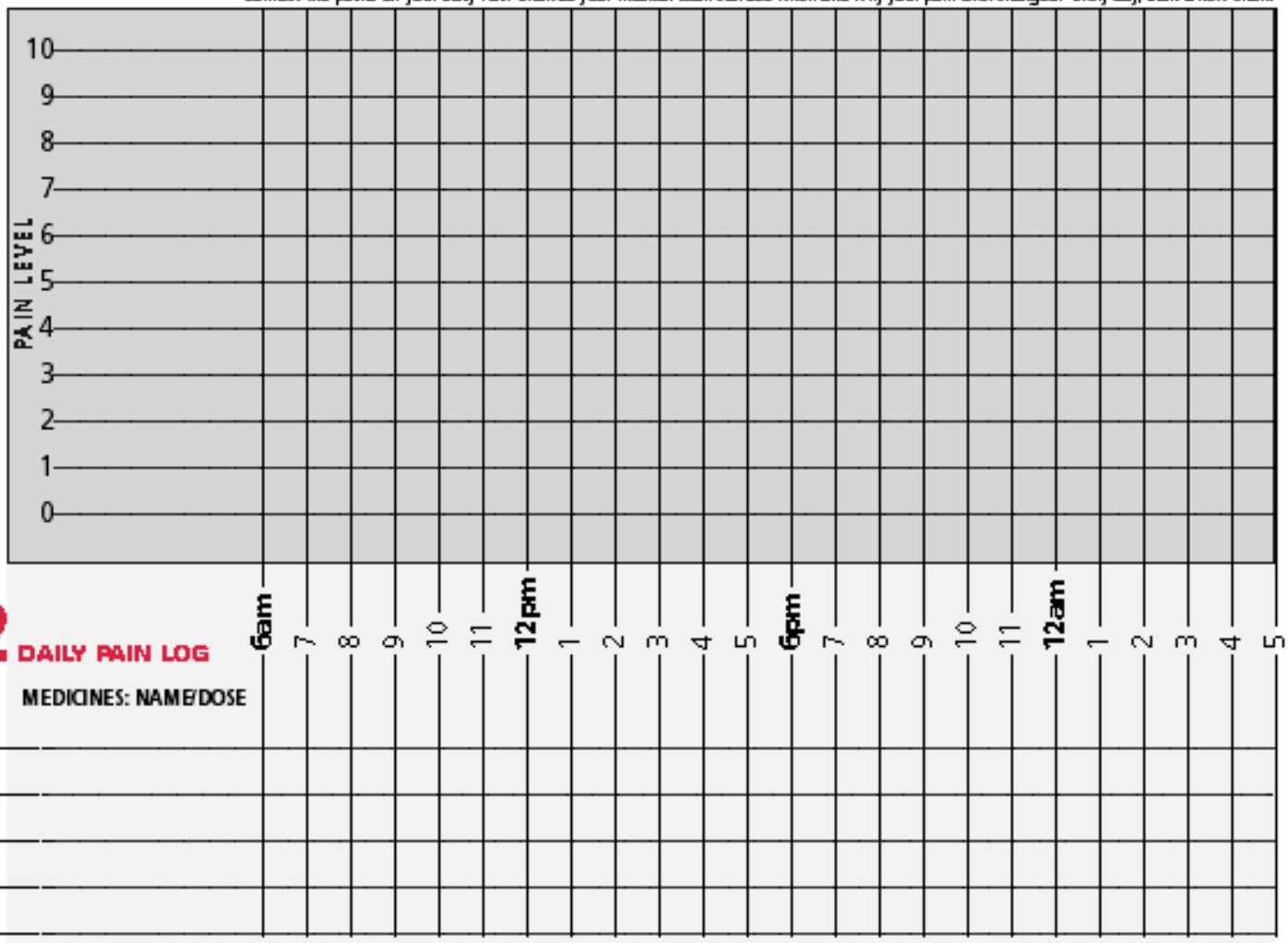
Name _____

Day _____

Date _____

1 DAILY PAIN CHART

Connect the points on your Daily Pain Chart so your medical team can see when and why your pain level changed. Every day, start a new chart.



2 DAILY PAIN LOG

MEDICINES: NAME/DOSE

#1 _____

#2 _____

#3 _____

#4 _____

#5 _____

NON-MEDICINE THERAPY (other than prescription medicines)

ACTIVITIES/EXERCISE

COMMENTS AND MORE INFORMATION: Make notes for and about visits with your healthcare provider, side effects from treatments you may be experiencing, and any problems you are having coping with your pain. You may also want to write more about some of your answers on the previous page.

Name _____

Day _____

Date _____

3 DAILY PAIN SUMMARY

Did you have pain today? ____NO ____YES

Did you avoid or limit any of your activities or cancel plans today because of pain or changes in your pain?

____NO ____YES: **What activities?**

_____

Did you take all your pain medicine today according to instructions? ____NO ____YES

Even though you took your pain medicine for persistent pain on schedule , were there times during the day that you experienced unrelieved breakthrough pain? ____NO ____YES

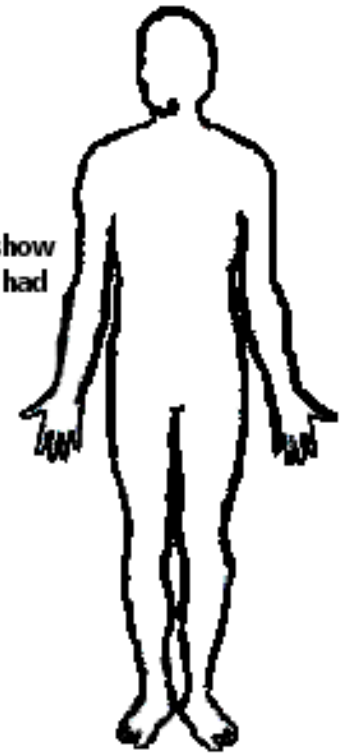
How many times did this happen today?

1 2 3 4 5 6 7 8 9 10 more than 10

Did any specific activity start your breakthrough pain? ____NO ____YES: **What activities?**

_____

Put an "X" on the body diagram to show each place you've had pain today.



What was your average level of pain today?

0 1 2 3 4 5 6 7 8 9 10

Other than prescription medicine, did you do anything else today to relieve the pain?
____NO ____YES **(Check any that you used.)**

____ Non-prescription drugs (e.g., acetaminophen, ibuprofen)
____ Herbal remedies
____ Hot or cold packs
____ Exercise
____ Changing position (such as lying down or elevating your legs)
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____ Other (describe):

_____

Check any of these common side effects that you've noticed after taking your pain medicine.

____ Drowsiness, sleepiness
____ Nausea, vomiting, upset stomach
____ Constipation
____ Lack of appetite
____ Other (describe):

_____

Did you skip any of your scheduled pain medicines today? ____NO ____YES: **Why?**

_____

Did you call your doctor's office or clinic between visits because of pain? ____NO ____YES

Overall, are you satisfied with your pain management? ____YES ____NO **(Explain what makes you satisfied or not satisfied. Use Log section.)**

What pain level overall would you find acceptable?

0 1 2 3 4 5 6 7 8 9 10

Notes

Learn More About Pain Relief

- American Pain Foundation (useful information and links to disease-specific information)
  www.painfoundation.org 888-615-PAIN
- American Academy of Pain Medicine
  www.painmed.org 847-375-4731
- American Academy of Pain Management
  www.aapainmanage.org 209-533-9744
- American Alliance of Cancer Pain Initiatives (find listings of state initiatives)
  www.aacpi.wisc.edu 608-265-4013
- American Board of Pain Medicine
  www.abpm.org 847-375-4726
- American Chronic Pain Association
  www.theacpa.org 800-533-3231
- American Pain Society
  www.ampainsoc.org 847-375-4715
- American Society of Pain Management Nursing
  www.aspmn.org 888-342-7766
- Cancer Care
  www.cancercare.org 800-813-4673
- Case Management Resource Guide
  www.cmrg.com 800-784-2332
- Commission on Accreditation of Rehabilitation Facilities
  www.carf.org 520-325-1044
- Mayo Clinic Pain Management Center
  www.mayoclinic.com/findinformation/diseasesandconditions/index.cfm
- National Cancer Institute
  www.nci.nih.gov/cancerinfo 800-422-6237
- National Chronic Pain Society
  www.ncps-cpr.org 281-357-4673
- National Hospice and Palliative Care Organization
  www.nhpco.org 703-837-1500
- National Pain Foundation
  www.nationalpainfoundation.org 303-756-0889
- Pain.com
  www.pain.com

Advisory Board

The Pain Notebook was developed in collaboration with:

Sally Adelus, DN Cert., RN, SRN
Hospice of the Valley
San Jose, California

Micke A. Brown, BSN, RN
American Pain Foundation
Baltimore, Maryland

Christine Miaskowski, PhD, RN, FAAN
University of California, San Francisco
San Francisco, California

Guadalupe Palos, DrPH, LMSW, RN
Department of Symptom Research
The University of Texas
M.D. Anderson Cancer Center
Houston, Texas

Michelle Rhiner, MSN, RN, NP
City of Hope National Medical Center
Duarte, California

Feedback!

We welcome your feedback on the Pain Notebook. Is it easy to use? Is it useful? Please send comments and suggestions to: painnotebook@painfoundation.org

American Pain Foundation • 201 N. Charles St., Suite 710
Baltimore, MD 21201-4111 • 1-888-615-PAIN(7246)
info@painfoundation.org • www.painfoundation.org

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