WorkSafeNB Opioid Review Process

The Opioid Review Process was developed by WorkSafeNB, in cooperation with the New Brunswick Medical Society (NBMS) and the New Brunswick Pharmacists' Association.

Opioids as a class of pharmaceuticals have both benefits and side effects which health professionals and regulatory bodies are encouraged to monitor and document.

Payment by WorkSafeNB for this agent was rejected, and additional information is required in order for payment to be considered.

Please work through the following pages with your patient. Fax all completed documents (pharmacists-3, physicians-4) to WorkSafeNB at **1 888 629-4722**. Keep the original in your chart / file.

Please note:
The information requested is based upon a reasonable standard of medical practice in the province of New Brunswick. The Review Process was developed according to the principles and guidelines of the Canadian Pain Society. A complete list of references can be found at **http://www.worksafenb.ca.** Go to the Health Care Providers section (tab at the top).

WORKSAFENB CONTACT INFORMATION

Claimant Inquiry Line
Toll free: 1 800 222-9775

Pharmacist / Physicians Inquiry Line
Toll free: 1-877 647-0777

Authorization is dependent upon receipt of forms from pharmacist and physician.
WorkSafeNB is unable to grant telephone authorization.

WorkSafeNB Opioid Review Process (PHARMACIST)

With the assistance of your client, please complete the following information.

Date: _____ WorkSafeNB Pharmacy Payee No. _____

HISTORY

Has WorkSafeNB paid for this medication before: ☐ Y ☐ N

If yes, when? (Date): _____

Has your patient completed any other WorkSafeNB Opioid Review Forms? ☐ Y ☐ N

If yes, reason for additional review. ☐ New Primary Pharmacy ☐ Primary Pharmacy Closed

_____

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Telephone: _____

Pharmacist Name: _____

PRESCRIPTION INFORMATION

Prescription Date: _____

Drug name and strength: _____

Quantity: _____

Scheduled Dosage: _____ tablets _____ times per day

Prescribing Physician: _____

What is the reason for the prescription? _____

CLIENT INFORMATION

Client Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

WorkSafeNB Claim Number: _____

Medicare Number: _____

Does client have a regular primary care physician? ☐ Yes ☐ No

INJURY INFORMATION

Date of Injury: _____

Employer: _____

WorkSafeNB Opioid Review Process (PHARMACIST) cont'd

REASON FOR REJECTION by E-Pay

What computer message was provided when the payment was denied? (Please check)

☐ patient has reached quantity limit or patient over quantity limit
☐ drug is a non-benefit
☐ multiple physicians prescribing and/or pharmacies dispensing

Action Items: Please work through the following checklist with your client, and initial each section to indicate completion.

1.

EXPLAIN: The completion of this **Opioid Review Process** is needed because either or both of the following are true: the prescribed quantities of this agent exceed established guidelines, and/or there is an issue with the duration or timeframe of your prescription.

☐ Pharmacist initial

2.

EXPLAIN: The **Opioid Review Process** was developed in cooperation with WorkSafeNB and New Brunswick doctors and pharmacists to ensure the highest standard of practice around the use of this class of medications.

☐ Pharmacist initial

3.

EXPLAIN: The **Opioid Review Process** is required for these agents to help educate patients about the potential side effects, dependency and addiction to this class of agents.

☐ Pharmacist initial

4.

EXPLAIN: This class of medication is often diverted from its intended use, which contributes to crime and negative social consequences in our communities. All parties must take some responsibility.

☐ Pharmacist initial

5.

EXPLAIN: WorkSafeNB requires me to report any problems of abuse or intimidation whether in person, writing, phone or electronically.

☐ Pharmacist initial

6.

COMPLETE: Appendix 1: Informed Consent.

☐ Pharmacist initial

WorkSafeNB Opioid Review Process (PHARMACIST) cont'd

7.
COMPLETE: Appendix 2: Opioid Therapeutic Agreement.

☐ Pharmacist initial

Client Action
With your client, please indicate which of the following next steps they will pursue.
Please check one and have your client sign that option.

☐ A. Prescription withdrawn

Prescription withdrawn by client. They will seek alternative therapy with their medical doctor.

Client signature _____

or

☐ B. Prescription paid for by patient

Opioid Review documents will be submitted to WorkSafeNB with the understanding that WorkSafeNB is not under an obligation to reimburse the client. The client will have their prescribing physician complete the DOCTOR part of the Opioid Review Process and return it to WorkSafeNB.

Client signature _____

or

☐ C. Prescription on hold until WorkSafeNB review completed

Opioid Review documents will be submitted to WorkSafeNB with the understanding that WorkSafeNB is **not** under an obligation to reimburse the client. The client will have their prescribing physician complete the DOCTOR part of the **Opioid Review Process** and return it to WorkSafeNB. Review by the medical advisor will occur after receipt of forms from pharmacist and physician.

Client signature _____

Drug Name: _____

DIN: _____

Quantity: _____

Signed:

_____ (Pharmacist Name)

_____ (DATE)

_____ (Pharmacy Phone Number)

Fee: WorkSafeNB will pay the pharmacy education fee per claim per year upon receipt of all three pharmacy sections. Each section must be complete.

WorkSafeNB Opioid Review Process (PHARMACIST) cont'd

APPENDIX 1: INFORMED CONSENT

Please discuss opioid therapy with your client, using the following suggested points of discussion.

1.

Describe and explain the purpose of opioid therapy (including the concept of **less pain rather than no pain** and **functional goals needed**) with the client, along with explaining the common side effects and their management. Preventative management of constipation should specifically be discussed. The risk of addiction should be addressed and differentiated from tolerance and physical dependence. Warn the client regarding withdrawal symptoms due to abrupt discontinuation of opioids. Discuss the concept of dose titration and the importance of **time-contingent dosing** versus **as required dosing** for around-the-clock pain. Discuss the appropriate use of breakthrough medication.

☐ Pharmacist initial

2.

Advise the client that drowsiness is a common side effect during titration of opioid therapy. The client should not drive a car or operate dangerous machinery until this phase of drowsiness has passed. Failure to comply with this advice may result in a duty to report to the provincial Ministry of Transportation.

☐ Pharmacist initial

3.

The client should be warned not to change the dosage of the opioid analgesic nor the dosing interval without specific instructions from the doctor. The client should be made aware that such unsanctioned dosage changes may compromise the pharmacist-patient relationship.

☐ Pharmacist initial

4.

Inform the client that regular follow-up appointments are required to monitor the effectiveness of opioid treatment, and to manage side effects. The frequency of follow-up appointments will vary depending on the phase of treatment – titration versus stable dosing.

☐ Pharmacist initial

5.

Inform the client that prescriptions for opioid analgesics should be obtained only from one physician or, in the absence of that physician, his or her designate. The client should have all prescriptions for psychoactive medication dispensed at one pharmacy, except in emergencies. Inform the client and/or guardian that seeking opioid treatment from other physicians and pharmacies without informing the prescribing physician undermines the trust essential to prescribing long-term opioid therapy.

☐ Pharmacist initial

6.
Advise the client to keep the opioid analgesics in a safe and secure place, and to not give, lend or sell the medication to anyone.

☐ Pharmacist initial

7.
Warn the client that there is a potential for significant cognitive dysfunction if opioids are combined with sedatives such as benzodiazepines, barbiturates, muscle relaxants, alcohol or other drugs. The client and/or guardian should be warned not to consume any of the above substances without first discussing this with the physician.

☐ Pharmacist initial

8.
Although the potential for abuse or addiction to prescribed opioid analgesics is small in low risk patients, the concurrent abuse of illicit substances such as marijuana, cocaine, stimulants, hallucinogens, heroin or the consumption of alcohol in a high risk pattern identifies an individual at increased risk of also abusing opioids. The use of these substances may also interfere with the therapeutic effect of opioids or cause increased side effects such as cognitive dysfunction. It is therefore advisable that the client abstain from taking any psychoactive substances without first discussing this with the physician.

☐ Pharmacist initial

9.
Inform the client that, aside from better pain control, a key measure of the efficacy of long term opioid therapy is improved physical and psychological function at home and/or work. The client and the physician may, therefore, discuss a set of reasonable specific functional goals. The physician will assess progress towards these goals at each visit and will use this information in evaluating the overall success of long-term opioid therapy. **Lack of functional improvement or persistent functional decline on opioids may result in re-evaluation of the patient and a reassessment of the treatment plan.**

☐ Pharmacist initial

REVIEWED AND COMPLETED BY:

Pharmacist Name: _____

Date: _____

Has their physician previously reviewed this information with your client? ☐ Y ☐ N

Pharmacist Signature: _____

Confirmed by Client (Signature): _____

WorkSafeNB Opioid Review Process (PHARMACIST) cont'd

APPENDIX 2: OPIOID THERAPEUTIC AGREEMENT

Please have your client complete the following.

1. I, _____, (patient Name) agree that Dr. _____ (Prescribing Doctor) will be the only physician prescribing OPIOID (also known as NARCOTIC) pain medication. My Pharmacy will be _____ at _____ (address).

2. I will take the medication at the dose and frequency prescribed by my physician. I agree not to increase the dose of opioids on my own and understand that doing so may lead to the treatment with opioids being stopped.

3. I will attend all appointments, treatments and consultations as requested by my physician.

4. I will not receive opioid pain medications from any other physician except in an emergency or in the unlikely event that I run out of medication. Should such occasions occur, I will inform my prescribing physician as soon as possible.

5. I understand that the common side effects of opioid therapy include nausea, constipation, sweating and itchiness of the skin. Drowsiness may occur when starting opioids therapy or when increasing the dosage. I agree to refrain from driving a motor vehicle or operating dangerous machinery until such drowsiness disappears.

6. I understand that there is a small risk that I may become addicted to the opioids I am being prescribed. As such, my physician may require that I have additional tests and/or see a specialist in addiction should a concern about addiction arise during my treatment.

7. I understand that the use of any mood-modifying substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens), can cause adverse effects or interfere with opioid therapy. Therefore, I agree to refrain from the use of all of these substances without first discussing it with my physician.

8. I agree to be responsible for the secure storage of my medication at all times. I agree not to provide my prescribed pain medication to any other person.

9. If I break this agreement, my physician reserves the right to stop prescribing opioid medications for me.

10. I hereby agree that my physician has the authority to disclose the prescribing information in my patient file to other health care professionals when it is deemed medically necessary in the physician's judgment.

PLEASE COMPLETE THE FOLLOWING:

Client Signature: _____

Pharmacist Signature: _____

Physician's Name: _____

Principal Pharmacy: _____

Address: _____Date: _____

WorkSafeNB Opioid Review Process (DOCTOR)

Date: _____ WorkSafeNB Physician Payee No. _____

Opioids as a class of pharmaceuticals have both benefits and side effects which health professionals and regulatory bodies are encouraged to monitor and document.

Payment for your patient's Opioid prescription was denied by WorkSafeNB due to one of the following:
a) Quantity limits exceeded;
b) The duration or timeframe of the prescription requires further clinical information; or
c) Multiple physicians prescribing and/or pharmacies dispensing.

Additional information is required in order for payment to be considered. Your patient was asked to make an appointment to complete this form, including the appendices. This form replaces the regular progress form. You do **not** have to submit a Form 10 or Form 10P for this visit.

PATIENT INFORMATION

Name: _____

WorkSafeNB Claim Number: _____

1.
Opioid prescription information Drug name _____

Quantity _____

Opioid prescription is ☐ for compensable injury – please complete all documents before faxing all pages.

☐ not for compensable injury – please sign and fax all pages.

2.
Pain Generator: The duration of pain symptoms
☐ as expected, or ☐ exceeded expected duration.
Based on the injury, the pain severity is
☐ as expected or ☐ greater than expected.
The patient reports that he or she is worse with activity:
☐ no ☐ yes.
The patient reports that nothing seems to help:
☐ no ☐ yes.
The patient reports that pain is getting worse over time:
☐ no ☐ yes.

3.
Primary Pain-Generator – Support for Objective Biological model:
☐ DEFINITIVE SUPPORT
Objective findings of pain generator confirmed both clinically and on correlating investigations.

☐ MODERATE SUPPORT
Positive clinical assessment but **no** objective supportive findings on investigations.

☐ MINIMAL SUPPORT
Negative exam and negative investigations

Describe _____

4.
Clinical Diagnosis: ☐ Certain ☐ Complex & Multi-factorial ☐ Uncertain

5.
Trial of Physical modalities (exercise, ROM, TENS) used:
☐ Yes ☐ No

6.
Trial of Step Ladder approach used with other non-opioid classes of medications:
☐ Yes ☐ No

7.
Are other medical professionals involved (physio, specialist, chiro, cadre, psychologist):
☐ Yes ☐ No

if yes, who?_____

8.
Neuropathic pain origin: ☐ Yes ☐ No

If yes, have adjuvents such as TCA and anticonvulsants used:
☐ Yes ☐ No

9.
EXPLAIN: WorkSafeNB requires me to report any problems of abuse or intimidation whether in person, writing, phone or electronically.

10.
Appendix 1: Addiction Screening completed:
☐ Yes ☐ No

11.
Appendix 2: Informed Consent completed:
☐ Yes ☐ No

12.
Appendix 3: Opioid Therapeutic Agreement completed:
☐ Yes ☐ No

I, Dr. _____, confirm the above information is accurate with evidence and documentation of the above being contained and available on the permanent office record of the above noted patient's file. I am aware of the physiologic effects of this class of agents (opioids) and practice in accordance with the Federal and Provincial Regulations that govern these agents.

Signed:

_____, MD

_____ (DATE)

Fee: upon receipt of all four physician sections, WorkSafeNB will pay the office visit fee until a contract fee is established. Each section must be complete to qualify for reimbursement by WorkSafeNB.

WorkSafeNB Opioid Review Process (DOCTOR)

APPENDIX 1: OPIOID RISK TOOL

Suggested addiction screening questions

In screening patients with chronic non-cancer pain for addiction risk, the clinician is primarily interested in assessing for patients with a history of alcohol abuse/dependence or with a history of polydrug abuse. A patient who has a past history of abusing one substance is at higher risk for abusing other psychoactive substances. The purpose of screening is not to deny patients opioids for pain, but to identify the small subgroup at higher risk for more detailed assessment and more careful monitoring.

The "Opioid Risk Tool" is a screening for risk of addiction to opioids.

Table 1. Opioid Risk Tool[1]:

FACTOR	MALE PATIENTS	FEMALE PATIENTS
Family history of substance abuse		
• Alcohol	❑ 3 points	❑ 1 point
• Illegal drugs	❑ 3 points	❑ 2 points
• Prescription drugs	❑ 4 points	❑ 4 points
Personal history of substance abuse		
• Alcohol	❑ 3 points	❑ 3 points
• Illegal drugs	❑ 4 points	❑ 4 points
• Prescription drugs	❑ 5 points	❑ 5 points
Age between 16 and 45	❑ 1 point	❑ 1 point
History of preadolescent sexual abuse	❑ 0 point	❑ 3 points
Psychiatric disease		
• Attention deficit disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia	❑ 2 points	❑ 2 points
• Depression	❑ 1 point	❑ 1 point

[1] Webster LR, Webster RM. Predicting aberrant behaviours in opioid-treated patients: validation of the Opioid Risk Tool. *Pain Med* 2005;6(6):432-42.

Total Score	Sum:	Sum:

Low Risk (0-3) ❑ Moderate Risk (4-7) ❑ High Risk (8 or greater) ❑

REVIEWED BY:

Patient Signature: _____

Physician Signature: _____

WorkSafeNB Opioid Review Process (DOCTOR)

APPENDIX 2: INFORMED CONSENT

Please discuss opioid therapy with your patient, using the following suggested points of discussion.

1.

Describe and explain the purpose of opioid therapy (**less pain rather than no pain** and **functional goals needed**) with the patient, along with explaining the common side effects and their management. Preventative management of constipation should specifically be discussed. The risk of addiction should be addressed and differentiated from tolerance and physical dependence. Warn the patient regarding withdrawal symptoms due to abrupt discontinuation of opioids. Discuss the concept of dose titration and the importance of **time-contingent dosing** versus **as required dosing** for around-the-clock pain. Discuss the appropriate use of breakthrough medication.

☐ MD initials

2.

Advise the patient that drowsiness is a common side effect during titration of opioid therapy. The patient should not drive a car or operate dangerous machinery until this phase of drowsiness has passed. Failure to comply with this advice may result in a duty to report to the provincial Ministry of Transportation.

☐ MD initials

3.

The patient should be warned not to change the dosage of opioid analgesic nor the dosing interval without specific instructions from the doctor. The patient should be made aware that such unsanctioned dosage changes may compromise the physician-patient relationship.

☐ MD initials

4.

Inform the patient that regular follow-up appointments are required to monitor the effectiveness of opioid treatment and to manage side effects. The frequency of follow-up appointments will vary depending on the phase of treatment – titration versus stable dosing.

☐ MD initials

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☐ MD initials

6.
Advise the patient to keep the opioid analgesics in a safe and secure place, and to not give, lend or sell the medication to anyone.

☐ MD initials

7.
Warn the patient that there is a potential for significant cognitive dysfunction if opioids are combined with sedatives such as benzodiazepines, barbiturates, muscle relaxants, or alcohol. The patient and/or guardian should be warned not to consume any of the above substances without first discussing this with the physician.

☐ MD initials

8.
Although the potential for abuse or addiction to prescribed opioid analgesics is small in low risk patients, the concurrent abuse of illicit substances such as marijuana, cocaine, stimulants, hallucinogens, heroin or the consumption of alcohol in a high risk pattern identifies an individual at increased risk of also abusing opioids. The use of these substances may also interfere with the therapeutic effect of opioids or cause increased side effects such as cognitive dysfunction. It is therefore advisable that the patient abstain from taking any psychoactive substances without first discussing this with the physician.

☐ MD initials

9.
Inform the patient that, aside from better pain control, a key measure of the efficacy of long term opioid therapy is improved physical and psychological function at home and/or work. The patient and the physician may, therefore, discuss a set of reasonable specific functional goals. The physician will assess progress towards these goals at each visit and will use this information in evaluating the overall success of long-term opioid therapy. **Lack of functional improvement or persistent functional decline on opioids may result in re-evaluation of the patient and a reassessment of the treatment plan.**

☐ MD initials

REVIEWED AND COMPLETED BY:

Physician Name: _____

Date: _____

Has their pharmacist previously reviewed this information with your client? ☐ Y ☐ N

Physician Signature: _____

Confirmed by Client (Signature): _____

WorkSafeNB Opioid Review Process (DOCTOR)

APPENDIX 3: OPIOID THERAPEUTIC AGREEMENT

Please have your patient complete the following.

1. I, _____, (patient name) agree that Dr _____ (Prescribing Doctor) will be the only physician prescribing OPIOID (also known as NARCOTIC) pain medication. My Pharmacy will be _____ at _____ (address).

2. I will take the medication at the dose and frequency prescribed by my physician. I agree not to increase the dose of opioids on my own and understand that doing so may lead to the treatment with opioids being stopped.

3. I will attend all appointments, treatments and consultations as requested by my physician.

4. I will not receive opioid pain medications from any other physician except in an emergency or in the unlikely event that I run out of medication. Should such occasions occur, I will inform my prescribing physician as soon as possible.

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6. I understand that there is a small risk that I may become addicted to the opioids I am being prescribed. As such, my physician may require that I have additional tests and/or see a specialist in addiction should a concern about addiction arise during my treatment.

7. I understand that the use of any mood-modifying substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens), can cause adverse effects or interfere with opioid therapy. Therefore, I agree to refrain from the use of all of these substances without first discussing it with my physician.

8. I agree to be responsible for the secure storage of my medication at all times. I agree not to provide my prescribed pain medication to any other person.

9. If I break this agreement, my physician reserves the right to stop prescribing opioid medications for me.

10. I hereby agree that my physician has the authority to disclose the prescribing information in my patient file to other health care professionals when it is deemed medically necessary in the physician's judgment.

PLEASE COMPLETE THE FOLLOWING:

Patient Signature: _____

Physician Signature: _____

Principal Pharmacy: _____

Date: _____