

Helpful Prescribing Tips

*The tips below are general recommendations.
They are not a standard of care.*

- Don't jump to conclusions. Just because the patient is there again and again for the same pain complaint, don't start rolling your eyes and label the patient a "drug seeker." The first thing to do is to treat this patient like any other patient sit down, take a good history and include a very detailed medication history. Do a thorough physical examination. Check the old chart. Do your homework even more than you would a different patient. See if something was missed on previous visits. I am sure you have seen a patients like this example. Chief complaint: "headache," and the staff say, "He just wants drugs." It would have been very easy to give drugs and move on to the next patient. It took much more time to do a thorough evaluation, do a lumbar puncture, and make the diagnosis to TB meningitis.
- CURES is your friend. It is a valuable tool, like checking allergies and old records. Use CURES to intervene before developing an addiction, not just for doctor shopping. CURES will help you prescribe smarter and be a better doctor.
- Don't assume patients expect a prescription. There are many patient advocates who are appalled by the number of prescriptions that we write for. We generally hear the complaints when we do not give prescriptions that patients are demanding. However, there are an equal number of people who are angry that doctors are over-prescribing. "I can't believe that the doctor gave me 30 Percocet after a simple cyst was removed!" I have seen a prescription of Vicoprofen given after a dental cleaning! The prescription was given to the wife of a prescription drug abuse advocate. Now it is a permanent exhibit in the anti-drug lectures.
- Add a few words when you give a prescription. A request from people who have lost loved ones to this epidemic, is that the doctor let the patient know that these are serious medications. "I will give you a prescription for Norco. Please realize that this is a medication that can be abused. Keep it secure, take it only as prescribed, and do not drive if not fully alert
- Use a Medication Agreement. This is recommended for any patient who needs more than 3 months or a controlled medication. This includes dental pain, fractures, fibromyalgia, cancer, anxiety, ADHD, and any condition. San Diego has two versions of a Medication Agreement with official endorsements that read at a 5th grade level. The agreement states that only ONE doctor and ONE pharmacy should prescribe controlled medication. The agreement also states that medications should not be refilled in the emergency department, that lost prescriptions will not be filled, and that patients should make appointments before

they run out of medication. The Agreement is not legally binding but sends a unified message of rules that need to be followed when taking these medications.

- Find out exactly how patient are taking their medications. If patients say that their medication is not working, ask "please tell me how you are taking your medication." You will be surprised how many patients used 400 mg of ibuprofen twice a day and it was not enough. Or they took one pill of Vicodin last night and now 8 hours later they are in the ED with pain again without taking anything in between. A detailed medication history and education on the right way to take the medication can go a long way.
- If a patient already has pain pills at home, they usually do not need more pills from you. A patient with kidney stone or humerus fracture, who already is on Percocet for back pain, usually does not need extra pills. Ask the patient if they have left over medication.
- If a patient says their medication was stolen, asked them if they filed a police report. These medications have a street value.
- Patients should know to watch their medication like they would their money. They should not lose their prescriptions. Why are there so many lost Vicodins and no lost Amoxicillin? The emergency departments in San Diego are united in not filling lost prescription. The private practitioner should be checking CURES and do a drug screen before considering filling a lost prescription.
- Use urine drug screens. This is one of the CDC recommendations for chronic treatment. A negative drug test indicates that the prescription is not being used as prescribed. The patient is either running out early or diverting. A drug test positive for marijuana places the patient in a high-risk category for adverse reaction. Patients may be given a choice of continuing marijuana or pain treatment. If you believe in "medical" marijuana, then simply monitor these patients more closely. Patient who test positive for an illegal substance cannot be continued on a controlled substance unless they stop the illegal drugs. You will place your license in jeopardy by prescribing a controlled substance to a known addict.
- Opioid withdrawal is uncomfortable, but not dangerous. New patients who present to the pain specialist are not immediately given whatever meds they state they need. The specialist first does research - CURES report, drug screen, reviews old records - and it may be two weeks before the patient is placed on a regular regimen. Do not feel badly if you are sending a patient home without a pain prescription in someone who has already received one in the past month from a different provider.

- Benzodiazepine withdrawal, unlike opioid withdrawal can be dangerous. You have to taper these medications to avoid seizures and serious reactions.
- For alcohol withdrawal, there is no point in writing a prescription for Librium if the patient plans on continuing to drink. Ask the patient what his or her intention is. If they want to try and stop, then by all means, write a prescription. The alcohol treatment programs recommend that you write the prescription "prn", so if your patient goes to a treatment program it can be given as needed instead of round the clock. Usually no more than 10 pills are needed.
- Patients should not mix opioids and benzodiazepines. Patients should not mix opioids with illegal drugs. Pain specialists as part of their practice make patients choose between opioids and benzodiazepines. There are unfortunate patients who have a legitimate pain condition, but refuse to stop abusing meth or heroin, and therefore the clinics will not refill pain prescription. Giving a controlled prescription to a patient who is a known addict is a DEA violation and can jeopardize your license.
- Xanax is a frequently requested medication and the number one prescribed benzodiazepine. However the half-life is short and abuse potential is high. According to the San Diego Coroner report, the deaths from Xanax are close to the deaths from oxycodone. The American Psychiatric Association does not recommend xanax for chronic use.
- Does your patient really need Soma (Carisoprodol)? This is a highly abused medication that is suppose to work as a muscle relaxant, but in fact is metabolized to meprobamate, a horse tranquilizer that is no longer available in Canada, Sweden, and Norway. If you are prescribing a muscle relaxant, use Flexeril (cyclobenzaprine) instead. Soma is part of the "Holy Trinity": Oxycodone, Xanax, and Soma. Some pharmacies have a red flag warning to call a physician for a written justification for all patients on the "Holy Trinity." It's much easier to just not write for Soma than to fill out paperwork explaining why the patient needs it.
- Tramadol/ Ultram is known as the "loop hole" drug. The loophole is that doctors and patients believe it is a non-narcotic because it is a scheduled V medication that does not show up on CURES. In fact, Tramadol 50 mg have 1.5 times the morphine equivalents at Hydcodone 5 mg. Tramadol is addictive. According the New York Prescription Drug Monitoring Program, Tramadol is the 3rd most frequently prescribed medication after hydrocodone and oxycodone. If you are prescribing something on a regular basis, think about using something that shows up in CURES.
- Phenergan with codeine cough syrup is a highly abused medication. There are cultures that put this medication in their drink and sip it all day. There have been pharmacies in some parts of town that received a fine for excessive loads of

Phenergan with codeine. I've seen funny hidden camera videos showing pharmacy techs sneaking sips of codeine while at work. If patient want something for a cough, prescribe an inhaler. An inhaler help get the "junk" out of the lungs, while a cough suppressant keeps it in.

- Ask patients with chronic abdominal pain and negative work ups how often they use marijuana. Cyclic vomiting syndrome is caused by chronic marijuana toxicity. Marijuana these days is not the marijuana of the 1970s. California marijuana can have 25% THC or more, while in the 70's marijuana was 3% THC. The treatment for THC associated cyclic vomiting syndrome is to get off the marijuana, and not replacing one addiction with another addiction. If you can convince the patient to stop marijuana for several months (not just a few days), they will be grateful later.
- In a hurry? Don't want confrontation? It is a lot easier to say "yes" and just give a few pills. It is much harder to say "no", look at CURES and check prior records. How bad can a few pills be? A few pills can mean continued addiction, drug diversion, avoiding getting help, and even death. The yes doctor is the "candy man." You need to follow the well know rule of medicine: "Physician do no harm".

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