DENTISTRY EXAMINING BOARD

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Dentistry Examining Board
Best Practices for Prescribing Controlled Substances Guidelines
(approved April 12, 2017)

2015 Wisconsin Act 269 granted authority to the Dentistry Examining Board to issue guidelines regarding best practices in prescribing controlled substances, as defined in s. 961.01 (4), Stats., for persons credentialed by the Dentistry Examining Board who are authorized to prescribe controlled substances.

The purpose of these guidelines is to provide guidance to dentists for prescribing controlled substances. These guidelines are intended to supplement and not replace the individual dentist's professional judgment.

These guidelines address acute pain as defined as "normal, predicted physiological response to an adverse chemical, thermal, or mechanical stimulus associated with surgery, trauma, or acute illness."[1] Dentists should recognize that the majority of dental pain is acute pain. Acute pain can be complex, felt differently by different patients and affected by a variety of factors including anxiety, depression, sleep deprivation and substance abuse.[1]

If a dentist is prescribing controlled substances for chronic pain, the dentist should refer to the latest version of the Wisconsin Medical Examining Board Opioid Prescribing Guideline (http://dsps.wi.gov/Documents/Board%20Services/Other%20Resources/MEB/20161116_MEB_Guidelines_v4.pdf) and CDC Guideline for Prescribing Opioids for Chronic Pain (https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm).

Before Prescribing or Dispensing

1. Diagnose – Dentists should establish a diagnosis and legitimate dental purpose appropriate for controlled substance therapy, through a history, physical exam, laboratory, imaging or other studies. A valid dentist-patient relationship must exist. This includes verification of dentist-patient relationship for after-hours emergency calls to providers.
2. Assess Risk – Dentists should conduct a risk assessment prior to prescribing controlled substances. Risk assessment is defined as identification of factors that may lead to adverse outcomes and include the following:
    - Age history, as younger patients (<45 years old) have higher risk for misuse.
    - Substance abuse history including alcohol, tobacco and other drug usage.
    - Medication history particularly relating to benzodiazepines and other opioids.
    - Mental health/psychological conditions history.

[1] *Acute Pain*, Daniel Carr, MD and Leonidas Goudas, MD

- Comorbidities history, including health conditions that could aggravate adverse reactions (such as COPD, CHF, sleep apnea, elderly, or history of renal or hepatic dysfunction).
- Family history and history of aberrant drug-related behavior.

If the assessment identifies risk factors, dentists should exercise greater caution before prescribing controlled substances, consult a specialist or put in place additional safeguards as part of the treatment plan.

3. Assess Pain – An appropriate pain assessment should include an evaluation of the patient's pain. Patients feel pain differently. Evaluate the nature, intensity, type and duration.
4. Review PDMP – Dentists should utilize the Prescription Drug Monitoring Program prior to prescribing or dispensing controlled substances. As of April, 2017, Wisconsin state law requires prescribers to review the PDMP before prescribing any controlled substance for greater than a three day supply. (https://pdmp.wi.gov/)
5. Collaborate with other providers – Dentists should coordinate care within the healthcare team to prevent under-prescribing, over-prescribing, misuse and abuse of controlled substances.
6. Definitively treat the dental need – Dentists should treat the underlying condition as the primary objective of care or refer the patient for that definitive treatment.

When Prescribing or Dispensing

1. Maximize non-opioid therapies - Dentists should maximize non-opioid strategies prior to treating with opioids. Unless contraindicated, non-steroidal anti-inflammatory drugs (NSAIDs) should be the first-line analgesic therapy, particularly in combination with acetaminophen. When opioids are used, combining non-opioid pharmacologic therapies, unless contraindicated, can achieve greater relief and lessen the opioid need.
2. Follow an established Controlled Substances Office Policy – A dental office should establish and implement a controlled substances office policy that includes the following:
    - Check PDMP and share information with patient.
    - Talk to other providers.
    - Assess misuse risk.
    - Prescribe minimal amounts of opioids.
    - Give specific directions for patients.
    - Reassess the patient as needed, particularly prior to re-prescribing.
    - Explain to patients how to store the prescription.
    - Educate the patient about proper disposal.
3. Start low and go slow
    - Prescribe an appropriate drug/preparation – Dentists should prescribe short-acting, immediate release preparations for acute pain.
    - Prescribe an appropriate dose – Dentists should prescribe the lowest possible effective dosage. Dentists should avoid prescribing opioid doses >50 mg morphine equivalents per day, recognizing that prescribing opioid doses ≥ 90 mg morphine equivalents per day dramatically increases risk and therefore requires justification and documentation. See appendix for commonly prescribed opioids, morphine milligram equivalents (MMEs) and calculating MMEs.

- Prescribe the appropriate quantity – Dentists should only provide the quantity needed for the expected duration of pain.

4. Educate the patient
    - Provide patients with specific directions for use and educate patients about risks of addiction, and alternatives. Risks include: overdose, misuse, diversion, addiction, physical dependence and tolerance, interactions with other medications or substances and death. Patients can make better informed decision about healthcare treatment when alerted to risk factors.
    - Discuss with patients the effect controlled substances may have on their ability to make decisions and to safely operate machinery or a vehicle in any mode of transportation.
    - Explain to patients how to store controlled substances. Ensure that they are not readily accessible to other family members including adolescents and children or to visitors.
    - Educate patients about proper disposal of the controlled substance. The best method for disposal of controlled substances is take-back events and permanent drop box locations.
    - Educate patient that prescriptions are patient specific and should not be shared with friends, family or others. Sharing may pose serious health risks including death.
    - Educate patients about the pain they should be realistically expecting. The patient should be able to function during the day and sleep at night without necessarily achieving a pain scale level of zero.
5. Follow-up - If the acute pain lasts longer than three days or the expected course, the dentist should reassess or refer to a specialist prior to re-prescribing.

Appendix

Commonly prescribed opioids and milligram morphine equivalents (MME)

50 MME/day	90 MME/day
50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300	90 mg of hydrocodone (9 tablets of hydrocodone/acetaminophen 10/325)
33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15 mg)	60 mg of oxycodone (~2 tablets of sustained-release 30 mg)

The total daily dose of opioids is calculated by determining the total daily amount of each opioid the patient takes, converting each to MMEs (by multiplying the dose for each opioid by the conversion factor) and adding them together.

Calculating MME

Opioid	Conversion Factor
Codeine	0.15
Hydrocodone	1
Hydromorphone	1
Morphine	1
Oxycodone	1.5
Oxymorphone	3
Hydromorphone	4

References –

Carr DB, Goudas LC. Acute Pain. *Lancet.* 1999 Jun 12;353(9169):2051-8.

Centers for Disease Control. (n.d.). Guideline for Prescribing Opioids for Chronic Pain. Retrieved from https://www.cdc.gov/drugoverdose/pdf/guidelines_factsheet-a.pdf.

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