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Board of Nursing
Best Practices for Prescribing Controlled Substances Guidelines

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

The purpose of this guideline is to provide guidance to advanced practice nurse prescribers for prescribing controlled substances. This guideline is intended to supplement and not replace the individual advanced practice nurse prescriber's clinical judgment. The guideline is not intended to address prescribing practices related to patients who are in active cancer treatment, palliative care, sickle cell or end-of-life care. Although not specifically designed for pediatric pain, many of the principles upon which this guideline is based could be applied there, as well.

It is important for advanced practice nurse prescribers to routinely discuss with patients the effect their diagnosed medical conditions or recommended drugs may have on their ability to make decisions and to safely operate machinery or a vehicle in any mode of transportation. Patients should be informed that there could be an increased effect when the patient is sick or there is a change in medication dosage.

Prior to prescribing controlled substances, there should be a well-documented evaluation which includes reason to treat and a history and physical. A review of the Prescription Drug Monitoring Program should be completed for all prescriptions to mitigate the risk of concurrent prescribing. Further information on a practitioners' requirement to review monitored prescription drug history reports may be found in CSB 4.105. The patient should be provided with education and a notice regarding use of controlled substances including risks, benefits, prohibition on sharing and how to properly dispose of controlled substances.

Opioids pose a potential risk to all patients. Providers are encouraged to implement safe practices for responsible prescribing which includes prescribing the lowest effective dose for the shortest possible duration.

Opioid Prescribing

1. Non-pharmacologic therapies (such as yoga, exercise, cognitive behavioral therapy and complementary/alternative medical therapies) and/or non-opioid (such as acetaminophen and anti-inflammatories) therapy should be strongly considered prior to prescribing opioids. Opioids should be used only if the expected benefits for pain and function outweigh risk to the patient. If opioids are prescribed, non-pharmacologic and/or non-opioid therapy should also be utilized as part of a multimodal approach.

2. Non-opioids should be considered first in treating acute pain. If non-opioid treatments are not efficacious, opioid therapy may be considered if benefits are anticipated to outweigh the risks. Realistic benefits and known risks of opioid therapy should be reviewed prior to prescribing opioid medications. Consultation should be considered if diagnosis and treatment is outside the scope of the prescribing practitioner.

3. When opioids are prescribed for acute pain, the quantity prescribed should be no greater than the expected duration of pain. Three days or less will often be sufficient.

4. Extended-release or long-acting opioids should not be prescribed for acute pain. When starting opioid therapy for chronic pain, advanced practice nurse prescribers should prescribe immediate-release opioids instead of extended-release or long-acting opioids.

5. If acute pain requires ongoing opioid therapy beyond the expected duration, the patient should be re-evaluated or referred to a pain management specialist.

6. Non-opioid therapy is preferred for subacute and chronic pain (greater than 3 months). If non-opioids are not adequate and expected benefits for pain and function outweigh risks, opioids may be considered acceptable. Risks and benefits should be reviewed. Opioids should be used in combination with non-pharmacologic or non-opioid pharmacologic therapy, as appropriate, to provide greater benefits.

7. Before starting opioid therapy for chronic pain, advanced practice nurse prescribers should establish realistic treatment goals with patients for pain and function, and discuss consideration for opioid therapy discontinuation if benefits do not outweigh risks. An advanced practice nurse prescriber should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety. A patient should have at least 30% improvement in pain scores, functional improvement, no signs of abuse or aberrant behavior and screened for medication side effects including sedation and constipation.

8. The advanced practice nurse prescriber should consider a controlled substances agreement in chronic pain situations. The management plan should incorporate strategies to mitigate risk. Components of ongoing assessment of risk should include:

a. Review of the Prescription Drug Monitoring Program (PDMP) information
b. Periodic urine drug screening (including chromatography) – at least yearly in low risk cases, more frequently with evidence of increased risk.
c. Violations of the opioid agreement.
d. Periodic pill counts may also be considered for high-risk patients.

9. Advanced practice nurse prescribers utilizing sound clinical judgment should do all of the following:

a. Use caution when prescribing at any dosage.

b. Prescribe the lowest effective dosage.

c. Before opioid dose changes, the advanced practice nurse prescriber should re-evaluate the patient, including benefits, harms and whether another drug is appropriate. If the harms outweigh the benefits of continued opioid therapy, the advanced practice nurse prescriber should use other therapies and work with patient to taper opioids to lower dose or discontinue.

d. Patients should be re-evaluated every 1-4 weeks during initial opioid titration. During chronic therapy, patients should be evaluated at least every 3 months, more frequently if they demonstrate higher risk.

e. Reassess individual benefits and risks when considering increasing dosage to ≥ 50 morphine milligram equivalents per day. Literature shows diminished return for doses above 50 morphine equivalents.

f. Avoid increasing to or maintaining dosage at ≥ 90 morphine milligram equivalents per day as there is no evidence base to support efficacy and there is significant increased risk of adverse effects.

g. Consider opioid taper, opioid detoxification, or pain management consultation prior to increasing to high doses.

10. Advanced practice nurse prescribers should review the patient's history of controlled substance prescriptions through the PDMP to determine whether the patient is receiving opioid dosages or dangerous combinations that put the patient at high risk. The PDMP data should be reviewed prior to starting a patient on opioid therapy and frequently during the opioid therapy. 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.

11. Patients should not receive opioid prescriptions from multiple prescribers. There should be a dedicated provider such as a primary care or pain specialist to provide all opioids used in treating any patient's chronic pain, with existing pain contracts being honored.

12. The advanced practice nurse prescriber may consider ordering naloxone in individual cases at higher risk including:

a. History of overdose (a relative contraindication to chronic opioid therapy)
b. Opioid doses over 50 MME/day
c. Clinical depression
d. Evidence of increased risk by other measures (behaviors, family history, PDMP, UDS, risk questionnaires, etc.)

Family members can be prescribed naloxone for use with the patient. The recommended dose is 0.4mg intramuscular or intranasal, with a repeat dose available if the first dose is ineffective or wears off before Emergency Medical Services (EMS) arrive.

13. Prescribing of opioids is strongly discouraged for patients abusing illicit drugs due to the high risk of overdose, abuse and death. If prescribed, clear clinical rationale should be present.

14. If you have a patient with opioid use disorder, advanced practice nurse prescribers should offer or arrange evidence-based treatment, including direct treatment (buprenorphine, naltrexone, etc. plus behavioral therapy), methods of detoxification and referral to an appropriate treatment center or provider willing to accept the patient. It is not acceptable to discharge from a provider's practice solely due to an opioid use disorder.

15. A patient should not be prescribed opioid and benzodiazepines or other respiratory depressants (gabapentin, pregabalin, muscle relaxants, sleep aids) concurrently, whether the prescribing is done by one practitioner or multiple practitioners. If prescribed concurrently, clear clinical rationale must exist.