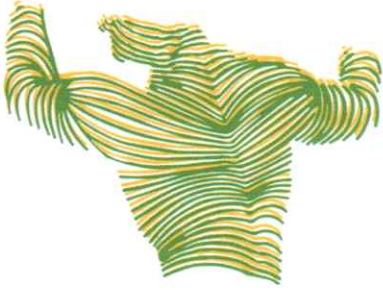


MJ HABER MD LLC

Non-Surgical Pain Specialists

Non-Surgical Orthopedic Pain Medicine

Pain Medicine & Sports Medicine

Initial here if not interested in opioids: ___

NSPS OPIOID MEDICATION POLICES Partial List

1. Controlled Medications are **NOT** prescribed on the first visit.
2. Patient is responsible to make sure they have a follow-up appointment in time before a refill is needed.
3. **Oxycodone** containing medications (Percocet, oxycontin) are **NOT** prescribed on a continuing basis (5 days).
4. **Alcohol, Marijuana, Kratom** and **Benzodiazepine** consumption are **NOT** allowed if chronic opioids are prescribed.
5. A reasonable decrease in pain or increased activity tolerance is a maximum of 20-30% per opioid use. These **medications are not "Pain Killers". Opioids DO NOT benefit all pain types.**
6. Continued prescribing of most opioids requires a clinic visit every 3 to 4 weeks.
7. At NSPS there is *rarely* a reason to exceed a 50mg of morphine equivalent dose (MED) per day of opioid, and almost never a reason to exceed 90 MED.
8. Opioid related risks include, but are not limited to the following: dependence, tolerance, addiction, and accidents.
9. Patients **CANNOT** take more pain medication than prescribed per time interval- HRS., Days, Wks.

10. Patients cannot take any prescription medications that have NOT been prescribed to the patient.
11. For the continuation of pain medication prescribing, only one clinician and one pharmacy are involved.
12. An office visit is **required** for medication changes and for providing a prescription.
13. Periodic urine/saliva drug screen tests are performed with opioid prescribing.
14. Pill counts are done at each medication appointment.
15. Periodic lab tests to monitor liver and kidney functions will be performed.
16. Patients are responsible to determine if they are at increased risk to themselves or others for potentially hazardous tasks
17. A replacement prescription will **NOT** be provided for lost, stolen, or running out of pain meds early.

18. Opioid medications are **ONLY** for pain, not to be taken to benefit a patient's mood.
19. Pain medication must be kept in a secured or locked container or location.
20. The purpose of opioid medications is to support patient exercise and conditioning, and to benefit activities of daily living -- ADLs (self-hygiene, transfers, dressing, toilet, etc.).
21. The goal is to take the least amount of opioid medication to help improve ADLs.
22. Opioids are prescribed as *one* part of an interdisciplinary, multimodal, treatment regimen.
23. In the situation of a surgery, procedure, accident, or the onset of new prominent acute pain, any additional pain medication is warranted **ONLY** by the doctor managing such event. This attending doctor (emergency room, dentist, surgeon) may provide an additional short-term pain medication, **ONLY** after the patient conveys to the attending doctor that continuous prescribing of pain medication is done per NSPS.

24. Opioid medication rotation from a multi-year use of an old opioid to a new opioid prescription, is often considered every 2 to 3 years, to allow the body to reset and improve effectiveness.

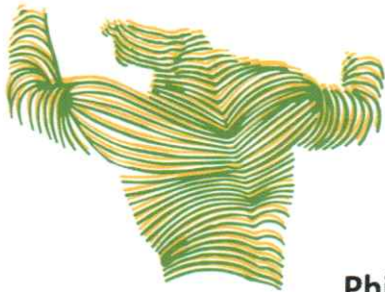
SIGNITURE after read: ______________________ DATE ______________

PRINT name: ______________________

1140 Willagillespie Rd., Ste. 42
Eugene, Or 97401

NSPainSpecialists.com

Phone 541-800-8970
Fax 541-844-1570



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Philosophical Approach to Opioid Medication Prescribing

Opioid medications are just one of many clinical tools available for chronic pain management. Our clinical philosophy emphasizes that opioid medication should only represent a small fraction of the therapeutic toolset to help patients improve function and quality-of-life measures.

To those patients who desire to have opioid medications included as part of their chronic pain management regimen, I urge them to review the following document and guidelines.

This document is to inform patients of our practice's pain management philosophy before they invest time and resources to attend an appointment at this clinic. A clear understanding of our clinical policies and approaches regarding opioid prescribing is important to provide a good doctor-patient relationship to achieve better outcomes in pain management.

Central to the philosophy of this clinic is the goal of optimizing patients' quality of life with improved activity tolerance and reduced overreliance on high-risk opioid and anti-inflammatory (NSAID) medications.

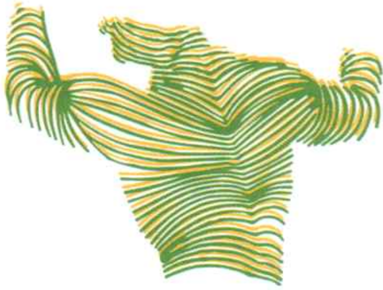
At Non-Surgical Pain Specialist (NSPS), we believe the doctor-patient relationship thrives on mutual agreement and shared understanding of expectations. It is only when both parties work as a team that we can effectively improve the patient's pain, function, and quality of life.

Dr. Haber's approach is to treat patients the way he would want his family members to be treated. Therefore, if a patient requests him to prescribe a medication regimen that he would not want for his own family member, he will not prescribe it for that patient. When considering treatments and diagnostic options, Dr. Haber will only offer those options that he is comfortable providing to his patients. If a treatment option is desired by the patient but not offered at NSPS, patient referral to another clinic would be undertaken.

Extensive research has not shown that long-term use of opioids had resulted in a significant improvement in patient quality of life or function. While opioid medications may help reduce pain severity by 10-30% for hours or weeks, but often with long-term use, opioids can induce increased pain, dependence, and tolerance.

Opioids are high-risk medications and require close scrutiny to ensure safety and compliance with governmental prescribing guidelines. For the patients attending our clinic, inclusion of an opioid medication as part of a medication regimen may or may not be considered for a particular patient or situation.

For each new patient at their initial appointment, a full clinical evaluation will be performed by Dr. Haber prior to developing a diagnostic and treatment plan. Under no circumstance will Dr. Haber simply renew a medication regimen based on another clinic's prior management of this patient. Furthermore, medications will not be prescribed at the first clinic visit at NSPS.
There are multiple government clinical treatment guidelines for pain management. They address the minimum steps mandated prior to providing opioid treatments and continue subsequently. The intent of guidelines is to achieve safer prescribing to benefit both the patient and the community. While a guideline may set an upper limit for a treatment parameter, every clinician reserves the right to provide treatment approaches they are comfortable with based on their own clinical and educational experience. Therefore, actual prescribing may be less than guideline set limits.



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OPIOID GUIDELINES

Important state and federal guidelines include: 2016 CDC guideline for Prescribing Opioids for Chronic Pain, Oregon Opioid Prescribing Guidelines, OHSU Adult Safe Opioid Prescribing Guideline for Chronic and Non-end-of-life pain. I will summarize a few key points from these guidelines:

1. Non-pharmacologic therapy and non-opioid 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 non-opioid 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 and community safety.
3. When opioids are started, clinicians should prescribe the lowest effective dose considered. Clinicians should use caution when prescribing opioids at any dosage.
4. The effectiveness of the treatment, particularly as it relates to the patient's functional status, should be regularly assessed, and documented. If benefits do not outweigh the risk and harms of the continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to the lower dosages or taper off and discontinue the opioids.
5. Urine drug testing is a tool used to assist providers in assessing whether patients are using opioids as prescribed, using other substances, or potentially diverting opioids.
6. The amount of prescribed opioid should be limited. When treating chronic pain, there is rarely a reason to exceed 50 morphine equivalent dose (MED) of opioid, and almost never a reason to exceed 90 MED.

Multiple other opioid related policies exist that may be discussed at clinic appointments if needed.