Opioid & Sedative Guidelines for Emergency Department and Urgent Care Providers

ED or Urgent Care providers **should not**

- dispense prescriptions for controlled substances that were lost, destroyed, stolen, or finished prematurely.
- prescribe or provide doses of methadone, buprenorphine (Suboxone), or long acting pain medications.

ED or Urgent Care providers **should** prescribe opiates for acute, short term pain for the shortest duration appropriate with national guidelines, generally no more than 3 days.

ED providers are **strongly encouraged** to access iStop when they have a reasonable suspicion that the patient has recently been prescribed a controlled substance by another provider, or if they suspect inappropriate use of opiates.

A dedicated primary care provider or relevant long-term care specialist (rather than ED or Urgent Care) should provide all opiates and sedatives to treat chronic ongoing condition.

An acute need for an opioid prescription **is not indicated** for any of the following signs/symptoms/conditions[1]:

- Abrasions
- Cellulitis
- Chest pain
- Chronic pain, such as back pain, abdominal pain, extremity pain, and headaches
- Contusions
- Cough
- Dental pain without acute trauma
- Dysuria
- Ear pain
- Hemorrhoids
- Lacerations
- Neck pain
- Sexually transmitted disease
- Sprains/strains from trauma
- Throat pain
- Urinary tract infection

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Many patients who present to the ED showing signs of addiction are often at their most vulnerable. These patients may be open to active discussion regarding their addictions and receptive to suggestions for treatment of their addiction. ED providers are **encouraged to** 1) counsel patients on appropriate use of opiates when prescribed for acute pain and 2) provide guidance on resources available for addiction treatment when inappropriate use of opiates or addiction is suspected.

Resources and provider listings can be found on this website:

https://ncadd-ra.org/news-resources/resources-advocacy-research

[1] Guidelines do not exclude the use of clinical judgment in the management of patients, but detailed documentation is indicated to support treatment outside of the recommended guidelines.

Opiate medications include, but are not limited to: codeine; hydrocodone (Norco, Vicodin, Lortab); oxycodone IR (Percocet) and SR (OxyContin); morphine IR and SR (MS Contin); hydromorphone IR (Dilaudid) and ER (Exalgo ER); methadone; fentanyl; oxymorphone ER (Opana ER).

Sedative medications include, but are not limited to: alprazolam (Xanax); clonazepam (Klonopin); diazepam (Valium); lorazepam (Ativan).

Guidelines reviewed by Rochester Regional Healthcare Association Medical Director Committee subgroup and Chiefs of Emergency Medicine from member hospitals.