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From Pain to Possibilities: Safe Opioid Use and Treatment of Patients with Pain

Announcer:
Welcome to CME on ReachMD. This activity titled “From Pain to Possibilities: Safe Opioid Use and Treatment of Patients with Pain,” is provided by Clinical Care Options, LLC, doing business as Decera Clinical Education. Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements, as well as the learning objectives.

Dr. Phipps:
Hello, I’m Lisa Phipps, Director of Scientific Services for Neuroscience here at Decera Clinical Education, and I’d like to thank you for joining us for our video module, which is part of a larger program called “Comprehensive Opioid Analgesic REMS Training: Immersive Education to Equip Healthcare Professionals for Safe and Compassionate Pain Management.” The video module is titled “From Pain to Possibilities: Safe Opioid Use and Treatment of Patients with Pain.” We’re so excited to be offering this program to you, which is provided by Clinical Care Options, LLC, doing business as Decera Clinical Education, and supported by an educational grant from the Opioid Analgesic REMS Program companies.

I’m pleased to introduce our presenters, Dr. Michael Sprintz, Medical Director of Substance Use Disorder and Mental Health Intensive Outpatient Programs at Ethnos Behavioral Health Group, and founder of the Sprintz Center for Pain and Recovery in Houston, Texas, and Amanda Zimmerman from West Forsyth Pain Management in Winston-Salem, North Carolina. You can see their disclosures here.

And now I will turn over the program to Mandy and Michael for our learning objectives, polling questions, and content. Over to you, Mandy.

Ms. Zimmerman:
Thank you, Lisa. Hi, everybody. Thank you for joining us. We’re going to go through these learning objectives. We’re going to differentiate the types of pain, including definitions, etiology, mechanisms and risk factors. We’re going to identify risk factors for nonmedical use and opioid use disorder as part of a thorough assessment of pain and refer to addiction medicine specialists when appropriate. We’re going to learn to develop an individualized pain management plan, considering all therapeutic options, including nonpharmacologic interventions, nonopioid medications and opioid analgesics. We’re going to counsel—We’re going to counsel patients and caregivers on the safe use, storage and disposal of their opioid analgesics, and the role of reversal agents. We’re going to learn to monitor patients receiving opioid therapy, including reviewing medication adherence, need for a referral to a pain specialist, the potential for nonmedical use, and situations when it is appropriate to taper or discontinue opioid therapy. We’re going to learn to construct a systematic approach to screening for and appropriately managing patients with opioid use disorder. So let’s get started.

So pain treatment is vital. So, you know, why are we here? As healthcare practitioners, we need to consider all the therapeutic options to optimize care and reduce risk. So, you know, we have a lot of guidelines. The DHHS, I like this best practices that they put out. I think it’s very agreeable and ethical. The CDC is a little more strict, I think, but, you know, we, we have a lot of policies that mirror those guidelines. We have to know that chronic pain affects at least 20% of US adults. And there’s probably a higher number than that because it’s very underreported. There’s a higher prevalence in non-Hispanic, American Indians, or Alaska Natives, those identifying as bisexual and those who are divorced or separated. And about 7% of US adults have high impact pain affecting their life and work, so it’s

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really important that as you're speaking to this pain patient who comes into your office, to try to reduce the stigma that they're dealing with more than just the pain. It's affecting their entire being, and you have to understand that.

So, you know, undertreatment of pain involves multiple factors. So we have from a healthcare perspective, we, you know, we underestimate the severity and the impact of the patient's pain. Like I mentioned, you know, we have to understand that this is high impact. You know, it's affecting their whole life. We fear disciplinary action or prosecution. We have—We're worried about the potential for misuse or addiction if we're going to use opioid therapy. We have a lack of training in opioid use. We have implicit biases, racial, ethnic and gender, that we employ when we're sitting there in the room with the patients. We have to try and overcome these things and, and mitigate. We have to use mitigation strategies for our own, you know, feelings as well.

From a patient standpoint, they have limited access to healthcare and or pain specialists, particularly in rural areas, and this becomes a real challenge for the primary care who are out there in rural areas and don't have access to a pain specialist. There's a fear of addiction. Tolerance and adverse events, the patients are afraid of these medications as well. There are socioeconomic and psychological factors. You know, they might be worried about how society perceives them, how you perceive them. And they don't really have a knowledge of all the treatment options. A lot of them are mis, misunderstanding to think that opioid therapy is the only thing that we could offer, but there is a wide range of therapeutic options. So then, of course, there's—for both of us, there's the communication between the, the provider and the patient, and then there's governmental and public policy on payment for opioid analgesics that we're both having to deal with, so we have to think about these things as we're formulating a plan and talking to our patient.

So we've had the first decline in opioid overdose deaths since 2018. I think this is multifactorial. You know, there's a lot of—I think we're coming down on fentanyl a little bit better, we're prescribing less opioids, we have higher access to naloxone, so lots of different factors are driving that. It's going to be kind of interesting to see where it, where it heads going forward.

So, what is acute versus chronic, right? Acute is duration of less than a month. That's your post-op pain that's expected to go away. Subacute, one to three months, and then we have the chronic or persistent, which is greater than three months. So this can be multifactorial. You know, you can have biological factors, psychological and social components. You can have two people that have had carpal tunnel surgery. One develops chronic pain; the other one does not. And why? There are multiple reasons. So the diagnosis is appropriate independently of identified biological or psychological contributors unless another diagnosis would better account for the presenting symptoms. And then you have primary versus secondary. Chronic secondary may be attributed to a distinct pathophysiologic process like chronic cancer pain, chronic secondary visceral pain, or neuropathic pain. So those are just your pain etiologies.

So again, we're going to talk about this biopsychosocial spiritual context of pain. So everybody perceives pain in a different way, and it is, you know, it's a very subjective kind of experience for every person. So there are biological factors. It affects your sleep and your fatigue, causes a lot of inflammation. There's a little bit of gender differences. You know, men respond to pain differently than women just based on their upbringing and psychosocial aspects, their positioning in life, nutritional status. It affects their conditioning. They may have a previous pain experience. Like, for example, you have the mother who, you know, the kid falls and hits his head, and one mother goes, "Hey, you're fine," you know, "Shake it off and move on," and the other mother is like, "It's the end of the world." So, you know, those people are going to perceive pain in a different way just by the way that people react around them.

So, from a social perspective, it's affecting their work status, their intimacy, their relationships, their finances, their family. All these things are being affected by their pain syndrome, and that affects them psychologically. It causes a lot of anxiety, some grief, some depression. They may catastrophize, you know, like "What's going to happen in five months from now? Am I going to—" You know, "In five years, am I going to be in a wheelchair?" I have people say that to me a lot. They worry, and I'm like, "That worry is making your pain worse, so we're not going to worry about that. We're going to live in the now."

And then from a spiritual perspective, you know, their religious faith, you know, "Why is God doing this to me? I don't deserve this. What did I do wrong?" You know, they have their suffering and their spiritual distress and their values. You know, it's affecting their values and everything, all this. And, you know, as you're sitting there with your patient, you have to think about all these things, and empathy from you can reduce that magnification in their mind of, you know, how this is affecting every aspect of their lives.

So, what are the types of pain? We've got nociceptive. That's just your inflammatory, broken bone, mechanical low back pain, described as dull, aching, you know, might be constant, might be intermittent, but it's usually kind of a dull ache or sharp pain. And then we have neuropathic, which is your nerve pain. That's your postherpetic neuralgia, trigeminal neuralgia, CRPS, radiculopathy. That's usually described as a burning, electrical, shooting, hot poker, tingling, paresthesias, those kinds of things. So in order to tease out what kind of pain it is which will guide your treatment, you need to figure out—you know, you need to ask these questions and figure out exactly what the nature of the pain is.

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So now I'm going to talk about nociplastic. This is a hypersensitization. So we know through, you know, more research with pain that people who have pain have an upregulation of these bad actors in their bodies—glutamate, substance P, amongst many others—and there's all these things that are happening physiologically in their body which cause pain. And people who have pain all the time have a lot of that running around, and that creates, can create a hypersensitization situation where their whole body just hurts. This is fibromyalgia, irritable bowel, nonspecific low back pain. These are the people that usually come in and we go, "You know what, you have nothing wrong with you." You know, "I'm just not-I'm not even going to entertain this."

So, but it is a very real thing, and it's usually associated with an initial injury and years of a chronic pain situation, and they can develop a nociplastic situation, except for people with fibromyalgia. And we don't really understand why, but those people just develop a generalized body pain situation, and that is just solely a nociplastic situation. But most people have mixed pain, right? So they have neuropathic component, a nociceptive component, and possibly a nociplastic component, so we have to think about all of that when we're developing our treatment plan to treat all of those different kind of pain generators so we can, we can win the game.

Pain assessment versus risk assessment. So, you know, a lot of us want to go down the rabbit hole of just risk assessment in the beginning, but we have to understand what the pain is, you know, before we can think about risk, even if we're, you know, if we're thinking about prescribing an opioid. So these things kind of happen concomitantly, particularly if you are, you are thinking about an opioid from the outset as you are assessing this patient. You know, you're going to kind of listen to these little clues as you go doing a risk assessment, which should continue throughout the length of the time that you're taking care of this patient, be that years. So a pain assessment is just your description, right? the location, intensity, quality, onset, duration, variations and patterns. This can help you understand the, the type of pain it is. What relieves the pain? What makes it better? What makes it worse? And what are the, what are the effects of the pain on the physical, emotional and psychosocial function?

So, if you talk to a patient about this and you're learning that they are a catastrophizer, you're going to, you know, really kind of formulate your treatment plan based on that. You know, that's going to be a component, a very important component. Their current level of pain and function, you know, are they functioning? What are they doing? You know, the person might be sitting there going, "My pain's at 10 over 10," and it's like, "Okay, how's your function?" "Well, you know, I'm working 12 hours a day, and then I go home, and I take care of the kids, and then I make dinner," you know, so it's—You know, you're actually functioning pretty well, even though you're complaining that your pain is at 10, so, you know, just kind of setting these expectations with your patient is very, very important. So you want to be doing a risk assessment at the same time. That's evaluation of risk.

So, what to look for in the history. So your medical and treatment history, you want to know what the nonpharmacologic or pharmacologic strategies to date have been. You know, you want to really tease out exactly what they've been taking. You know, and don't just base it on the medication list. You know, some people have a medication list that says hydrocodone Q5 milligram, Q4 to 6 hours. Okay, what does that mean? You know, are you taking it three times a day? Are you taking it twice a day? Are you taking it every four hours? You know, are you taking it once a day? Are you taking it twice a week? What are you, what are you doing with this medicine? So you don't want to just go on what the medication list says. You want to ask the patient exactly what they're taking and how they've taken it. You know, they might have, they might have pregabalin on their list, and they're like, "Oh no, I haven't taken that in, like, months because it makes me so dizzy and horrible, but the pharmacy keeps filling it for me.

So you have relevant illnesses, other current prescriptions, past and current opioid use. Look at the PDMP, obtain the prior medical records. Your medical records are tantamount. Many times chronic pain patients come to us with sort of a murky diagnosis, so looking at those medical records can really help you formulate your own diagnosis and treat the pain appropriately. For opioids currently prescribed, you want, again, the opioid dose regimen and duration, and you want to determine if they're opioid tolerant. You know, you want to know this information so you don't cause an accidental overdose.

You want to know their cycle—social and psychological history. This has a huge impact on how they perceive pain and how they cope with pain. Do they have a psychiatric diagnosis? Depression, anxiety, PTSD, those things are very important. Do they have a history of alcohol, tobacco, recreational drug use? And, you know, you have to do this in a very nonjudgmental manner. You know, I'm just trying to—And one thing I say to my patients a lot is "I'm just trying to keep you safe. That's my overarching goal." You want to know about their history of adverse childhood experiences. You know, there's a very high incidence of opioid use disorder in people who've been sexually abused, very high incidence of chronic pain in people who've been sexually abused, so you need to know that information because that's going to kind of, you know, guide the way they respond to treatment. Family history of substance use disorder and psychiatric disorders, so all the—the social and psychological history is really, really important.

So you do have an assessment, a toolbox. You have the PEG tool, the Brief Pain Inventory, the 5 A's, Universal Pain Assessment. That is your pain assessment. You can do functional assessment questionnaires. You can ask about adverse childhood experiences. You can look at pain in advanced dementia. And then psychological measurement tools, you can use the PHQ-9 or the GAD-7. These things

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are great. They're good to have in your chart as just another assessment tool that is part of your documentation for your reasons for your decision-making.

So there has been a paradigm shift. You know, we used to just escalate the opioid to the point where we got rid of the pain, right? But now we're not doing that anymore. So we're, we're, we're focused on increasing function, and this is something you really need to talk to about—talk to your patient about and understand and be on the same page about your goals. You know, we're not looking to get rid of your pain completely. That is not a realistic expectation. You know, I often say, you know, the sign on the door says Pain Management not Pain Cure, so we really want to focus on the fact that we're trying to improve their function, get them back to their regular life. And, you know, everybody has different goals, so you want to, you know, know what their specific goals are, document that, and then document when they're achieving those goals; like they're playing with their grandchildren; they've gone back to work; or, you know, whatever; they've lost 20 pounds; whatever it is that they, they, you know, that they want to do.

So, what are our goals? You know, so in acute pain, we want to facilitate recovery and healing, minimize the impact of pain. We want to stop this from going to chronic pain, which is, you know, a good dose of empathy and understanding and appropriate treatment from the beginning. Chronic pain, we want to restore their function, like I talked about, and that's not just physical function. It's emotional and social as well. We want to reduce the pain intensity so that they can go back to function, improve their quality of life, minimize adverse events and correct the consequences of the pain, the postural deficits, the deconditioning, their coping, their maladaptive behavior. You know, I just—you know, I mean, I get calls on the weekends sometimes. "Oh my gosh, I'm having this flare of pain, and I can't do anything, and I've been in the recliner for a week," and it's like, "Get out of the recliner. It's just making your pain worse. It's locking up your back."

So palliative care pain is a different animal. You know, you want to optimize their quality of life. You want to give comfort care, support system for the families, and you want to take care of their psychological and spiritual needs, so different goals for different situations. So again, setting realistic expectations, right? "Analgesic medication will completely eliminate my pain." No. You know, I always tell people, "30–50% pain relief, we're winning, and if I were to completely eliminate your pain, you'd be sleeping all the time or you wouldn't be breathing," so, you know, there's, there's that. "A nerve block injection therapy is a one-and-done deal." No. I always say, "We're looking for long-term temporary relief. It's not going to take it away. It doesn't fix the problem. It's just decreasing the inflammation." "Pharmacologic approaches alone will manage pain and restore function." No. You need to have a combination, mindfulness, physical therapy. The patient has to have some agency. You know, they tend to sometimes just give up. They're like, "I can't do anything about this. You have to fix it." No. They have to have a role, and you have to empower them to have that role and make them feel like they have some control because they feel like they've lost total control of their lives.

So you want to have an individualized patient-centered care, right? So, what's good for patient A might not be what's good for patient B or C or D. So patient A might do really well with NSAIDs, yoga and nerve blocks. Fine, stable, doing great. Patient B may need short-term opioids, some behavioral health and some physical therapy. Patient C may do really well with acupuncture, surgery and self-management. Patient D may, may need gabapentinoids and, and participates in Tai Chi and needs some epidural steroid injection. So, you know, you have this toolbox, which is here in the middle, of all your different things you, you can choose from. And, you know, one thing I do with my patients, I like them to have a heavy dose of education about what's available to them. I think that helps them to cope and not feel so helpless and hopeless, like "There's just nothing that can help me, and I'm stuck in this situation forever and ever." And, you know, it's like, "Well, we have a lot of different things, and I want you to know as much about it as I do, so it's my job to present all your options to you, and then you and I can make an informed decision together about what would be best for you."

So, you know, there's a lot of gray in pain management. It's not black and white. I think a lot of the regulatory rules try to make it, you know, you've got to do this, this, this. It's just not like that in pain management. You know, in diabetic management, we do have that kind of, you know, very set plan that we follow for diabetic treatment, but pain management is just not, not like that, and that's why we have such a problem with guidelines and things.

So, what do we want to consider when we're choosing a treatment modality? We want to know the etiology and the type of the pain, right? Nociceptive versus neuropathic. We want to know if it's acute or chronic. Is an opioid necessary? We want to have our rationale. We want to document these things very well. What are the goals? What are we trying to achieve? Does the benefit outweigh the risk? You know, their career, their activities of daily living, family social life, document these things. What are the—What is the treatment history? What are the different modalities? What worked? What didn't work? Has anything changed, or is there new pain? Their social history and risk assessment, which continues on because people's lives change, circumstances change over time, and even though they may have presented to you with this totally stable, you know, soccer mom situation, doing great, you know, very stable home life, and then maybe everything kind of falls apart, right? They get a divorce; they're—they might become homeless; they might, you know, God knows what could happen; but that increases their risk, right? That changes the situation, so you want to be aware of those things

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as you're, as you're continuing treatment.

So, what are their comorbidities? Have they developed sleep apnea? other respiratory complications? renal liver disease? Benzodiazepines on board? Have they been added? You know, I often talk about the geriatric population. We need to be careful. You know, they may be stable on one dose of opioid for many, many years, but then they become elderly, and they're, they're not clearing the medication the way they used to, so you want to maybe think about reducing those doses to improve their safety. And you need to explain that to them. Like, "I'm not trying to take your pain control away, but, you know, you have a higher risk of overdose now because your body has changed." So patient preferences, you know, what does the patient want? Family concerns, job concerns, dosing schedules, you want to be talking to your patient about all those things when you're thinking about your treatment.

So, when do you refer to a pain specialist? Early referral is key, but the original provider, PCP, still needs to establish care. And what indicates it's time to refer? If they're really complex, they have a lot of different multiple comorbidities, conditions, if they're requiring greater than 50 morphine equivalent, if they're using multiple concurrent CNS depressants to target pain symptoms—this is, you know, this polypharmacy problem, which is a very real significant thing—you have a high risk for misuse is identified, like their family, their circumstances have changed, or even early on that they have a high risk for misuse—you're going to be like, "Okay, we need somebody who can really monitor you much more closely than I can"—if they refuse nonopioid medications or they refuse to reduce the opioid dose. You know, I know that primary care, you guys just don't have time to really tease through all of that with those patients because you're dealing with multiple other things. So they may warrant interventional treatment. You know, we have a lot of really great new interventional things that we can offer patients that have come a long way, and they're really effective. And if, if their pain becomes less responsive to the current treatment, so they're just not responding any longer and things aren't working, or if you need to explore next steps or other modalities for pain control. So that's really—are the indications for referral.

Why try nonpharmacologic options in chronic pain? So these are often associated with less risk and long-lasting improvements that persist after cessation of treatment. So, you know, you, you have ways to try to intervene early. You want to allow the patient preference and agency, right? like we talked about, shared decision-making, guide a selection of approach. At a broad level, these interventions include psychosocial, complementary and integrative rehab, exercise, and interventional therapies.

Now, I know that from an insurance perspective, a lot of times, you know, they won't pay for these types of things. That is improving. So, you know, the, the VA just changed their whole paradigm. Some of you may work at the VA. They did a paradigm shift away from opioid therapy to these more integrative treatments, which it's my hope that maybe that data will be robust enough for insurance companies to start kind of paying for these things, but I don't know. We'll see. So, you know, they serve as an effective adjunctive treatment modality for the management of chronic pain conditions. It can also be used as monotherapy, so there is a role for sure.

So I love this slide. So we're going to start with the injury. So these—this is the different types of personality people and how they respond to pain. So we start with the injury up at the top. And so then you have your pain experience, right? Everybody experiences pain in a different way. And then you have the patient who has low fear. And then they confront the pain, and they recover. They move on. Life goes on as normal. And then you have a different person whose pain experience is completely different. They might be—You know, they, they're going to catastrophize. They're going to ruminate over it. They're going to magnify it. They're going to feel helpless and hopeless. They're going to feel like their lives are over, and they don't know what to do, and they're never going to be the same again, and they've lost everything. And then they have this fear. They, they have defensive motivation. You know, there's avoidance. They have overgeneralization, heightened emotions, jumping to conclusions. And all these things, you know, create this—these chemical pathways in their brains that create more pain, and then they avoid the pain, meaning they're sitting in the recliner, not moving, and then they end up with disuse, disability and depression. And, you know, that's just this nasty thing.

So you as the practitioner, when they have the initial injury, you can say, "You know, we're going to deal with this together. We're going to get through it. I'm going to help you. I'm your partner. We're going to do it together. You're going to, you're going to recover, and everything's going to be fine." And, you know, hopefully, you can reduce their fear and stop this bad pattern from happening. So, you know, this can be managed with graded exposure therapy. So, yeah, you have to recognize it. You know, I think that, particularly in primary care, you know the personalities of your patients, so you can almost know the people who are going, who are going to go into that bad place from the beginning, and you can try to intervene. Particularly if they're going to have surgery, you can try and intervene even pre-op, before they even have the surgery, like, "Here's how we're going to do it."

So, you know, we have to think about the whole healthcare, right? So the mindful and awareness, they can pace their activities, have mindful movement, good family and social support, do meditation, guided imagery. I mean, now, you know, we have the VR that has been approved for the—by the FDA for pain conditions, and it really does work. Healthy sleep habits, this is huge in chronic pain people. They do not sleep. And, you know, get their nutrition right. Manage their weight. Manage their surroundings. They're working their body. Their energy, their flexibility, the power of the mind, the spirit and soul, the family, recharging, sleeping, food and drink, all of these things

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are very, very important, and we have to really kind of pound this home with our patients because a lot of them just kind of give up and, and, and go to McDonald's, so we have to be thinking about that.

So, what are your nonpharmacologic treatments? There's a lot of evidence to support these things. Exercise, yoga, Tai Chi. Exercise doesn't have to be a gym membership, but a lot of like, you know, insurance companies are covering the Silver Sneakers program. Encourage them to get into that. Do yoga. They can even do these things at home. There are free, you know, YouTube things they can watch. Complementary integrative treatments, you know, your acupuncture, manipulation, massage therapy, those things are all really good. And then, of course, your cognitive behavioral therapy. I do that really in the office with my empowering, you know, just kind of help them to give them some coping mechanisms. Mindfulness and meditation. And then neuromodulation come a long, long way. Here, recently, we have some really good neuromodulation options.

So cognitive behavioral techniques, you know, this is diaphragmatic and other breathing techniques, meditation, mindfulness, living in the now, stress management, trying to, you know, manage their stuff. It can—You know, the pros are it can result in actual changes in brain neural pathways, and there are many modalities to offer patients and tailor-to-treatment plans. You have—There are some apps that patients can get that they can do these little exercises every day. It allows the patient some agency, right? So they have some control. You know, chronic pain is a, is a real loss of control for these people, so any control you can give them is going to help them. So, but it does take practice and adequate motivation and the cost, of course, if it's therapist-guided, so there are some cons to starting these things.

So I'm not going to spend too much time on acupuncture. There's a good evidence base, may be cost prohibitive, chiropractic manipulation, some moderate quality but inconsistent. I think early on in a, in a pain situation, particularly a spinal situation, I think it can really, really help. Massage therapy, of course, you know, these things are sometimes cost-prohibitive, but they do have some evidence to show that they really do work and help. Neuromodulation, you have your noninvasive. That's your TENS units. BNS there's a little bit of less evidence for. Invasive, you've got the spinal cord stimulator. We have peripheral nerve stimulation. We're seeing fantastic results with peripheral nerve stimulation at the moment. Intrathecal therapy, the intersinus—spinous spacers for spinal stenosis, really, really good. These are kinds of things that, you know, even just to go and talk to a pain specialist, have the patient go and, and talk about what's available, might be very helpful for the patient just to get some, you know, factfinding, on a fact-finding mission.

So, in order to really choose our treatment modality, we have to understand where these medications work. So the way that pain is transmitted in the body, I first want you to focus on the purple line. So you touch the hot stove. That's nociception. It goes up into the DRG, through the spinal cord, up the dorsal horn into the brain. So, and then—And so drugs that—That's the ascending pathway of pain, right? So drugs that inhibit this ascending pain transmission include acetaminophen, NSAIDs, lidocaine, capsaicin, menthol, opioids, cannabinoids and ketamine, so you're going to, you know, you're going to inhibit that pathway. And then we have a descending pathway. So this descending pathway, that releases agents that quell down the ascending pathway, so they kind of quell down those bad actors, like glutamate and substance P that are causing the pain. Right? So, and things that, that activate that are gabapentinoids, sodium channel agents, your TCAs, your SNRIs, so, you know, you can kind of do a multimodal approach where you're inhibiting that ascending pathway and you're activating that descending pathway to reduce that pain transmission even more. So, you know, that's the reason for this kind of multimodal treatment plan, is kind of hit the both pathways as best as you can, and that can help, you know, reduce their opioid load as well.

So corticosteroids, indication multiple pain issues, dosing administration, oral tapers, joint injections, you know, can cause hyperglycemia, weight gain. You guys know a lot about this. I'm not going to spend a lot of time on that, just a strong anti-inflammatory. Common muscle relaxers, baclofen, cyclobaz—benazaprine—benzaprine, tizanidine, you know, they're varied mechanism of action. We don't really know how muscle relaxers work, but, you know, I just kind of tell everybody it's a mixed bag; we can try them. Cyclobenzaprine, try and stay away from in the elderly because it does have a significant fall risk and can cause a lot of sleepiness. You know, you've just got to kind of fiddle around with it and see what works best for people.

Antidepressants, like I said, the TCAs, SNRIs, they work on that descending pathway. That's—You know, they can be a good adjuvant. Duloxetine can be alone therapy for its initiate—You know, it's indicated for osteoarthritis as well as neuropathic pain conditions, so, you know, you can, you can hit all the, all the things with that. And, of course, the analgesic effect is independent of the antidepressant activity, so I always say duloxetine is kind of not a great antidepressant, but it's actually better for pain. But, you know, these people are depressed as well, so you're kind of hitting all that action. TCAs, amitriptyline, I'm using this a lot for sleep hygiene—try and get away from the benzos or get the patients away from the benzos—and that seems to be working pretty well.

Anticonvulsants, gabapentinoids, we're going to talk more about that, but, you know, they work. They, they, they carry a lot of risk, but, you know, for neuropathic pain, they hit that neuropathic pain while you're treating the nociceptive pain with another agent. So oxcarbazepine, topiramate, all of these are good for pain management, reducing the neuronal hyperexcitability. So using

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anticonvulsants in practice, gabapentinoids, most adverse events are dose-dependent, common dizziness, somnolence, peripheral edema, weight gain, blurred vision. There's an associated risk of dementia. There's a study that just came out of Australia about that. There's low—You want to start low and titrate every one to two weeks. It's important to remember that gabapentin really over 1,800 mg is not getting absorbed in their body, so there's really no reason to go over that dose. It just causes more side effects. I see a lot of people who are on way more gabapentin than that, and I don't really think it's really helping them very much. So, with oxcarbazepine, most AEs are dose-dependent. Dizziness, drowsiness, same. May cause fetal harm. Topiramate, high rates of adverse events, can cause kidney stones. It's teratogenic. It's not, it's not as strong as gabapentinoids for neuropathic pain, but it does have a role if they just can't tolerate the gabapentinoid medications.

We have new medication, sodium channel blockers. This is your suzetrigine that just came on the market last year. This—We've discovered that the sodium channels that live on the peripheral nerves have some role in pain transmission, particularly NAV1.7, 8 and 9. So suzetrigine, basically, you know, you touch the hot stove, the pain transmission travels up the nerve to the brain, and it travels through the sodium channels that live on those peripheral nerves, so it's just like this "ch-ch-ch-ch" sending the signal. So these—this agent, it basically blocks that transmission, so it, it, it, it sort of slows that pain transmission. So they studied it head to head against hydrocodone 5 mg in bunionectomy as well as tummy tuck surgery. They gave one group 5 mg hydrocodone Q4 and the other group suzetrigine twice a day, and it had equal efficacy in acute pain for both those situations, so that was, that was pretty good. I am clinically seeing—I'm just kind of throwing it at everybody to see what happens, and I'm seeing most, I'm seeing most impact in neuropathic pain conditions. I had a guy tell me his diabetic neuropathy was gone, which is crazy. So, you know, that's where I'm just a little clinical pearl there.

So you want to have rational polypharmacy, right? You want to think about the advantages, greater analgesic activity, hitting different mechanism, multi-mechanism—mechanistic effects, complementary, reinforcing each other. You want—You can target symptom clusters. You can have a reduction in adverse events, reduction in end-organ toxicity because you're able to use lower doses. You can have functional improvements in anxiety, mood and sleep. But you may increase drug-to-drug interactions. It may increase the cost to the patient. And every analgesic has its own unique adverse event profile so—and you have to have a good knowledge of the drug, the PK data, the pharmacodynamics to be able to make this work.

Okay, at this point, I'm going to turn it over to Dr. Sprintz.

Dr. Sprintz:
All right. Thank you very much. Hey, everyone. I'm going to just briefly tell you—so my background is I'm both an addictionologist—I'm boarded in an addiction-I'm also boarded in pain medicine and anesthesiology as well and had a clinical practice for many years that treated both chronic pain and patients with substance use disorders.

So the goal here—and, and again, there's a lot of information in the slides and the larger slide deck. I encourage you to go and look at the larger slide deck. There's a lot of information here, so I'm going to try and really focus on the most clinically relevant issues for you to —that you can take back into your practice right away.

So, when we're talking about risk of opioid harms, you know, first let's decide, well, what is risk? Well, it's the probability and severity of opioid-related harms for a specific patient and timeframe. Again, so if you're prescribing an opioid, remember it is not just about thinking about "Oh, do they have a substance use disorder?" or "Are they at risk for OUD?" When we are prescribing any medication, we have to think of risks, benefits, alternatives, side effects, and really unintended consequences. So, when you think about prescribing opioids, you want to think about not just OUD, but you also want to think about patients who may have respiratory compromise, who, who you may have an unintended overdose in patients, patients with cognitive dysfunction or memory issues, falls, accidents, motor vehicles, as well as OUD and substance use disorders.

So, when we talk about, you know, assessing risk and stratifying patients, what are the things that you should consider? When you're thinking about OUD, you think about drug testing; PDMP checks; genetic risk; depression; anxiety—and we're going to go into that more in detail—think about co-prescribed medications that can interact and have a synergistic effect with opioids, so we're talking about CNS depressants; unintentional overdoses, which can occur with comorbid medical conditions; people with sleep apnea, morbid obesity, COPD, lung disease, right? your liver impairment, which impacts the metabolism of opioids and other drugs; and then memory impairment or cognitive dysfunction—if you're taking a medication that can increase risk of respiratory depression and you forgot you take it so you take it again, that can cause, that, that increases the risk for an inadvertent overdose and potential death—and then falls, accidents, and other injuries, patients who are medically fragile, who have balance or gait dysfunction.

So again, when, when we're thinking about risk, it, it really is about—it's a holistic approach to the patient. Patients are not cookbooks. And we can do risk scores. We can do validations. Remember that all of this gives us information that—and data that we plug into our

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overall assessment of the patient, so when we're looking at our patient or making a decision whether to prescribe or not prescribe opioids, we need to look at everything, the biocycle aspects of that, history, physical, the social situations, you know, risk of harm, screening tools, as well as, you know, I've had patients who they live in an environment in which one of their family members has an active substance use disorder. The patient doesn't. Another thing to think about also is sometimes, and this is a really challenging situation, is where you have elder abuse, where an elderly patient who has a legitimate appropriate need for, for opioids lives with a family member who's caring for them and who's stealing their medications. That's beyond the scope of this, but it's—you know, these are things that we do want to think about. We want to keep our patients as safe as possible and manage their pain as best as possible, and that's really where we define risk. But remember, risk is a clinical—a risk level is a clinical decision that you as the provider makes. It's not just a score, okay? And everyone, every provider has different levels or determinations of risk, so this is really where your judgment comes in as a, as a clinician.

So just a quick brief overview of terminology. So misuse is taking medication in any other way than the label says, right? So, if you're, if you're supposed to take it every four hours and you're taking it every three hours or every six hours, that's technically misuse. Diversion, stealing medications, right? You're diverting it, whether for the illegal market or to give it to friends and family or, or to sell it, but for whatever reason, you're stealing it.

Opioid use disorder is a, is a clinically diagnosed, a problematic pattern of opioid use with impairment or distress, and there's clear criteria to determine OUD. The key thing to remember is misuse does not necessarily mean an opioid use disorder. Physical dependence does not necessarily mean an opioid use disorder. People with OUD are physically, do become physically dependent on opioids, but there's lots of patients who will come in and they're like, "I'm addicted." "Well, why?" "Well—" You know, I mean, when we talk about physical dependence, it's really about a physiologic response to a medication, so tolerance, meaning I have to take more of the medication in order to get the same effect, or withdrawal; I suddenly stop taking the medication, and I experience withdrawal symptoms. This happens with opioids, but it also happens with other medications. A real big category that people don't think about that have physical dependence and withdrawal syndromes are your SSRIs, your antidepressants, your SNRIs, but also your gabapentinoids and pregabalin and, and gabapentin. Those medications you need to taper off or else a patient will experience withdrawal syndromes. Okay?

Let's keep on moving. So factors to consider that are both increased risk factors and preventative factors. So, if you've got a patient who, who is smoking, who drinks a lot of caffeinated beverages, who drinks alcohol, who takes cough syrup and decongestants regularly, all of these things are indications. Again, all these factors play into an overall assessment of risk. If a patient is, is using cannabis products, especially if they're bought from friends and it's not medical marijuana and they haven't been evaluated appropriately, any illicit drugs a personal family history of a substance use disorder. Remember that the brain doesn't care whether it's alcohol, cocaine, sex, chocolate cake, gambling. It's—When we talk about addiction, we'll do this in a little bit. It's a brain—It's a dysfunction of the reward center in the brain. It's not the substance. And that's a significant thing to remember.

History of criminal activity, especially DUI, risk factors, their social environment. More stress equals increased risk of wanting to do behaviors and substances to relieve that stress, so these are all things to think about. None of these are 100% absolute determinants. These are all potential factors that can increase or protect against the risk of a substance use disorder. Depression, anxiety, PTSD, major psychiatric diagnoses increase the risk of having a substance use disorder as well as increasing the risk of developing a chronic pain condition. Adverse childhood events, physical, emotional, sexual trauma, PTSD, all of those increase the risk for both chronic pain as well as developing a substance use disorder. But there are also protective factors. Patients who have good control, self-control, patients that are very structured and routine in their life, support systems, stable home environment, academic achievement, community engagement, people that are involved in a supportive communal—a support, who have a supportive community around them, that can absolutely be a protective factor.

So, when you're reviewing the medical record, you know, things that you want to look at, you want to look for red flags. You know, does a patient, as soon as they leave their office, have they called nine times within the next two hours asking if the prescription's already been sent to the pharmacy? Do they request multiple refills, multiple months? How frequently does that happen? Unes—Unauthorized dose escalations, right? So they're increasing medications that you find out later. Review the most recent visits. If maybe one of the other providers saw the patient, make sure you're up-to-date on what's going on with the patient. If the family expresses concerns, then you should be concerned. Okay? It means that you need to investigate further. Has the patient shown up to the ER multiple times or goes to very different urgent cares? Those are things that you want to look at because all of those are breadcrumbs that give you an idea of what's going on with your patient.

Using the Prescription Drug Monitoring Database, I would expect by now everyone on this call understands and/or has used the Prescription Drug Database. Every state has a database. It tracks controlled substances. Some—Most of the states now, there's cross-

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sharing of data, but in many states there is a requirement that we check the PDMP before prescribing an opioid and other substances. Every state is a little bit different, so please check your own state for what the rules and regulations are as to checking a PDMP before prescribing. Again, it works when you review this beforehand, but remember also that PDMPs, just like urine drug testing, while they're very valuable, they are not addiction diagnosis genies, right? They provide information that we put into the overall assessment of our patient, so use it as information. PDMPs have—the data is, for the most part, reliable, but sometimes it may not, and there can be patient identification crossovers. So you should use the PDMP, and the data is, for the most part, very trustworthy, but also, if something doesn't make sense, look at the whole patient, okay? That's really important.

So, when we're talking about drug release, it's just—this is a quick one. Immediate release is what most of us know most of the pills are. You take the pill, it dissolves, and, and the drug is released into the system. You have a peak concentration, and then it, it goes away. Delayed release is an immediately—it's an immediate-release drug that is released later. So sometimes, for some drugs that need to be absorbed further down in the GI tract, we use a delayed-release drug delivery mechanism. And then you have extended release, ER or IR. Now, extended release tends to have a higher concentration that releases the drug in a longer steady-state manner so you don't have—The peaks and the troughs are not as extreme, so you end up in the therapeutic range for the majority of the duration of the drug effects. And there are significant advantages to that.

All right. So opioid drug-drug interaction. So when we talk about pharmacokinetics, this is what the body does to the drug. Pharmacodynamics, what the drug does to the body. And there's a bunch of enzymes that interact with the opioid to detoxify it and, and eliminate it from the body. Pharmacodynamic effects is really what we're—you know, the other piece of this that matters, because when we're prescribing opioids for a patient, we want to know what other drugs interact with opioids that can increase risk of overdose or death or other issues and problems. And then from a pharmacokinetic side is we want to understand how this patient metabolizes medications because that impacts blood-level concentrations and duration.

So the biggest thing that you want to think about when you're considering prescribing opioids for a patient is what other medications is this patient taking, and are they taking other CNS depressants that can have a synergistic effect and increase the risk of respiratory depression and overdose? So the biggest thing that we talk about, most people are, are aware of, you know, the, the risk of mixing benzodiazepines with opioids has a dramatic and increased effect, you know, two to five times a greater effect on respiratory depression. One of the things that we think about, the gabapentinoids, the FDA actually released a warning in 2019 about the combination of gabapentinoids and opioids. Again, we're not saying don't do it. What we're saying is be aware of the risk. And that's important because a lot of times we're going to have patients where we're, we're prescribing the opioids and potentially a gabapentinoid in, in a chronic pain patient, but then they're seeing their, their primary care doctor, who gives them zolpidem for sleep, and then they're seeing their psychiatrist, who's giving them benzos for, for anxiety, and then they go home, and they're drinking alcohol at night that they're not sharing with us. So those are things that it's worth seeing what other medications the patient's on. That's really where the, the PDMP really helps in seeing what other prescribers are prescribing.

Again, there are, there are times—Always remember this. The way I look at it is, when I'm making these decisions, is What is best for the patients, and what will I say on the stand? And generally speaking, if I'm doing what's best for the patient and document that, it is—I, I have no problem sitting on a stand saying and explaining why. The next thing is, the question I ask is, Does the benefits outweigh the risk in this patient, in this particular situation? And as long as, as long as you document that in this patient, in this situation, the benefits outweigh the risk, that's the way that you do what's best for the patient. You document it, and you also protect yourself because you are doing what's best for the patient and you're explaining why.

Also, co-prescribed naloxone, that was right at the bottom. If you're prescribing opioids, prescribe naloxone as well. Now, naloxone is now available over the counter, so you can also just educate your patient about that. They can get it over the counter. Sometimes, if their insurance will cover naloxone, it's better to write a prescription because what that will do is that saves your patient money because even over-the-counter naloxone can be expensive—and depending on the financial situation of that patient.

So there are some atypical opioids that have mechanisms of action different or slightly different than the, you know, traditional full mu agonists like oxycodone, hydrocodone, et cetera. So we're talking—Let's start on the right with tramadol. I'm pretty sure most folks are familiar with that these days since they rescheduled hydrocodone back a number of years ago. So tramadol is a mu-opioid agonist, but it also has serotonin and norepinephrine reuptake inhibition, so again, SNRI activity as well as mu opioid activity.

What's really important, so patients who overdose on tramadol are at risk for seizure, so that's something to, to think about; but also remember, tramadol is not benign if you stop it, so if a patient has been on tramadol for a long period of time and they're trying—and you're trying to taper them down, you also—you don't just treat the opioid receptor withdrawal. You also need to treat the serotonin and norepinephrine reuptake withdrawal too. Okay? So that's really important if you've got someone who's struggling with stopping tramadol. Now, tapentadol is a mu opioid receptor agonist with norepinephrine reuptake inhibition, and that's a schedule II, and that has

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been shown that it may have some benefit in neuropathic pain as well.

All right, so opioid warnings, again, CNS depression; there's physical dependence; there is the risk for developing addiction, opioid use disorder. Opioids can impair your memory, judgment, and decision-making ability, and that's really important when you're having conversations with patients. And it's important to document that you are—that you've explained those risks to that patient because they're—patients on chronic opioids will most likely drive or do other things, and it's your job or our job as, as clinicians is to educate them on the risks and benefits. We can't enforce patients to do anything outside of our office, but we can educate them so they can—and help them make better decisions.

We worry about respiratory depression, especially gabapentin, gabapentinoids and benzos, but don't forget to talk about alcohol. I know it's legal. I know everyone, most people drink. But alcohol at home, and depending on how much they drink, can really tip the scales in a patient, so it's important. Not asking the question doesn't absolve us from our responsibility to do the best we can to save our patients and keep them safe.

Contraindications, significant respiratory compromise. An active patient with substance use disorder who's not receiving treatment is essentially pretty much the biggest, highest risk in that regard. Acute psychiatric instability or a high suicide risk, you know, a lot of people take pills in an overdose, so those are things to think about; or if they're actively on naltrexone, which is an opioid antagonist, meaning that if you prescribe opioids and they're on naltrexone, it won't work. And then nausea, vomiting, itching, constipation, sedative—sedation, and cognitive impairment, which we just discussed.

All right, so there was a big push in—a number of years ago, like right around 2017 to 2023, about abuse-deterrent formulations of opioids. They really only hit a small percentage of the market. But the key thing about abuse-deterrent formulations 1) most of them were, were branded only; there were no generics, so a lot of patients couldn't afford it; but more importantly, abuse-deterrent formulations make it difficult to crush, melt, snort, smoke or shoot the drug, right? So taking an opioid in a different way makes it harder to abuse. It doesn't prevent misuse or abuse. The most common way that people abuse medications, in particular opioids, is they take more of them orally, okay?

Abuse-deterrent formulations, they don't prevent abuse; they don't prevent addiction; they don't change the rates of addiction at all; because again, remember, addiction is in the brain, not in the drug. They haven't shown any improvement in patient outcomes. And, and again, it can be helpful, and it can decrease risk, especially if you have that patient who may be living with someone else who is a risk for this patient. Having an abuse-deterrent formulation makes it less attractive to them. They may look elsewhere.

It's important to talk about both kratom and cannabis. I'm going to start with kratom. This has exploded across the country. I know we see it in Texas a lot. Kratom is a—it's derived from an East Asian plant, Mitragyna. And so, what we're seeing now, it's not illegal. It's found in—you know, different various formulations are found in gas stations and convenience stores. They have now purified it into 7-OH as well as mitragynine, so people are taking much more potent, purified versions of this. View kratom as an illegal opioid. All the same risks of any other opioid is, you know, addiction, respiratory depression. The problem is there's, there's no, there's no regulation over how it's produced, so people don't know what they're getting or the potency of it.

There is withdrawal as well, and more importantly is kratom hits multiple receptors other than just, other than just opioids. It hits alpha-adrenergic receptors. It hits serotonin, and it hits serotonin receptors as well, so people trying to get off kratom end up going through multiple withdrawal syndromes at the same time. For myself, if I know that a patient has been—patients will come in, and they're like, "I'm using kratom for pain, and, and, and it's really helping," I will not prescribe opioids to a patient taking kratom. What I will do is I'll have a conversation with them about the risks of kratom and, and get them help that they need to get off of that.

Okay, cannabis. This is an entire webinar and discussion. It could be a whole weekend course. The bottom line is that right now CBD alone has no clear benefit for pain. There—With the increased potency of THC now, there is a very large risk for cannabis use disorder and psychosis, accidents, sedation, time distortion. The evidence is mixed right now as it comes to—when it comes to cannabis for chronic pain. My suggestion is, first of all, look at what your local and federal laws are as it relates to cannabis. Every state is different. Just because you don't test for it doesn't mean you don't have a responsibility when you're prescribing opioids. So the way I look at cannabis, I look at it as I look at any other potentially abusable substances. There are risks involved, and I need to consider those risks. It's not about politics. It's not about economics. It's not about judgment. It's about how do I keep my patient as safe as I possibly can.

Buprenorphine, one of the great things about buprenorphine, which is a partial mu agonist, the thing that's really come out is that buprenorphine has a ceiling effect on the respiratory depression effects of the mu receptor. This is really significant for not just patients with a substance use history. We use buprenorphine for patients with opioid use disorder, and it's really effective. It keeps people in treatment. It keeps them from going through withdrawal, and it helps them maintain a long-term sobriety, at which point they can taper off of it. The key thing, though, is it's a great analgesic medication for patients with chronic pain with or without a substance use

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disorder, and that's really key. It has a much higher safety profile than full mu agonists. Remember this, it may be a question.

And the other interesting thing is that a patient who's on buprenorphine, you can still prescribe other lower doses of opioids. What's great is if a patient is on buprenorphine, it does actually—the respiratory ceiling effect is protective even on other opioids. It doesn't mean someone cannot overdose on buprenorphine and other drugs. They can. It's happened. People have died with it. But it is safer than other full mu agonists. It's also been good with patients with opioid-induced hyperalgesia. So we'll have patients that get sent to us from other pain practices, and they're on ungodly amounts of oxycodone or hydrocodone or morphine, and we'll transition them over, and, and their pain is worse, and they're taking more meds, and they're not getting relief. We'll transition them to buprenorphine, and they actually end up going on lower doses, and their pain is improved. And there are those patients that have opioid-induced hyperalgesia.

All right, so, when we talk about a harm reduction strategy, the goal of a harm reduction strategy is, well, duh, it's to reduce harm. It's not to eliminate all risks. It's to reduce harm. A well-educated patient is a fantastic—is one of the best harm reduction strategies you can. So, you know, again, harm reduction, the set of practical strategies and ideas to reduce negative consequences with drug use. The key part about the harm reduction strategy in general is meeting a patient where they're at. We're going to have patients that are not going to listen to our recommendations. We're going to have patients who, who may be using other medications or—You know, I, I often will talk with my patients and like, "Look, it's what—I'm not here to judge you for whatever you're taking. I don't care about that. I just need to know so I can help you as best as I can."

And again, pain patients are used to feeling judged, right? whether at the pharmacy, whether it's in, in their social world. They experience it in the healthcare system. So the better job we can do about just meeting them where they're at, whatever they're doing, okay, you know, and that builds trust. And again, the patient—the therapeutic relationship between a patient and a provider is the most important factor on the probability of a patient doing better, so the less we can present in a judgmental way, the more we are accepting of where they're at. We may not agree, but just allowing them to be where they're at so we can help them do better is great, because if they don't come back to us and they go to someone else, who knows what's going to happen? Okay? So we talk about proper use of opioids and the risks with it. We talk about safeguarding measures so it doesn't get stolen or, or lost. We monitor with our patient, and, you know, we look for adverse events, and if the patient understands those things, that can help them make better choices when they're not in our office.

The patient-prescriber agreement, this pretty much talks about the expectations for what the prescriber will do and the expectations of the patient. The goal is not to use this as a, as a gotcha so you can discharge your patient. The goal is to help the patient understand what's expected of them and what's expected of us so you both are on the same page on, on the opioid use. Right? It should be signed after the assessment but before you start opioids. You don't want to start this—You don't want to give them the agreement after you've already prescribed for them. But if you have to, then, then you have to.

Monitoring and required risks, every state—check with your, you state medical board as, as it relates to opioid prescribing and what are the required actions that we have to do as providers. Every state has different requirements. Requirements around telehealth visit, you know, and the most important thing is that you in your clinic have standard policies and procedures that are written down for how you monitor patients on opioids, and the importance of that for you is 1) you have a clear protocol for how you, how you monitor patients, and the patients have a clear idea, so there's never a concern that you're ever going to be accused of, of bias or prejudice in how you are drug testing patients or how many offices that they're having. You've got a clear policy. "This is how we do it." And in terms of every individual patient, the monitoring may change based on risk, based on events, based on changes that occur in the clinical—in the patient's clinical picture. Again, it's not a cookbook.

Safe opioid disposal, there are a number of take-back locations, mail-in programs. The FDA has a list of what you can flush and what you can't. Some things you don't want to flush because of the, the risk of contaminating the, the water supply, but there are some medications that are actually more risky to be just thrown in the trash because of kids and pets who can overdose and die on that.

So, when do I tell my patient to call? Well, I always—you know, it's always "Hey, look, call if you have questions or concerns, but if your pain's getting worse or the medication we're using isn't working, give me a call. If you're having new symptoms, different symptoms or worsening symptoms, let us know, and we can make a decision there. If you're starting to find yourself taking more than you want to take or more than you should be taking, let me know. If you—If the medication is lost or stolen, absolutely need to know about it." And by the way, if it's lost or stolen more than once, that is an absolute red flag that you really want to look at with what's going on with the patient. Either the patient's environment is not safe, or there's something else going on with that patient—serious adverse events, accidental overdoses, family members call you. Overdose events, a lot of times we don't know about them until later. They're getting better with having overdose databases that—I don't think it's everywhere yet, but they're starting to do it, which is helpful for us. But I'd rather have a patient call and have it be nothing than have a patient not call and have it be something.

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It's important for us to educate our patients on what overdose looks like from an opioid and what to do. Signs and symptoms: difficult to wake, somnolence, slow, shallow breaths. You know, if they've got a respiratory rate less than 6, 4 to 6, absolutely, it's an issue. Bradycardia, hypotension, constricted pupils. This is really important for the family member. Sometimes you'll have a patient who comes in with a family member. This conversation is really for everyone around the patient taking opioids, because if they're the one who has overdosed, it's the other people that need to understand that. So just what I would recommend is actually creating a very small brochure that describes it, and on the backside what to do, or even half and half on what to do. Make it simple, 6th-grade level. Pictures and infographics are, are perfect.

And again, this comes back to naloxone. Naloxone is a competitive antagonist for opioids. It kicks opioids off the mu receptor and helps reverse opioid-induced overdose. It doesn't treat opioid use disorder. It is an acute rescue medication. A lot of times, if a patient overdoses, especially on illicits that may be combined with a number of different drugs, naloxone will reverse opioids. It doesn't reverse anything else. So, if they're on other sedative drugs, that may still be effect. General rule is, if a patient has overdosed, administer naloxone; call 911. Give them naloxone; call 911. If you don't have naloxone, call 911, because we don't know what's going on with the patient or what they've ingested, especially if you didn't see them go down or you didn't see what they take. Naloxone works quickly, but it, it doesn't last extremely long, so patients can get re-narcotized, so again, that's why you call the EMS service. It's very safe, otherwise. You can give it in the nose. You can inject it. You can squirt it down the throat. It's absorbed through mucous membranes. And so any way that you can get it in there, get it in there.

All right, so documentation requirements for monitoring for patients with opioids. The key thing here is document, document, document. As we all know, if it isn't documented, it didn't happen, so we want—when you're documenting for "Why am I prescribing opioids?" you want to document the rationale. "Why am I prescribing this?" The way I look at it is, first of all, is the pain appropriate for opioids, and is the patient appropriate for opioids? You have a thorough history and physical exam, and there's a pain condition that is appropriate for opioid use, or as we had in one of our patients in, in the example, that they had failed all conservative nonopioid therapies, and now it was worth considering a trial for that.

Risk assessment levels at least once a year, and that's really important. And a lot of people just do a validated screening tool like ORT or SOAPP-R or COMM. I caution all of you. Those are—Again, they are not—There's a lot of false positives, because remember, a patient is filling this out. This is a patient self-reported tool, and so it's really great for a patient who has no idea that they may have an opioid use problem. For anyone who has been through the system for a while, when a patient comes to a pain doc, they want to present as low risk and as good as possible, right? because there's a huge motivation for them to appear as low risk as possible because there's a fear of not getting a treatment that they feel that they need. And so when we talk about risk assessment—we talked about it earlier—it's overall risk assessment. Do not just rely on those validated screening tools. There—They provide information and data, but there's a significant, there's a significant false negative in, in those tests, and the CDC even put that out in their, in their 2022 guidelines. So again, when you're assessing for that, look at it all.

You reassess risk, ideally every visit, right? Does something change? Does the pain change? Does behavior change? Are there events in the patient's life that changes their risk, right? Loss of a job, a major life change, a move, a divorce, birth of a child, all of those things are really significant and can impact someone's risk for potential opioid use disorder, or they have a new diagnosis, you know, had a lung transplant, whatever. Those are things to think about. Review the—You know, you need the opioid patient agreement. My recommendation, states have different requirements, but I always check the PDMP before I prescribe, just every time as a routine to see if there's anything else going on. Urine drug testing and compliance documentation. Again, urine drug testing, the most important thing you do is, 1) absolutely a comprehensive risk assessment. Don't just rely on the ORT or SOAPP-R. And 2) you decide the risk level of the patient. You are the provider and the clinician. Don't let a self-reported patient tell you what their risk levels are.

Your screening, your, you opioid— or, I'm sorry, your urine drug testing should correlate with your—with the patient. If something's changing and there's issues and you have concerns, you should test the patient and document. As long as you're documenting the rationale for why you're doing what you're doing, you're fine, within the bounds of usual and customary clinical practice. Patient education. Again, talk to the patient about the risk, limitations of therapy. Mandy was great about that. Like this is pain management, not pain cure, so expectations are really important, and trust and communication with your patient are really important.

All right. Frequency of follow-up after changes in opioid prescribing. So, if I'm changing therapy, I generally like them to come back usually within about two weeks. Every patient can be different. Somewhere between one to four weeks after we change the therapy, assess and document changes in analgesia, adverse events, affect, aberrant behaviors or activities of daily living. Depending on what was done for nonpharmacologic therapies, we have a follow-up in three to six months, a psychologist, physical therapist. If you're doing an intervention, you're an interventional pain provider, one to four weeks depending on what the procedure is and what your professional judgment states.

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If there are no improvements, if, if there are no improvements, then you want to engage with the patient to understand what other options there are. Oh, and on that one, what I mean is, so a lot of times if opioids are not effective after one month, the probability of them being effective after six months is not there. So, statistically, if, if opioids are not working, they're not working. Increasing a dose is obviously a consideration in certain patients. And again, it's about looking at the whole patient. But overall, if all you're doing is increasing and it's never really working, most likely it's not going to keep working.

All right, dosing pearls. You know, the easiest way to remember is start low and go slow. You want to give the lowest dose to treat the issue for the shortest period of time as possible. It helps you to determine response and tolerance. Again, when you're converting between immediate release and extended release of the same opioid, you do it at the same level, right? That was the test that we just did. If you're going to convert to a new opioid, meaning you're switching from oxycodone to tapentadol or hydrocodone to oxycodone, then it's recommended that you reduce the dose by 25–50% for the initial dose to see how they respond. There is no max dose for opioids. It's, it's really—A lot of times it's, it's the toxicity level of a combination drug like acetaminophen that matters.

So, when would I increase the opioid dose? Well, some of the reasons are, well, the pain's not sufficiently managed on the current dose. We start someone on, on, on an opioid and it gives them some relief and some improvement in function, but it's still not optimal.

And again, but if the patient does not have pain relief at one month, they're unlikely to experience it with opioids at six months, as I was just saying. You can increase dose if functional goals are not being met. And Mandy was talking about a great situation where someone comes in and he's like, "Yeah, you know, my pain's a 10 out of 10, but I'm doing all of these things." So again, expectations are really important in which if the opioids can get you to a functional level, you know, again, as you start to increase opioids, you increase side effects, and that may actually decrease their functional level, and it may or may not actually relieve their pain, so our goal really is improving function.

If the patient's receiving around-the-clock short-acting, you may want to either increase dose or convert to an extended release to manage end-of-dose failure if they develop tolerance or the pain is evolving, meaning the pathologic process causing pain is, is worsening or there's a new pain event, and then we reevaluate our patient.

Okay, so who's appropriate for taping—tapering opioids? Any patient who asks to be tapered, absolutely. If there's possible ways that we can do it, no question. If there's aberrant behavior, again, candidates for opioid tapering is when the risks outweigh the benefits. Not every patient wants to taper, and not everyone is going to be really excited about it, but it's really about your assessment of this patient of does continuing to prescribe these opioids—do the risks of prescribing these opioids outweigh the benefits in this patient in this situation? And if the answer is yes, then having a conversation with the patient in a nonjudgmental way is the most—is the best chance you have for success with that. It can actually really improve patients and decrease cost, decrease side effects, physical dependence, addiction, long-term adverse events.

So, when we are tapering a patient off, the most important thing I can tell you is treat the withdrawal symptoms, right? You don't—Just tapering down like people used to do traditionally, "Oh, you just cut it down by 25%," or something like that without treating the withdrawal is a recipe for failure, and then the patient get, gets blamed for failing. Basically, after you abruptly stop a short-acting opioid —hydrocodone, oxycodone—basically, the acute withdrawal phase lasts about 7 to 10, about 7 to 10 days with a peak at about day 3 to 4, you know, insomnia, mood disruption, vomiting, anxiety, diarrhea, pupil dilation, goosebumps. Here's the significant thing, muscle aches and pains and joint aches. So remember, when you're tapering someone down and they have mild opioid withdrawal that is not treated, they are going to complain of pain. Everything is going to hurt worse, so help yourself and help your patient by treating opioid withdrawal as you're tapering, even if it's mild. That will make it—That will increase the chance of success and make for a much happier patient and much less phone calls for you.

Patient buy-in is important. They may not love it, but do the best that you can in order to buy in and let them know that you're there to support them so they don't go through withdrawal. That's the biggest fear every patient has about opioids is "I'm going to go through withdrawal." Treat the withdrawal. Trazodone, loperamide if there's any diarrhea. Zofran, or ondansetron, helps. For, for pain and aches, muscle relaxers. Clonidine is really wonderful, and it decreases symptoms of opioid withdrawal. There are also some nonpharmaceutical opioid withdrawal devices that are now FDA-cleared that, that stimulate branches of the trigeminal and vagus nerve that actually have been very effective in treating symptoms of opioid withdrawal without chemicals.

So the American Society of Addiction Medicine in 2019 redefined or updated the definition of addiction as a treatable chronic medical disease influenced by brain circuitry, genetics, the environment, and an individual's life experience that results in compulsive use of substances or engagement in behaviors that continue despite harmful consequences. Bad things happen, and I keep doing it. However, the success of prevention and treatment for addiction, substance use disorders, is comparable to that of other chronic diseases like diabetes and hypertension and asthma. That's really important. It has a good success rate when treated appropriately. People do get

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better.

So substance use disorders, addiction—I'm going to kind of use those interchangeably—are characterized by impaired control, "I can't stop," craving, and overwhelming thoughts and obsessive thoughts and desire for a drug or a behavior. Compulsive use, right? So "I can't stop," or "I can't stop, and if I can stop, I can't stay stopped," and "When I'm doing it, I do as much as I can." Continue to use despite adverse consequences. Bad things happen. It is the only disease that tells you you don't have it. So, often there's—it's always accompanied by denial and dysfunctional emotional response, meaning most patients who have substance use disorders, they tend to be stuck at the emotional level where they, where they started, when they started using.

A lot of risk factors for developing substance use disorders. So we know that there's a genetic factor. It runs in families. Again, these are risk factors, not absolutes, so even though people in your family may have it or the patient's family, it doesn't mean you'll, you'll get it. And sometimes there are people who don't have genetic factors that they know of, but they develop a substance use disorder. Psychological factors, physical, sexual, emotional abuse, all increase the risk of developing substance use disorder. Depression, anxiety, PTSD, ADHD. What is ADHD? It's, it's a disorder of impulse control. It has a 9x greater risk of developing substance use disorders.

Family environment, again, adverse childhood events, dysfunctional families, witnessing violence in the home, witnessing drug use in the home, all of those impact. Social factors, economic deprivation, being around a social situation where drugs and alcohol are always present where it's normalized. And again, one of the most pos—one of the most significant impacts on, on people are their peer group. You know, show me your five closest friends, and I'll show you who you are, and so that—And it can also be positive, right? So, if you're all surrounded by people who are not—who don't use drugs and are not okay with it, that also influences you. There's a lot of disparity in the healthcare system in general, and opioid use disorder is no different, and it's unfortunate. The people who need it most are the least likely to have access and, and availability for treatment.

Again, we've already talked about harm reduction. Again, it's about meeting people where they're at in a nonjudgmental, noncoercive way and providing them help for where they're at. You know, I've got some patients who, for instance, who, who would—and this was long before marijuana was considered legal, but they're like, "I smoke marijuana, and I'm not willing to give that up," and so it became a discussion, meeting them where they're. "Okay. Well, here are the things that I'm able to do and help you with, and here are some of the things that, that I can't at this time." And it's not about judgment. It's just about meeting them where they are, and as you build trust, helping them move to a place where they may be more open to doing things that are less harmful. And educating them is one of those things that can really help them start to see things in a different way and move more towards a willingness to change, rather than just kicking them out or discharging them or judging them.

Screening brief intervention or referral to treatment. This actually used to be a billable code. I'm not certain if it is still billable or not, but basically, it's a single-item screening that says, "How many times in the past year have you used an illegal drug or used prescription medication for nonmedical reasons?" And then depending on, on those answers, you determine the risk. If there's no risk, don't do anything. If there's moderate risk, you have a brief intervention and a conversation with them. Moderate to high risk, you, you can either, you know, start like a medication like buprenorphine or something like that or refer them to a specialist. You don't have to be an addiction specialist, but you need to know enough to refer to one instead of just discharging the patient. That's where you can make the biggest difference. Instead of ignoring it or discharging the patient, refer them. Refer them to someone who can help them, the same way we would do it if the patient had an abnormal heart murmur and we're not a cardiologist.

So, when you're not sure what to say, you know, there, there's a lot of ways to handle these uncomfortable conversations. You know, as a patient shares something really deep or intense or powerful with you that may—you may be uncomfortable about it, the easiest responses are "Thank you for trusting me with this. I can imagine how challenging it must have been to share that." So validate them, understand them. If they're really distressed, "Hey, let's slow down, and let's figure this out together." A lot, you know, when describing with pain patients is "What would a good day look like? What does that mean for you?" You know, "What is—what's your goal?" For some people it's "Walk around the mall." For other people it's, you know, "Pick up my grandchild." There's a lot of different things, so meet them where they're at and have conversations in a nonjudgmental way that builds trust. Trust is really the most important thing we have to help our patients.

So, when we're treating substance use disorders, we need to treat the physical and the psychological aspects. You can't just treat one. So there are medications that help with, with addiction. Counseling also helps. We are retraining the brain to deal with emotional and, and dysregulation of our nervous system in a way that's not harmful to themselves or other people. And the, the advantage of medications like buprenorphine is it helps people stay in treatment or in therapy so they can learn the other tools so that they can eventually not need the medication anymore because they built healthy behavioral recovery tools.

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Treatment for opioid use disorder, there are abstinence-based programs. People are familiar with Alcoholics Anonymous and other 12-step programs. There are behavioral, like motivational interviewing, cognitive CBT. There are medications that are antagonists like naltrexone, which decreases total—it decreases cravings for opioids and alcohol. And there's opioid agonist medication, like methadone or buprenorphine. One is not better than any other for any other reason. They're all different, and they all have advantages and disadvantages. The important thing is figuring out what, what will help this patient the best in order to have the best chance for long-term recovery. And often, it can be a combination of both. Again, just like with pain, think comprehensive multimodal care, right? Address physical, psychological, social, biological, and spiritual needs. It, it takes a village. It's a team approach: psychologists, therapists, social workers, peer counselors.

Medication treatment isn't—it's not just prescribing buprenorphine and walking away. Buprenorphine helps. It's the same thing when I'll talk to patients who are on anxiety medicines. I'm like, "Well, are you in therapy?" and they go, "No. I'm taking alprazolam." Like, "Well, okay, you're not actually getting better. You're just treating a symptom. Therapy helps you understand the causes and develop ways so you don't need to take—need the medication." Right? Mutual support groups, there's a lot of different resources out there. Please look them up locally in your state. Having that available when a patient's in your office is really helpful for them.

Medications for opioid use disorder, long-term pharmacotherapy. Patients don't necessarily need to be on these medications forever, but some do. My goal, like with any other medication, is to be on it for a period of time so you can develop skills, tools, lifestyle, so that there's a point in time where you don't necessarily need that, the same conversation you have with people on diabetes medications and blood pressure medicines. There's, there's multiple things we do in addition to the drugs.

Antagonists like naltrexone, again, naltrexone, it's an opioid antagonist, long-acting. It decreases cravings for alcohol and, and opioids, and it decreases total drinking days. Methadone and bup, we've already gone through. Always prescribe naloxone if they're on methadone or bup. Again, with buprenorphine, it's much safer than methadone from overdose risk and respiratory depression. It's less restricted. It's a Schedule II. Anyone with a DEA license up to schedule III are, are able to prescribe this. You don't need daily clinic visits. And there are monthly long-acting injectables available, which is great if you're ever worried about a concern about them selling it or, or, or using too much. Methadone is for patients with very high tolerance. It's highly regulated schedule II. You often need to go to an opioid clinic for that that's specially licensed. Naltrexone doesn't have any—it's the opioid antagonist. It controls craving, and it's not a controlled. There is a monthly injectable. But again, if a patient is on opioids, you cannot start naltrexone for at least seven days after the last dose of, of an opioid, and that—again, remember, we had a question about that.

All right, office-based opioid treatment, there's no X waiver. Anyone can do it as a DEA license up to schedule III. Naltrexone, you don't even need a—you, you don't need a DEA license because it's not controlled. Addiction counseling is separate, and you can always prescribe the medication and then have them go to an addiction counselor. We've already gone through naltrexone and, and explained that. When you're initiating buprenorphine, you want a history and physical, review the prescription drug database.

Basic labs, you know, to make sure that the patient doesn't have any, you know, liver or kidney dysfunction, pregnancy, a CD screen. These are more about a comprehensive care model. You can refer them out. Again, the benefits of prescribing, you don't necessarily need to wait for labs unless you have a specific concern for that patient. Sometimes the benefit of prescribing and then getting labs can outweigh those risks because if a patient overdoses and dies, that can be a problem. Discuss the safety concerns with them.

There's a lot of different ways that you can initiate a transition to buprenorphine. My recommendation is you go online and look. There's a—Go to the ASAM, American Society of Addiction Medicine's website. There's a SAMHSA website on buprenorphine. There's a lot of different ways people are now initiating buprenorphine that minimizes any opioid withdrawal.

Patients on OUD medications that are having surgery, I'm going to keep this short and simple. Do not stop buprenorphine or methadone if a patient is having surgery. They used to say that. Here's the deal. The bottom line is the risks of stopping are much greater than continuing the medication through the surgery. The only one you do stop is naltrexone, right? because it's an opioid blocker. Naltrexone you want to stop three days post-op and restart seven days afterwards, but buprenorphine and methadone, keep the patient on their dose. You talk to the anesthesiologist or the surgeon, and you say, "They are still on this." Postoperatively, you keep them on their same dose, and you treat the acute postoperative pain above and beyond their standard dose. A lot of surgeons think that they should—"Oh, well, they're already on buprenorphine," or "They're already on methadone. That should cover their post-acute surgery." No, it doesn't. That's their baseline. You have to treat above it.

Again, managing pain in the setting of a patient with an opioid use disorder, keep it simple. The overarching principle is we manage them the same as a patient with or without. We use a multimodal approach. We try to minimize the use of opioids if we can, and we maximize the use of nonopioid analgesics, multimodal therapy, interventions, physical therapy, psychological, mindfulness, behavioral health therapy, as well as kinesiology and other factors, interventions, stimulators, injections, et cetera. Evaluate the use of MOD and

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the effect on treatment options. You know, again, buprenorphine's a great option or if you're looking at an appropriate opioid patient with, you know, opioid pain with that. And again, you can always have them, you know, comanage care with an addiction specialist, and that can be really helpful for you and the addiction specialist.

Monitoring for harmful use, relapse happens. Drug test the patient, check the PDMP. Look at, look at, look at the patient, how they're doing. If you have concerns, you know, drug test them; talk to family; talk to other providers. That's really important. And do drug testing, and make sure that you document what's going on with that patient. Relapse can happen. It doesn't necessarily mean you have to kick the patient out, but it does mean that your management changes, and, and often a referral to an addiction specialist is, is absolutely warranted. Thank you.

Dr. Phipps:
Thank you both so much for that amazing presentation. We covered so much material today. We have a lot of really great questions. I'm going to ask a few in the OUD and addiction section first since I know, Michael, that you are going to have to take off fairly quickly, so I want to get some of those questions asked. We have one here from Melissa. She wants to know if there are medications to try for nonopioid behavior addictions.

Dr. Sprintz:
That is actually a great question. There are—Actually, Lisa, you probably know better than I in that. There's, there's not a ton, although there is some evidence that is coming out now with GLP-1s with a lot of, behavior and substances. It's—There's not enough evidence at this point, and it's not FDA approved for any of that, but there's a lot of research going into it in that it's, it, it's decreasing a lot of addictive-type behaviors.

Ms. Zimmerman:
...craving. I think it's the dopamine, something to do with dopamine.

Dr. Sprintz:
Well, yeah. Well, dopamine drives all addictive behaviors.

Ms. Zimmerman:
Right.

Dr. Phipps:
Yeah. And, and we're seeing some evidence about naloxone sort of modulating that reward system as well. So, you know, we don't have a lot of evidence yet, but we'll see about, you know, what comes out as people begin to study it more. We have another question here about will buprenorphine help when tobacco cessation treatments are not working for someone that really wants to quit smoking?

Dr. Sprintz:
Personally, I do not recommend starting a patient on buprenorphine or tobacco cessation. I think, I think you're asking for trouble in that regard because we already know they have, they have an addiction problem to nicotine, and it's not being successful of all the different therapeutic options that are out there, and there's zero evidence that switching to buprenorphine would help with tobacco cessation. I think in that situation the risks far outweigh any potential benefit. I think you'll, you'll get someone who's now taking buprenorphine and smoking.

Dr. Phipps:
Yeah. And all of the literature that I've seen about buprenorphine in smoking cessation are in patients who already have OUD, so I haven't seen any.

Dr. Sprintz:
They're actually getting treated for that.

Dr. Phipps:
Right, right. Let's see. The next one is about what steps need to be taken. So this one, either of you really probably could answer, and it's What steps need to be taken to see kratom be federally regulated and no longer available OTC? So that's kind of a, you know, what do we have to do to get something regulated?

Dr. Sprintz:
We've been trying. There's a lot of people that are trying. There's a lot of money in kratom, and there's a lot of lobbying against it. And generally speaking, you know, we tend to not get stop signs or stoplights until someone who's got a lot of leverage loses in a car accident because there was no stop sign, so the answer is we need to talk to our states. We need to talk to our congress people. There is absolutely an effort to try and regulate it. I think that there will be a tipping point where there is enough death of significance that, you

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know, and, and harm done before people do it, but we're clear on it, and there is, there is a lot of movement to try and get it regulated. I know it failed in Texas about two years ago.

Dr. Phipps:
Would you recommend prescription naltrexone for ketamine addiction?

Dr. Sprintz:
I don't believe there's any evidence to show that naltrexone is effective in decreasing risk or cravings for ketamine. That said, I'm a big fan of, if it doesn't cause harm and there is a potential of benefit, it may be worth trying it as an off-label use, meaning if the patient's appropriate and you've tried everything else for ketamine addiction and they're doing other things and there's a motivation for it, it absolutely may be worth a short trial of doing it, but I don't—there's nothing in the evidence that I know of that says yes or no. You know, and then again, we look at what's going on with GLP-1s in, in a lot of different areas. There's not—There's anecdotal evidence, but there's not—

Dr. Phipps:
Right. And likelihood that's also being used in smoking cessation, right? naltrexone, so there's thought that it may mitigate the reward system so—

Dr. Sprintz:
If you can block the reward behavior—

Dr. Phipps:
If it mitigates the reward system in one place. Maybe it mitigates it in another. We don't have the data. We don't know.

Dr. Sprintz:
As mentioned, you're able to—

Dr. Phipps:
Right.

Dr. Sprintz:
You're able to use off-label uses, document, and, you know, and as long as, as long as the, the potential benefits and the risks are low, and I think with naltrexone, risks are generally pretty low, so it would be worth it.

Dr. Phipps:
So then the follow-up question here that came in was What do you recommend for ketamine addiction? Or do you have it? Do you have a recommendation for ketamine addiction?

Dr. Sprintz:
Yeah, treatment. I don't have a medication solution. It's not, it's not magic. You have someone who—Again, addiction is in the brain, not necessarily the drug, so part of it is working on all the other issues that resulted in why they use ketamine for that, so it sounds like that's someone who, who would benefit from potential residential treatment.

Dr. Phipps:
Right.

Dr. Sprintz:
Yeah.

Dr. Phipps:
All right, I'm going to move. We had several questions about suzetrigine, so I want to move to a few of those. Kind of had a—When do you reach for it?

Dr. Sprintz:
Yeah, and please, if there are other questions, you can e-mail me. Lisa has my e-mail address, and I'd be happy to answer questions afterwards too by e-mail. So thank you all very much. I appreciate it.

Dr. Phipps:
Thanks. Yeah, so, Mandy, if you can stick around—

Ms. Zimmerman:
Yeah.

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Dr. Phipps:
...for a few minutes we have a lot of the pain-related questions. So we had kind of Have you had any experience with prescribing it? When's the right time to reach for suzetrigine?

Ms. Zimmerman:
So we have to remember suzetrigine is nonopioid, right?

Dr. Phipps:
Right.

Ms. Zimmerman:
So you can just pile it on. And it really doesn't interact with a whole lot of things because it has a mechanism of action that is very unique. And it does have CYP3A inhibition, so if you have a strong 3YA inhibitor or inducer, you need to be cognizant of that. There could be an interaction there, but that's really the only cautionary thing you have to worry about with suzetrigine, so I, I give it concomitantly. I'm just like, "Here, try it. We'll see what happens." First-line, definitely. You know, and then for the example of the patient who we gave ibuprofen to for the acute mechanical back pain, that would be the perfect candidate. Give them suzetrigine. They can use it short term. Suzetrigine actually has a 24-hour half-life, so I'm not really sure why it is BI—it was indicated BID—it was approved for BID dosing. Maybe you just kind of really keep it in the system. But I have patients who are taking it once a day and doing very, very well so—And, you know, and then there's the whole PRN question. You know, "Can it be used PRN? Do you need to keep it on board all the time?" I don't know the answer to that. I do have some people who are taking it PRN and it works.

Dr. Phipps:
The other question about suzetrigine here is, Is it limited to only specialists to prescribe? And is it a scheduled medication?

Ms. Zimmerman:
It is not scheduled. It is nonopioid. So, you know, I give it to everybody. I'm like, "Here, try this." I give them samples. There is technically a loading dose where they take two pills at once in the beginning and then 12 hours later they start the once every 12 hours. I don't know how important that really is. I think that if that's the only thing they're taking and they're using it for sort of an ongoing pain situation, that would be appropriate. As an adjuvant, I think once a day, twice a day, PRN. Just try it and see how the patient does. It's not going to harm anyone. And, you know, it's not opioid so—

Dr. Phipps:
Let me ask you, let me ask you this one about buprenorphine, because as a, as a pain specialist, someone said, "You mentioned—" Erica asks, "You mentioned buprenorphine buccal film as an option for pain management. In your experience, have you encountered challenges with insurance coverage for this indication? If so, how have those barriers affected patient access and outcomes?"

Ms. Zimmerman:
Yeah, so buprenorphine buccal film is indicated only for pain, chronic pain. It does not have an indication for addiction treatment, so, you know—and of course insurance companies want to balk at it, but basically, what I tell them is if you are going to require this patient try and fail methadone, fentanyl, you know, oxycodone before you're going to allow them a much safer medication, then you need to take some culpability for the opioid epidemic. And I will say that to the PharmD that I'm doing the peer-to-peer whatever with. Whoever I'm the peer-to-peer with, I will say that to them. And this is just a much safer, appropriate medication, and it is—has an indication for chronic pain. So, yeah, there are challenges with insurance, no doubt, just like any brand name, but I'm going to stand my ground for, you know, advocating for that for patients, for safety, for long-term, appropriate, better outcomes. So, yeah, I mean, I get it.

Dr. Phipps:
We have another one about, lots of questions about buprenorphine, of course. This one is—We've had this one before. Many primary care providers don't have experience with prescribing buprenorphine. What suggestions do you have for primary care providers?

Ms. Zimmerman:
Yeah, so, so the thing about buprenorphine is it's super, super safe. Like Michael talked about, it has a ceiling effect for respiratory depression, so it would be really hard to kill someone with buprenorphine. It's interesting because, you know, a lot of people are like, "Well, you know, hydrocodone." Well, you can kill someone with hydrocodone. It would be—It's much easier to kill someone with hydrocodone than it is with buprenorphine. So its safety profile makes it so that, you know, you shouldn't be afraid of it, and you shouldn't be afraid of the dosing because the resp—you know, it has a ceiling effect, so even if you increase the dose, the respiratory depression risk does not increase.

Dahan did a great study. He took some people, put them on ventilators. He gave some of them fentanyl, and he gave other ones

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buprenorphine. The—All the fentanyl people stopped breathing. None of the buprenorphine people stopped breathing regardless of dose. And also he, he put hot pokers on their legs. The buprenorphine people had just as much analgesia as the fentanyl people, so it's a good, strong analgesic. I will give you a little education the way I like to educate about buprenorphine. If you think about mu receptors on the brain, which are the bad actors, right? they cause all the problems associated with opioid medications, tolerance, euphoria, dependence, you know, all the things so—respiratory depression. So, if you have like 10 morphine, a full agonist opioid is just going to hit all 10 of those indiscriminately. Buprenorphine is only going to cover like maybe four, so you're going to have six left alone, right? And, but it has the same amount of analgesia as covering all 10 of those because it binds really deeply and strongly to the mu receptor. So, because of that strong binding, we get equal amounts of analgesia without covering all the mu receptors, so then we reduce the risk of adverse events. So, you know, your, your adverse event profile is so much safer and so much better.

And don't be afraid of the dosing. Remember, we're doing microgram dosing for pain, milligram dosing for substance use disorder. So microgram dosing of Butrans, you know, a buprenorphine buccal, a patch, is the max is 20 mcg per hour, which is a total of like 300 mcg per day, so it's really not a whole bunch of medication that they're getting. So I use it a lot in the elderly. I will just add it on. It's a good long-acting, stays in their system all the time, seven day. My little old ladies tolerate it very, very well, and it gives them some sort of, you know, analgesic pain control through, through the day without the euphoria and without the goofiness. And that's what they really want.

So I have a lot of success with buprenorphine, and I'm not afraid of it, so don't be afraid of it. You're not going to hurt anybody. And don't be afraid to push the dose because they're, they're not going to have problems with it.

Dr. Phipps:
And I would add not to be afraid to, to, you know, inquire with somebody, inquire with a pharmacist, make friends with a pain specialist, you know, and ask for some advice there too.

Ms. Zimmerman:
Yeah, I mean, I wrote a paper about converting high-dose opioids to buprenorphine buccal film and did a retrospective analysis and the pain scores stayed the same or got better. Morphine equivalents dropped significantly. So a lot of my colleagues and friends that I know will text me and say, "Hey, I got somebody on 30 mg of morphine three times a day. I want to switch them to buprenorphine buccal film." Yeah.

Dr. Phipps:
I like this question as well because it's sort of a complicated question about tapering when someone's on multiple medications. So Judy kind of asks two questions one right after the other, so I'm going to kind of combine them. If a patient is on an opioid, for example, oxycodone and other medications, for example, duloxetine and gabapentin for chronic pain, what is the best way to stop and taper medications? Should the dose taper be done such that you do one of the medications while not changing the other ones? Which one would you taper first? What do we do with this patient if we're trying to decrease the medications here?

Ms. Zimmerman:
Right. So I, I would start with the one that has probably the least effect. I wouldn't do them all at the same time. I would do one at a time and very slowly. I think I would start with the duloxetine just because duloxetine doesn't have a huge amount of effect with pain. You know, it is kind of a good adjuvant to put extra on, so I think I would start with that and just kind of taper that over a week or two depending on the dose they have, and then I would start the gabapentin. I do the oxycodone last. So, yeah, I do that sort of differently. And the gabapentin, you know, just slowly over one to two weeks, decrease the dose, like maybe every three to five days, depending on the dose, and just have a, have a good follow-up with them. Give them your number. Make sure they can get in touch with you. You know, make sure you're kind of really available for them during that time.

Dr. Phipps:
Okay. I don't want to take up too much more of your time and other people's time, but let's just do a—they want to hear localized mild pain management. Would you recommend topical CBD-THC? Are there variations in preparations? So we have to address the cannabis.

Ms. Zimmerman:
Yeah. CBD, THC. So I'm in North Carolina where nothing is legal.

Dr. Phipps:
This one's asking about topical, but we might as well kind of—

Ms. Zimmerman:

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Yes, with CBD we do have—

Dr. Phipps:
...cover the gambit because I know the questions will roll in now that we said the word.

Ms. Zimmerman:
The THC word. So, yeah, so we do have topical. We do have CBD gummies and topical CBD, so, you know, it's a, it's a mixed bag. I think, you know, you have—because it's not regulated, you don't—the patients don't really know that they're getting what the package says is in the package, right? So you just don't know, and so my advice to them is to make sure you get it from a reputable source or try to, you know, who's doing testing, can show you the testing of the percentages that are in there and, you know, what's really in the package, so that's the first thing. The second thing is my 83-year-old mother, who is extremely active and plays tennis, she freaking loves her CBD cream. She rubs it all over her body all the time so—and it's not harming her. I think topically, you know, whatever. I think it does have a place, and I—it's not going to really hurt anybody unless they're, you know, taking a bunch of gummies and they're just totally sleepy and not functioning, can't drive. But, you know, I, I would tell them, you know, "You can, you can kind of fiddle around with it and see if it helps." You know, I think it's pretty benign for the most part, particularly topically. I think that it does have some value. I mean, it's not going to replace an opioid, but I think as an adjuvant it does help with some joint stuff and muscle pains and things like that.

Dr. Phipps:
We very much appreciate it. And be on the lookout for Decera Clinical Education activities, and we appreciate your attendance today.

Ms. Zimmerman:
Thank you, everybody.

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