

Prescription Drug Monitoring Planning Questionnaire

This questionnaire can help you develop a PDM Plan for your practice.

The questionnaire is based on the American Pain Society (APS) and American Academy of Pain Medicine (AAPM) Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain, published in The Journal of Pain, 2009.

This questionnaire is meant to be a starting point for the development of your protocol. For additional guidance in developing your protocol, please refer to your state licensing board (Federation of State Medical Boards: fsmb.org) and State Prescription Drug Monitoring Program (Alliance of States with Prescription Monitoring Programs: pmpalliance.org), if available.

Once you have completed the questionnaire and reviewed your state and local requirements, fill out the protocol flow chart based on your responses.

Risk Assessment

- 1.** Prior to initiating Chronic Opioid Therapy, will you perform a Risk Assessment for outcomes associated with the abuse liability of opioids including misuse, abuse, addiction and diversion?
 - Yes
 - No
- 2.** If yes, do you plan to use a Risk Assessment Tool such as COMM[®], DIRE, ORT or SOAPP[®]/SOAPP[®]-R?
 - Yes
 - No
- 3.** If yes, which Risk Assessment Tool do you plan to use?
 - COMM[®] (Current Opioid Misuse Measure)
 - DIRE (Diagnosis, Intractability, Risk, Efficacy)
 - ORT (Opioid Risk Tool)
 - SOAPP[®]/SOAPP[®]-R (Screener and Opioid Assessment for Patients with Pain (revised))
 - Other _____ (Please Specify)
- 4.** Will you monitor your patients differently based on assessed risk?
 - Yes
 - No

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This is a continuation of the questionnaire from the previous page.

5. If yes, will you monitor your patients who were assessed as high-risk more frequently than those who were assessed as low-risk?
 - Yes
 - No
6. Do you use or have access to a pharmacy database to check patient prescription history?
 - Yes
 - No
7. Will you monitor your patients who are already being treated with Chronic Opioid Therapy?
 - Yes
 - No

Treatment Plans

8. Will your *new* patients sign a consent document or other written treatment plan or agreement?
 - Yes
 - No
9. Will your *existing* patients sign a consent document or other written treatment plan or agreement?
 - Yes
 - No
10. At which point(s) of the patient's treatment do you plan to perform Urine Drug Testing?
 - New patient
 - Prior to or at treatment initiation
 - At dosage change
 - Prescription change
 - Aberrant behavior
 - Unexpected urine drug test result

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Below are the final questions.

11. Do you plan to have a minimum testing frequency?

- Yes
- No

12. What will be your planned minimum annual testing frequency for

- Low-risk patients _____ / year
- High-risk patients _____ / year

13. Will you change the frequency of testing if the urine drug test results are unexpected?

- Yes
- No

14. If yes, how will the frequency change?

- Unexpected urine drug test results _____ / year

15. Will you change the frequency of testing if aberrant behavior is present or there is a change in behavior?

- Yes
- No

16. If yes, how will the frequency change?

- Aberrant behavior _____ / year

17. Will you change the frequency of testing if a patient's urine drug test results have been consistent or expected for a period of time?

- Yes
- No

18. If yes, how will the frequency change?

- Consistent/expected results _____ / year

Prescription Drug Monitoring Protocol Worksheet for Long Term Pharmacological Therapy

Office Name: _____

Physician Name: _____

Effective Date: _____

Existing Patient

New Patient

