Survey Questions for Opioid Prescribers

The following questions concern prescription opioid medications for non-cancer pain unless noted otherwise.

1. **Which of the following statements do you believe are true about prescription opioids?** For each statement, please say whether you believe it is true, false, or not sure.
    - Objective data show that opioids are effective for relieving non-cancer pain long term. (F)
    - Prescription opioids can be safely used in patients with substance use disorders. (T)
    - Opioids are approved for post-surgical pain in children. (T)
    - Prescribing opioids to patients taking benzodiazepines and other sedatives is not associated with serious risks. (F)
    - Opioids contain a boxed warning about the risks of abuse and addiction. (T)
    - Annual deaths from heroin outnumber annual deaths from prescription opioids. (F)
    - Prescribing opioids for acute pain for more than 5 days dramatically increases the likelihood of long-term chronic use. (T - CDC)
    - Immediate-release opioids are less addictive than extended-release/long-acting (ER/LA) opioids. (F)
    - All opioids include a Risk Evaluation and Mitigation Strategy (REMS) to help mitigate the risks associated with these medicines. (F - ER/LAs and TIRF)
    - Use of heroin and other opioids is often preceded by the use of prescription opioids. (T)
    - A patient who takes their opioids as prescribed should not become addicted to them. (F)
    - The most common route for abusing prescription opioids is through crushing and snorting the pills. (F)
    - Abdominal pain, diarrhea, and insomnia are symptoms of opioid withdrawal. (T, CDC guidelines, p. 26)
    - People at the highest risk of an opioid overdose are those getting opioids from a friend or relative or other illicit means. (F)
    - The risk of overdose begins to increase with opioid doses of 90 morphine milligram equivalents (MMEs) per day. (F - it at least doubles at 50 MMEs/day)
    - Opioid use disorders involving prescription opioids outpace those involving heroin. (T)
    - Fentanyl poses about the same level of risk as other prescription opioids (F)

2. **Which of the following statements best represents your opinion about abuse-deterrent formulations (ADFs) of opioids?** Choose one answer.
    - An ADF of a drug has a lower addictive potential than a non-ADF of the same drug.
    - An ADF of a drug has the same addictive potential as a non-ADF of the same drug. (correct option)
    - An ADF of a drug has a higher addictive potential than a non-ADF of the same drug.

3. **Which of the following do you believe are true about ADFs of opioids?** For each question, please say whether you believe it is true, false, or not sure.
    - ADFs are the same as their non-ADF counterparts except that they cannot be abused. (F)

- ADFs start to work more slowly than their non-ADF counterparts. (F)
- ADFs use different mechanisms for preventing manipulation of opioid medications. (T)
- ADFs have been proven to reduce the most common route of abuse. (F)

4. Which of the following do you believe are true about medications used to treat opioid dependence or addiction, often referred to as medication-assisted treatment (MAT)? (T/F/not sure)

- MAT can be used in pregnant women. (T)
- The death rate from all causes is higher among patients receiving methadone than in the general population. (F - it's the same)
- MAT reduces all-cause mortality. (T)
- No special requirements need to be met to prescribe MAT. (F)
- All MAT drugs are long-acting opioids. (F)
- People may safely take MAT medications for their entire lives. (T/SAMHSA)

5. Which of the following do you believe are true about medications used to reverse opioid toxicity? (T/F/not sure)

- In the state in which your primary practice is located, naloxone can be purchased without a prescription. (depends on state)
- Naloxone is used to reverse the effects of prescription opioids but not heroin. (F)
- Naloxone should be used only in cases of confirmed opioid overdose. (F)
- You do not need a special license to prescribe opioid-reversal agents. (T)
- Repeated doses of naloxone can be administered. (T)

The next questions relate to your prescribing practices.

6. How effective do you think each of the following is in assessing an opioid patient's pain? (7-point scale: Extremely ineffective, Ineffective, Somewhat ineffective, Neither ineffective nor effective, Somewhat effective, Effective, Extremely effective)

- Pain assessment scales
- Pain inventories or questionnaires
- Functional changes/changes in activities of daily living
- Recent and current psychological or emotional state

7. When prescribing an opioid to a patient for chronic non-cancer pain <u>for the first time</u>, how often do you do each of the following? For the purposes of this survey, chronic pain is pain that has lasted for three or more months. (7-point scale: Never, Rarely, Occasionally, About half the time, Frequently, Usually, Always)

- I don't prescribe ongoing opioid therapy for chronic non-cancer pain. [Skip to next question]
- Consult your state's Prescription Drug Monitoring Program (PDMP) or other prescribing/dispensing databases
- Establish an opioid contract or agreement with the patient
- Review the official FDA prescribing information/drug labeling
- Provide risk counseling related to the opioid being prescribed beyond what you do when prescribing opioids for acute pain
- Prescribe an immediate-release opioid first

- Prescribe a limited number of days and require a follow-up office appointment for reassessment
- Prescribe multi-modal therapy (a combination of non-pharmacological and/or pharmacological therapies)
- Use the Patient Counseling Document that accompanies ER/LA opioids (e.g., OxyContin, MS Contin)
- Co-prescribe an opioid-reversal agent such as naloxone, Narcan, or Evzio
- Conduct a functional status assessment
- Assess current and past mental health issues
- Assess use of alcohol, marijuana, or illegal drugs
- Assess current use of benzodiazepines or other sedatives
- Assess for prior use of prescription opioids
- Assess for prior substance abuse
- Assess for prior overdose (opioid or other drug)
- Other (open ended)

8. How often do you consider each of the following when determining whether the benefits of opioids outweigh the risks for <u>each</u> pain patient? (7-point scale: Never, Rarely, Occasionally, About half the time, Frequently, Usually, Always)

- Over-the-counter (OTC) options have not been effective in treating the pain
- Non-opioid prescription medications have not been effective in treating the pain
- Other alternatives have not been effective
- Patient refused physical therapy or exercise
- Patient refused surgical interventions/treatments or they are not an option
- Patient couldn't afford the alternative treatments
- Physical therapy was not accessible in nearby locations
- Patient was in too much pain to undergo the physical therapy/exercise without opioid pain relief
- Patient history of mental health issues
- Patient history of substance abuse
- Patient is currently taking another opioid
- Patient is taking a benzodiazepine or other sedatives

9. How often do you recommend or prescribe each of the following alternative therapies <u>before</u> prescribing opioids for chronic non-cancer pain? (7-point scale: Never, Rarely, Occasionally, About half the time, Frequently, Usually, Always)

- I don't prescribe ongoing opioid therapy for chronic non-cancer pain. [Skip to next question]
- Oral OTC pain medications
- Topical OTC medications
- Prescription NSAIDS, including COX-2 inhibitor drugs
- Cognitive behavioral therapy
- Hydro/water therapy
- Physical therapy
- Home exercise
- Weight loss
- Chiropractic or other manipulation
- Relaxation training/biofeedback
- Acupuncture

- Transcutaneous electrical nerve stimulation (TENS) or other device-based therapies
- Nerve blocks or epidural injections
- Herbal remedies or other alternative medicines
- Multi-modal therapy (combination of medications and non-medication therapies)
- Other (open)

10. When <u>monitoring</u> patients on ongoing opioid therapy for chronic non-cancer pain, how often do you do each of the following? (7-point scale: Never, Rarely, Occasionally, About half the time, Frequently, Usually, Always)

- I don't prescribe ongoing opioid therapy for chronic non-cancer pain. [Skip to next question]
- Consult your state's PDMP or other prescribing/dispensing databases.
    - Conduct or order urine drug testing.
    - Review a patient agreement or contract.
    - Conduct periodic unscheduled pill counts.
    - Revisit the official FDA prescribing information/drug labeling.
    - Provide additional risk counseling.
    - Assess for changes in mental health.
    - Assess for signs or symptoms of tolerance.
    - Assess for signs or symptoms of withdrawal.
    - Assess for signs or symptoms of addiction.
    - Assess changes in level of pain.
    - Assess changes in functional status.
    - Assess side effects or adverse events experienced.
    - Assess use of alcohol, marijuana, or illegal drugs.
    - Assess current use of benzodiazepines or other sedatives.
    - Require follow-up office visits to monitor progress at least monthly.
    - Refer for a psychological consultation.
    - Refer to a pain specialist or clinic.

11. In your experience, how effective have you found each of the following alternative therapies for treating chronic non-cancer pain? (7-point scale: Extremely ineffective, Ineffective, Somewhat ineffective, Neither ineffective nor effective, Somewhat effective, Effective, Extremely effective)

- I don't prescribe ongoing opioid therapy for chronic non-cancer pain. [Skip to next question]
- Oral OTC pain medications
- Topical OTC medications
- Prescription NSAIDS, including COX-2 inhibitor drugs
- Cognitive behavioral therapy
- Hydro/water therapy
- Physical therapy
- Home exercise
- Weight loss
- Chiropractic or other manipulation
- Relaxation training/biofeedback
- Acupuncture
- TENS or other device-based therapies
- Nerve blocks or epidural injections
- Herbal remedies or other alternative medicines

- Multi-modal therapy
- Other (open)

12. In your <u>own</u> practice, to what extent have you experienced each of the following among your patients taking opioids for chronic non-cancer pain? (7-point scale: Never, Rarely, Occasionally, About half the time, Frequently, Usually, Always)

- o I don't prescribe ongoing opioid therapy for chronic non-cancer pain. [Skip to next question]
- o Difficulty adequately treating chronic non-cancer pain
- o Unrealistic patient expectations for pain relief
- o Misuse
- o Abuse
- o Tolerance
- o Addiction
- o Withdrawal
- o Overdose
- o Patient request or pressure to prescribe an/any opioid
- o Patient request or pressure to prescribe a specific named opioid (Specify which_____)
- o Patient request or pressure to prescribe a stronger opioid
- o Patient request or pressure for an ER/LA opioid.
- o Patient request or pressure to prescribe a greater daily dose
- o Patient reports they are allergic to or cannot take certain opioids.
- o Patient reports that a prescription opioid was lost or stolen.
- o Patient requests additional opioids before a refill is due.
- o Patient receiving opioid prescriptions from other prescribers at the same time
- o Patient sharing opioids with family members or friends
- o Prescribed opioids falling into the wrong hands (children, teens)
- o Other pressure to prescribe opioids (e.g., practice setting policies, standing orders, medical specialty, or colleague prescribing practices)
- o Concurrent use of alcohol
- o Concurrent use of recreational marijuana
- o Concurrent use of illegal drugs such as heroin or cocaine
- o A state PDMP or other prescribing/dispensing database "flagged" one of your opioid patients.
- o Challenges to your ability to prevent problematic opioid use
- o Need for adjunctive mental health counseling or behavioral therapy
- o Other (open)

13. When you have experienced patient misuse, abuse, and/or addiction in your practice, to what extent did you do each of the following? (7-point scale: Never, Rarely, Occasionally, About half the time, Frequently, Usually, Always)

- o I have not experienced patient misuse, abuse, or addiction in my practice. [IF YES, skip to next question]
- o I continued to treat the patient with the same opioid at the same dose.
- o I conducted or ordered urine drug testing.
- o I spoke with the patient about my concerns.
- o I reduced the dose of the opioid the patient was taking.

- o I switched the patient to a weaker opioid.
- o I consulted my state's PDMP or another prescribing/dispensing database.
- o I recommended a non-opioid alternative treatment.
- o I stopped prescribing opioids to the patient.
- o I referred the patient to a pain management specialist/clinic for treatment.
- o I referred the patient for inpatient addiction treatment.
- o I referred the patient to an addiction specialist or outpatient addiction treatment facility.
- o I co-prescribed naloxone or another opioid-reversal agent.
- **o** I prescribed an abuse-deterrent formulation of an opioid.
- **o** I prescribed a MAT medication such as buprenorphine or naltrexone.
- o I terminated the patient from the practice.
- o Other (open).

14. How much confidence do you have doing each of the following in your practice setting? (No confidence at all, Very little confidence, A little confidence, Some confidence, A moderate amount of confidence, A good amount of confidence, A great deal of confidence**)**

- o Using your state's PDMP or another prescribing/dispensing database.
- o Using opioid treatment contracts
- o Advising patients on proper storage of opioids
- o Advising patients on proper disposal of opioids
- o Discussing potential side effects and risks of opioids with patients
- o Objectively assessing level of pain
- o Discussing patients' expectations for pain relief
- o Determining the best starting dose for patients with chronic non-cancer pain
- o Determining if/when to increase dosage for patients with chronic non-cancer pain
- o Identifying potential opioid misuse or abuse in patients
- o Discussing perceived opioid misuse or abuse issues with patients
- o Implementing efforts/strategies to prevent misuse or abuse
- o Identifying a patient addicted to opioids
- o Refusing to prescribe opioids to a patient
- o Counseling patients about perceived opioid addiction-related issues
- o Treating your patients who become addicted to opioids
- o Discussing alternative treatment options with patients addicted to or abusing opioids
- o Prescribing buprenorphine or naltrexone to treat opioid addiction
- o Prescribing opioid-reversal agents such as naloxone, Narcan, or Evzio
- o Prescribing abuse-deterrent forms of opioids
- o Identifying a patient who is using illegal substances
- o Knowing when to refer the patient to a pain specialist
- o Knowing when to refer a patient to an addiction specialist or treatment facility
- o Identifying mental health issues that may complicate treatment
- o Converting the total daily dose of the opioids you are prescribing into morphine milligram equivalents (MME)
- o Knowing how to appropriately treat pain patients who have/had problems with substance abuse.

15. To what extent do you disagree or agree that each of the following influences your opioid prescribing practices? (7-point scale: Strongly disagree, Disagree, Somewhat disagree, Neither agree nor disagree, Somewhat agree, Agree, Strongly agree)

- o Knowledge acquired from formal training in medical school/residency
- o Knowledge acquired from formal training in residency
- o Knowledge from opioid-prescribing training/continuing education (CE) courses
- o Information gained from discussions with colleagues
- o Previous experience managing opioid patients in your own practice
- o Information from drug companies or their representatives
- o Patient satisfaction
- o The official FDA prescribing information/drug labeling
- o CDC's Guideline for Prescribing Opioids for Chronic Pain
- o Opioid prescribing guidelines from your state medical board
- o Opioid prescribing guidelines from a professional organization
- o Drug Enforcement Agency regulations
- o Cost of a medication
- o Insurance coverage of a medication
- o Health system/hospital/practice policy
- o Health system/hospital/practice formularies
- **o** Legal or liability concerns
- o Other influences (open)

The next questions ask for your opinions.

16. How much do you agree or disagree with each of the following statements? (7-point scale: Strongly disagree, Disagree, Somewhat disagree, Neither agree nor disagree, Somewhat agree, Agree, Strongly agree)

- o The potential for opioid abuse, addiction, and overdose outweighs the benefits of prescribing opioid drugs for chronic non-cancer pain.
- o Prescribers spend adequate time communicating with patients regarding potential risks of opioids.
- o The use of ER/LA opioids is a primary reason for the current opioid epidemic.
- **o** If I refuse to prescribe opioids to patients, they will get them from another healthcare provider.
- o Use of opioids for more than 3 months can lead to changes in a patient's behavior and personality.
- o Patients who are abusing or addicted to prescription opioids lack the willpower or self-control to get and stay clean.
- o Healthcare providers are resistant to changing their opioid prescribing practices.
- o Patients are reluctant to accept referrals for alternative treatments for pain management.
- o Non-pharmacologic pain treatments can reduce patients' need for prescription opioids.
- o Medical marijuana is an alternative to prescription opioids for chronic pain management.
- o If more patients used ADFs, there would be fewer cases of misuse and abuse.
- o ADFs reduce morbidity and mortality associated with prescription opioids.

- o ADF opioids are as effective in treating pain as their non-ADF counterparts.
- o Overdoses from opioid MAT medications such as methadone and buprenorphine are common.
- o Opioid treatment agreements successfully prevent abuse, misuse, and addiction.
- o Healthcare providers should consider prescribing an opioid-reversal agent to patients with risk factors for overdose.
- **o** Opioid-reversal agents such as naloxone prevent people abusing opioids from seeking treatment.
- **o** Enough different opioids are already available on the market to treat pain.
- **o** The broader public health consequences of opioids should outweigh the individual needs of patients having non-cancer pain.
- o Knowing how others in my medical profession prescribe opioids would help me assess my own prescribing.
- o MAT medications should be used with counseling and/or behavioral therapies.
- o ADFs don't decrease abuse; it's just a marketing designation.
- o Only patients prescribed opioids for chronic non-cancer pain become addicted.
- o Drug company representatives should continue to be allowed to talk directly to healthcare providers about the opioids their company is selling.
- o No new opioids should be allowed to be sold unless they are proven to be non-addictive.
- o Having an adult with an addiction to opioids or other substances in a home increases the chances that a child will have later substance-abuse problems.
- o People prescribed opioids for pain usually do not throw any extras away because they think they might need them in the future.
- o Healthcare providers who prescribe opioids should be trained to prescribe MATs to treat patients who become addicted.

17. Among opioid users <u>generally</u>, how often do you think each of the following occurs when opioids are used to treat chronic non-cancer pain? (7-point scale: Never, Rarely, Occasionally, About half the time, Frequently, Usually, Always)

- o Difficulty adequately treating chronic non-cancer pain
- o Unrealistic patient expectations for pain relief
- o Misuse
- o Abuse
- o Physical dependence
- o Tolerance
- o Addiction
- o Withdrawal
- o Overdose
- o Patient request or pressure to prescribe opioids
- o Other pressure to prescribe opioids (e.g., practice setting policies, standing orders, medical specialty, or colleague prescribing practices)
- o Patient is receiving opioid prescriptions from multiple prescribers at the same time.
- o Prescription opioid medications are shared with family members or friends.
- o Concurrent use of alcohol
- o Concurrent use of recreational marijuana

- Prescription opioids lead to the use of stronger opioids such as fentanyl.
- Prescription opioids lead to the use of illegal drugs such as heroin or cocaine.

18. To what extent do you agree or disagree that the following are signs that a patient may be abusing their opioid medication? (7-point scale: Strongly disagree, Disagree, Somewhat disagree, Neither agree nor disagree, Somewhat agree, Agree, Strongly agree)

- Patient reports lost or stolen medication more than once.
- Patient calls for early refills frequently.
- Patient makes strong and persistent requests for pain medication.
- Patient requests a specific drug.
- Patient reports allergies to specific drugs.
- Lack of objective evidence of pain or condition/source causing the pain, such as an MRI.
- Patient refuses other treatments for pain.
- Patient requests an increased dosage without identifying decreases in function or ability to do activities.
- Patient reports new areas of pain.
- Patient reports they still need opioids longer than originally planned.
- Increased dosages or frequency are necessary to achieve pain relief.
- Patient or family member reports social or interpersonal problems associated with opioids.
- Patient is preoccupied with taking the next dose.

19. To what extent do you agree or disagree that the following are barriers to healthcare providers prescribing abuse-deterrent opioids (ADFs)? (7-point scale: Strongly disagree, Disagree, Somewhat disagree, Neither agree nor disagree, Somewhat agree, Agree, Strongly agree)

- Patients would react poorly if ADFs were suggested.
- ADFs of the opioids they prescribe are not available.
- ADFs aren't covered by most health insurance.
- ADFs can only be prescribed by pain specialists.
- ADFs are more expensive than non-ADFs.
- ADFs don't work as well as non-ADFs.
- Providers don't know enough about ADFs to prescribe them.
- Providers think they have patients who don't need ADFs.
- ADFs are not part of the system/hospital/practice formulary.
- Other (open ended)

20. To what extent do you agree or disagree that each of the following is a benefit of medication-assisted treatments (MAT) medications such as methadone, buprenorphine, and naltrexone for treating opioid addiction? (7-point scale: Strongly disagree, Disagree, Somewhat disagree, Neither agree nor disagree, Somewhat agree, Agree, Strongly agree)

- MATs are effective in reducing opioid addiction.
- MATs prevent patients who are abusing or addicted to prescription opioids from progressing to street drugs like heroin.
- MATs prevent patients who are abusing or addicted to prescription opioids from progressing to stronger opioids like fentanyl.
- MATs allow patients addicted to prescription opioids to maintain a steady daily dose of opioids without the need to increase doses.

- MATs allow patients addicted to prescription opioids to continue to work and otherwise be productive members of society.
- MATs allow patients addicted to prescription opioids to continue to keep their personal relationships intact.
- MATs allow patients addicted to prescription opioids to focus on issues of life rather than singularly focusing on getting "high" or having euphoric effects.
- MATs decrease drug-related crimes.
- MATs decrease HIV/AIDS and other diseases transmitted through sharing needles.
- MATS decrease the risk of overdose.
- Patients addicted to prescription opioids can be safely maintained indefinitely on MATs.

21. To what extent do you agree or disagree that each of the following is a barrier to healthcare providers prescribing MAT medications to treat opioid addiction? (7-point scale: Strongly disagree, Disagree, Somewhat disagree, Neither agree nor disagree, Somewhat agree, Agree, Strongly agree)

- Patients would react poorly if MATs were suggested.
- MATs are not covered by insurance.
- MATs are expensive for patients.
- They believe MATs should not be used to treat opioid addiction.
- They don't have sufficient training or experience to prescribe MATs.
- Providers believe they don't have patients who need MATs.
- They believe MATs replace one addiction with another.
- The certification requirements to be able to prescribe MATs are too burdensome.
- They don't know how to/are unable to refer a patient to concurrent behavioral health counseling.
- There is a lack of support for MATs among policymakers.
- MATs are not part of the system/hospital/practice formulary.
- They believe treating opioid addiction is not their responsibility.
- Patients do not use MATs as directed.
- Patients using MATs face stigma or shame.
- Patients on MATs are less adherent to these than patients who are taking medications for other chronic diseases.
- Other (open ended)

22. To what extent do you agree or disagree that each of the following is a barrier to healthcare providers prescribing opioid-reversal agents? (7-point scale: Strongly disagree, Disagree, Somewhat disagree, Neither agree nor disagree, Somewhat agree, Agree, Strongly agree)

- Opioid-reversal agents aren't covered by most health insurance.
- They are typically used only in emergency departments/settings.
- They are expensive for patients.
- They are not part of the hospital's/clinic's drug formulary.
- Healthcare providers don't know enough about these medications to prescribe them.
- Healthcare providers think opioid-reversal agents can cause harmful side effects.
- Healthcare providers think they promote opioid misuse and abuse.
- Other (open ended)

23. How effective do you believe each of the following would be in improving opioid prescribing practices among healthcare providers? (7-point scale: Extremely ineffective, Ineffective, Somewhat ineffective, Neither ineffective nor effective, Somewhat effective, Effective, Extremely effective)

- Improving communication among healthcare providers treating the same patient
- Improving healthcare providers' knowledge about abuse-deterrent formulations
- Occasional internal audits of opioid prescribing patterns in healthcare provider practices
- Use of objective pain scales or questionnaires to access patients' opioid needs
- Limiting prescriptions of opioids for acute pain due to an injury to 3 to 7 days
- Referral to a specialist if pain persists longer than 3 months
- Evaluating benefits and harms of continued opioid therapy with patients frequently
- Requiring mandatory training for all healthcare providers prescribing opioids
- Reimbursing healthcare providers for educating patients on safe use
- Other (open)

24. How effective do you believe the following would be in reducing patient abuse of prescription opioids? (7-point scale: Extremely ineffective, Ineffective, Somewhat ineffective, Neither ineffective, nor effective, Somewhat effective, Effective, Extremely effective)

- Taking a history of personal substance use and abuse
- Taking a history of family substance use and abuse
- Setting achievable functional goals for pain relief
- Reviewing current and past prescriptions opioids
- Assessing functional status changes
- Consulting your state PDMP or other prescribing/dispensing databases
- Using a written opioid treatment contract or agreement
- Using urine drug screens
- Random pill counts
- Not prescribing opioids to new patients
- Not prescribing opioids to patients younger than 30 years old
- Requiring an office visit for an opioid prescription refill
- Prescribing an ADF opioid
- Prescribing a limited amount of the opioid initially to see how the patient handles it
- Assessing current and past history of psychological problems
- Conducting monthly follow-up visits to monitor progress in meeting pain management goals
- Improving patient education about safe opioid use
- Improving physician–patient communication about opioids

How much do you agree or disagree with each of the following statements about opioid addiction? (Strongly disagree, Disagree, Somewhat disagree, Neither agree nor disagree, Somewhat agree, Agree, Strongly agree)

- Opioid addiction is a long-term chronic disease.
- Like other chronic diseases such as diabetes and heart disease, opioid addiction should be treated with medicines that a person may need to take for a long time or forever.People addicted to prescription opioids do not seek treatment because they worry they will be called an "addict."
- People addicted to prescription opioids do not seek treatment because they don't know where to find help.
- People addicted to opioids do not seek treatment because they cannot afford it.

- People addicted to opioids do not seek treatment because it's not covered by their insurance.
- People addicted to opioids do not seek treatment because they worry family members or friends will disapprove.
- People addicted to opioids do not seek treatment because they worry about how it will affect their jobs.
- There aren't enough addiction treatment centers to treat everyone who is addicted to opioids.
- The healthcare provider who prescribes an opioid should also have enough training to be able to treat a patient who becomes addicted to it.
- Opioid addiction is a public health problem that entire communities should be involved in helping to solve.

25. How much do you agree or disagree with how well each of the following explains the concept of abuse-deterrent opioids. When making your rating, focus on the following information: Abuse-deterrent properties are defined as those shown to meaningfully *deter* abuse even if they do not fully *prevent* abuse. These opioids target the known or expected routes of abuse, such as crushing in order to snort or dissolving in order to inject, for each specific opioid. Using abuse-deterrent opioids does not mean it is impossible to abuse them, and they still have the potential to be addictive. (7-point scale: Strongly disagree, Disagree, Somewhat disagree, Neither agree nor disagree, Somewhat agree, Agree, Strongly agree)

- Crush proof
- Abuse resistant
- Manipulation resistant
- Abuse prevention
- Abuse averting
- Abuse avoiding
- Tamper resistant
- Abuse reducing
- FDA would like to hear your suggestion (Write in)

26. In your opinion, what percentage of patients overall misuse, abuse, and/or become addicted to prescription opioids? Choose one.

- 0 to 5%
- 6–10%
- 11–15%
- 16–20%
- 20–30%
- 31–50%
- 51–75%
- More than 75%

The next questions ask about communication with your opioid patients.

27. How often do you discuss the following with each patient before prescribing an opioid? (7-point scale: Never, Rarely, Occasionally, About half the time, Frequently, Usually, Always)

- Patient goals for therapy related to improvements in function, work, and/or quality of life
- The extent to which you expect their functional capability to improve
- The extent to which the patient can expect the prescribed opioid to relieve their pain
- How long you expect they will need to take the medication
- Not sharing the medication with others
- Taking the medication as prescribed without dose or schedule changes
- Depression or other mental health issues
- Past patient history of addiction and/or substance abuse
- History of prior overdose
- Prior use of prescription opioids
- Current use of other opioids
- Use of benzodiazepines or other sedatives
- Use of alcohol
- Use of marijuana
- Use of illegal drugs
- Safe storage of their prescribed opioid
- Proper disposal of unused medication
- Other (open ended)

28. How often do you discuss each of the following side effects with patients <u>before</u> starting them on opioids? (7-point scale: Never, Rarely, Occasionally, About half the time, Frequently, Usually, Always)

- Possible drowsiness and avoidance of driving
- Possible respiratory depression
- Possible constipation
- Potential feeling of euphoria
- Dangers of misusing the opioid
- Possible tolerance
- Possible addiction/dependency
- Potential for overdose
- Possible mental health effects/changes
- Serious side effects when combining the prescribed opioid with alcohol, marijuana, or illegal drugs
- Other (open)

29. How often do you discuss the following with each patient when <u>initially</u> prescribing an opioid for chronic non-cancer pain? (7-point scale: Never, Rarely, Occasionally, About half the time, Frequently, Usually, Always)

- I don't prescribe ongoing opioid therapy for chronic non-cancer pain. [Skip to next question]
- Lack of evidence/data showing effectiveness of opioids for chronic non-cancer pain
- A plan for getting off the medication
- Importance of periodic reassessments
- Routine monitoring practices used for opioid patients such as treatment agreements, urine testing, pill counts, etc.

- Possible mental health effects/changes
- Other (open ended)

30. How often do you discuss the following with each patient to whom you have prescribed an opioid for chronic non-cancer pain when seeing them during <u>follow-up</u> appointments? (7-point scale: Never, Rarely, Occasionally, About half the time, Frequently, Usually, Always)

- I don't prescribe ongoing opioid therapy for chronic non-cancer pain. [Skip to next question]
- Lack of evidence/data showing effectiveness of opioids for chronic non-cancer pain
- A plan for getting off of the medication
- Urine or blood screening results showing the presence of non-prescribed drugs
- Any changes in their behavior
- Any changes to their ability to fulfill their obligations at home, work, etc.
- Any changes in relationships with others
- Use of alcohol or marijuana
- Use of illegal substances
- Need for adjunctive mental health/behavioral therapy

31. To what extent do you experience the following when communicating with your patients about opioid abuse or misuse? (7-point scale: Never, Rarely, Occasionally, About half the time, Frequently, Usually, Always)

- Job-related time constraints
- Concern or fear about a patient's response
- Uncertainty about how to initiate an inquiry
- Uncertainty about how to discuss misuse or abuse
- Fear I may damage the relationship with my patients if I raise opioid misuse or abuse
- Concern they may blame me/my prescribing decisions
- Concern that colleagues may disagree with how I'm handling these issues
- Other (open ended)

32. To what extent do you agree or disagree that resources on the following would be helpful to have when interacting with patients about opioids? (**Strongly disagree, Disagree, Somewhat disagree, Neither agree nor disagree, Somewhat agree, Agree, Strongly agree**

- How best to deal with requests for opioids from new chronic pain patients
- How best to deal with aggressive and manipulative patients
- Identifying patients at high risk for opioid abuse and/or addiction
- **o** How to recognize signs of opioid abuse and/or addiction
- Identifying patients who truly need opioids chronically (balancing real need with potential abuse)
- Setting realistic goals for pain relief from opioids
- Addressing unrealistic patient expectations
- Introducing and recommending alternatives to opioids for pain management
- **o** Overcoming patient resistance to trying alternative therapies
- Addressing patient resistance to previously agreed upon opioid treatment plans
- Discussing monitoring strategies with patients on chronic opioids to normalize the use of monitoring tools
- Complete list of opioid risks to discuss with a patient

- Guidelines for continued use or discontinuation of opioids
- Explaining the limitations in achieving complete pain relief with opioids alone
- Refusing to prescribe an opioid to a demanding or persistent patient
- How to discuss addiction treatment with a patient
- Safe storage and disposal of opioids
- Other (open)

33. In which of the following formats would you prefer the information you said would be helpful when interacting with patients about opioids? (Select all that apply)

- Videos
- Podcast
- Fact sheet
- Checklist
- Web page
- Links to online resources
- Email
- Continuing education/continuing medical education courses
- Other (open)

34. How often do you provide the following types of <u>printed/hard-copy</u> information to your patients for whom you prescribe opioids? (7-point scale: Never, Rarely, Occasionally, About half the time, Frequently, Usually, Always)

- I don't provide printed/hard-copy information to patients about opioids. [Skip to next question]
- Specific printed information about the opioid I am prescribing
- Printed information that applies to opioids generally
- Printed information from the electronic medical record or other online system affiliated with my practice
- Printed information obtained from a professional organization
- Information printed from a government agency website (specify _____)
- Information printed from another website (specify _____)
- Printed information or brochures about the specific drug developed by the drug company
- The official patient medication guide associated with the specific drug I am prescribing
- A printed list of online or other resources about opioids
- Opioid education materials developed by third parties (not the drug company or government)
- Other (open ended)

The next questions ask about education and training.

35. To what extent have/do you use each of the following to obtain information about prescribing opioids? (7-point scale: Never, Rarely, Occasionally, About half the time, Frequently, Usually, Always)

- Knowledge acquired in medical school
- Knowledge or experience acquired in residency

- ER/LA Risk Evaluation and Mitigation Strategy (REMS)-compliant continuing education course
- Other opioid continuing education/continuing medical education courses (non-REMS)
- Professional society/medical association newsletters, emails, or other similar sources
- Articles in peer-reviewed journals
- The official FDA prescribing information/drug labeling
- Pharmaceutical representatives
- Drug company websites
- Information/resources provided by my institution/practice/health system
- Professional conferences
- Other (open)

36. To what extent do you agree or disagree that each of the following would be effects of mandatory opioid prescriber education or training for opioid prescribers? (7-point scale: Strongly disagree, Disagree, Somewhat disagree, Neither agree nor disagree, Somewhat agree, Agree, Strongly agree)

- It would lead to under-treatment of patients with a legitimate need for chronic pain medication.
- Prescribers would be better informed about appropriate prescribing recommendations.
- They would better understand how to identify the risk of abuse in their patients.
- They would know how to treat addicted patients more effectively.
- They would be more aware of new and/or updated opioid prescribing guidelines.
- They would be more aware of new opioids and their risks.
- They would be more knowledgeable about abuse-deterrent formulations.
- They would be more knowledgeable about opioid reversal agents.
- They would be more knowledgeable about medication assisted treatment for opioid addiction.
- They would know how to more closely tailor the number of opioid doses to a specific patient and medical indication.
- They would be better able to counsel patients on the risks of opioids.
- They would be better prepared to treat patients who become addicted to opioids.
- Some current opioid prescribers would stop prescribing opioids.
- It would increase the use of non-opioid alternative therapies for pain.

The next questions ask about FDA's role in the opioid epidemic.

37. To what extent do you agree or disagree with each of the following statements about what strategies FDA should undertake to address the opioid epidemic? (7-point scale: Strongly disagree, Disagree, Somewhat disagree, Neither agree nor disagree, Somewhat agree, Agree, Strongly agree)

- Increase requirements for data showing long-term effectiveness before approving new opioids
- Consider the risks to society as part of the drug review process for new opioid applications
- Require that all new opioids have abuse-deterrent properties to reduce the risk of misuse and abuse
- Set narrow indications for use of opioids to specific patients and/or conditions

- Set limits on the number of opioid doses that can be prescribed to one patient based on their medical indication
- Restrict the supply of new prescription opioids available on the market
- Increase communication and education to providers about the risks of prescription opioids and safe pain management
- Increase communication and education to healthcare providers about evidence-based methods to prevent, reduce, and manage opioid abuse and addiction
- Increase communication and education to consumers about the risks of prescription opioids and safe pain management
- Other (specify_____)

The final questions are about your practice.

38. How much do you prescribe each of the following for pain? (7-point scale: Not at all, Very little, A little, Some, A moderate amount, A large amount, A very large amount)

- Extended-release/long-acting opioids (ER/LAs) (OxyContin, MS Contin)
- Immediate-release opioids (e.g., morphine, oxycodone, hydrocodone)
- Fentanyl
- Abuse-deterrent formulations
- MAT medications (e.g., buprenorphine and naltrexone)
- Opioid-reversal agents (e.g., naloxone, Narcan, and Evzio)
- Gabapentin (e.g., Neurontin, Horizant)
- Pregabalin (e.g., Lyrica)
- Other

39. To what extent do you agree or disagree with each of the following statements about how you may have deliberately changed your opioid prescribing practices for <u>acute</u> non-cancer pain over the past 12 months? (7-point scale: Strongly disagree, Disagree, Somewhat disagree, Neither agree nor disagree, Somewhat agree, Agree, Strongly agree)

- I have not changed my prescribing practices.
- I am seeing fewer patients who need opioids for acute pain.
- I am prescribing opioids to fewer patients.
- I am prescribing lower doses of opioids.
- I am prescribing fewer opioid doses in each prescription.
- I changed the type of opioids I prescribe. Specify_____

40. To what extent do you agree or disagree with each of the following statements about how you may have deliberately changed your opioid prescribing practices for <u>chronic</u> non-cancer pain over the past 12 months? (7-point scale: Strongly disagree, Disagree, Somewhat disagree, Neither agree nor disagree, Somewhat agree, Agree, Strongly agree)

- I don't prescribe ongoing opioid therapy for chronic non-cancer pain. [Skip to next question]
- I have not changed my prescribing practices.
- I am seeing fewer patients who need opioids for chronic pain.
- I am prescribing opioids to fewer patients.
- I am prescribing lower doses of opioids.
- I am prescribing fewer opioid doses in each prescription.

- I changed the type of opioids I prescribe. Specify _____
- I refer more of my patients to pain specialists/clinics.
- I refer more patients to mental health professionals.
- Other (open).

41. How would you prefer to receive information about opioids related to prescribing changes, safety issues, or other changes made to the official FDA prescribing information/drug labeling or other regulatory issues? (select all that apply)

- o FDA website
- o Targeted FDA emails healthcare providers can sign up to receive
- o Text messages healthcare providers can sign up to receive from FDA
- o FDA electronic newsletter
- o As part of continuing education/continuing medical education trainings
- o Drug company representatives
- o Professional journals
- o I don't want to receive this information.

42. In the past 30 days, for what percentage of your patients have you prescribed opioids for non-cancer pain? (ranges)

- 0 to 5%
- 6–10%
- 11–15%
- 16–20%
- 21–25%
- 26–30%
- 31–50%
- 51–75%
- More than 75%

43. In the past 30 days, for about how many patients have you prescribed opioids for non-cancer pain?

[Specify: 0 to 5000]

44. For how many of those patients had you previously prescribed an opioid for non-cancer pain?

[Specify: 0 to 5000]

45. In the past 30 days, for how many patients have you prescribed opioids for <u>chronic</u> non-cancer pain?

[Specify: 0 to 5000]

46. On average, over the past 6 months, for how many days' worth of opioids have you written in each prescription for <u>acute</u> non-cancer pain?

- 1–3 days
- 4–7 days
- 8–10 days
- 11–15 days
- 16–20 days
- 21–30 days

- More than 30 days

47. On average, over the past 6 months, for how many days' worth of opioids have you written in each prescription for chronic non-cancer pain?

- Less than 15 days
- 15–30 days
- 31–60 days
- More than 60 days

48. Over the past 30 days, for how many patients did you prescribe ER/LA opioids for chronic non-cancer pain?

[Specify: 0 to 5000]

49. How do you think your opioid prescribing compares to that of other providers in your medical specialty?

- I prescribe significantly less.
- I prescribe less.
- I prescribe slightly less.
- I prescribe about the same.
- I prescribe a little more.
- I prescribe more.
- I prescribe significantly more.

Do you have any comments you would like to share with the FDA about this topic? (Write in)

The FDA greatly appreciates your participation in this survey. Your answers will help us better understand healthcare providers' thinking about this important topic.