Team-based Care of Patients Who Take Opioids: An Interactive Workshop

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WASHINGTON STATE UNIVERSITY HEALTH SCIENCES SPOKANE


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Workshop roadmap

- We will have a standardized patient present today for group interview to help explore care of patients who take opioids for pain.
- We will practice treatment planning and discuss how clinics can identify their strengths and areas for improvement to provide team-based care.
- **We recognize that there is a lot of patient care information. We will highlight pertinent details of the patient case as we proceed.**

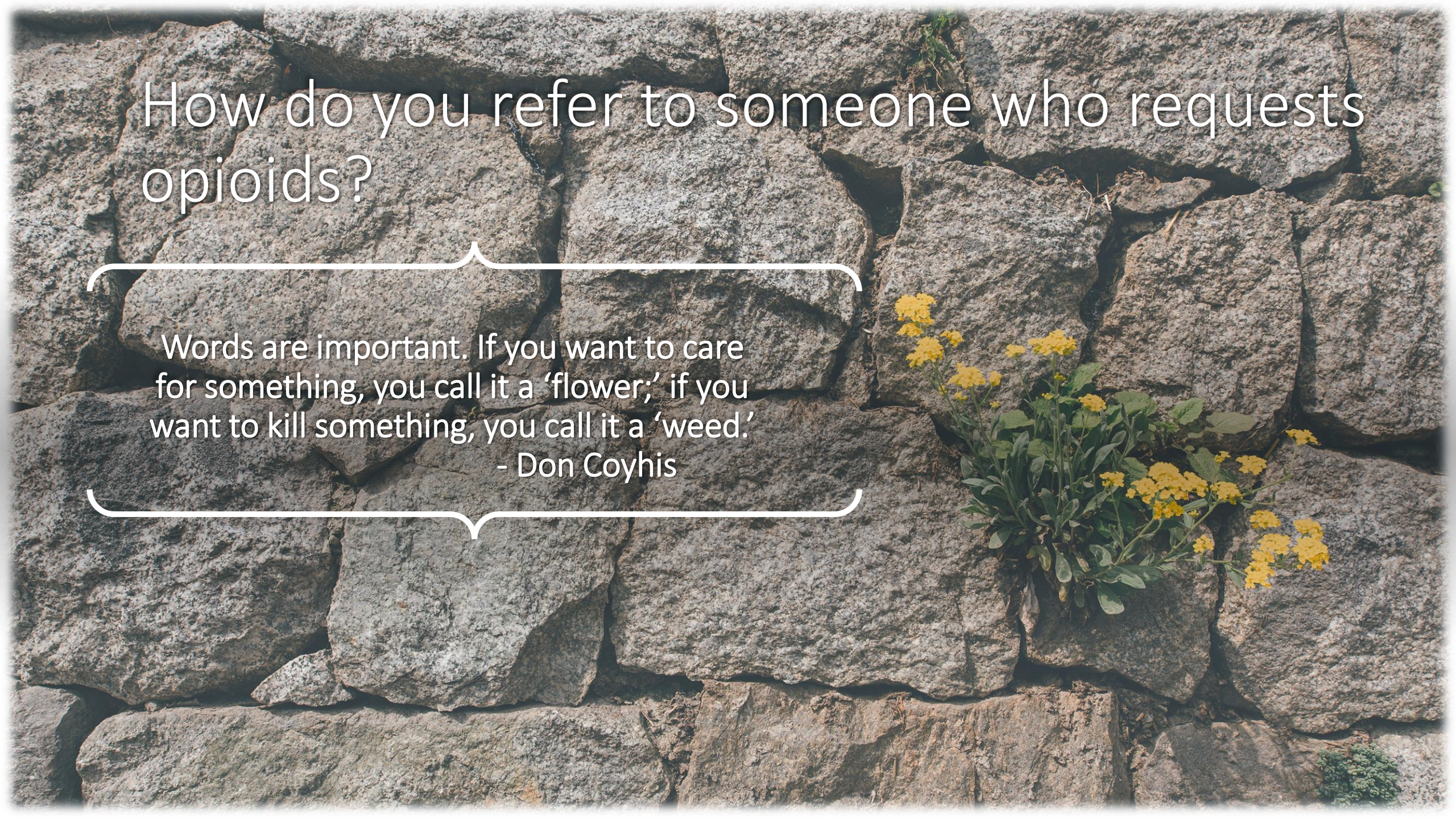
Learning objectives

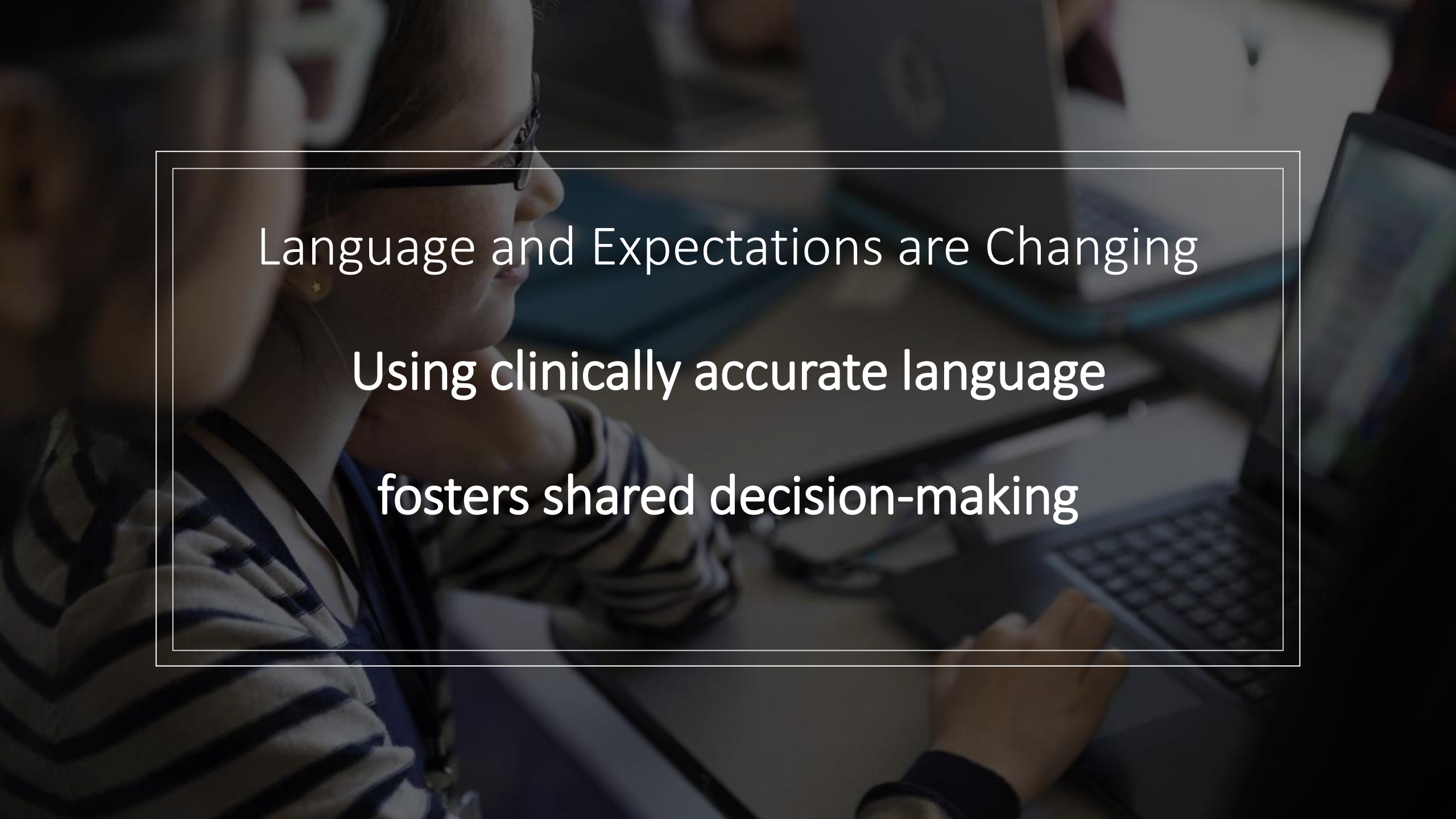
	By the end of this session, participants should be able to:
1	Describe the roles and responsibilities of healthcare team members and work collaboratively to develop a patient care plan for a person with pain who takes opioids.
2	Utilize best-practice non-stigmatizing communication to enhance care outcomes for patients who take or potentially misuse opioids and other substances.
3	Discuss risks, benefits, treatment options and patient/team perceptions of tapering opioid therapy in the context of opioid therapy for chronic pain.

How do you refer to someone who requests opioids?

Words are important. If you want to care for something, you call it a ‘flower;’ if you want to kill something, you call it a ‘weed.’

- Don Coyhis





Language and Expectations are Changing

Using clinically accurate language

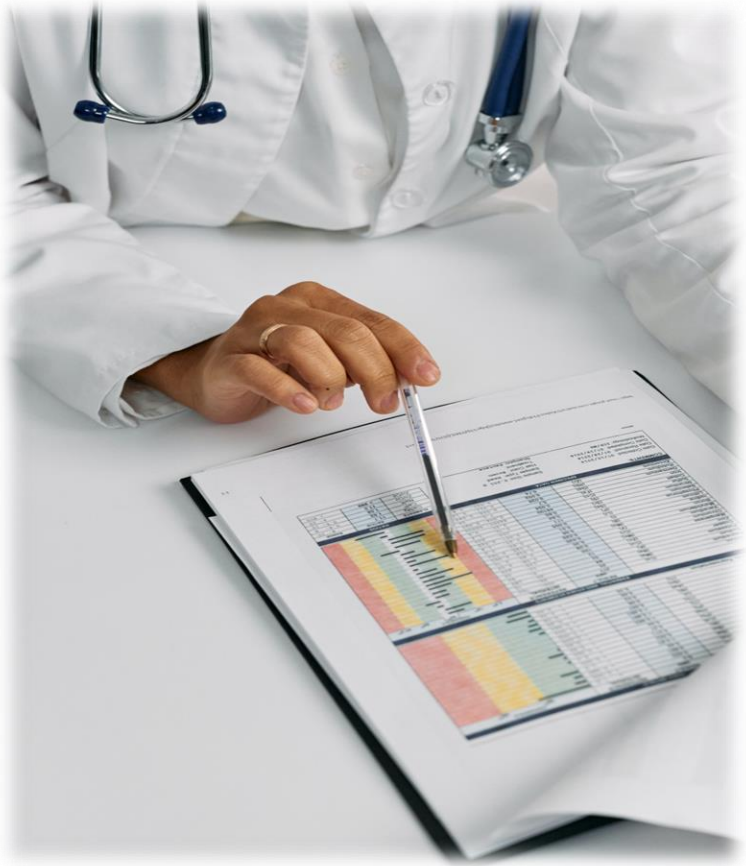
fosters shared decision-making

Let's Get Started with Today's Activity

Collect and assess relevant patient information – Review patient history

- Think about how this information is normally communicated to and among team members and identify opportunities to improve interprofessional communication.

Review screening tool results

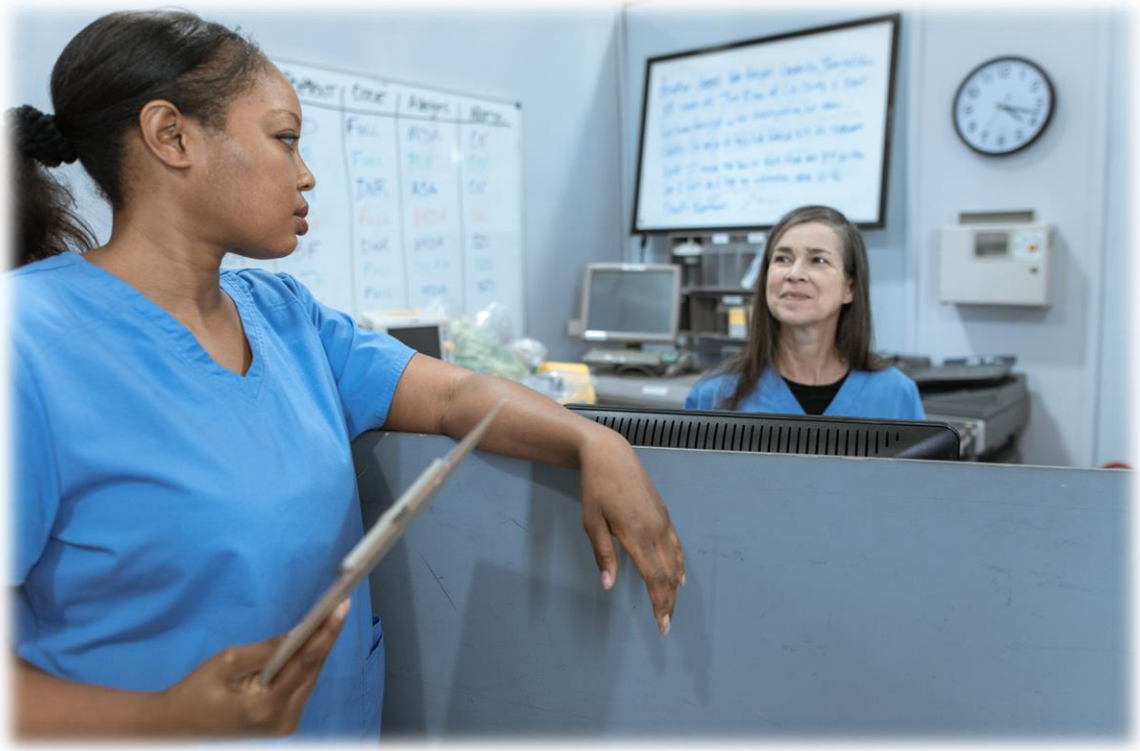


- Pain: Pain, Enjoyment, General Activity (PEG) scale
- Opioid use: Opioid Risk Tool (ORT-OUD)
- Depression: Patient Health Questionnaire (PHQ-9)

Screening tools should be used as diagnostic aids only in conjunction with complete patient information and appropriate clinical judgement.

Who administers and reviews screening tools in your setting? Are there barriers to your use of screening tools for pain/substance use disorders?

Review Prescription Monitoring Program (PMP) Information



Best practice: check PMP w/each prescription

- Each state's PMP centrally tracks prescription drug dispensing of controlled substances.
- WA state opioid prescribing guidelines recommend checking the PMP prior to new prescriptions and refills (depending on profession).
- **Consider who is responsible for checking and documenting the PMP in your clinic. Are there barriers to consistent practice?**

Calculate Morphine Equivalent Dose (MED)

- Assessing MED, a patient's cumulative intake of opioids over 24 hours, reduces the likelihood of overdose.
- There are online calculators. Today we suggest you use: https://www.oregonpainguidance.org/opioidmedcalculator/
  - Note: interchanging opioids is a more complex decision requiring specialized training.

Who calculates the MED in your setting? Is it consistently calculated and shared with team members? Is there a dose limit guideline for your clinic?

Let’s Review Your Patient Sam’s History

Case
Sam Jones, 63 year-old retired lawyer
Case Setting *(assume no pandemic is occurring)*
The patient has previously seen a former clinic prescriber (Dr. J. Larson) who no longer works at the clinic. Recently, the primary care clinic has adopted a team-based approach for pain management. This is the first time the patient care team will meet to plan Sam's care.
Chief Complaint
Here today requesting additional pain medications for ongoing back pain due to car accident.
Progress Note
Visit 1 (Three months ago): Patient was in car accident with acute back injury diagnosed as a lumbar strain with negative lumbar spine x-rays. Emergency department-initiated hydrocodone/acetaminophen 5 mg/325 mg 1 tab PO q 4-6 hours prn pain for 14 days.
Visit 2 (2.5 months ago): Ten days following the accident, the patient had a follow up clinic appointment with PCP. Reported continued pain (6 out of 10) despite prescribed hydrocodone/acetaminophen. Average Pain, Enjoyment, General activity (PEG) score was 7 out of 10 (with 10 indicating a poor function). Prescribed additional hydrocodone/acetaminophen 5 mg/325 mg 1 tab PO q 4-6 hours prn pain for 15 days.
Visit 3 (Two months ago): One month following the accident patient returned to clinic. Patient reported taking prescription medications every 4 hours. Patient's pain 7 out of 10. Average PEG score 7 out of 10. Prescriber increased dose of hydrocodone/acetaminophen to 10 mg/325 mg 1 tab PO q 4-6 hours prn pain and initiated methocarbamol 1500 mg 1 tab PO TID and at bedtime prn back muscle spasm.

Past Medical History

Allergies: Penicillin (rash)

Problem List:

1. Hypertension
2. Hyperlipidemia
3. History of depression 10 years ago. Improvement following counseling, exercise
4. Lumbar strain from car accident

Social History

1 year ago: Reports drinking occasionally 3-4 drinks per week either beer or wine. Drinks 1-2 cups of coffee per day. Does not smoke or use tobacco products. Patient reports using cannabis gummies at night "once in awhile" to help with sleep. Retired lawyer who lives with spouse and two dogs. No children.

Family History

Reports father died of alcoholic cirrhosis.

Currently Prescribed Medications

1. Hydrocodone/acetaminophen 10 mg/325 mg 1 tab PO q 4-6 hours prn pain for back pain
2. Methocarbamol 1500 mg 1 tab PO TID and at bedtime prn back muscle spasm
3. Lisinopril 10 mg 1 tab PO daily for hypertension
4. Rosuvastatin 20 mg 1 tab PO daily for hyperlipidemia

Note: The patient reports taking the following in the last 24-hour period:

- 8 tablets - Hydrocodone/ acetaminophen 10 mg/325 mg
- 3 tablets - Methocarbamol 1500 mg
- 4 tablets - Oxycodone/ acetaminophen 7.5 mg/325 mg

TODAY'S VISIT

Visit 4 (Today): Patient returns having had regular refills of prescriptions from visit 3. PEG score remains 7 out of 10. Pain is localized to lumbar area with no radiating pain or lower extremity weakness. There is no bowel or bladder incontinence. Exam confirms normal vital signs and no lower extremity weakness or sensory deficits. Patient requests ongoing medication refills.

Let’s Review Your Patient Sam’s Screening Results

PEG Score

Results of screening tools administered today

Pain, Enjoyment, General Activity (PEG) Scale Assessing Pain Intensity & Interference

1. What number best describes your pain on average in the past week?

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10
Does not interfere — Completely interferes

PEG score: 7

Calculating the PEG Score: Add the responses to the three questions, then divide by three to get a mean score out of 10 points.

Using the PEG Score: The score is best used to track an individual's changes over time. The initiation of therapy should result in the individual's score decreasing over time.

Krebs, E. E., Lorenz, K. A., Bair, M. J., Damush, T. M., Wu, J., Sutherland, J. M., Asch S, Kroenke, K. (2009). Development and Initial Validation of the PEG, a Three-item Scale Assessing Pain Intensity and Interference. Journal of General Internal Medicine, 24(6), 733–738.

OUD Score

Opioid Risk Tool - OUD (ORT-OUD)[a]

		Yes	No
1. Family history of substance abuse	• Alcohol	1	0
	• Illegal drugs	1	0
	• Prescription drugs	1	0
2. Personal history of substance abuse[b]	• Alcohol	1	0
	• Illegal drugs	1	0
	• Prescription drugs	1	0
3. Age (mark box if 16 to 45)		1	
5. Psychological disease	• Attention deficit disorder • Obsessive compulsive disorder • Bipolar • Schizophrenia	1	0
	• Depression	1	0
TOTAL (1 point for each yes)		2	
Total score risk category: • Low risk for future opioid use disorder: 0 to 2 • High risk for opioid use disorder: ≥ 3			

[a] Scoring of ORT-OUD differs from the ORT.
[b] The published tool uses the terminology of "substance abuse." This potentially stigmatizing. The preferred language is "substance use disorder."

https://www.drugabuse.gov/nidamed-medical-health-professionals/screening-tools-resources/opioid-risk-tool-oud-ort-oud
Cheatle M, Compton P, Dhingra L, Wasser T, O'Brien. Development of the Revised Opioid Risk Tool to Predict Opioid Use Disorder in Patients with Chronic Non-Malignant Pain. Journal of Pain. 20 (7): 842-851, 2019.

Patient Health Questionnaire (PHQ-9)

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully and circle your response.

	Not at all (0 points)	Several days (1 point)	More than half the days (2 points)	Nearly every day (3 points)
a. Little interest or pleasure in doing things			x	
b. Feeling down, depressed, or hopeless			x	
c. Trouble falling asleep, staying asleep, or sleeping too much				x
d. Feeling tired or having little energy			x	
e. Poor appetite or overeating			x	
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down		x		
g. Trouble concentrating on things such as reading the newspaper or watching television		x		
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual	x			
i. Thinking that you would be better off dead or that you want to hurt yourself in some way	x			
Totals				

Score total: __13__

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult At All	Somewhat Difficult	Very Difficult	Extremely Difficult
	x		

PHQ-9 Score


Which other tools might you suggest?

Sam's Prescription Monitoring Program Results

- Prescriptions from urgent care and dentist
- Cash payment for several prescriptions
- More than one pharmacy being used

What is Sam's MED?

The patient reports taking the following in the last 24-hour period:

- 8 tablets - Hydrocodone/ acetaminophen 10 mg/325 mg
- 3 tablets - Methocarbamol 1500 mg
- 4 tablets - Oxycodone/ acetaminophen 7.5 mg/325 mg

= 125 MED

Meet Sam

- This is your first meeting with Sam Jones, who is visiting the clinic today requesting additional pain medications for unresolved back pain.
- Your clinic has adopted a team-based approach for pain management given research showing it improves outcomes.
- **Audience: As you are observing this interaction, please construct your own problem list and treatment priorities**


It’s time to meet your patient

Sam's MED (morphine equivalent dose)? → 125 mg

The patient reports taking the following in the last 24-hour period:
8 tablets - Hydrocodone/ acetaminophen 10 mg/325 mg
3 tablets - Methocarbamol 1500 mg
4 tablets - Oxycodone/ acetaminophen 7.5 mg/325 mg

Starting the difficult conversation

- *It may not be possible to completely eliminate your pain, so our goal today is to help you function while reducing the pain is much as possible.*
- *There are a number of treatment options. Let's explore them together.*
- *Tell me about any methods for pain relief you've tried that did not involve opioids.*

- *Trouble controlling your use of opioid medication makes it unsafe, and long-term risks can be substantial.*
- *It looks like you have received a number of prescriptions from several different providers, which concerns me.*

Problem list – Chronic, unresolved pain

- After 3 months, *this patient has **chronic pain***. PEG score 7/10 with no improvement on high morphine equivalent dose opioid therapy.

  - For most patients, opioids are not a good choice for chronic pain therapy.
  - Current treatment inadequate/ineffective but alternatives are limited.

Problem list – Safety concerns

- Methocarbamol should not be prescribed with opioids; overlapping adverse effects.
- Potentially exceeding maximum daily dose of acetaminophen.
- Combining acetaminophen and opioids with alcohol is highly problematic.
- **Multiple prescribers: Research shows that risk of opioid overdose is 6.5 times higher when patients use 4 or more opioid prescribers in a year, and 6 times higher when 4 or more pharmacies for opioid prescriptions are used.**
- **High MED (Morphine Equivalent Dose of 125 mg)**

Gwira Baumblatt JA, Wiedeman C, Dunn JR, Schaffner W, Paulozzi LJ, Jones TF. High-risk use by patients prescribed opioids for pain and its role in overdose deaths. JAMA Intern Med. 2014;174(5):796-801. doi: 10.1001/jamainternmed.2013.12711

Problem list – Potential depression

PHQ-9 score suggests depression: Patient reports reduced physical activity and unable to exercise, weight gain, strained relationship with spouse.

- Patients using opioids are more likely to develop depression

→ Patients with depression are more likely to *misuse* opioids.

- Patients with chronic pain using opioids are also at high risk for suicide and self-harm.

Problem list – Concerning behaviors

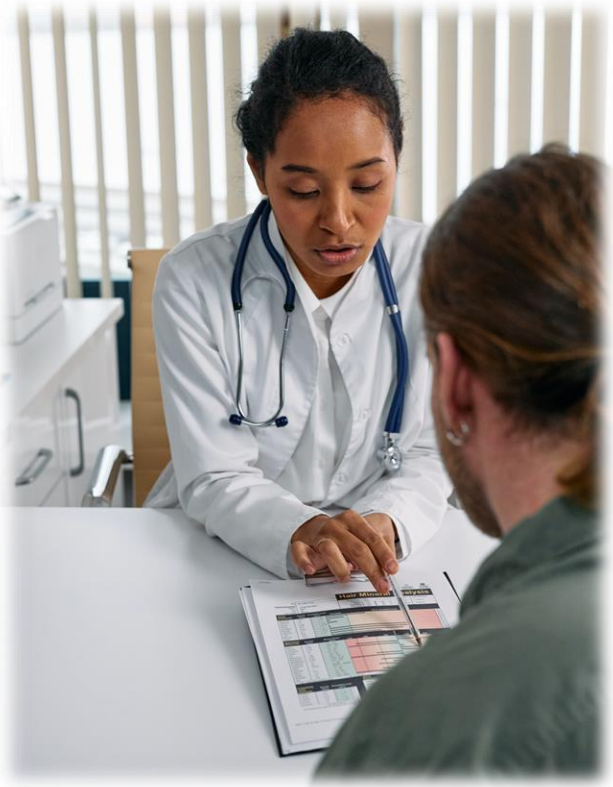
- Asking for more pain medication.
- Increasing hydrocodone dosing without instruction to do so from the provider.
- Prescription Monitoring Plan (PMP) report suggests potential misuse.
  - Obtaining prescriptions (oxycodone) from sources other than the primary care provider.
  - Paying cash, using multiple pharmacies.

The above behaviors may be the result of untreated pain.

- Sam may have underlying OUD. Evaluate opioid risk scores.


What would you like to do next?
Share your treatment plan ideas

Assessment & Plan: **Evidence of Opioid Use Disorder (OUD)?**



To confirm a diagnosis of OUD, at least two of the following should be observed within a 12-month period:

- ❑ Opioids are often taken in larger amounts or over a longer period than was intended.
- ❑ There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- ❑ A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- ❑ Craving, or a strong desire or urge to use opioids.
- ❑ Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
- ❑ Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- ❑ Important social, occupational, or recreational activities are given up or reduced because of opioid use.
- ❑ Recurrent opioid use in situations in which it is physically hazardous.
- ❑ Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- ❑ Exhibits tolerance
- ❑ Exhibits withdrawal

https://www.cdc.gov/drugoverdose/training/oud/accessible/index.html

Treatment plan options – Chronic, unresolved pain

- Work with Sam to develop realistic goals for pain and function.
  - Review risks and benefits of using opioids for chronic pain.
- Consultation/referral to a pain specialist (or pain self-management program):
  - Specialist Needed *if continuing* **> 120 mg/day MED** (WA State Prescribing Requirements).
- Consider an individualized, patient-centered opioid tapering plan – opioids not recommended for long term chronic back pain. See CDC and VA resources.

Opioids should not be tapered rapidly or discontinued suddenly given risk of significant opioid withdrawal, emotional distress, and suicide risk.

Treatment plan options – Chronic, unresolved pain

Primary care clinicians can become or be recognized as a "pain management specialist”

All pain management specialists must have at least 30% current practice in the direct provision of pain management care or be in a multidisciplinary pain clinic.

- WAC 246-840-493: ARNP criteria, credentialing, CE and expertise
- WAC 246-918-895: PA criteria, credentialing, CE and expertise
- WAC 246-919-945: Physician criteria & board certification recognized in WA

Treatment plan options – Non-opioid therapies

Discuss therapies and align with Sam's preferences:

- Movement therapies: Exercise, physical therapy, yoga, tai chi, aquatic therapy
- Non-opioid medications: NSAIDs [short term], antidepressants, topical ointments/gels
- Cognitive behavioral therapy or mindfulness meditation to address pain-related fear/anxiety, improve pain coping skills
- Hypnotherapy/relaxation techniques
- Acupuncture, massage, TENS unit [transcutaneous electrical nerve stimulation]

Re-Evaluation recommended every 1 to 4 weeks after changes; every 3 months if stable

Treatment plan options – Depression

Overlap with pain control → double benefit of treatment

- Consider referral for Counseling and/or Cognitive behavioral therapy (CBT)
  - Encourage exercise and other complementary approaches (previous slide)
- Consider initiation of anti-depressant medication therapy.
- Because of increased risk and access to opioids → Discuss and reassess patient safety and support frequently.

Treatment plan options – Safety concerns

- Overdose risk: WA state requires that patients on >120 MEDs:
  - **Confirm or prescribe naloxone to high-risk patients.**
  - Provide naloxone training to the patient and spouse.
- Provide an alternative to methocarbamol due to synergistic CNS and respiratory depression.
- Acetaminophen – patient education.
  - In past 5 days, has taken 3900 mg/day of acetaminophen. When used for longer durations (>7 days), generally recommend a lower max dose of 3 g/day in adults.
- Educate on risks of combining alcohol and opioids.

Treatment plan options – Concerning behaviors

- Establish a trusting patient-provider relationship. Avoid judgement.
- Discuss with Sam the multiple prescribers and volume of opioids prescribed.
- Initiate a pain agreement that may include use of a single prescriber/single pharmacy and/or urine drug testing.
- Consider a consult/referral to an addiction specialist to assess potential OUD.

Options if diagnosed with OUD:

- Referral for pharmacotherapy at a methadone clinic.
- Initiation in clinic or referral for buprenorphine therapy by a prescriber.
- Cognitive behavioral therapy helps improve treatment outcomes **and** reduces chronic pain.

Treatment plan options – Concerning behaviors

- Is the patient's use of cannabis in this scenario a concerning behavior?
- Taking a history of cannabis use:
  - Is the use of cannabis medical, non-medical or ambiguous?
  - What is the symptom being treated with cannabis used medically? Does it work?
  - How often does the patient use cannabis?
  - Where do they obtain their cannabis?
  - What is the quantity of THC and/or CBD in the cannabis product?
  - How is it used (smoking, transdermal, vaping, edibles, tinctures)?
  - Screening tools for concerning use include CUDIT-R. Copy with scoring available at: http://www.thecarlatcmeinstitute.com/complete/html/assess/11CUDIT-R.pdf

Washington law: **Mandatory** rx for naloxone

Dentist	MD/DO	ARNP	Physician Assistant
"High Risk Patient"	"High Risk Patient"	50 MED or above OR "High Risk Patient"	"High Risk Patient"

The Cannabis Conundrum

About 1/3 of US patients with OUD live in states where cannabis is legalized (including WA)

Limited research shows that cannabis *may* be a useful adjunct for some patients who are tapering/withdrawing from opioids (citation) - some patients report decreases in anxiety, tremor, difficulty sleeping

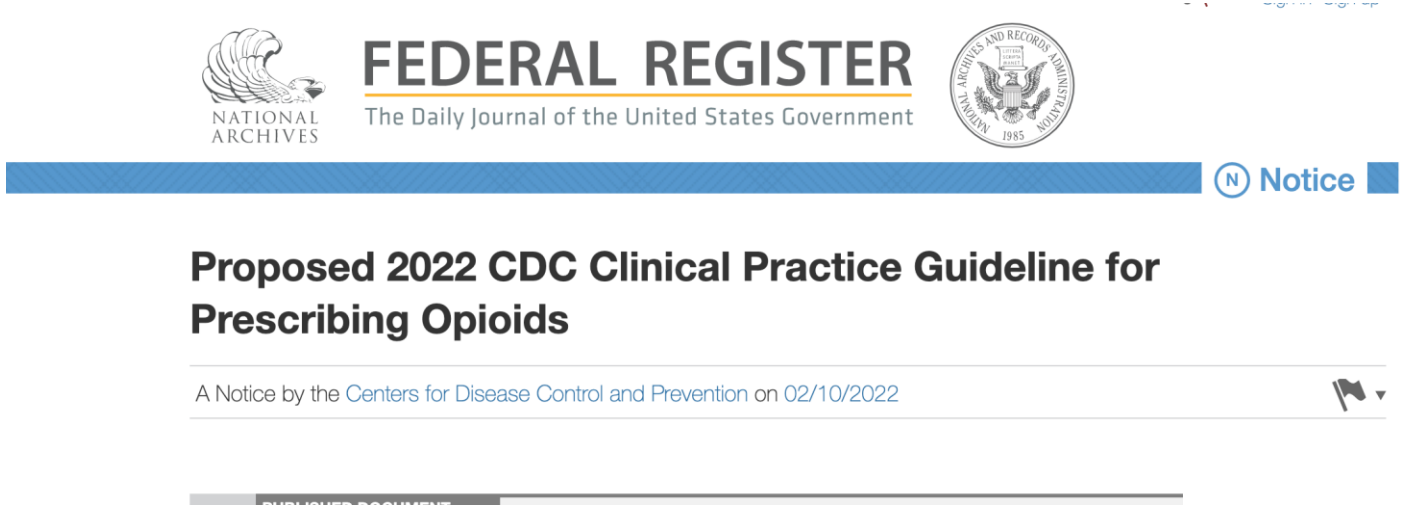
The myriad of cannabis formulations limits reliability of research findings, e.g., meta-analyses

Physicians' attitudes about continuing opioids may emphasize risk while patients may emphasize benefit (from both opioids and cannabis), creating counseling challenges – but cannabis may be less risky than opioids for patients with OUD and may help patients decrease opioid use...

This will be an ongoing debate given concerns about risks of driving and risks to performance (e.g., in college students or in job performance)

Bergeria CL, Huhn AS, Dunn KE. The impact of naturalistic cannabis use on self-reported opioid withdrawal. J Subst Abuse Treat. 2020 Jun;113:108005. doi: 10.1016/j.jsat.2020.108005. Epub 2020 Mar 30. PMID: 32359667; PMCID: PMC7212528.

CDC Updates



NATIONAL ARCHIVES

FEDERAL REGISTER

The Daily Journal of the United States Government

Notice

Proposed 2022 CDC Clinical Practice Guideline for Prescribing Opioids

A Notice by the Centers for Disease Control and Prevention on 02/10/2022

- CDC has draft updates to their 2016 opioid prescribing guidelines which have been open in 2022 for comments
- While they are not yet finally approved potential changes include:
  - Clarification that the misapplication of guidelines is potentially harmful to patients: (including application of the guidelines to patient populations for whom they were not intended (children, palliative care)); opioid tapers, abrupt discontinuation without patient collaboration, rigid application of opioid dosage thresholds, duration limits and patient abandonment
  - Emphasis on use of short acting opioids for any acute, subacute OR chronic pain
  - Less emphasis on MED and more on individualized therapy
  - Discouraging use of methadone for long-acting pain management due to risk profile

Resources to Build Pain Management Capacity

- American Academy of Pain Medicine. (2022). https://painmed.org/cme-program/
- American Society for Pain Management Nursing. (2022). Certification (aspmn.org)
- Devan, H., et al. (2019). Evaluation of Self-Management Support Functions in Apps for People With Persistent Pain: Systematic Review, JMIR Mhealth Uhealth, 7(2): e13080 https://mhealth.jmir.org/2019/2/e13080
- Chronic Pain Self-management Program (2022). https://selfmanagementresource.com/programs/small-group/chronic-pain-self-management-small-group/
- Pain Reprocessing Therapy Institute.(2022) https://www.painreprocessingtherapy.com/learning-resources
- Providers Clinical Support System (PCCS). https://pcssnow.org/
- U.S. Dept. of Health and Human Services. (2019). Pain Management Best Practices. https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf
- VA Opioid Tapering Tool https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf
- CDC Opioid Tapering Guide https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf

Thank you!

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Supplemental information

Medications for Opioid Use Disorder (OUD):

Select for pt-specific situation/mechanism

Methadone	Buprenorphine	Naltrexone	Naloxone (Narcan)
Specific eligibility criteria. Must be dispensed as part of an Opioid Treatment Program and includes mandatory counseling	Dispensed as part of an Opioid Treatment Program or clinical office with qualified provider (MD/DO, NP, PA)	Approved for alcohol and opioid dependence	Used to reverse overdose-related respiratory arrest
Full opioid agonist Close monitoring on initiation, electrocardiogram screenings recommended, multiple drug interactions >40 years of data to support safety and efficacy Stigma persists "substituting one drug for another"	***Partial opioid agonist:*** Relieves or precipitates withdrawal – depending on if opioids in system Multiple formulations: Sublingual tablets or film, injections, implants Naloxone combination products (Suboxone) to decrease misuse/diversion => will precipitate withdrawal if injected Long-term studies lacking on newer medications	***Opioid antagonist:*** blocks opioid receptors and reverses or prevents opioid euphoric effects Will precipitate withdrawal if opioids in system Various formulations: oral (ReVia) and injectable (Vivitrol)	***Opioid antagonist:*** rapidly reverses an opioid overdose. Recommended or required in some states when high dose opioids prescribed, after an overdose, following voluntary or mandatory abstinence (e.g. after incarceration).

Medications for Alcohol Use Disorder (AUD): Select for pt-specific situation/mechanism

Disulfiram (Antabuse)	Acamprosate (Campral)	Naltrexone
Oral medication	Oral medication	Oral (ReVia) and injectable (Vivitrol) products
Discourages drinking by making a person physically ill when alcohol is consumed – *aversive effect*	Reduces post-acute withdrawal symptoms – *negative reinforcement (avoids a negative or aversive event)*	Discourages drinking by blocking opioid receptors which reduces euphoria when alcohol is consumed - *reduces positive reinforcement*

Idaho Law and Controlled Substances

- No MED limits in law
- Prescribers of controlled substances are required to register with Prescription Monitoring Program (AWARxE) as well as the Idaho Board of Pharmacy and Drug Enforcement Administration
- Querying requirements:

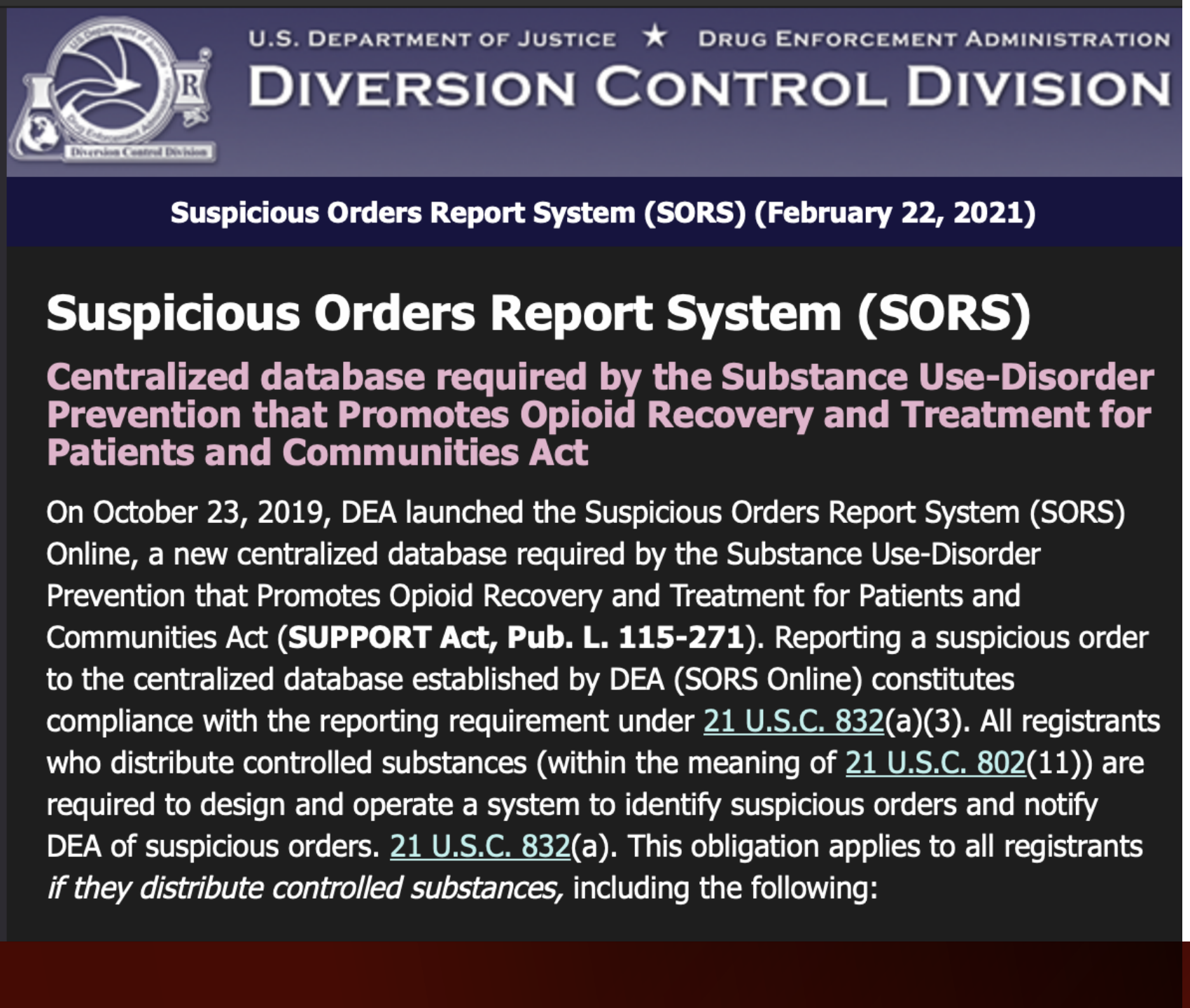
PMP to be queried 'prior to issuing a patient a prescription for outpatient use for an opioid analgesic or benzodiazepine listed in schedule II, III, or IV, the prescriber or the prescriber's delegate shall review the patient's prescription drug history for the preceding twelve (12) months from the prescription drug monitoring program and evaluate the data for indicators of prescription drug diversion or misuse.' Idaho Code 37- 2722(f)

Idaho Law and Controlled Substances

Access to Naloxone

Idaho allows pharmacists and other health professionals to prescribe and dispense the opioid antagonist, naloxone, to anyone at risk for an opioid-related overdose or anyone who may know of an individual at risk of an opioid overdose. The Idaho Office of Drug Policy has a standing order to obtain naloxone on behalf of eligible agencies. These agencies will then be equipped to administer naloxone and keep an overdose patient alive until they can be transported to an emergency department. The agencies may also distribute the naloxone to individuals at risk of overdose, as well as their friends and family. The Idaho Department of Health and Welfare (DHW) now has a website for organizations in Idaho, such as crisis centers, homeless shelters, and law enforcement agencies, to order naloxone at no charge. You can request the order form by emailing naloxone@dhw.idaho.gov. In addition, DHW has set up a naloxone locator map at *https://hshslocator.dhw.idaho.gov/prevent/default.aspx*.

This interactive map allows individuals to locate naloxone dispensers within a 50-mile radius of a given area. Information on recognizing and responding to an opioid overdose can be found on DHW's website at *https://healthandwelfare.idaho.gov/services-programs/behavioral-health/prevention-offering-support*.



- The SUPPORT Act states the term "suspicious order" may include, but is not limited to: **an order of a controlled substance of unusual size; an order of a controlled substance deviating substantially from a normal pattern, and; orders of controlled substances of unusual frequency.**

- Reporting SORS to the Administrator of the DEA and the Special Agent in Charge of the Division Office of the DEA for the area in which the registrant is located or conducts business local DEA Field Office and DEA Headquarters, or to DEA's centralized database, satisfies the requirement to report such orders to the Administrator of the DEA and the Special Agent in Charge of the Division Office of the DEA for the area in which the registrant is located or conducts business. 21 U.S.C. 832.
- DEA registrants that are ARCOS Online and ARCOS EDI reporters should utilize their current ARCOS log on information to access the system. DEA registrants that are not currently ARCOS reporters may register on the website in order to report SORS to DEA's centralized database. The registration process is as follows:
- Go to https://apps2.deadiversion.usdoj.gov/arcos-online and click on "**SORS Registration (for Non-ARCOS Reporters)**" hyperlink. After completing the initial registration, a confirmation e-mail will be sent to the e-mail address provided.Once DEA approves the registration, another e-mail will be sent with a temporary password.
- Go to https://apps2.deadiversion.usdoj.gov/arcos-online and type in your username and the temporary password. The system will require you to change the temporary password.
- Upon successfully changing the password, the account will be fully registered to report to the SORS Online system.
- For more information, contact SORS@dea.gov