Opioid Prescribing: Podiatric Implications

It's today's hot button issue.

BY ROBERT G. SMITH, DPM, MSC, RPH

Learning Objectives

- Recognize the importance of federal strategies centered on opioid prescribing regulations and apply it to practicing podiatry.
- Follow an evidence-based protocol for starting patients on opioid analgesic therapy, including safely initiating and titrating opioids.
- Define risk factors for potential misuse, abuse, and diversion of prescribed opioid medications.
- Appreciate and recognize tools to screen for the risk of opioid misuse.

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*Following this article, an answer sheet and full set of instructions are provided (pg. 168).—**Editor***

Introduction

The unpleasant and subjective sensation resulting from a noxious sensory stimulus defines the phenomenon of pain. The podiatric physician is no stranger to the difficulties in achieving optimal pain therapy. Podiatric physicians must develop analgesic regimens to treat patients with acute, chronic, and post-operative pain.[1] The topic of pain management remains a minor component of the formal education and training of residents and physicians in the United States. Misguided attitudes concerning acute and chronic pain management, in addition to reservations about the legal aspects of pain management, often translate into a "fear of the unknown" when it comes to narcotic prescriptions.[2]

On an average day in the United States, more than 650,000 opioid prescriptions are dispensed.[3] Further, the United States accounts for 4.6% of the world's population yet it is estimated that the United States consumes 80 percent of the global opioid supply as well as approximately 99% of hydrocodone.[4] The United States is in the grips of an "Opioid Crisis" described by staggering data. Of the 20.5 million Amer-

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icans 12 years old or older that had a substance use disorder in 2015, two million had a substance use disorder involving prescription pain relievers and 591,000 had a substance use disorder involving heroin.[5]

Podiatric physicians during their role of patient pain management frequently prescribe opioids. Podiatrists have an ethical obligation to prescribe responsibly yet cautiously to diminish the potential for opioid diversion and to help minimize the growth of the current epidemic of opioid abuse. The *Podiatry Management* 35th annual survey of 1,039 respondents reported data on podiatric physicians' prescribing habits.[6] Respondents admitted to prescribing 6.1 prescriptions weekly. The amount of oral analgesic prescriptions prescribed data reveals the following percentages: Norco® (13%), Percocet® (13%), Hydrocodone (11%), Ultram® (4%), Tylenol#3® (4%), Vicodin® (3%), Lortab® (1%). Notable difference between 2016 and 2017 data were a 2% increase in Percocet® prescriptions and a 4% decrease in Vicodin® prescriptions.[6]

Through alterations in the attitudes of patients and podiatric physicians, the podiatrist can manage the pain of the patient while minimizing diversion potential through careful procedural techniques, non-steroidal anti-inflammatory drug use, and limited opioid prescriptions of appropriate quantities when deemed necessary. In order to manage their patients' pain after invasive podiatric procedures, every practicing podiatrist must prescribe medication on occasion.

Many of these analgesic medications are associated with a high likelihood of physical dependence, as well as a relatively high risk of addiction. It is critical that podiatric physicians understand the underlying issues of how these medications work and how they can be abused, as well as exercise sound clinical judgment in identifying patients who might possibly have or develop a physical or psychological dependence on these drugs. There is a dilemma for the podiatric physician regarding balancing patient treatment with opioids and avoiding adverse effects contributing to the opioid crisis. This review focuses on the prescribing strategies of opioid analgesics to treat lower-extremity pain.

The selection of an appropriate opioid agent and prescribing strategies are introduced. Then, to enrich the podiatric physician's body of knowledge the National Academies of Sciences and Engineering and Medicine for opioid prescribing strategies are presented. Finally, building on the aforementioned opioid prescribing strategy monitoring tools and strategies are presented for consideration to recognize and reduce the risk of aberrant opioid misuse and abuse.

On an average day in the United States, more than 650,000 opioid prescriptions are dispensed.

FIGURE 1:
Opioid Equivalency

Opioid Products	Oral Route	IV/SC/IM Routes
Morphine	30 mg	10 mg
Codeine	130 mg	75 mg
Hydromorphone	7.5 mg	1.5 mg
Methadone	5-15 mg	2.5mg–10 mg
Meperidine	300 mg	75 mg
Levorphanol	4 mg	2 mg
Oxymorphone	10 mg	1 mg
Pentazocine	50 mg	30 mg
Hydrocodone	20 mg	N/A
Oxycodone	20 mg	N/A
Buprenorphine	N/A	0.3 mg–0.4 mg
Butorphanol	N/A	2 mg
Fentanyl	N/A	0.1 mg
Nalbuphine	N/A	10 mg

Prescribing Opioid Strategies in Podiatry

Analgesic opioid therapy has been the cornerstone of the pharmacologic management of acute and chronic pain. Ideally, opioid analgesics are prescribed by balancing the beneficial and adverse effects. Although often overlooked as a source of opioid medications, podiatric and orthopedic surgical interventions are often painful during the post-operative period; therefore, these specialists are frequent opioid prescribers. Ringwalt, et al. accentuates this assertion by their findings centered on medical specialty opioid prescribing for non-chronic, non-cancer pain.[7] They reviewed 1.28 million

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filled prescriptions for an opioid analgesic over a one year time frame.[7] They concluded that general practitioner/family medicine specialists and internists were least likely to prescribe opioids, while orthopedists were most likely to prescribe opioids.[7] While there is currently no direct evidence, a contribution to non-medical opioid misuse is presumed to be a result of normal prescribing for orthopedic surgical interventions.[7]

Opioid analgesics are classified as agonist or antagonist drugs depending on their ability to bind or block opioid receptors.[1,8] Each opioid produces a wide spectrum of pharmacologic effects, including analgesia, dysphoria, euphoria, somnolence, respiratory depression, diminished gastrointestinal motility, altered circulatory dynamics, urinary retention, histamine release, and physical dependence.[1]

The podiatric physician must remember that comfort is the ultimate goal when using any medication, including opioids, to manage pain. Before podiatric clinicians consider an opioid analgesic, they need to ensure that a complete psychosocial and physical evaluation of the patient has been performed.[1] Opioid therapy should be prescribed appropriately to avoid under-treating patients with painful symptoms.

According to *Podiatry Management's* 35th annual survey, 13% of podiatrists wrote prescriptions for Norco®.

Opioid Selection

Opioid selection is based on patient-specific factors, such as age and renal function. When selecting an opioid, immediate-release formulations are safer than extended-release or long-acting opioids, regardless of whether the drug is used for acute or long-term treatment. In the setting of acute pain, some podiatric clinicians become competent in the prescribing and use a few opioid analgesics. Although no opioid seems to be superior in relieving pain, certain products are clearly inferior because of increased risks of toxic effects.[1,9]

In some circumstances, pain control is inadequate despite dosage increases. MacPherson[1,9] reviewed the concept of opioid rotation. This method is characterized by the replacement of the current opioid regimen with another. Analgesic equivalence is the central theme when considering opioid substitution.[1,10]

Mercadante[11] defines the concept of opioid rotation as the substitution of another opioid for a previous one to obtain a more favorable response. Two types of opioid rotation strategies have been used: a change in opioid product or a change in the route of administration. Morphine-equivalent tables have been developed, and their purpose is to assist clinicians in determining equianalgesic doses of various opioid agents when changing therapy. A table of opioid equianalgesic doses is presented in Figure 1.

The last key to the rotation strategy of opioid analgesic therapy that the podiatric physician must consider is the route of administration. Various methods of drug delivery have been used to treat patients in pain. Selecting the route of administration must be precise and tailored to the patent's needs and tolerability.[1]

The Institute for Clinical Systems Improvement published an acute pain assessment and appropriate opioid prescribing protocol in 2014.[12] The podiatric physician may find the following clinical points essential when prescribing opioids for acute pain.[12] Providers should avoid prescribing more than three days or 20 doses to a patient.[12] Select the lowest dose and

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FIGURE 2:

Risk Factors for Prescription Drug Abuse

Past or present addictions to other substances, including alcohol and tobacco

Family history of substance abuse problems

Lack of knowledge about prescription drugs and their potential harm

Age group 16 to 45 Younger age, especially the teens or early 20s greater risk

Exposure to peer pressure or a social environment where there's drug use

Easier access to prescription drugs, such as having prescription medications in the home medicine cabinet

Certain pre-existing psychiatric conditions
- Bipolar Affective Disorder
- Attention Deficient Affective Disorder
- Generalize Anxiety Disorder
- Major Depressive Disorder
- Obsessive Compulsive Disorder
- Personality Disorder

Having multiple health problems and taking multiple drugs can put seniors at risk of misusing drugs or becoming addicted.

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the shortest acting opioid product.[12]

Consider that tramadol is an atypical opioid and should be managed appropriately.[12] Never prescribe long-acting/extended release opioid for acute pain. Exercise caution when prescribing opioids to the elderly patient.[12] Schedule the patient to follow up within three to five days.[12] Share decision-making and review responsible use, driving, work, storage and disposal with the patient.[12] According to Dowell, et al. treatment for three or fewer days is often sufficient for most patients with acute pain and more than seven days is rarely required.[13]

Published clinical-based evidence has described the effects of employing local anesthetic products to reduce post-operative pain and reduce the need for opioid analgesics.[14-16] Kim, et al. investigated 30 consecutive patients who underwent bilateral proximal osteotomies for the correction of hallux valgus deformities.[14] Each patient acted as their own control as one foot received local infiltration of a test solution made with ropivacaine, morphine, ketorolac and epinephrine while the other foot received the same amount of normal saline.[14]

A visual pain analogue scale was used to assess at four hours after the surgical intervention and throughout the night of the first post-operative day.[14] The difference in visual analogue scale values between the two sides was most notable at eight hours after the operation and then gradually decreased through the first and second post-operative day.[14] These investigators concluded that the local multi-drug cocktail was easy to perform, safe, and effective in reducing pain and enhancing patient satisfaction after hallux valgus surgery.[14]

Luiten, et al. investigated their hypothesis that a continuous peripheral nerve block would reduce pain scores more effectively than systemic analgesics, improve recovery, and lead to reduced hospital length of stay.[15] They retrospectively analyzed three years of data centered on patients who underwent open reduction and internal fixation of talar or calcaneal fractures who either received intravenous opioid patient-controlled analgesics or continuous peripheral nerve block.[15] Their findings reveal that the patient-controlled analgesic group required about 30-fold more opioids compared to the continuous peripheral nerve block group on the first post-operative day.[15]

Gadek and Liszka evaluated the influence of local anesthetic infiltration before hallux valgus surgery on

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FIGURE 3:

Opioid Risk Tool Patient Form

Name: _____

Age: _____

		Mark Each Box That Applies	Score If Female	Score If Male
1) Family History of Substance Abuse	• Alcohol	—	1	3
	• Illegal Drugs	—	2	3
	• Prescription Drugs	—	4	4
2) Personal History of Substance Abuse	• Alcohol	—	3	3
	• Illegal Drugs	—	4	4
	• Prescription Drugs	—	5	5
3) Age (Mark Box if 16-45 Years)		—	1	1
4) History of Preadolescence Sexual Abuse		—	3	0
5) Psychological Disease	• Attention Deficit/Hyperactivity Disorder; Obsessive Compulsive Disorder; Bipolar Disorder; Schizophrenia	—	2	2
	• Depression	—	1	1

Total Score: _____ **Risk Category:** _____

Low Risk 0–3
Moderate Risk 4–7
High Risk >7

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post-operative pain and the need for analgesics.[16] Their study group consisted of 134 patients who underwent chevron or mini-invasive Mitchell-Kramer osteotomy of the first distal metatarsal.[16] Each patient was randomized to receive either 7 mL of local anesthetic (4 mL of 0.25% bupivacaine and 3 mL of 2% lidocaine) or normal saline 15 minutes prior to skin incision.[16] Each patient's level of pain was assessed by the visual analogue scale at hours 2, 4, 8, 12, 16, 24, and 72 hours after release of the tourniquet.[16] They concluded that pre-emptive local anesthetic infiltration significantly decreased pain during the first 24 hours after hallux valgus surgery.[16]

National Academies of Sciences and Engineering and Medicine Strategies

On July 13, 2017, the Board on Health Sciences Policy of the Health and Medicine Division of the National Academies of Sciences Engineering and Medicine (NASEM) issued a report titled "Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use."[17] The US Food and Drug Administration (FDA) commissioned this comprehensive report to provide an update on current evidence on research, care, and education in the pain field, and to identify actionable measures for the FDA to more adequately address the ongoing opioid epidemic. The report highlights the fact that "A sustained, coordinated effort is necessary to stem the still-escalating prevalence of opioid-related harms, including a culture change in prescribing for chronic non-cancer pain, aggressive regulation of opioids by the FDA, and multi-pronged policies by state and local governments."[17]

Many treatments are available to manage pain. Some non-opioid therapies are likely to be as effective as opioids, or even more so, and potentially carry lower risk when used appropriately. Any meaningful effort to improve pain management will require a basic culture shift in the nation's approach to mandating pain-related education for all health professionals who provide care to people with pain. Prescribing guidelines may be most effective when accompanied with education, and so an evidence-based national approach to pain education, including pharmacologic and non-pharmacologic treatments and materials on opioid prescribing, is needed.

Insurance-based policies have substantial potential to reduce the use of specific prescription drugs. Coverage for and access to comprehensive pain management that includes both pharmacologic and non-pharmacologic options should be expanded. Prescription drug monitoring programs (PDMPs) can help address the opioid epidemic by enabling prescribers and other stakeholders to track prescribing and dispensing information, but PDMP data currently are not being used to their full potential.

The White House Office of National Drug Control Policy recommended the use of prescription drug monitoring programs to reduce abuse in 2011.

Strategies for Addressing the Opioid Epidemic

The Board proposes that a constellation of policies, interventions, and tools related to lawful access to opioids and clinical decision-making can help reduce or contain opioid-related harms while meeting the needs of patients with pain.[17] These strategies include: restricting the lawful supply of opioids; influencing prescribing practices; reducing demand and reducing harm.[17] Further, the board acknowledges that although more research is needed, limited evidence suggests that state and local interventions aimed at reducing the supply of prescription opioids in the community may help curtail access.[17]

Importantly, however, none of these studies investigates the impact of reduced access on the well-being of individuals suffering from pain whose access to opioids was curtailed.[17] Drug take-back programs allow people with unused medications to bring them in for proper disposal. These programs can increase awareness of the need for the safe disposal or return of many unused drugs. Access to these programs should be expanded, with states convening public-private partnerships to implement take-back programs year-round rather than the standard occasional take-back event.[17]

The Board's recommended changes to provider education and payer policy should be accompanied by a change in patient expectations with respect to the treatment and management of chronic pain to reduce demand. Further, attention is not being paid to educating the general public on the risks and benefits of opioid therapy, or the comparative effectiveness of opioids with non-opioid or non-pharmacologic therapies. Medication-assisted treatment for opioid use disorder is the standard of care, but it is under-used. Evidence-based treatment for opioid use disorder should be expanded by states, and barriers to coverage for these medications should be removed.[17] It is hoped that the Board's recommendations for chronic pain may be translated to better acute pain management.

Further, the Board proposes, in order to reduce harm, that life-saving medication for treating opioid overdose, called naloxone, be available, but its high and unpredictable cost impedes its use.[17] Prescribers and pharmacists can help address opioid use disorder and opioid overdose by counseling patients who may be at risk and offering naloxone when an opioid is prescribed or when opioid-related treatment is sought.[16] States can improve access to naloxone and safe injection equipment by implementing laws and policies to remove existing barriers.[17]

Prescription drug monitoring programs (PDMPs) are state-based monitoring programs for controlled substances that are prescribed by licensed practitioners and dispensed by

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pharmacies. Although prescription drug monitoring programs have existed for many years, the White House Office of National Drug Control Policy recommended the use of prescription drug monitoring programs to reduce abuse in 2011. Congress passed the National All Schedules Prescription Electronic Reporting Act (NASPER) requiring the Secretary of Health and Human Services (HHS) to award grants to states to establish or improve PDMPs.

Unfortunately, the amount of funding to support this program has been limited, and the plan to fully integrate the prescription drug monitoring programs for the entire country has yet to be realized. Currently, 48 states and one territory either have PDMPs or have passed legislation to implement them.[17] Clinicians should review PDMP data, if available, at the start of therapy as well as throughout therapy to help determine if the patient is actually using the opioid as prescribed or if there are any dangerous combinations that put their patients at high risk for overdose.

Opioid Aberrant Behaviors

Yorkgitis and Brat recently reported that many opioid prescription medications after surgery go unused, with the potential for diversion and misuse.[18] Further, they assert as surgeons become increasingly aware of their role in opioid misuse, better tools are needed to guide behavior. Based on an extensive review of recent literature, they developed the acronym **RIGHTT**: **R**isk for adverse event, **I**nsight (it is important that surgeons recognize the potential for opioid misuse in their patients, **G**oing over pain plan, **H**alting opioids, **T**ossing unused opioids and **T**rouble identification.[18] RIGHTT provides a simple acronym for surgeons to integrate best-practice strategies into their management of post-surgical opioids.[18] Strategies have been developed to decrease the risk of prescribing opioids.[18]

Sharma et al. led an investigation to determine the predictability of aberrant behavior to opioids using a comprehensive scoring algorithm incorporating phenotypic and, more uniquely, genotypic risk factors.[19] They did a multicenter observation validation study with 452 American participants diagnosed with opioid use disorder and 1237 American controls. It led to the development of an algorithm that successfully categorized patients at high and moderate risk of opioid use disorder with 91.8% sensitivity. Regardless of changes in the prevalence of opioid use disorders, sensitivity of the algorithm remained >90%. The algorithm correctly stratifies primary care patients into low-, moderate-, and high-risk categories to appropriately identify patients in need for additional guidance, monitoring, or treatment changes.[19]

The treatment of acute and chronic pain through opioid therapy involves a risk of possible dependence or abuse of the prescribed substances. While substance abuse tools assess whether a patient was or is currently involved in alcohol or drug abuse, risk assessment tools measure additional factors involved in a patient's overall level of risk of developing abuse or addiction. Beyond taking a good medical history via an effective patient interview, there are several risk assessment tools that may be used to further evaluate how likely it is that patients will have difficulty using opioid analgesics as prescribed.

The following terms are used to describe aberrant opioid behaviors: Misuse of a medication in a manner other than as specifically directed by a healthcare professional. Self-titration due to poor pain control or anxiety. Abuse–deliberate nonmedical use: crushing, snorting, injecting. Diversion (buying/selling/stealing). All these behaviors have contributed to opioid-related deaths. The biggest identified risk factors for substance abuse are presented in Figure 2.

Podiatric physicians can screen for risk factors before prescribing opioids. It is ideally done on the patient's first visit or before prescribing opioids, although even patients who have been taking opioids for long periods of time should be routinely screened. Choice of substance abuse risk assessment tools may depend on time available, substance involved, format to be used (paper, computer, interview), and depth desired.

There are a number of screening tools that have been developed specifically to screen for risk of opioid misuse in the context of chronic pain treatment and that have been demonstrated to have predictive value; these tools may be helpful in determining relative risk in addition to the medical history.

A recent review found that the opioid risk tools, diagnosis, intractability, risk, efficacy, the screener and opioid assessment for patients with pain-revised assessment tools appear to have good validity.[20] A generic opioid risk tool patient form is presented as Figure 3.

Conclusions

Podiatric physicians during their role of patient acute pain management frequently prescribe opioids. Podiatrists have an ethical obligation to prescribe responsibly and cautiously to diminish the potential for opioid diversion and to help minimize the growth of the current opioid abuse epidemic. This review focuses on the prescribing strategies of opioid analgesics to treat lower-extremity pain. The selection of an appropriate opioid agent and prescribing strategies were introduced.

Also presented were non-opioid acute post-operative treatment options to potentially decrease the use of opioid therapy during a recovery from surgical interventions. Then, to enrich the podiatric physician's body of knowledge, the National Academies of Sciences and Engineering and Medicine for opioid prescribing strategies were presented. Finally, building on the opioid prescribing strategy foundation, monitoring tools and strategies was presented to recognize and reduce the risk of aberrant opioid misuse and abuse. **PM**

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CME EXAMINATION

SEE ANSWER SHEET ON PAGE 169.

1) On an average day in the United States more than _____ opioid prescriptions are dispensed.
- **A) 1,000,000**
- **B) 350,000**
- **C) 888,000**
- **D) 650,000**

2) Which one of the following percentages from *Podiatry Management's* 35th annual survey on the amount of oral analgesic prescriptions written is true?
- **A) Percocet®—22%**
- **B) Norco®—13%**
- **C) Ultram®—4%**
- **D) Hydrocodone—28%**

3) Reflecting on the four strategies addressing the opioid epidemic, which strategy does the podiatric medical physician have direct influence over?
- **A) restricting the lawful supply of opioids**
- **B) reducing demand**
- **C) influencing prescribing practices**
- **D) reducing harm**

4) The White House Office of National Drug Control Policy recommended the use of prescription drug monitoring programs to reduce abuse in _____.
- **A) 2016**
- **B) 2012**
- **C) 2011**
- **D) 2013**

5) Reflecting on the prescriber's role to improve opioid prescription writing strategy, which statement is FALSE?
- **A) Enforce a strict refill policy and guidelines on lost prescriptions.**
- **B) Adhere to strict policies regarding prescribing.**
- **C) Safeguard license and DEA numbers and only utilize them as required by state law.**
- **D) Give unlimited refills on Schedule II Narcotics**

6) According to Figure 1, a podiatric physician is considering opioid rotation using morphine equivalents to switch oxycodone 20 mg to hydrocodone. What would be the hydrocodone dose?
- **A) Hydrocodone—10 mg**

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B) Hydrocodone—20 mg
C) Hydrocodone—30 mg
D) Hydrocodone—54 mg

7) Reflecting on Kim et al., investigation of hallux valgus deformities of patients who received local infiltration of a test solution: Which product was not part of the test solution?
A) Lidocaine
B) Morphine
C) Ketorolac
D) Epinephrine

8) There are a number of screening tools that have been developed specifically to screen for risk of opioid misuse in the context of chronic pain treatment and that have been demonstrated to have predictive value. Identify which tool(s) may be helpful in determining relative risk in addition to the medical history.
A) Opioid Risk Tools
B) Diagnosis, Intractability, Risk, Efficacy
C) The Screener and Opioid Assessment for Patients with Pain-Revised
D) all of the above tools are used in determining risk in addiction

9) The acronym "RIGHTT" relates to symptoms the patient may experience prior to sleep apnea diagnosis and treatment. Match the "Letter" with its corresponding correct word meaning.
A) "R"—Rate of adverse event
B) "G"—Getting rid of pain
C) "H"—Halting Opioids
D) "I"—Interviewing family members

10) Reflecting on the podiatric prescriber's role to improve opioid prescription writing strategy, which statement is true?
A) Take caution in the manner that prescriptions are written or dispensed.
B) Limit the number of pills prescribed.
C) Write out the number of pills prescribed ("ten" instead of "10").
D) All the above strategies are true

SEE ANSWER SHEET ON PAGE 169.

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(3) All answers should be recorded on the answer form below. For each question, decide which choice is the best answer, and circle the letter representing your choice.

(4) Complete all other information on the front and back of this page.

(5) Choose one out of the 3 options for testgrading: mail-in, fax, or phone. To select the type of service that best suits your needs, please read the following section, "Test Grading Options".

TEST GRADING OPTIONS

Mail-In Grading

To receive your CME certificate, complete all information and mail with your credit card information to: **Program Management Services, P.O. Box 490, East Islip, NY 11730. PLEASE DO NOT SEND WITH SIGNATURE REQUIRED, AS THESE WILL NOT BE ACCEPTED.**

There is **no charge** for the mail-in service if you have already enrolled in the annual exam CME program, and we receive this exam during your current enrollment period. If you are not enrolled, please send $27.00 per exam, or $219 to cover all 10 exams (thus saving $51 over the cost of 10 individual exam fees).

Facsimile Grading

To receive your CME certificate, complete all information and fax 24 hours a day to 631-532-1964. Your CME certificate will be dated and mailed within 48 hours. This service is available for $2.50 per exam if you are currently enrolled in the annual 10-exam CME program (and this exam falls within your enrollment period), and can be charged to your Visa, MasterCard, or American Express.

If you are *not* enrolled in the annual 10-exam CME program, the fee is $27 per exam.

Phone-In Grading

You may also complete your exam by using the toll-free service. Call 1-800-232-4422 from 10 a.m. to 5 p.m. EST, Monday through Friday. Your CME certificate will be dated the same day you call and mailed within 48 hours. There is a $2.50 charge for this service if you are currently enrolled in the annual 10-exam CME program (and this exam falls within your enrollment period), and this fee can be charged to your Visa, Mastercard, American Express, or Discover. If you are not currently enrolled, the fee is $27 per exam. When you call, please have ready:

1. Program number (Month and Year)
2. The answers to the test
3. Credit card information

In the event you require additional CME information, please contact PMS, Inc., at **1-631-563-1604**.

ENROLLMENT FORM & ANSWER SHEET

Please print clearly...Certificate will be issued from information below.

Name _____ Email Address _____
Please Print: FIRST MI LAST

Address _____

City _____ State _____ Zip _____

Charge to: _____Visa _____ MasterCard _____ American Express

Card # _____ Exp. Date _____ Zip for credit card _____

Note: Credit card is the only method of payment. Checks are no longer accepted.

Signature _____ Email Address _____ Daytime Phone _____

State License(s) _____ Is this a new address? Yes _____ No _____

Check one:

_____ I am currently enrolled. (If faxing or phoning in your answer form please note that $2.50 will be charged to your credit card.)

_____ I am not enrolled. Enclosed is my credit card information. Please charge my credit card $27.00 for each exam submitted. (plus $2.50 for each exam if submitting by fax or phone).

_____ I am not enrolled and I wish to enroll for 10 courses at $219.00 (thus saving me $51 over the cost of 10 individual exam fees). I understand there will be an additional fee of $2.50 for any exam I wish to submit via fax or phone.

Over, please

ENROLLMENT FORM & ANSWER SHEET *(continued)*

EXAM #5/18
Opioid Prescribing: Podiatric Implications
(R. Smith)

Circle:

1.	A	B	C	D	6.	A	B	C	D
2.	A	B	C	D	7.	A	B	C	D
3.	A	B	C	D	8.	A	B	C	D
4.	A	B	C	D	9.	A	B	C	D
5.	A	B	C	D	10.	A	B	C	D

This CME activity is free from commercial biases and is under the overall management of *Podiatry Management Magazine*.

Medical Education Lesson Evaluation

Strongly agree [5]	Agree [4]	Neutral [3]	Disagree [2]	Strongly disagree [1]

1) This CME lesson was helpful to my practice ____

2) The educational objectives were accomplished ____

3) I will apply the knowledge I learned from this lesson ____

4) I will makes changes in my practice behavior based on this lesson ____

5) This lesson presented quality information with adequate current references ____

6) What overall grade would you assign this lesson?

A B C D

How long did it take you to complete this lesson?

_____hour _____minutes

What topics would you like to see in future CME lessons ?
Please list :

_____

_____

_____

_____

_____

_____