



2016

PAINWEEK[®]

September 6—10, 2016

The Cosmopolitan of Las Vegas

Program Guide

Program guide is sponsored by  Depomed



TWO SOURCES OF PAIN

ONE SOURCE OF RELIEF

NUCYNTA[®] ER is the first and only FDA-approved long-acting opioid designed to control both nociceptive pain and the neuropathic pain associated with diabetic peripheral neuropathy (DPN).

NUCYNTA[®] ER is an opioid agonist indicated for the management of:

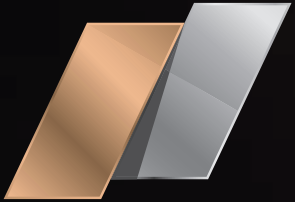
- pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate
- neuropathic pain associated with DPN in adults severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate

Not an actual patient.

Limitations of Use

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve NUCYNTA[®] ER for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain
- NUCYNTA[®] ER is not indicated as an as-needed (prn) analgesic

Please see additional Important Safety Information, including BOXED WARNING, and Brief Summary on the following pages.



NUCYNTA[™] ER
TAPENTADOL
EXTENDED-RELEASE
TABLETS



TIME TO DUAL

PRESCRIBE NUCYNTA[®] ER FOR ONE SOURCE OF RELIEF

- **Proven efficacy** in chronic low back pain and DPN^{1,2}
 - Based on efficacy demonstrated in a prospective, randomized, double-blind, active- and placebo-controlled, multicenter phase 3 chronic low back pain study (N=981) showing significant change in mean pain intensity from baseline in Week 15 (Week 12 of the maintenance phase) vs placebo¹
 - Based on efficacy demonstrated in a double-blind, parallel-group, enriched-enrollment randomized withdrawal phase 3 DPN study (N=977) showing significant change in mean pain intensity over the last week of the 12-week, double-blind, maintenance phase vs placebo²
- **5 dosage strengths: 50 mg, 100 mg, 150 mg, 200 mg, and 250 mg^{3*}**
Individualize dosing based on patient's prior analgesic treatment experience and risk factors for addiction, abuse, and misuse; titrate as needed to provide adequate analgesia and minimize adverse reactions
- **Administer NUCYNTA[®] ER ~q12h³**

VISIT NUCYNTA.COM FOR MORE INFORMATION AND TO DOWNLOAD A NUCYNTA[®] ER SAVINGS CARD[†]

- \$0 co-pay for first prescription of NUCYNTA[®] ER with a \$25 co-pay on each additional prescription if eligible[†]

COVERED FOR
94%
OF COMMERCIALLY
INSURED PATIENTS.[‡]
PREFERRED FOR
UNITEDHEALTH
GROUP AND
SILVERSCRIPT/
CVS CAREMARK
PART D PLANS[‡]

WARNING: ADDICTION, ABUSE, AND MISUSE; LIFE-THREATENING RESPIRATORY DEPRESSION; ACCIDENTAL INGESTION; NEONATAL OPIOID WITHDRAWAL SYNDROME; and INTERACTION WITH ALCOHOL

See full prescribing information for complete boxed warning.

- **NUCYNTA[®] ER exposes users to risks of addiction, abuse, and misuse, which can lead to overdose and death. Assess each patient's risk before prescribing, and monitor regularly for development of these behaviors or conditions. (5.1)**
- **Serious, life-threatening, or fatal respiratory depression may occur. Monitor closely, especially upon initiation or following a dose increase. Instruct patients to swallow NUCYNTA[®] ER tablets whole to avoid exposure to a potentially fatal dose of tapentadol. (5.2)**
- **Accidental ingestion of NUCYNTA[®] ER, especially in children, can result in fatal overdose of tapentadol. (5.2)**
- **Prolonged use of NUCYNTA[®] ER during pregnancy can result in neonatal opioid withdrawal syndrome, which may be life-threatening if not recognized and treated. If opioid use is required for a prolonged period in a pregnant woman, advise the patient of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available. (5.3)**
- **Instruct patients not to consume alcohol or any products containing alcohol while taking NUCYNTA[®] ER because co-ingestion can result in fatal plasma tapentadol levels. (5.4)**

CONTRAINDICATIONS: Significant respiratory depression; acute or severe bronchial asthma or hypercarbia in an unmonitored setting or in the absence of resuscitative equipment; known or suspected paralytic ileus; hypersensitivity (e.g., anaphylaxis, angioedema) to tapentadol or to any other ingredients of the product; concurrent use of monoamine oxidase inhibitors (MAOIs) or use within the last 14 days.

*Please see full Prescribing Information for DOSAGE AND ADMINISTRATION.

[†]Some restrictions and limitations apply. See full terms and conditions available at NUCYNTA.com. Available to commercially insured and cash-paying patients only. Patients covered by Medicare, Medicaid, or any other federally funded benefit program are excluded. Patients must be 18 years of age or older. This promotion cannot be combined with any other programs, offers, or discounts. Depomed reserves the right to rescind, revoke, or amend this offer without further notice.

[‡]Data on file. Depomed, Inc. formulary data are sourced from MMIT. Transaction data are sourced from SHA Health. Data are current as of July, 2015.

References: 1. Buynak R, Shapiro DY, Okamoto A, et al. Efficacy and safety of tapentadol extended release for the management of chronic low back pain: results of a prospective, randomized, double-blind, placebo- and active-controlled Phase III study. *Expert Opin Pharmacother.* 2010;11(11):1787-1804. 2. Schwartz S, Etropolski M, Shapiro DY, et al. Safety and efficacy of tapentadol ER in patients with painful diabetic peripheral neuropathy: results of a randomized-withdrawal, placebo-controlled trial. *Curr Med Res Opin.* 2011;27(1):151-162. 3. NUCYNTA[®] ER [package insert]. Titusville, NJ: Janssen Pharmaceuticals, Inc; 2014.

NUCYNTA® ER (tapentadol) IMPORTANT SAFETY INFORMATION (continued)

WARNINGS AND PRECAUTIONS: Addiction, Abuse, and Misuse: NUCYNTA® ER contains tapentadol, an opioid agonist and a Schedule II controlled substance that can be abused in a manner similar to other opioid agonists, legal or illicit. There is a greater risk for overdose and death due to the larger amount of tapentadol present in NUCYNTA® ER. Assess risk for opioid abuse or addiction prior to prescribing NUCYNTA® ER. Addiction can occur in patients appropriately prescribed NUCYNTA® ER at recommended doses; in those who obtain the drug illicitly; and if the drug is misused or abused. Therefore, routinely monitor for signs of misuse, abuse, and addiction. Patients at increased risk (e.g., patients with a personal or family history of substance abuse or mental illness) may be prescribed NUCYNTA® ER, but use in such patients necessitates intensive counseling about the risks and proper use along with intensive monitoring for signs of addiction, abuse, and misuse.

Life-threatening Respiratory Depression:

Can occur at any time during the use of NUCYNTA® ER even when used as recommended. Respiratory depression from opioid use, if not immediately recognized and treated, may lead to respiratory arrest and death. To reduce the risk of respiratory depression, proper dosing and titration are essential. Overestimating the dose when converting patients from another opioid product can result in fatal overdose with the first dose. Management of respiratory depression may include close observation, supportive measures, and use of opioid antagonists, depending on the patient's clinical status.

Neonatal Opioid Withdrawal Syndrome:

Prolonged use of NUCYNTA® ER during pregnancy can result in withdrawal signs in the neonate, which may be life-threatening and require management according to protocols developed by neonatology experts. Neonatal opioid withdrawal syndrome presents as poor feeding, irritability, hyperactivity and abnormal sleep pattern, high-pitched cry, tremor, rigidity, seizures, vomiting, diarrhea, and failure to gain weight.

Interactions With Central Nervous System

Depressants: Hypotension, profound sedation, coma, respiratory depression, and death may result if NUCYNTA® ER is used concomitantly with alcohol or other central nervous system (CNS) depressants (e.g., sedatives, anxiolytics, hypnotics, tranquilizers, general anesthetics, neuroleptics, other opioids). When considering the use of NUCYNTA® ER in a patient taking a CNS depressant, assess the duration of use of the CNS depressant and the patient's response, including the degree of tolerance that has developed to CNS depression. If the decision to begin NUCYNTA® ER is made, start with NUCYNTA® ER 50 mg every 12 hours, monitor patients for signs of sedation and respiratory depression, and consider using a lower dose of the concomitant CNS depressant.

Use in Elderly, Cachectic, or Debilitated Patients:

Life-threatening respiratory depression is more likely to occur in elderly, cachectic, or debilitated patients as they may have altered pharmacokinetics or altered clearance. Because elderly patients are more likely to have decreased renal and hepatic function, consideration should be given to starting elderly patients in the lower range of recommended doses. Closely monitor these patients, particularly when initiating and titrating NUCYNTA® ER and when given concomitantly with other drugs that depress respiration.

Use in Patients With Chronic Pulmonary Disease:

Patients with significant chronic obstructive pulmonary disease or cor pulmonale and patients having a substantially decreased respiratory reserve, hypoxia, hypercarbia, or pre-existing respiratory depression, should be monitored for respiratory depression particularly when initiating therapy and titrating with NUCYNTA® ER. Consider the use of alternative nonopioid analgesics in these patients.

Hypotensive Effect: May cause severe hypotension. There is an increased risk in patients whose ability to maintain blood pressure has already been compromised by a reduced blood volume or concurrent administration of certain CNS depressant drugs (e.g., phenothiazines or general anesthetics). Monitor for signs of hypotension during dose initiation or titration. Avoid use in patients with circulatory shock; may cause vasodilation that can further reduce cardiac output and blood pressure.

Use in Patients With Head Injury or Increased Intracranial Pressure:

Monitor patients who may be susceptible to the intracranial effects of CO₂ retention (e.g., those with evidence of increased intracranial pressure or brain tumors) for signs of sedation and respiratory depression, particularly when initiating therapy. NUCYNTA® ER may reduce respiratory drive, and the resultant CO₂ retention can further increase intracranial pressure. Opioids may also obscure the clinical course in a patient with a head injury.

Seizures: May aggravate convulsions in patients with convulsive disorders and may induce or aggravate seizures. Monitor patients with a history of seizure disorders for worsened seizure control during therapy.

Serotonin Syndrome: Cases of life-threatening serotonin syndrome have been reported with the concurrent use of NUCYNTA® ER and serotonergic drugs. Serotonergic drugs comprise selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants (TCAs), triptans, drugs that affect the serotonergic neurotransmitter system, and drugs that impair metabolism of serotonin (including MAOIs). This may occur within the recommended dose. Serotonin syndrome may include mental-status changes (e.g., agitation, hallucinations, coma), autonomic instability (e.g.,

tachycardia, labile blood pressure, hyperthermia), neuromuscular aberrations (e.g., hyperreflexia, incoordination), and/or gastrointestinal symptoms (e.g., nausea, vomiting, diarrhea) and can be fatal. If concomitant treatment with SSRIs, SNRIs, TCAs, or triptans is clinically warranted, careful observation of the patient is advised, particularly when initiating or titrating the dose.

Use in Patients With Gastrointestinal (GI)

Conditions: Contraindicated in patients with GI obstruction including paralytic ileus; may cause spasm of the sphincter of Oddi. Monitor patients with biliary tract disease, including acute pancreatitis, for worsening symptoms.

Avoidance of Withdrawal: Withdrawal symptoms (e.g., anxiety, sweating, insomnia, restlessness, pain, nausea, tremors, diarrhea, upper respiratory symptoms, piloerection) may occur:

- After abrupt discontinuation or a significant dose reduction of NUCYNTA[®] ER in physically dependent patients. When discontinuing NUCYNTA[®] ER, gradually taper the dose.
- If mixed agonist/antagonist (e.g., butorphanol, nalbuphine, pentazocine) and partial agonist (e.g., buprenorphine) analgesics are used in patients who have received or are receiving NUCYNTA[®] ER. Avoid use with mixed agonists/antagonists and partial agonists.
- If opioid antagonists (e.g., naloxone, nalmefene) are administered in physically dependent patients. Administration of the antagonist should be begun with care and by titration with smaller than usual doses of the antagonist.

Driving and Operating Heavy Machinery: May impair the mental or physical abilities needed to perform potentially hazardous activities such as driving a car or operating machinery. Warn patients not to drive or operate dangerous machinery unless they are tolerant to the effects of NUCYNTA[®] ER and know how they will react to the medication.

Hepatic Impairment: Avoid use in patients with severe hepatic impairment (Child-Pugh Score 10 to 15). In patients with moderate hepatic impairment (Child-Pugh Score 7-9), initiate treatment with NUCYNTA[®] ER 50 mg no more than once every 24 hours, with a maximum dose of 100 mg per day. Monitor for respiratory and CNS depression when initiating and titrating NUCYNTA[®] ER.

Renal Impairment: Use in patients with severe renal impairment ($CL_{CR} < 30$ mL/min) is not recommended due to accumulation of a metabolite formed by glucuronidation of tapentadol. The clinical relevance of the elevated metabolite is not known.

Please see additional Important Safety Information, including BOXED WARNING, and Brief Summary on the following pages.

DRUG INTERACTIONS

Alcohol: See **BOXED WARNING**.

Muscle Relaxants: Monitor patients receiving muscle relaxants and NUCYNTA[®] ER for signs of respiratory depression that may be greater than otherwise expected. Tapentadol may enhance the neuromuscular blocking action of skeletal muscle relaxants and produce an increased degree of respiratory depression.

Anticholinergics: Use with anticholinergic products may increase the risk of urinary retention and/or severe constipation, which may lead to paralytic ileus.

USE IN SPECIFIC POPULATIONS

Pregnancy/Nursing Mothers: *Pregnancy Category C.* NUCYNTA[®] ER should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Neonates born to mothers physically dependent on opioids will also be physically dependent and may exhibit respiratory difficulties and withdrawal symptoms. Observe newborns for symptoms of neonatal opioid withdrawal syndrome. Withdrawal symptoms can occur in breast-feeding infants when maternal administration of NUCYNTA[®] ER is stopped.

Labor and Delivery: Opioids cross the placenta and may produce respiratory depression in neonates. NUCYNTA[®] ER is not for use in women during and immediately prior to labor, when shorter-acting analgesics or other analgesic techniques are more appropriate.

Use in Elderly, Renal Impairment, and Hepatic Impairment: See WARNINGS AND PRECAUTIONS.

**DRUG ABUSE AND DEPENDENCE:
See BOXED WARNING**

OVERDOSAGE: Institute supportive measures to manage respiratory depression, circulatory shock, and pulmonary edema as required. The opioid antagonists, naloxone or nalmefene, are specific antidotes to respiratory depression.

ADVERSE REACTIONS: In clinical studies, the most common ($\geq 10\%$) adverse reactions were nausea, constipation, vomiting, dizziness, somnolence, and headache.

Select Postmarketing Adverse Reactions: Anaphylaxis, angioedema, and anaphylactic shock have been reported very rarely with ingredients contained in NUCYNTA[®] ER. Advise patients how to recognize such reactions and when to seek medical attention. Panic attack has also been reported.



NUCYNTA[®] ER
TAPENTADOL
EXTENDED-RELEASE
TABLETS



BRIEF SUMMARY OF FULL PRESCRIBING INFORMATION

This does not include all the information needed to use NUCYNTA[®] ER safely and effectively. See full Prescribing Information for NUCYNTA[®] ER.

INDICATIONS AND USAGE

NUCYNTA[®] ER is indicated for the management of:

- pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate
- neuropathic pain associated with diabetic peripheral neuropathy (DPN) in adults severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

Limitations of Usage

- Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve NUCYNTA[®] ER for use in patients for whom alternative treatment options (e.g., nonopioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.
- NUCYNTA[®] ER is not indicated as an as-needed (prn) analgesic.

WARNING: ADDICTION, ABUSE, AND MISUSE; LIFE-THREATENING RESPIRATORY DEPRESSION; ACCIDENTAL INGESTION; NEONATAL OPIOID WITHDRAWAL SYNDROME; AND INTERACTION WITH ALCOHOL

See full prescribing information for complete boxed warning.

- NUCYNTA[®] ER exposes users to risks of addiction, abuse, and misuse, which can lead to overdose and death. Assess each patient's risk before prescribing, and monitor regularly for development of these behaviors or conditions. (5.1)
- Serious, life-threatening, or fatal respiratory depression may occur. Monitor closely, especially upon initiation or following a dose increase. Instruct patients to swallow NUCYNTA[®] ER tablets whole to avoid exposure to a potentially fatal dose of tapentadol. (5.2)
- Accidental ingestion of NUCYNTA[®] ER, especially in children, can result in fatal overdose of tapentadol. (5.2)
- Prolonged use of NUCYNTA[®] ER during pregnancy can result in neonatal opioid withdrawal syndrome, which may be life-threatening if not recognized and treated. If opioid use is required for a prolonged period in a pregnant woman, advise the patient of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available. (5.3)
- Instruct patients not to consume alcohol or any products containing alcohol while taking NUCYNTA[®] ER because co-ingestion can result in fatal plasma tapentadol levels. (5.4)

CONTRAINDICATIONS

Significant respiratory depression; acute or severe bronchial asthma or hypercarbia in an unmonitored setting or in the absence of resuscitative equipment; known or suspected paralytic ileus; hypersensitivity (e.g., anaphylaxis, angioedema) to tapentadol or to any other ingredients of the product; concurrent use of monoamine oxidase inhibitors (MAOIs) or use within the last 14 days.

WARNINGS AND PRECAUTIONS

Addiction, Abuse, and Misuse: NUCYNTA[®] ER contains tapentadol, a Schedule II controlled substance. As an opioid, NUCYNTA[®] ER exposes users to the risks of addiction, abuse, and misuse. As modified-release products such as NUCYNTA[®] ER deliver the opioid over an extended period of time, there is a greater risk for overdose and death due to the larger amount of tapentadol present.

Although the risk of addiction in any individual is unknown, it can occur in patients appropriately prescribed NUCYNTA[®] ER and in those who obtain the drug illicitly. Addiction can occur at recommended doses and if the drug is misused or abused.

Assess each patient's risk for opioid addiction, abuse, or misuse prior to prescribing NUCYNTA[®] ER, and monitor all patients receiving NUCYNTA[®] ER for the development of these behaviors or conditions. Risks are increased in patients with a personal or family history of substance abuse (including drug or alcohol addiction or abuse) or mental illness (e.g., major depression). The potential for these risks should not, however, prevent the prescribing of NUCYNTA[®] ER for the proper management of pain in any given patient. Patients at increased risk may be prescribed modified-release opioid formulations such as NUCYNTA[®] ER, but use in such patients necessitates intensive counseling about the risks and proper use of NUCYNTA[®] ER along with intensive monitoring for signs of addiction, abuse, and misuse.

Abuse or misuse of NUCYNTA[®] ER by crushing, chewing, snorting, or injecting the dissolved product will result in the uncontrolled delivery of tapentadol and can result in overdose and death.

Opioid agonists such as NUCYNTA[®] ER are sought by drug abusers and people with addiction disorders and are subject to criminal diversion. Consider these risks when prescribing or dispensing NUCYNTA[®] ER. Strategies to reduce these risks include prescribing the drug in the smallest appropriate quantity and advising the patient on the proper disposal of unused drug. Contact local state professional licensing board or state controlled substances authority for information on how to prevent and detect abuse or diversion of this product.

Life-Threatening Respiratory Depression: Serious, life-threatening, or fatal respiratory depression has been reported with the use of modified release opioids, even when used as recommended. Respiratory depression from opioid use, if not immediately recognized and treated, may lead to respiratory arrest and death. Management of respiratory depression may include close observation, supportive measures, and use of opioid antagonists, depending on the patient's clinical status. Carbon dioxide (CO₂) retention from opioid-induced respiratory depression can exacerbate the sedating effects of opioids.

While serious, life-threatening, or fatal respiratory depression can occur at any time during the use of NUCYNTA[®] ER, the risk is greatest during the initiation of therapy or following a dose increase.

Closely monitor patients for respiratory depression when initiating therapy with NUCYNTA[®] ER and following dose increases. To reduce the risk of respiratory depression, proper dosing and titration of NUCYNTA[®] ER are essential. Overestimating the NUCYNTA[®] ER dose when converting patients from another opioid product can result in fatal overdose with the first dose.

Accidental ingestion of even one dose of NUCYNTA[®] ER, especially by children, can result in respiratory depression and death due to an overdose of tapentadol.

Neonatal Opioid Withdrawal Syndrome: Prolonged use of NUCYNTA[®] ER during pregnancy can result in withdrawal signs in the neonate. Neonatal opioid withdrawal syndrome, unlike opioid withdrawal syndrome in adults, may be life threatening if not recognized and treated, and requires management according to protocols developed by neonatology experts. If opioid use is required for a prolonged period in a pregnant woman, advise the patient of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available.

Neonatal opioid withdrawal syndrome presents as irritability, hyperactivity and abnormal sleep pattern, high pitched cry, tremor, vomiting, diarrhea and failure to gain weight. The onset, duration, and severity of neonatal opioid withdrawal syndrome vary based on the specific opioid used, duration of use, timing and amount of last maternal use, and rate of elimination of the drug by the newborn.

Interactions with Central Nervous System Depressants: Patients must not consume alcoholic beverages or prescription or non-prescription products containing alcohol while on NUCYNTA[®] ER therapy. The co-ingestion of alcohol with NUCYNTA[®] ER may result in increased plasma tapentadol levels and a potentially fatal overdose of tapentadol.

Hypotension, profound sedation, coma, respiratory depression, and death may result if NUCYNTA[®] ER is used concomitantly with alcohol or other central nervous system (CNS) depressants (e.g., sedatives, anxiolytics, hypnotics, neuroleptics, other opioids).

When considering the use of NUCYNTA[®] ER in a patient taking a CNS depressant, assess the duration of use of the CNS depressant and the patient's response, including the degree of tolerance that has developed to CNS depression. Additionally, evaluate the patient's use of alcohol or illicit drugs that cause CNS depression. If the decision to begin NUCYNTA[®] ER is made, start with NUCYNTA[®] ER 50 mg every 12 hours, monitor patients for signs of sedation and respiratory depression, and consider using a lower dose of the concomitant CNS depressant.

Use in Elderly, Cachectic, and Debilitated Patients: Life-threatening respiratory depression is more likely to occur in elderly, cachectic, or debilitated patients as they may have altered pharmacokinetics or altered clearance compared to younger, healthier patients. Therefore, closely monitor such patients, particularly when initiating and titrating NUCYNTA[®] ER and when NUCYNTA[®] ER is given concomitantly with other drugs that depress respiration.

Use in Patients with Chronic Pulmonary Disease: Monitor for respiratory depression those patients with significant chronic obstructive pulmonary disease or cor pulmonale, and patients having a substantially decreased respiratory reserve, hypoxia, hypercarbia, or pre-existing respiratory depression, particularly when initiating therapy and titrating with NUCYNTA[®] ER, as in these patients, even usual therapeutic doses of NUCYNTA[®] ER may decrease respiratory drive to the point of apnea. Consider the use of alternative non-opioid analgesics in these patients if possible.

Hypotensive Effect: NUCYNTA[®] ER may cause severe hypotension. There is an increased risk in patients whose ability to maintain blood pressure has already been compromised by a reduced blood volume or concurrent administration of certain CNS depressant drugs (e.g., phenothiazines or general anesthetics). Monitor these patients for signs of hypotension after initiating or titrating the dose of NUCYNTA[®] ER. In patients with circulatory shock, NUCYNTA[®] ER may cause vasodilation that can further reduce cardiac output and blood pressure. Avoid the use of NUCYNTA[®] ER in patients with circulatory shock.

Use in Patients with Head Injury or Increased Intracranial Pressure: Monitor patients taking NUCYNTA[®] ER who may be susceptible to the intracranial effects of CO₂ retention (e.g., those with evidence of increased intracranial pressure or brain tumors) for signs of sedation and respiratory depression, particularly when initiating therapy with NUCYNTA[®] ER. NUCYNTA[®] ER may reduce respiratory drive, and the resultant CO₂ retention can further increase intracranial pressure. Opioids may also obscure the clinical course in a patient with head injury.

Avoid the use of NUCYNTA[®] ER in patients with impaired consciousness or coma.

Seizures: NUCYNTA[®] ER has not been evaluated in patients with a predisposition to a seizure disorder, and such patients were excluded from clinical studies. The active ingredient tapentadol in NUCYNTA[®] ER may aggravate convulsions in patients with convulsive disorders, and may induce or aggravate seizures in some clinical settings. Monitor patients with a history of seizure disorders for worsened seizure control during NUCYNTA[®] ER therapy.

Serotonin Syndrome: Cases of life-threatening serotonin syndrome have been reported with the concurrent use of tapentadol and serotonergic drugs. Serotonergic drugs comprise Selective Serotonin Reuptake Inhibitors (SSRIs), Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs), tricyclic antidepressants (TCAs), triptans, drugs that affect the serotonergic neurotransmitter system (e.g. mirtazapine, trazodone, and tramadol), and drugs that impair metabolism of serotonin (including MAOIs). This may occur within the recommended dose. Serotonin syndrome may include mental-status changes (e.g., agitation, hallucinations, coma), autonomic instability (e.g., tachycardia, labile blood pressure, hyperthermia), neuromuscular aberrations (e.g., hyperreflexia, incoordination) and/or gastrointestinal symptoms (e.g., nausea, vomiting, diarrhea) and can be fatal.

Use in Patients with Gastrointestinal Conditions: NUCYNTA[®] ER is contraindicated in patients with GI obstruction, including paralytic ileus. The tapentadol in NUCYNTA[®] ER may cause spasm of the sphincter of Oddi. Monitor patients with biliary tract disease, including acute pancreatitis, for worsening symptoms.

Avoidance of Withdrawal: Avoid the use of mixed agonist/antagonist (i.e., pentazocine, nalbuphine, and butorphanol) or partial agonist (buprenorphine) analgesics in patients who have received or are receiving a course of therapy with a full opioid agonist analgesic, including NUCYNTA[®] ER. In these patients, mixed agonists/antagonists and partial agonist analgesics may reduce the analgesic effect and/or may precipitate withdrawal symptoms.

When discontinuing NUCYNTA[®] ER, gradually taper the dose.

Driving and Operating Heavy Machinery: NUCYNTA[®] ER may impair the mental or physical abilities needed to perform potentially hazardous activities such as driving a car or operating machinery. Warn patients not to drive or operate dangerous machinery unless they are tolerant to the effects of NUCYNTA[®] ER and know how they will react to the medication.

Hepatic Impairment: A study with an immediate-release formulation of tapentadol in subjects with hepatic impairment showed higher serum concentrations of tapentadol than in those with normal hepatic function. Avoid use of NUCYNTA[®] ER in patients with severe hepatic impairment. Reduce the dose of NUCYNTA[®] ER in patients with moderate hepatic impairment. Closely monitor patients with moderate hepatic impairment for respiratory and central nervous system depression when initiating and titrating NUCYNTA[®] ER.

Renal Impairment: Use of NUCYNTA[®] ER in patients with severe renal impairment is not recommended due to accumulation of a metabolite formed by glucuronidation of tapentadol. The clinical relevance of the elevated metabolite is not known.

ADVERSE REACTIONS

The following serious adverse reactions are discussed elsewhere in the labeling:

- Addiction, Abuse, and Misuse [see Warnings and Precautions (5.1)]
- Life-Threatening Respiratory Depression [see Warnings and Precautions (5.2)]
- Neonatal Opioid Withdrawal Syndrome [see Warnings and Precautions (5.3)]
- Interaction with Other CNS Depressants [see Warnings and Precautions (5.4)]
- Hypotensive Effects [see Warnings and Precautions (5.7)]
- Gastrointestinal Effects [see Warnings and Precautions (5.11)]
- Seizures [see Warnings and Precautions (5.9)]
- Serotonin Syndrome [see Warnings and Precautions (5.10)]

Clinical Trial Experience

Commonly-Observed Adverse Reactions in Clinical Studies with NUCYNTA® ER in Patients with Chronic Pain due to Low Back Pain or Osteoarthritis

The most common adverse reactions (reported by $\geq 10\%$ in any NUCYNTA® ER dose group) were: nausea, constipation, dizziness, headache, and somnolence.

The most common reasons for discontinuation due to adverse reactions in eight Phase 2/3 pooled studies reported by $\geq 1\%$ in any NUCYNTA® ER dose group for NUCYNTA® ER- and placebo-treated patients were nausea (4% vs. 1%), dizziness (3% vs. <1%), vomiting (3% vs. <1%), somnolence (2% vs. <1%), constipation (1% vs. <1%), headache (1% vs. <1%), and fatigue (1% vs. <1%), respectively.

Commonly-Observed Adverse Reactions in Clinical Studies with NUCYNTA® ER in Patients with Neuropathic Pain Associated with Diabetic Peripheral Neuropathy

The most commonly reported ADRs (incidence $\geq 10\%$ in NUCYNTA® ER-treated subjects) were: nausea, constipation, vomiting, dizziness, somnolence, and headache.

Postmarketing Experience: The following adverse reactions, not above, have been identified during post approval use of tapentadol. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

Psychiatric disorders: hallucination, suicidal ideation, panic attack.

Anaphylaxis, angioedema, and anaphylactic shock have been reported very rarely with ingredients contained in NUCYNTA® ER. Advise patients how to recognize such reactions and when to seek medical attention.

DRUG INTERACTIONS

Alcohol: Concomitant use of alcohol with NUCYNTA® ER can result in an increase of tapentadol plasma levels and potentially fatal overdose of tapentadol. Instruct patients not to consume alcoholic beverages or use prescription or non-prescription products containing alcohol while on NUCYNTA® ER therapy.

Monoamine Oxidase Inhibitors: NUCYNTA® ER is contraindicated in patients who are receiving monoamine oxidase inhibitors (MAOIs) or who have taken them within the last 14 days due to potential additive effects on norepinephrine levels, which may result in adverse cardiovascular events.

CNS Depressants: The concomitant use of NUCYNTA® ER with other CNS depressants including sedatives, hypnotics, tranquilizers, general anesthetics, phenothiazines, other opioids, and alcohol can increase the risk of respiratory depression, profound sedation, coma and death. Monitor patients receiving CNS depressants and NUCYNTA® ER for signs of respiratory depression, sedation and hypotension.

When combined therapy with any of the above medications is considered, the dose of one or both agents should be reduced.

Serotonergic Drugs: There have been post-marketing reports of serotonin syndrome with the concomitant use of tapentadol and serotonergic drugs (e.g., SSRIs and SNRIs). Caution is advised when NUCYNTA® ER is coadministered with other drugs that may affect serotonergic neurotransmitter systems such as SSRIs, SNRIs, MAOIs, and triptans. If concomitant treatment of NUCYNTA® ER with a drug affecting the serotonergic neurotransmitter system is clinically warranted, careful observation of the patient is advised, particularly during treatment initiation and dose increases.

Muscle Relaxants: Tapentadol may enhance the neuromuscular blocking action of skeletal muscle relaxants and produce an increased degree of respiratory depression. Monitor patients receiving muscle relaxants and NUCYNTA® ER for signs of respiratory depression that may be greater than otherwise expected.

Mixed Agonist/Antagonist Opioid Analgesics: Mixed agonist/antagonist analgesics (i.e., pentazocine, nalbuphine, and butorphanol) and partial agonists (e.g., buprenorphine) may reduce the analgesic effect of NUCYNTA® ER or precipitate withdrawal symptoms. Avoid the use of mixed agonist/antagonist analgesics in patients receiving NUCYNTA® ER.

Anticholinergics: The use of NUCYNTA® ER with anticholinergic products may increase the risk of urinary retention and/or severe constipation, which may lead to paralytic ileus.

USE IN SPECIFIC POPULATIONS

Pregnancy

Clinical Considerations

Fetal/neonatal adverse reactions

Prolonged use of opioid analgesics during pregnancy for medical or nonmedical purposes can result in physical dependence in the neonate and neonatal opioid withdrawal syndrome shortly after birth. Observe newborns for symptoms of neonatal opioid withdrawal syndrome, such as poor feeding, diarrhea, irritability, tremor, rigidity, and seizures, and manage accordingly.

Teratogenic Effects - Pregnancy Category C

There are no adequate and well-controlled studies in pregnant women. NUCYNTA® ER should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Labor and Delivery: Opioids cross the placenta and may produce respiratory depression in neonates. NUCYNTA® ER is not for use in women during and immediately prior to labor, when shorter acting analgesics or other analgesic techniques are more appropriate. Opioid analgesics can prolong labor through actions that temporarily reduce the strength, duration, and frequency of uterine contractions. However this effect is not consistent and may be offset by an increased rate of cervical dilatation, which tends to shorten labor.

Nursing Mothers: There is insufficient/limited information on the excretion of tapentadol in human or animal breast milk. Physicochemical and available pharmacodynamic/toxicological data on tapentadol point to excretion in breast milk and risk to the breastfeeding child cannot be excluded.

Because of the potential for adverse reactions in nursing infants from NUCYNTA® ER, a decision should be made whether to discontinue nursing or discontinue the drug, taking into account the importance of the drug to the mother.

Withdrawal symptoms can occur in breast-feeding infants when maternal administration of

NUCYNTA® ER is stopped.

Pediatric Use: The safety and efficacy of NUCYNTA® ER in pediatric patients less than 18 years of age have not been established.

Geriatric Use: Of the total number of patients in Phase 2/3 double-blind, multiple-dose clinical studies of NUCYNTA® ER, 28% (1023/3613) were 65 years and over, while 7% (245/3613) were 75 years and over. No overall differences in effectiveness or tolerability were observed between these patients and younger patients.

In general, recommended dosing for elderly patients with normal renal and hepatic function is the same as for younger adult patients with normal renal and hepatic function. Because elderly patients are more likely to have decreased renal and hepatic function, consideration should be given to starting elderly patients with the lower range of recommended doses.

Renal Impairment: The safety and effectiveness of NUCYNTA® ER have not been established in patients with severe renal impairment ($CL_{CR} < 30$ mL/min). Use of NUCYNTA® ER in patients with severe renal impairment is not recommended due to accumulation of a metabolite formed by glucuronidation of tapentadol. The clinical relevance of the elevated metabolite is not known.

Hepatic Impairment: Administration of tapentadol resulted in higher exposures and serum levels of tapentadol in subjects with impaired hepatic function compared to subjects with normal hepatic function. The dose of NUCYNTA® ER should be reduced in patients with moderate hepatic impairment (Child-Pugh Score 7 to 9).

Use of NUCYNTA® ER is not recommended in severe hepatic impairment (Child-Pugh Score 10 to 15).

DRUG ABUSE AND DEPENDENCE

Controlled Substance: NUCYNTA® ER contains tapentadol, a Schedule II controlled substance with a high potential for abuse similar to fentanyl, methadone, morphine, oxycodone, and oxycodone. NUCYNTA® ER can be abused and is subject to misuse, addiction, and criminal diversion. The high drug content in the extended release formulation adds to the risk of adverse outcomes from abuse and misuse.

Abuse: All patients treated with opioids require careful monitoring for signs of abuse and addiction, because use of opioid analgesic products carries the risk of addiction even under appropriate medical use.

Drug abuse is the intentional non-therapeutic use of an over-the-counter or prescription drug, even once, for its rewarding psychological or physiological effects. Drug abuse includes, but is not limited to the following examples: the use of a prescription or over-the-counter drug to get "high," or the use of steroids for performance enhancement and muscle build up.

Drug addiction is a cluster of behavioral, cognitive, and physiological phenomena that develop after repeated substance use and include: a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal.

"Drug-seeking" behavior is very common to addicts and drug abusers. Drug-seeking tactics include emergency calls or visits near the end of office hours, refusal to undergo appropriate examination, testing or referral, repeated claims of loss of prescriptions, tampering with prescriptions and reluctance to provide prior medical records or contact information for other treating physician(s). "Doctor shopping" (visiting multiple prescribers) to obtain additional prescriptions is common among drug abusers, and people suffering from untreated addiction. Preoccupation with achieving pain relief can be appropriate behavior in a patient with poor pain control.

Abuse and addiction are separate and distinct from physical dependence and tolerance. Physicians should be aware that addiction may not be accompanied by concurrent tolerance and symptoms of physical dependence in all addicts. In addition, abuse of opioids can occur in the absence of true addiction.

NUCYNTA® ER, like other opioids, can be diverted for non-medical use into illicit channels of distribution. Careful record-keeping of prescribing information, including quantity, frequency, and renewal requests, as required by law, is strongly advised.

Proper assessment of the patient, proper prescribing practices, periodic re-evaluation of therapy, and proper dispensing and storage are appropriate measures that help to limit abuse of opioid drugs.

Dependence: Both tolerance and physical dependence can develop during chronic opioid therapy. Tolerance is the need for increasing doses of opioids to maintain a defined effect such as analgesia (in the absence of disease progression or other external factors). Tolerance may occur to both the desired and undesired effects of drugs, and may develop at different rates for different effects.

Physical dependence results in withdrawal symptoms after abrupt discontinuation or a significant dose reduction of a drug. Withdrawal also may be precipitated through the administration of drugs with opioid antagonist activity, e.g., naloxone, nalmefene, mixed agonist/antagonist analgesics (pentazocine, butorphanol, nalbuphine), or partial agonists (buprenorphine). Physical dependence may not occur to a clinically significant degree until after several days to weeks of continued opioid usage.

NUCYNTA® ER should not be abruptly discontinued. If NUCYNTA® ER is abruptly discontinued in a physically-dependent patient, an abstinence syndrome may occur. Some or all of the following can characterize this syndrome: restlessness, lacrimation, rhinorrhea, yawning, perspiration, chills, pilo-erection, myalgia, mydriasis, irritability, anxiety, backache, joint pain, weakness, abdominal cramps, insomnia, nausea, anorexia, vomiting, diarrhea, increased blood pressure, respiratory rate, or heart rate.

Infants born to mothers physically dependent on opioids will also be physically dependent and may exhibit respiratory difficulties and withdrawal symptoms.

OVERDOSAGE

Clinical Presentation: Acute overdose with opioids can be manifested by respiratory depression, somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, constricted pupils, and sometimes pulmonary edema, bradycardia, hypotension and death. Marked mydriasis rather than miosis may be seen due to severe hypoxia in overdose situations.

Treatment of Overdose: In case of overdose, priorities are the re-establishment of a patent and protected airway and institution of assisted or controlled ventilation if needed. Employ other supportive measures (including oxygen, vasopressors) in the management of circulatory shock and pulmonary edema as indicated. Cardiac arrest or arrhythmias will require advanced life support techniques.

Rx Only

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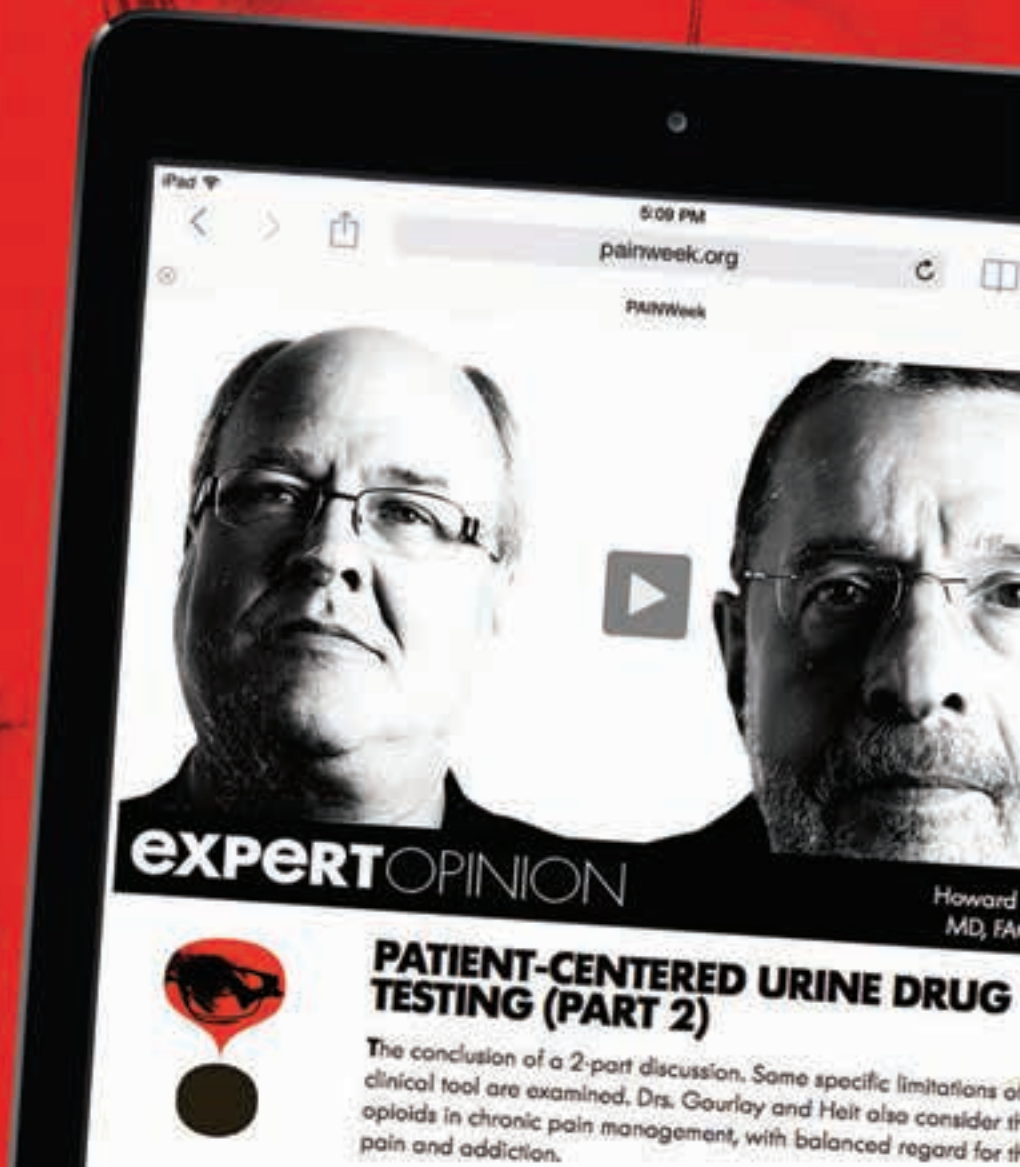
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PAIN & CHEMICAL DEPENDENCY

Jeffrey Fudin
Douglas Gourlay
Howard Heit
Mel Pohl

Friday
September 9



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10TH ANNUAL

The front of the PAINWeek name badge contains both attendee information and a bar code that can be scanned quickly to capture data. Information that is collected by scanning into PAINWeek core sessions will only be utilized by PAINWeek and Global Education Group for the purpose of processing your CME application and certificate. If you scan your badge at a satellite event or exhibit booth, your contact information (name, address, degree, specialty, company, telephone, fax, NPI, and email) will be provided to the respective party who scanned your badge. Please note that to comply with Sunshine Act reporting and corporate policies, third-party program organizers may not allow access to their program without scanning. Name badges must be worn for admittance to all PAINWeek 2016 events. Please return to registration if you have lost your name badge. There is a \$50 fee for replacement badges. A photo ID is required.

Information provided was accurate as of press time. For the most up to date information please visit m.painweek.org. Any and all changes made subsequently regarding dates, times, courses, and faculty will also be reflected in PAINWeek Daily News and on handouts available at the registration desk.

AWARDS

This year, **PAINWeek** and the **American Society of Pain Educators (ASPE)** are proud to honor those who have demonstrated a commitment to clinical pain practice and pain education.

PAINWEEK PRACTITIONER OF THE YEAR

Jeffrey A.
Gudin
MD

For the last 17 years, Dr. Gudin has been the Director of Pain Management and Palliative Care at Englewood Hospital and Medical Center, a Mt. Sinai University School of Medicine teaching affiliate in New Jersey. He remains active in teaching and research and has lectured internationally on a variety of topics in pain management, palliative care, and addiction medicine. He is a Clinical Instructor in Anesthesiology at Mt. Sinai University School of Medicine in New York. Dr. Gudin completed his residency in Anesthesiology at the Yale University School of Medicine and his fellowship at the Yale Center for Pain Management. While in New Haven, Dr. Gudin also trained in Addiction Medicine and directed a substance abuse treatment center. Dr. Gudin has dedicated his career to promoting education in pain management. He attends and has presented at PAINWeek, American Pain Society, American Academy of Pain Management (AAPM), American Academy of Physical Medicine and Rehabilitation, and other venues. He serves as a consultant to state medical boards on challenging cases, as well as to industry on novel analgesic products and risk management associated with opioids. He has presented annually at the AAPM Safe Opioid Prescribing Course. Dr. Gudin is recognized nationally as a leader in pain management, is an experienced researcher, consultant, and speaker, and has collaborated with numerous initiatives to enhance responsible prescribing and the safe use of opioid pain medications.

"As a clinician who has dedicated my life to improving the suffering of pain patients and my career to teaching others, I can honestly say that PAINWeek is the conference that I look forward to each year. I always take home new information—whether about practice or pharmacology, pain or psychology, testing or treatment. New innovations abound, the breadth of content is tremendous, and the quality of the presentations is

outstanding. I am always energized by the excitement of participants and faculty alike and impressed by the desire for progress in our field. PAINWeek tackles difficult and controversial topics facing our specialty, and brings great minds together from across the country and around the world. I look forward to being part of this special organization for years to come."

Sponsored by **Teva Pharmaceuticals**

With a diverse portfolio and pipeline of branded specialty products as well as generic medicines, Teva Pharmaceuticals is working to help advance treatments in pain management. Teva understands that chronic pain affects more than 100 million people and can touch many aspects of everyday life. And, while prescription pain medications play a role in managing pain for some, the reality is they have the potential to be abused and misused.

As part of our ongoing commitment to support healthcare professionals and patients dealing with chronic pain, we are developing an innovative abuse deterrence technology platform to address the challenges of opioid abuse and misuse. With this commitment comes responsibility to provide information and resources that support responsible pain management. Pain Matters was developed by Teva Pharmaceuticals to offer practical tools for healthcare professionals and people affected by pain as they navigate the evolving and complex pain-care landscape.

PainMatters.com is an online resource that features downloadable tools and resources including a one-of-a-kind video on abuse deterrence technology, Pain Perspectives which offers community insights on a variety of pain topics, and the Discovery Channel documentary "Pain Matters". Teva is also partnering with leading advocacy and professional organizations to bring Pain Matters directly to those looking for resources through screenings of the "Pain Matters" documentary and educational programming on abuse deterrence at medical meetings.

To learn more about Teva's commitment to responsible pain management, visit PainMatters.com.

ADVANCED PRACTICE PROVIDER OF THE YEAR

Brett B.
Snodgrass
FNP-C, CPE, FACPP, FAANP

Brett Snodgrass is a Family Nurse Practitioner practicing at LifeLinc Pain in Memphis, Tennessee, where she is the Director of Clinical Operations. She is also an award winning healthcare blogger: The NP Mom (www.thenpmom.wordpress.com). The blog offers answers to patient's questions they often forget to ask! Brett is board certified with the American Association of Nurse Practitioners, where she is currently the Tennessee state representative. She is also a member of the American Academy of Pain Management and Sigma Theta Tau. Brett is honored to have been named national faculty and clinical expert for the FDA REMS education initiative CO*RE, a multiprofessional organization and initiative to support educational activities addressing the public health crisis surrounding the use, abuse, diversion, and overdose associated with extended-release/long-acting (ER/LA) opioids. She presents both locally and nationally on healthcare related topics, and has been an invited speaker at national conferences throughout the US. Brett received the 2015 AANP State Excellence Award for her work on the Tennessee Chronic Pain Task Force, as well as advocating for Tennessee Full Practice Authority for Nurse Practitioners. She is married with 2 teenage daughters.

ASPE PAIN EDUCATOR OF THE YEAR

Paul J.
Christo
MD

Dr. Paul Christo is an Associate Professor in the Division of Pain Medicine at Johns Hopkins University School of Medicine. He hosts *Aches and Gains*®, a nationally syndicated SIRIUS XM radio talk show telling compelling stories of people who have found pain relief, sharing cutting edge treatments from contributing experts, and offering ways that people in pain can cope themselves. It has earned him the John and Emma Bonica Public Service Award from the American Pain Society, and he was named a "Hero" by The Pain Community for his work. Dr. Christo was also selected as a Mayday Pain and Society Fellow. He served as Director of the Multidisciplinary Pain Fellowship Program for 8 years and the Blaustein Pain Treatment Center for 5 years at Johns Hopkins Hospital. Dr. Christo is an invited lecturer both nationally and internationally, serves on 4 journal editorial boards, has published more than 100 articles and book chapters, coedited 3 textbooks on pain, and actively teaches medical students, residents, and pain fellows. He's a member of *Men's Health* medical advisory board, serving as their first pain specialist. Dr. Christo has directed or coordinated many national conferences focusing on educating both specialists and generalists on important aspects of pain diagnosis and treatment. He serves on the Board of Directors and Executive Committee of the American Academy of Pain Management. He earned an MBA from the Johns Hopkins Carey Business School in Health Care Management.



LOGiSTiCS

Welcome | Conference Floor Plan | Keynote | Welcome Reception

WELCOME



PAINWeek 2016 marks the 10th annual PAINWeek National Conference, and we welcome our new and returning participants to the experience!

As we embark on the largest and most diverse event to date, we reflect on all that has been achieved, and look forward to all that remains to be done. In 10 years of continued success, we've provided over 100,000 hours of certified pain education. Some 20,000 frontline practitioners have shared the collaborative experience that PAINWeek provides. We've developed the most comprehensive curriculum on multimodal pain treatment available anywhere. And we've evolved our delivery of pain education to a platform of live conference, digital, and print resources for busy practitioners of all specialties.

The gathering storm of prescription opioid abuse coupled with alarming trends in heroin addiction and overdose fatality have prompted regulatory and administrative reaction at both federal and state levels. On March 18, the Centers for Disease Control issued new guidelines for prescribers directed at opioid therapy for chronic pain. In recent years, many states have joined the state of Washington in issuing both advisory and mandatory dosage thresholds, at varying levels of daily morphine equivalency. But the limitations posed by these responses have been voiced by many, including many of our own PAINWeek faculty. Variances in individual patient characteristics, prescribing environments, even the unproven reliance on morphine equivalency as parameter of risk, have all been cited as reasons for concern over the impact of these initiatives on the treatment outcomes for legitimate pain patients. Clearly, the need is for more education, not regulation.

For education there's no better place than PAINWeek 2016. As you review this program book, you'll find over 120 CE/CME hours of instruction, taught by over 90 pain management thought leaders. We're offering new course tracks in Acute Pain Management, Chronic Pain Prevention and Care, Pain Management in the Emergency Department, Women's Health, and for the Advanced Practice Provider. A new application based workshop, "Winning the Game of Groans," will detail strategies and tactics for prescriber survival in today's controlled medication therapy environment. A Special Interest Session, "If 6 Were 9," will feature a faculty panel discussion of the development history of, and substantive concerns raised by, the new CDC prescribing guidelines.

We welcome our participating organizations, and their respective programs, including the American Academy of Pain Medicine, the National Association of Drug Diversion Investigators, the American Pain Society, and the Veterans Health Administration. The American Society of Pain Educators once again presents its highly popular Pain Educators Forum, including "Neuropathica Galactica," the interactive workshop exploring assessment, patient education, and treatment planning.

For our new participants, PAINWeek 101, offered on Monday evening, is a special opportunity to orient and prepare for the conference experience. The Keynote Presentation on Wednesday will be followed by refreshments and the opportunity to converse with faculty and colleagues at the Welcome Reception in the Exhibit Hall.

Above all else, PAINWeek is a community. We gather, we debate, and we learn together. With you, we celebrate all that we've accomplished. With you, we embrace and aspire to a better world for 100 million Americans with pain. The journey continues!

women's health

thursday
september 8



jennifer hah georgine lamvu

ravi prasad

d.fressé 16

women's health

d.fossa 16



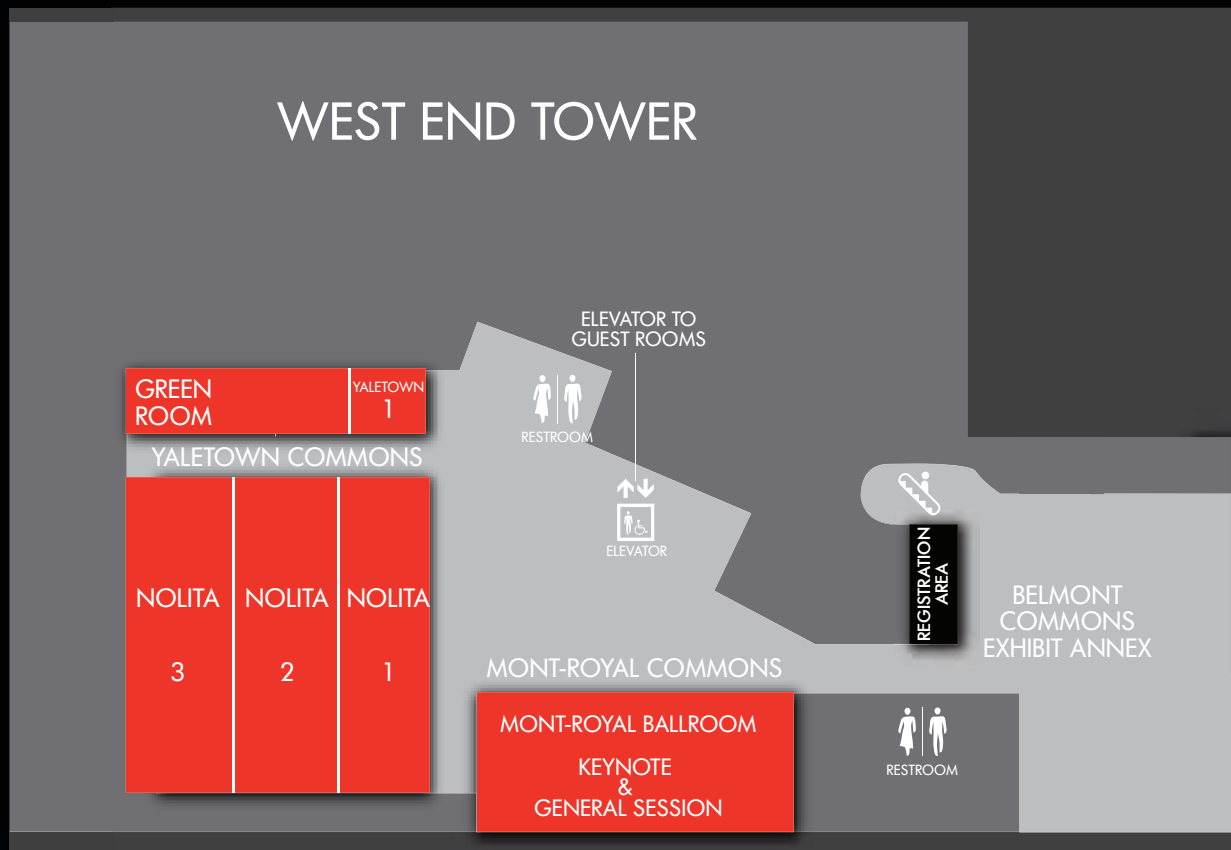
burnout!

How to recognize the
symptoms in ourselves
as pain healthcare professionals,
enhance resilience,
reduce stress, and
improve quality of life

Dawn Buse

**Tuesday
September 6**

CONFERENCE

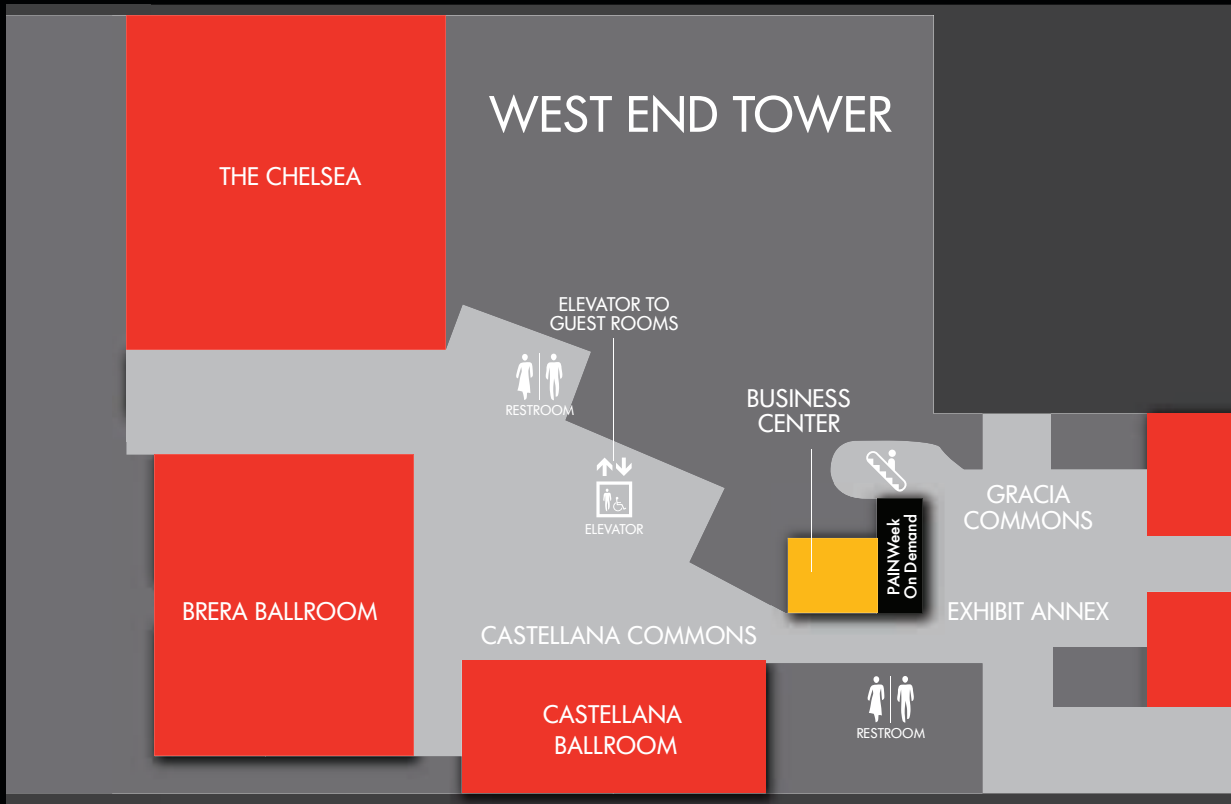


LEVEL 4

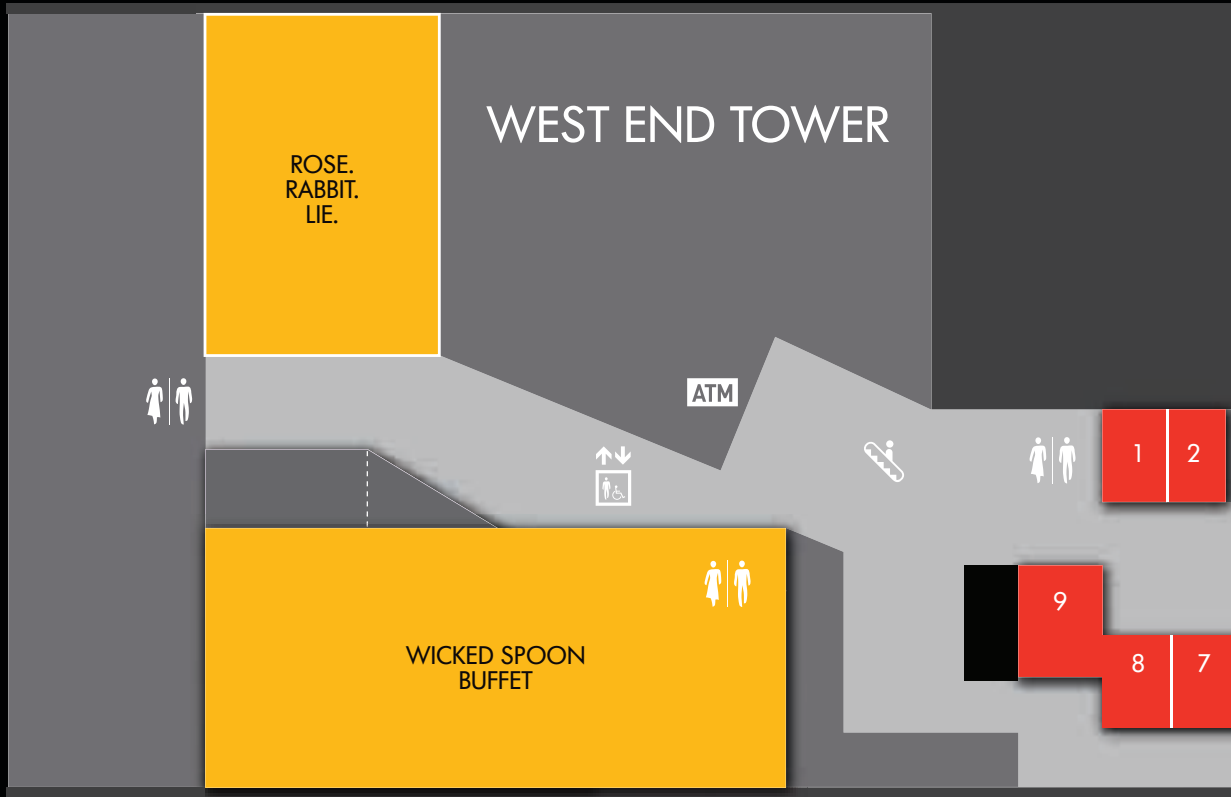
FLOOR PLAN



LEVELS 3 & 2



LEVEL 3



LEVEL 2




Please Note: **The Henry** (restaurant) is located on Level 1

For relief of mild to moderate acute pain in adults

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INDICATION

ZIPSOR[®] (diclofenac potassium) Liquid Filled Capsules are indicated for relief of mild to moderate acute pain in adults [18 years of age or older].

Non-Interchangeability with Other Formulations of Diclofenac

Different formulations of oral diclofenac are not bioequivalent even if the milligram strength is the same. Therefore, it is not possible to convert dosing from any other formulation of diclofenac to ZIPSOR.

IMPORTANT SAFETY INFORMATION

WARNING: RISK OF SERIOUS CARDIOVASCULAR AND GASTROINTESTINAL EVENTS

Cardiovascular Risk

- Nonsteroidal anti-inflammatory drugs (NSAIDs) may increase the risk of serious cardiovascular (CV) thrombotic events, myocardial infarction, and stroke, which can be fatal. This risk may increase with duration of use. Patients with cardiovascular disease or risk factors for cardiovascular disease may be at greater risk.
- ZIPSOR is contraindicated for the treatment of perioperative pain in the setting of coronary artery bypass graft (CABG) surgery.

Gastrointestinal Risk

- NSAIDs increase the risk of serious gastrointestinal (GI) adverse reactions including, bleeding, ulceration, and perforation of the stomach or intestines, which can be fatal. These events can occur at any time during use and without warning symptoms. Elderly patients are at greater risk for serious gastrointestinal events.

CONTRAINDICATIONS

ZIPSOR is contraindicated in patients with known hypersensitivity (e.g., anaphylactoid reactions and serious skin reactions) to diclofenac.

ZIPSOR is contraindicated in patients who have experienced asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDs. Severe, rarely fatal, anaphylactic-like reactions to NSAIDs have been reported in such patients.

ZIPSOR is contraindicated for the treatment of perioperative pain in the setting of coronary artery bypass graft (CABG) surgery.

ZIPSOR contains gelatin and is contraindicated in patients with known hypersensitivity to bovine protein.

WARNINGS AND PRECAUTIONS

Cardiovascular Thrombotic Events

Clinical trials of several COX-2 selective and nonselective NSAIDs of up to three years duration have shown an increased risk of serious cardiovascular (CV) thrombotic events, myocardial infarction, and stroke, which can be fatal. **[See Boxed Warning for additional information].**

Gastrointestinal (GI) Effects – Risk of GI Ulceration, Bleeding, and Perforation

NSAIDs, including diclofenac, can cause serious gastrointestinal (GI) adverse events including, bleeding, ulceration, and perforation of the stomach, small intestine, or large intestine, which can be fatal. These serious adverse events can occur at any time, with or without warning symptoms, in patients treated with NSAIDs. **[See Boxed Warning for additional information].**

Please see additional Important Safety Information and brief summary of full Prescribing Information for ZIPSOR[®] on adjacent pages. Full Prescribing Information and Medication Guide are available at www.ZIPSOR.com.

IMPORTANT SAFETY INFORMATION (Cont'd)

Hepatic Effects

Elevations in one or more liver function tests may occur during therapy with ZIPSOR. Physicians should measure transaminases (ALT and AST) periodically in patients receiving long-term therapy with diclofenac because severe hepatotoxicity may develop without a prodrome of distinguishing symptoms. If abnormal liver tests persist or worsen, if clinical signs and/or symptoms consistent with liver disease develop, or if systemic manifestations of hepatotoxicity occur, discontinue ZIPSOR immediately. Exercise caution when prescribing ZIPSOR with concomitant drugs that are known to be potentially hepatotoxic, and advise patients to avoid unprescribed acetaminophen while using ZIPSOR.

Hypertension

NSAIDs, including diclofenac, can lead to new onset or worsening of preexisting hypertension, either of which may contribute to the increased incidence of CV events. Use NSAIDs, including ZIPSOR, with caution in patients with hypertension. Monitor blood pressure (BP) closely during the initiation of NSAID treatment and throughout the course of therapy.

Patients taking ACE inhibitors, thiazides or loop diuretics may have impaired response to these therapies when taking NSAIDs.

Congestive Heart Failure and Edema

Fluid retention and edema have been observed in some patients taking NSAIDs. ZIPSOR should be used with caution in patients with fluid retention or heart failure.

Renal Effects

Use caution when initiating treatment with ZIPSOR in patients with considerable dehydration.

Long-term administration of NSAIDs has resulted in renal papillary necrosis and other renal injury, particularly in patients with impaired renal function, heart failure, liver dysfunction, those taking diuretics and ACE inhibitors, and the elderly. Treatment with ZIPSOR is not recommended in patients with advanced renal disease.

Anaphylactoid Reactions

As with other NSAIDs, anaphylactoid reactions may occur in patients without known prior exposure to ZIPSOR. ZIPSOR is contraindicated in patients with the aspirin triad.

Adverse Skin Reactions

NSAIDs, including ZIPSOR, can cause serious skin adverse events such as exfoliative dermatitis, Stevens-Johnson Syndrome, and toxic epidermal necrolysis, which can be fatal. These serious events can occur without warning. ZIPSOR should be discontinued at the first appearance of skin rash or other sign of hypersensitivity.

Corticosteroid Treatment

ZIPSOR cannot be expected to substitute for corticosteroids or to treat corticosteroid insufficiency. Abrupt discontinuation of corticosteroids may lead to exacerbation of corticosteroid-responsive illness.

Masking of Inflammation and Fever

The pharmacological activity of diclofenac in reducing inflammation, and possibly fever, may diminish the utility of diagnostic signs in detecting infectious complications of presumed noninfectious, painful conditions.

Hematological Effects

Anemia may occur in patients receiving NSAIDs. This may be due to fluid retention, occult or gross GI blood loss, or an incompletely described effect upon erythropoiesis. In patients on long-term therapy with NSAIDs, including diclofenac, check hemoglobin or hematocrit if they exhibit any signs or symptoms of anemia or blood loss. ZIPSOR is not indicated for long-term treatment.

NSAIDs inhibit platelet aggregation and have been shown to prolong bleeding time in some patients.

Use in Patients with Preexisting Asthma

See CONTRAINDICATIONS

ADVERSE REACTIONS

The following serious adverse reactions are discussed elsewhere in the labeling:

- Cardiovascular thrombotic events (see **Boxed Warning and Warnings and Precautions**)
- Gastrointestinal effects (see **Boxed Warning and Warnings and Precautions**)
- Hepatic effects (see **Warnings and Precautions**)
- Hypertension (see **Warnings and Precautions**)
- Congestive heart failure and edema (see **Warnings and Precautions**)
- Renal effects (see **Warnings and Precautions**)
- Anaphylactoid reactions (see **Warnings and Precautions**)
- Serious skin reactions (see **Warnings and Precautions**)

The most common adverse reactions reported in ZIPSOR clinical trials ($\geq 1\%$ and greater than placebo) were abdominal pain, constipation, somnolence, and increased sweating.

DRUG INTERACTIONS

(See full Prescribing Information for full information on drug interactions)

Aspirin

Concomitant administration of ZIPSOR and aspirin is not generally recommended because of the potential for increased adverse effects including increased GI bleeding.

Anticoagulants

Concomitant use of anticoagulants and ZIPSOR has a risk of serious GI bleeding higher than users of either drug alone.

ACE-inhibitors

NSAIDs may diminish the antihypertensive effect of angiotensin converting enzyme (ACE) inhibitors.

USE IN SPECIFIC POPULATIONS

Use in Pregnancy

There are no adequate and well-controlled studies in pregnant women. Prior to 30 weeks gestation, ZIPSOR should be used in pregnancy only if the potential benefit outweighs the risk to the fetus (Category C). Starting at 30 weeks, ZIPSOR can cause fetal harm (Category D).

Nursing Mothers

It is not known whether this drug is excreted in human milk; however, there is a case report in the literature indicating that diclofenac can be detected at low levels in breast milk. It is not known whether this drug is excreted in human milk.

Pediatric Use

The safety and effectiveness of ZIPSOR in pediatric patients has not been established.

Geriatric Use

Clinical studies of ZIPSOR did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Elderly patients are at increased risk for serious GI adverse events.

OVERDOSAGE

Symptoms following acute NSAID overdoses include lethargy, drowsiness, nausea, vomiting, and epigastric pain, which are generally reversible with supportive care. Gastrointestinal bleeding can occur. Hypertension, acute renal failure, respiratory depression and coma may occur.

Please see Brief Summary of Full Prescribing Information on adjacent pages for additional Important Safety Information.



BRIEF SUMMARY of Prescribing Information. For full Prescribing Information, please visit www.Zipsor.com.

WARNING: RISK OF SERIOUS CARDIOVASCULAR AND GASTROINTESTINAL EVENTS

Cardiovascular Risk

- **Nonsteroidal anti-inflammatory drugs (NSAIDs) may increase the risk of serious cardiovascular (CV) thrombotic events, myocardial infarction, and stroke, which can be fatal. This risk may increase with duration of use. Patients with cardiovascular disease or risk factors for cardiovascular disease may be at greater risk [see Warnings and Precautions].**
- **Zipsor is contraindicated for the treatment of perioperative pain in the setting of coronary artery bypass graft (CABG) surgery [see Contraindications].**

Gastrointestinal Risk

- **NSAIDs increase the risk of serious gastrointestinal (GI) adverse reactions including, bleeding, ulceration, and perforation of the stomach or intestines, which can be fatal. These events can occur at any time during use and without warning symptoms. Elderly patients are at greater risk for serious gastrointestinal events [see Warnings and Precautions].**

INDICATIONS AND USAGE

Zipsor is indicated for relief of mild to moderate acute pain in adults (18 years of age or older).

DOSAGE AND ADMINISTRATION

Initiating Therapy

For treatment of mild to moderate acute pain, the dosage is 25 mg four times a day. Use the lowest effective dose for the shortest duration consistent with individual patient treatment goals.

Non-Interchangeability with Other Formulations of Diclofenac

Different formulations of oral diclofenac are not bioequivalent even if the milligram strength is the same. Therefore, it is not possible to convert dosing from any other formulation of diclofenac to Zipsor. The only approved dosing regimen for Zipsor is 25 mg four times a day.

CONTRAINDICATIONS

Zipsor is contraindicated in patients with known hypersensitivity (e.g., anaphylactoid reactions and serious skin reactions) to diclofenac [see Warnings and Precautions].

Zipsor is contraindicated in patients who have experienced asthma, urticaria, or other allergic-type reactions after taking aspirin or other NSAIDs. Severe, rarely fatal, anaphylactic-like reactions to NSAIDs have been reported in such patients [see Warnings and Precautions].

Zipsor is contraindicated for the treatment of perioperative pain in the setting of coronary artery bypass graft (CABG) surgery [see Warnings and Precautions].

Zipsor contains gelatin and is contraindicated in patients with known hypersensitivity to bovine protein.

WARNINGS AND PRECAUTIONS

Cardiovascular Thrombotic Events

Clinical trials of several COX-2 selective and nonselective NSAIDs of up to three years duration have shown an increased risk of serious cardiovascular (CV) thrombotic events, myocardial infarction, and stroke, which can be fatal. Patients with known CV disease or risk factors for CV disease may be at greater risk. To minimize the potential risk for an adverse CV event in patients treated with an NSAID, use the lowest effective dose for the shortest duration possible. Physicians and patients should remain alert for the development of such events, even in the absence of previous CV symptoms. Inform patients about the signs and/or symptoms of serious CV events and the steps to take if they occur.

There is no consistent evidence that concurrent use of aspirin mitigates the increased risk of serious CV thrombotic events associated with NSAID use. The concurrent use of aspirin and an NSAID, such as diclofenac, does increase the risk of serious GI events.

Gastrointestinal (GI) Effects – Risk of GI Ulceration, Bleeding, and Perforation
NSAIDs, including diclofenac, can cause serious gastrointestinal (GI) adverse events including, bleeding, ulceration, and perforation of the stomach, small intestine, or

large intestine, which can be fatal. These serious adverse events can occur at any time, with or without warning symptoms, in patients treated with NSAIDs. Only one in five patients, who develop a serious upper GI adverse event on NSAID therapy, is symptomatic. Longer duration of use increases the likelihood of developing a serious GI event at some time during the course of therapy. However, even short-term NSAID therapy is not without risk.

Prescribe NSAIDs, including Zipsor, with extreme caution in patients with a prior history of ulcer disease or gastrointestinal bleeding. Other factors that increase the risk for GI bleeding in patients treated with NSAIDs include concomitant use of oral corticosteroids or anticoagulants, longer duration of NSAID therapy, smoking, use of alcohol, older age, and poor general health status. Most spontaneous reports of fatal GI events are in elderly or debilitated patients, and therefore special care should be taken in treating this population.

To minimize the potential risk for an adverse GI event in patients treated with an NSAID, use the lowest effective dose for the shortest possible duration. Patients and physicians should remain alert for signs and symptoms of GI ulceration and bleeding during Zipsor therapy and promptly initiate additional evaluation and treatment if a serious GI adverse event is suspected. This should include discontinuation of Zipsor until a serious GI adverse event is ruled out. For high risk patients, alternative therapies that do not include NSAIDs should be considered.

Hepatic Effects

Elevations in one or more liver function tests may occur during therapy with ZIPSOR. Physicians should measure transaminases (ALT and AST) periodically in patients receiving long-term therapy with diclofenac because severe hepatotoxicity may develop without a prodrome of distinguishing symptoms. If abnormal liver tests persist or worsen, if clinical signs and/or symptoms consistent with liver disease develop, or if systemic manifestations of hepatotoxicity occur, discontinue ZIPSOR immediately.

To minimize the potential risk for an adverse liver-related event in patients treated with Zipsor, use the lowest effective dose for the shortest duration possible. Exercise caution when prescribing Zipsor with concomitant drugs that are known to be potentially hepatotoxic (e.g., acetaminophen, certain antibiotics, antiepileptics). Caution patients to avoid taking unprescribed acetaminophen while using Zipsor.

Hypertension

NSAIDs, including diclofenac, can lead to new onset or worsening of preexisting hypertension, either of which may contribute to the increased incidence of CV events. Use NSAIDs, including Zipsor, with caution in patients with hypertension. Monitor blood pressure (BP) closely during the initiation of NSAID treatment and throughout the course of therapy. Patients taking ACE inhibitors, thiazides or loop diuretics may have impaired response to these therapies when taking NSAIDs.

Congestive Heart Failure and Edema

Fluid retention and edema have been observed in some patients taking NSAIDs. Use Zipsor with caution in patients with fluid retention or heart failure.

Renal Effects

Use caution when initiating treatment with Zipsor in patients with considerable dehydration.

Long-term administration of NSAIDs has resulted in renal papillary necrosis and other renal injury. Renal toxicity has also been seen in patients in whom renal prostaglandins have a compensatory role in the maintenance of renal perfusion. In these patients, administration of an NSAID may cause a dose-dependent reduction in prostaglandin formation and, secondarily, in renal blood flow, which may precipitate overt renal decompensation. Patients at greatest risk of this reaction are those with impaired renal function, heart failure, liver dysfunction, those taking diuretics and ACE inhibitors, and the elderly. Discontinuation of NSAID therapy is usually followed by recovery to the pretreatment state.

Treatment with Zipsor is not recommended in patients with advanced renal disease. If Zipsor therapy must be initiated, close monitoring of the patient's renal function is advisable.

Anaphylactoid Reactions

As with other NSAIDs, anaphylactoid reactions may occur in patients without known prior exposure to Zipsor. Zipsor is contraindicated in patients with the aspirin triad [see Contraindications].

Adverse Skin Reactions

NSAIDs, including diclofenac, can cause serious skin adverse reactions such as exfoliative dermatitis, Stevens-Johnson Syndrome (SJS), and toxic epidermal necrolysis (TEN), which can be fatal. These serious events may occur without warning. Patients should be informed about the signs and symptoms of serious skin manifestations, and to discontinue Zipsor at the first appearance of skin rash or any other sign of hypersensitivity [see Contraindications].

Pregnancy

[see Use in Specific Populations]

Corticosteroid Treatment

Zipsor cannot be expected to substitute for corticosteroids or to treat corticosteroid insufficiency. Abrupt discontinuation of corticosteroids may lead to exacerbation of corticosteroid-responsive illness. Patients on prolonged corticosteroid therapy should have their therapy tapered slowly if a decision is made to discontinue corticosteroids.

Masking of Inflammation and Fever

Zipsor may diminish the utility of diagnostic signs in detecting infectious complications of presumed noninfectious, painful conditions.

Hematological Effects

Anemia may occur in patients receiving NSAIDs. In patients on long-term therapy with NSAIDs, including diclofenac, check hemoglobin or hematocrit if they exhibit any signs or symptoms of anemia or blood loss. Zipsor is not indicated for long-term treatment.

NSAIDs inhibit platelet aggregation and have been shown to prolong bleeding time in some patients. Unlike aspirin, their effect on platelet function is quantitatively less, of shorter duration, and reversible. Carefully monitor patients treated with Zipsor who may be adversely affected by alterations in platelet function.

Use in Patients with Preexisting Asthma

Patients with asthma may have aspirin-sensitive asthma. The use of aspirin in patients with aspirin-sensitive asthma has been associated with severe bronchospasm which can be fatal. Zipsor is contraindicated in patients with this form of aspirin sensitivity and should be used with caution in all patients with preexisting asthma [see Contraindications].

Monitoring

Because serious GI tract ulcerations and bleeding can occur without warning symptoms, physicians should monitor for signs or symptoms of GI bleeding. Discontinue Zipsor if abnormal liver tests or renal tests persist or worsen. Zipsor is not indicated for long-term treatment.

ADVERSE REACTIONS

The following serious adverse reactions are discussed elsewhere in the labeling:

- Cardiovascular thrombotic events [see Boxed Warning and Warnings and Precautions]
- Gastrointestinal effects [see Boxed Warning and Warnings and Precautions]
- Hepatic effects [see Warnings and Precautions]
- Hypertension [see Warnings and Precautions]
- Congestive heart failure and edema [see Warnings and Precautions]
- Renal effects [see Warnings and Precautions]
- Anaphylactoid reactions [see Warnings and Precautions]
- Serious skin reactions [see Warnings and Precautions]

Clinical Study Experience

The most common adverse reactions (i.e., reported in $\geq 1\%$ of Zipsor treated patients) were as follows: gastrointestinal experiences including abdominal pain, constipation, diarrhea, dyspepsia, nausea, vomiting, dizziness, headache, somnolence, pruritus, and increased sweating.

DRUG INTERACTIONS

Aspirin

Concomitant administration of Zipsor and aspirin is not generally recommended because of the potential of increased adverse effects.

Anticoagulants

The effects of anticoagulants such as of warfarin and NSAIDs on GI bleeding are synergistic, such that users of both drugs together have a risk of serious GI bleeding higher than that with use of either drug alone.

ACE-inhibitors

NSAIDs may diminish the antihypertensive effect of angiotensin converting enzyme (ACE) inhibitors.

Diuretics

Clinical studies, as well as post-marketing observations, have shown that NSAIDs can reduce the natriuretic effect of furosemide and thiazides in some patients. During concomitant therapy of Zipsor and diuretics, observe patients closely for signs of renal failure [see Warnings and Precautions], as well as to assure diuretic efficacy.

Lithium

NSAIDs have produced an elevation of plasma lithium levels and a reduction in renal lithium clearance. When Zipsor and lithium are administered concurrently, observe patients carefully for signs of lithium toxicity.

Methotrexate

NSAIDs may enhance the toxicity of methotrexate. Use caution when Zipsor is administered concomitantly with methotrexate.

Cyclosporine

Diclofenac, like other NSAIDs, may affect renal prostaglandins and increase the toxicity of certain drugs. Therefore, concomitant therapy with Zipsor may increase cyclosporine's nephrotoxicity. Use caution when Zipsor is administered concomitantly with cyclosporine.

Inhibitors or Substrates of Cytochrome P450 2C9 Other Considerations

Diclofenac is metabolized predominantly by cytochrome P450 2C9. Co-administration of diclofenac with another drug medication known to be metabolized by or that which inhibits Cytochrome P450 2C9 may unpredictably affect the pharmacokinetics of diclofenac or the co-administered drug medication. Caution should be used to evaluate each patient's medical history when consideration is given to prescribing Zipsor [see Clinical Pharmacology in the full Prescribing Information for Zipsor].

USE IN SPECIFIC POPULATIONS

Pregnancy

Teratogenic Effects: Pregnancy Category C prior to 30 weeks gestation; Category D starting 30 weeks gestation.

Starting at 30 weeks gestation, Zipsor, and other NSAIDs, should be avoided by pregnant women as premature closure of the ductus arteriosus in the fetus may occur. Zipsor can cause fetal harm when administered to a pregnant woman starting at 30 weeks gestation. If this drug is used during this time period in pregnancy, the patient should be apprised of the potential hazard to a fetus. There are no adequate and well-controlled studies in pregnant women. Prior to 30 weeks gestation, Zipsor should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Labor and Delivery

The effects of Zipsor on labor and delivery in pregnant women are unknown. In rat studies maternal exposure to NSAIDs, as with other drugs known to inhibit prostaglandin synthesis, increased incidence of dystocia, delayed parturition, and decreased pup survival.

Nursing Mothers

It is not known whether this drug is excreted in human milk; however, there is a case report in the literature indicating that diclofenac can be detected at low levels in breast milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions in nursing infants from Zipsor, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use

The safety and effectiveness of Zipsor in pediatric patients has not been established.

Geriatric Use

Clinical studies of Zipsor did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and concomitant disease or other drug therapy.

Diclofenac is known to be substantially excreted by the kidney, and the risk of adverse reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function. Older age increases the risk for GI bleeding. Most spontaneous reports of fatal GI events are in elderly or debilitated patients, and therefore special care should be taken in treating this population [see Gastrointestinal (GI) Effects – Risk of GI Ulceration, Bleeding, and Perforation].

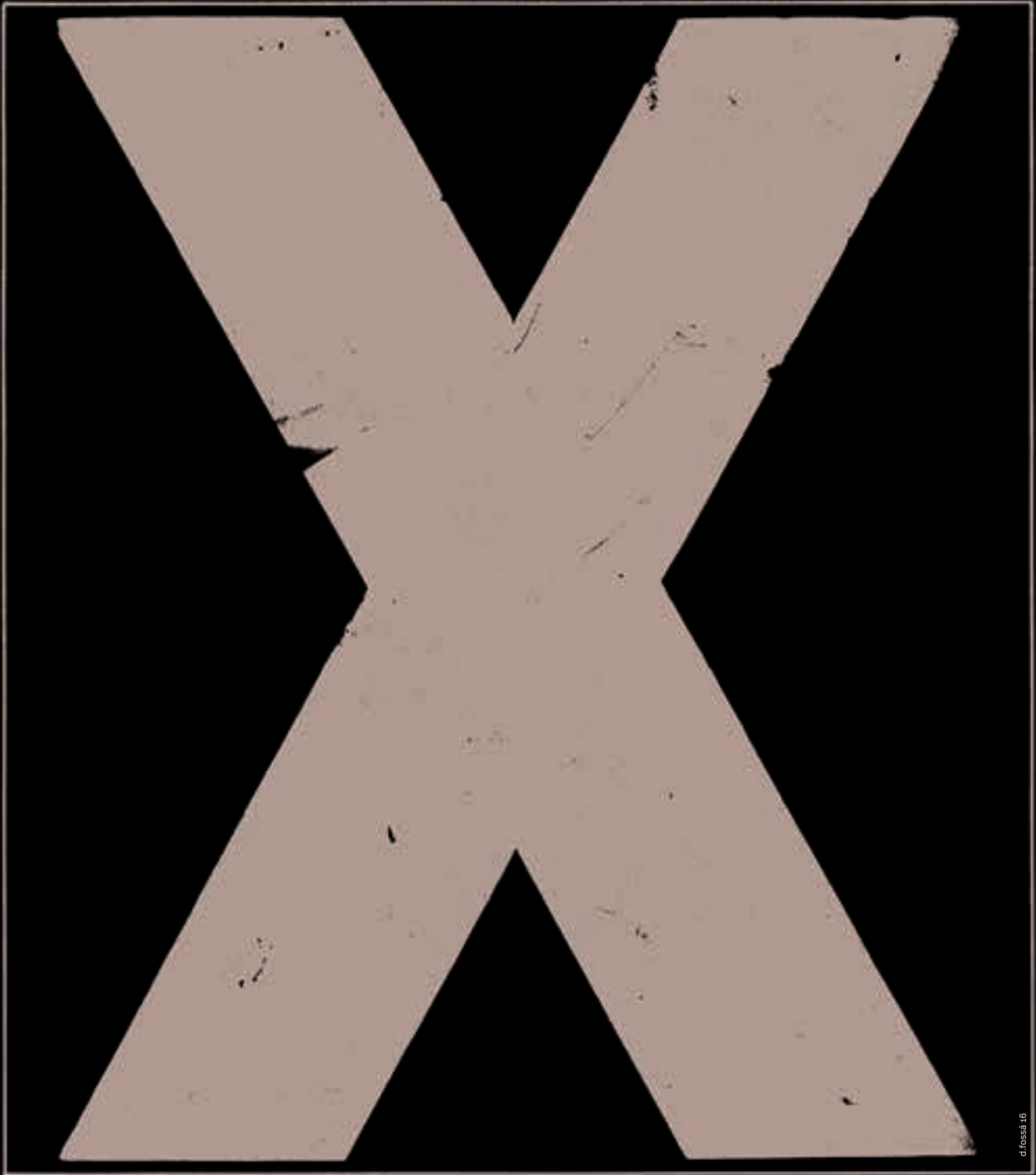
OVERDOSAGE

Symptoms following acute NSAID overdoses include lethargy, drowsiness, nausea, vomiting, and epigastric pain, which are generally reversible with supportive care. Gastrointestinal bleeding can occur. Hypertension, acute renal failure, respiratory depression and coma may occur.

Patients should be managed by symptomatic and supportive care following an NSAID overdose [see *OVERDOSAGE* in the full Prescribing Information for Zipsor].

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KEYNOTE



d.rossi 16

it's not what you think

Steven Passik Wed. Sept. 7 5:45p

mont-royal ballroom

level 4

WELCOME RECEPTION

Wednesday
September 7

6:45p–9:00p
Exhibit Hall



d.fossá

Sponsored by

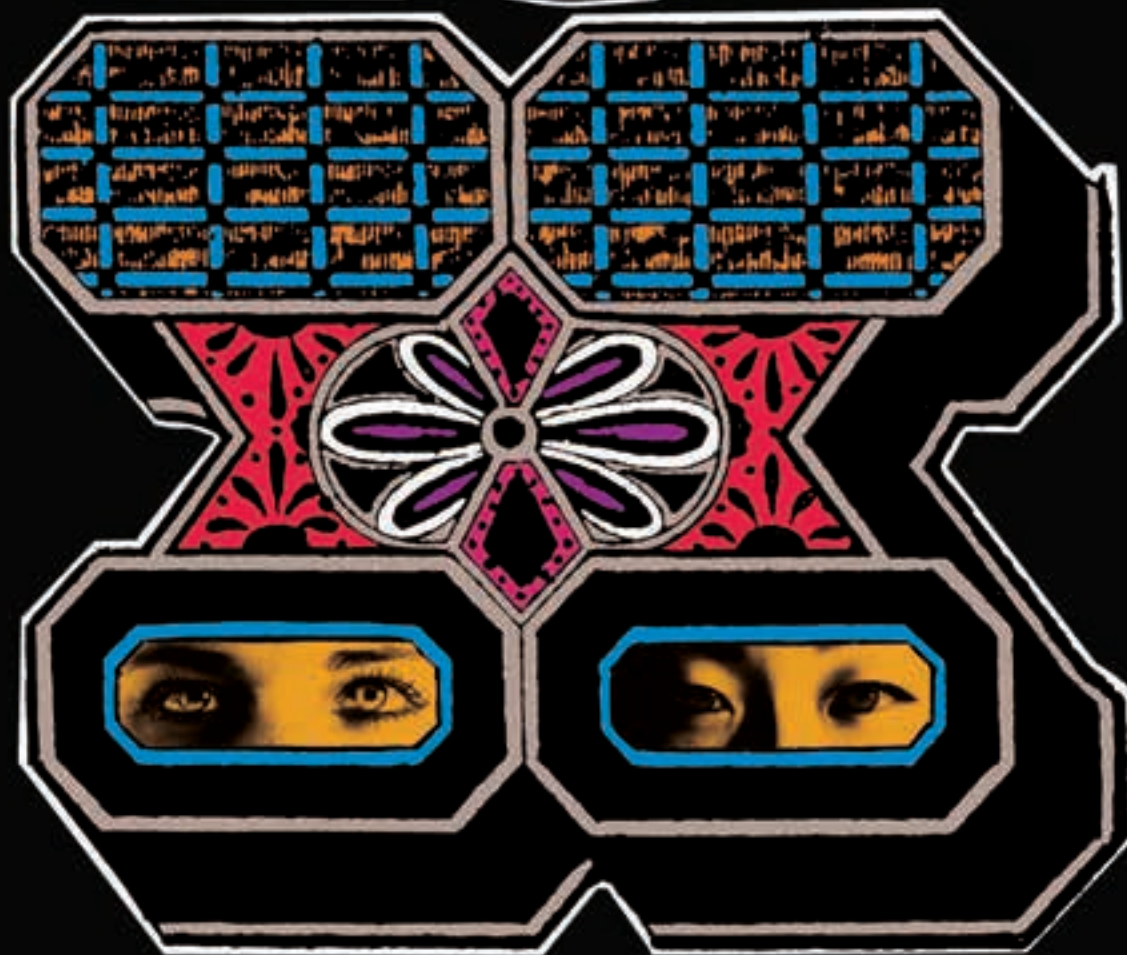


Pharmacotherapy



Michael Bottros
Abigail Brooks
Jennifer Hah
Courtney Kominck
Mary Lynn McPherson
Ravi Prasad
Kathryn Walker

**Friday/Saturday
September 9&10**





ACCREDITATION

ACCREDITATION

This activity is provided by Global Education Group.



Target Audience

The educational design of this activity addresses the needs of physicians, physician assistants, nurse practitioners, nurses, pharmacists, psychologists, and social workers involved in the treatment of patients with pain.

Purpose Statement

PAINWeek® provides practical knowledge and tools for busy pain management practitioners to utilize in their daily practice.

Educational Need

"Chronic pain is on the doorstep of every healthcare provider on Main Street. It doesn't matter whether you're in Kentucky or Iowa or Ohio or California or New York, it is everywhere. To me someone who says to a patient 'I don't treat chronic pain because I'm not a pain management physician' is really saying there are 7,000 board certitude pain clinicians in the United States. That's a fact. More or less 7,000 versus the number of people in the United States who suffer with chronic pain which, according to the Institute of Medicine, is somewhere around a 100 million people. If you do the math there's not enough healthcare providers in that 7,000 to see patients 24 hours a day, 7 days a week, 365 days a year."
Kevin L. Zacharoff, MD, FACIP, FACPE, FAAP

Over 140 hours of content will be presented!

Learning Objectives

After attending PAINWeek® 2016, learners should be better able to:

- Explain pain terminology
- Describe the protocols for acute and chronic pain assessment
- Interpret basic diagnostic procedures used to identify pain disorders
- Describe mechanisms by which regular physical activity and exercise decrease pain
- Identify the specific pain pathways acted upon by certain pharmacotherapies
- Calculate opioid conversions
- Cite current medical/legal issues impacting clinical pain management
- Assess strategies for treating pain and chemical dependency
- Identify the top prescription drugs of abuse
- Recognize a patient centered approach to chronic pain management
- Apply adult learning theories to patient, provider, and caregiver communications

For full learning objectives, please visit m.painweek.org.

Physician Accreditation Statement


Global Education Group is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Physician Credit Designation

Global Education Group designates this live activity for a maximum of 36.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Pharmacist Continuing Education

Accreditation Statement

 Global Education Group is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.

Credit Designation

Global Education Group designates this continuing education activity for 36.0 contact hours (3.6 CEUs) of the Accreditation Council for Pharmacy Education.

Please see www.painweek.org for full ACPE information and UAN numbers.

Please note: Pharmacy learners will not be eligible to receive partial credit. Individual courses must be attended in their entirety in order to be eligible to receive credit.

PHARMACY LEARNERS: Instructions for Credit—In order to receive credit, pharmacist participants must attend an entire course and complete the online credit application and evaluation form. These forms are available to complete at <http://www.painweek.org/eval>. An NABP number and date of birth (DOB) will be required to complete these forms and earn credit. Please bring this information with you to the conference for use while completing your evaluations.

ACPE credit cannot be uploaded to CPE Monitor more than 60 days after the session occurred.

Nursing Continuing Education

Global Education Group is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's COA.

This educational activity for 36.0 contact hours is provided by Global Education Group. Nurses should claim only the credit commensurate with the extent of their participation in the activity.

Psychologist Continuing Education

Global Education Group (Global) is approved by the American Psychological Association (APA) to sponsor continuing education for psychologists. Global maintains responsibility for this program and its content.

This activity has been approved for a maximum of 36.0 CE credits for psychologists. The instructional level of this activity is introductory. Psychologists should only claim credit commensurate with the extent of their participation in the activity.

Please note: Attendance of psychology learners will be monitored. As with all conference participants, psychology learners will be

required to scan in using their coded badge. Psychology learners must then formally sign out for each session in which they are applying for continuing education credit.

Nurse Practitioner Continuing Education



This program was planned in accordance with AANP CE Standards and Policies and AANP Commercial Support Standard.

Global Education Group is approved as a provider of nurse practitioner continuing education by the American Association of Nurse Practitioners: AANP Provider Number 110121. This program has been approved for 36.0 contact hours of continuing education (which includes pharmacology hours). Nurse practitioners should claim only the credit commensurate with the extent of their participation in the activity.

Please see www.m.painweek.org for full AANP Rx hours.

Physician Assistants

The AAPA accepts AMA PRA Category 1 Credit™ from organizations accredited by the ACCME.

American Academy of Family Physicians Continuing Education

This Live activity, PAINWeek 2016, with a beginning date of 09/06/2016, has been reviewed and is acceptable for up to 37.25 Prescribed credit(s) by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Please note: The American Academy of Family Physicians' credit calculations differ from other accreditation boards, resulting in a different number of credit hours.

National Association of Social Workers Continuing Education

This program is Approved by the National Association of Social Workers (Approval # 886551415-0) for 36 Social Work continuing education contact hours.

ALL OTHER LEARNERS: Instructions for Credit—In order to receive credit, participants must attend the course and complete the online credit application and evaluation form. These forms are available to complete at <http://www.painweek.org/evals>. Participants can only claim the hours they were actually in attendance for CME credit. Statements of credit are available to print upon completion of online forms.

Please note that registration fees apply to this conference.

For information about the accreditation of this program, please contact Global at (303) 395-1782 or cme@globaleducationgroup.com.

Supported by an educational grant from Daiichi Sankyo, Inc. This activity is supported in part by an educational grant from Pfizer.

Disclosure of Unlabeled Use

This educational activity may contain discussion of published and/or investigational uses of agents that are not indicated by the FDA. Global Education Group (Global) does not recommend the use of any agent outside of the labeled indications.

The opinions expressed in the educational activity are those of the faculty and do not necessarily represent the views of any organization associated with this activity. Please refer to the official prescribing information for each product for discussion of approved indications, contraindications, and warnings.

Disclaimer

Participants have an implied responsibility to use the newly acquired information to enhance patient outcomes and their own professional development. The information presented in this activity is not meant to serve as a guideline for patient management. Any procedures, medications, or other courses of diagnosis or treatment discussed in this activity should not be used by clinicians without evaluation of patient conditions and possible contraindications on dangers in use, review of any applicable manufacturer's product information, and comparison with recommendations of other authorities.


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The planners and managers reported the following financial relationships or relationships to products or devices they or their spouse/life partner have with commercial interests related to the content of this CME activity:

Name of Planner or Manager	Reported Financial Relationship
Kelvin Burton, MD	Nothing to disclose
Kristen Delisi, NP	Nothing to disclose
Andrea Funk	Nothing to disclose
Amanda Glazar, PhD	Nothing to Disclose
Ashley Marostica, RN, MSN	Nothing to Disclose

Americans with Disabilities Act

 Event staff will be glad to assist you with any special needs (physical, dietary, etc).

thursday september 8

jennifer bolen paul christo douglas gourlay howard heit stephen ziegler

THE MEDICAL STASI

Is risk management for controlled substances
destroying the provider-patient relationship?

d.fossa 16

AGENDA



TUESDAY/96 | WEDNESDAY/97 | THURSDAY/98 | FRIDAY/99 | SATURDAY/910

TUESDAY

9.6

CPS-O1	Chronic Pain Prevention	7:00a – 7:50a	Level 3/ Gracia 3	James R. Friction, DDS, MS
EMD-O1	Child Life 101 for Emergency Departments and Emergency Care Providers: Using Nonpharmacologic Methods to Relieve and Manage Pain and Anxiety	7:00a – 7:50a	Level 3/ Gracia 1	Phyllis L. Hendry, MD, FAAP, FACEP Danielle Eaves Hernandez, BS, CCLS Colleen Kalynych, MSH, EdD
SIS-O1	Physician Orders for Life Sustaining Treatment (POLST)	7:00a – 7:50a	Level 4/ Nolita 1	Jeffrey A. Gudim, MD
CPS-O2	Managing Odd Neuropathic Pain Disorders	8:00a – 10:00a	Level 4/ Mont-Royal Ballroom	Ignacio J. Badiola, MD Martin D. Cheattle, PhD Peter G. Pryzbylkowski, MD Peter Yi, MD
BHV-O1	Biobehavioral Management of Migraine	9:00a – 9:50a	Level 4/ Nolita 3	Dawn C. Buse, PhD
EMD-O2	Case Scenarios in ED Pain Management: Don't Let First Impressions Fool You!	9:00a – 9:50a	Level 4/ Nolita 2	Phyllis L. Hendry, MD, FAAP, FACEP Alexis LaPietra, DO
MAS-O1	Neurogenic Thoracic Outlet Syndrome	9:00a – 11:00a	Level 4/ Yaletown 1	Allen J. Togut, MD
MDL-O1	Winning the Game of Groans: Strategies and Tactics for Preserving the Pain Practitioner's Decision to Prescribe Controlled Medication	9:00a – 12:00p	Level 2/ Condesa 8	Jennifer Bolen, JD Douglas L. Gourlay, MD, MSc, FRCPC, FASAM Ted W. Jones, PhD, CPE Darren McCoy, FNP-BC, CPE
PREPEF-O1	Neuropathica Galactica	9:00a – 5:00p	Level 3/ Gracia 5	Sondra M. Adkinson, PharmD, DAAPM, CPE, BSPH Mary Lynn McPherson, PharmD, MA, BCPS, CPE
	Break	10:00a – 10:30a		
CPS-O3	Transformative Care for Chronic Pain: Orofacial	10:30a – 11:20a	Level 4/ Nolita 3	James R. Friction, DDS, MS
EMD-O3	How to Complete a Rapid Pain Assessment in a Busy ED	10:30a – 11:20a	Level 4/ Nolita 2	Alexis LaPietra, DO Sophia Sheikh, MD
SIS-O2	Stop the Carousel I Want to Get Off: The Pressures of Managing Chronic Pain Patients in Clinical Practice	10:30a – 11:20a	Level 4/ Mont-Royal Ballroom	Kevin L. Zacharoff, MD, FACIP, FACPE, FAAP
SIS-O3	Clinical Conundrum: Catch-22	10:30a – 11:50a	Level 3/ Gracia 1	Gary W. Jay, MD, FAAPM, FACFEI
POP-O1	14 Miles From Wisdom: Things I Learned By Accident	11:30a – 12:00p	Level 4/ Mont-Royal Ballroom	Becky L. Curtis, PCC
POP-O2	The Unstable Argument for Core Stabilization	11:30a – 12:00p	Level 4/ Nolita 1	Kathryn A. Schopmeyer, PT, DPT, CPE
PDM-O2	Guidelines, Practice, and Policy: Separating the Myths From the Facts With OADP* Sponsored by Purdue Pharma L.P.	12:30p – 1:30p	Level 3/ Brera Ballroom	Ellen Battista, NP J. David Haddox, DDS, MD

*Not certified for credit

TUESDAY

9.6

PDM-03	Clinical Dialogues: What Is the Role of Buprenorphine in Chronic Pain?* Sponsored by Endo Pharmaceuticals	12:30p – 1:30p	Level 3/ Castellana Ballroom	Faculty TBA
BHV-02	Burnout! Recognize Symptoms, Enhance Resilience, and Improve Quality of Life	1:40p – 2:30p	Level 4/Nolita 3	Dawn C. Buse, PhD
HCH-01	Pain Management Coaching: Integrative and Complimentary Strategies for Complicated Pain	1:40p – 2:30p	Level 4/Nolita 2	Lesa R. Abney, BSN, MINT Lisa Creekmur, BSN, MINT Becky L. Curtis, PCC
SIS-04	Functional Pain Syndromes	1:40p – 3:40p	Level 4/Nolita 1	Martin D. Cheatle, PhD Peter G. Pryzbylkowski, MD Peter Yi, MD
SYM-01	A Comprehensive Approach to the Safe Management of Extended-Release/ Long-Acting Opioids	1:40p – 4:40p	Level 3/Gracia 3	Jeffrey A. Gudin, MD Bill H. McCarberg, MD
BHV-03	The Gentle Art of Saying No: How to Establish Appropriate Boundaries With Chronic Pain Patients	2:40p – 3:30p	Level 4/Nolita 3	David Cosio, PhD
HCH-02	How Pain Management Coaching Impacts Pain Outcomes	2:40p – 3:30p	Level 4/Nolita 2	Lesa R. Abney, BSN, MINT Lisa Creekmur, BSN, MINT Becky L. Curtis, PCC
PDM-04	Sponsored Break*	3:40p – 4:30p	Level 3/ Castellana Ballroom	Faculty TBA
BHV-04	Falling Down the Rabbit Hole: A Primer for Chronic Pain Management and Substance Abuse Disorders	4:40p – 5:30p	Level 4/Nolita 3	David Cosio, PhD
EMD-04	Why Emergency Departments Love Ketamine	4:40p – 5:30p	Level 4/Nolita 2	Phyllis L. Hendry, MD, FAAP, FACEP Sophia Sheikh, MD
SIS-05	Managing Pain in Workers' Compensation Claims	4:40p – 5:30p	Level 4/Nolita 1	Robert Hall, MD
CPS-04	Transformative Care for Chronic Pain: Myofascial	5:40p – 6:30p	Level 4/Nolita 1	James R. Friction, DDS, MS
SIS-06	The Silent Healthcare Epidemic: Counterfeit Medicine	5:40p – 6:30p	Level 4/Nolita 2	Jay Joshi, MD, DABA, DABA-PM, FABA-PM
SIS-07	Exercise as Medicine: How to Get Pain Patients Active Again	5:40p – 6:30p	Level 4/Nolita 3	Peter A. Abaci, MD

*Not certified for credit

WEDNESDAY

9.7

ACU-01	Case Based Challenges in Acute Pain Management	7:00a – 7:50a	Level 3/ Gracia 1	Debra B. Gordon, RN, DNP, FAAN
PEF-01	Pain Terminology: Knowing the Difference Makes a Difference!	7:00a – 7:50a	Level 3/ Gracia 3	David M. Glick, DC, DAAPM, CPE, FASPE Mary Lynn McPherson, PharmD, MA, BCPS, CPE
SYM-02	The Need for a Personalized Team Approach in Managing Chronic Pain	7:00a – 7:50a	Level 3/ Gracia 5	John A. Hopper, MD Sanford M. Silverman, MD
PDM-05	Teva Pharmaceuticals Sponsored Program*	8:00a – 8:50a	Level 3/ Brera Ballroom	Charles E. Argoff, MD, CPE
PDM-06	Beyond Chronic Pain in the Opioid-Managed Patient: Addressing Comorbid Sleep and Psychiatric Disorders* Supported by Pernix Therapeutics	8:00a – 8:50a	Level 3/ Castellana Ballroom	Jeremy A. Adler, MS, PA-C Jeffrey Fudin, BS, PharmD, FCCP Jay Joshi, MD, DABA, DABA-PM, FABA-PM
AAPM-01	It Takes a Village (Part 1): Caring for the Whole Patient From an Integrative Therapies Perspective	9:00a – 9:50a	Level 3/ Gracia 1	Heather Tick, MD
ACU-02	New Treatment Options for Managing Pain in the ED	9:00a – 9:50a	Level 4/ Nolita 1	Alexis LaPietra, DO
PEF-02	Pain Pathophysiology Unraveled	9:00a – 9:50a	Level 3/ Gracia 3	David M. Glick, DC, DAAPM, CPE, FASPE
SIS-08	If 6 Were 9: The CDC's Prescribing Guidelines and the Veil of Secrecy	9:00a – 11:00a	Level 4/ Mont-Royal Ballroom	Jennifer Bolen, JD Jeffrey Fudin, BS, PharmD, FCCP Steven P. Stanos, DO Stephen J. Ziegler, PhD, JD
	Break	10:00a – 10:30a		
AAPM-02	It Takes a Village (Part 2): Caring for the Whole Patient With an Interdisciplinary Team	10:30a – 11:20a	Level 3/ Gracia 1	Ravi Prasad, PhD
ACU-03	Acute Pain in Patients With Active Substance Use Disorder	10:30a – 11:20a	Level 4/ Nolita 1	Debra B. Gordon, RN, DNP, FAAN
PEF-03	Chronic Pain Assessment	10:30a – 11:20a	Level 3/ Gracia 3	Michael R. Clark, MD, MPH, MBA
SIS-09	Why Skin Matters	10:30a – 11:50a	Level 4/ Nolita 2	Philip J. Albrecht, PhD Charles E. Argoff, MD, CPE Frank L. Rice, PhD
POP-03	Aches, Pains, and Secondary Gains	11:30a – 12:00p	Level 4/ Mont-Royal Ballroom	Dawn C. Buse, PhD
POP-04	Clinical Conundrum: Catch-22 (Encore)	11:30a – 12:00p	Level 3/ Gracia 3	Gary W. Jay, MD, FAAPM, FACFEI
PDM-07	Targeting Success: An Interactive Discussion of a Next Generation Molecule* Sponsored by Depomed, Inc.	12:30p – 1:30p	Level 3/ The Chelsea	Joseph V. Pergolizzi, MD Steve Vacalis, DO
SIS-10	If the Phone Doesn't Ring, It's Me: Communication and Pain Management	1:40p – 2:30p	Level 4/ Mont-Royal Ballroom	Kevin L. Zacharoff, MD, FACIP, FACPE, FAAP

*Not certified for credit

WEDNESDAY

9.7

MAS-02	When That Shark Bites: Classic Central Pain Syndromes	1:40p – 3:40p	Level 3/ Gracia 5	Gary W. Jay, MD, FAAPM, FACFEI
PEF-04	Pain Therapeutics	1:40p – 3:40p	Level 3/ Gracia 3	Anna Ratka, PhD, PharmD, CPE
AAPM-03	CRPS and New Developments in Fibromyalgia & Diabetic Neuropathy	2:40p – 3:30p	Level 3/ Gracia 1	R. Norman Harden, MD
ACU-04	Balancing Analgesia vs ORAEs in Postoperative Acute Pain: Consequences, Strategies, and New Approaches	2:40p – 3:30p	Level 4/ Nolita 1	Charles E. Argoff, MD, CPE
SIS-11	Platelet Rich Plasma (PRP): Hoax or Hope?	2:40p – 3:30p	Level 4/ Nolita 2	Peter G. Pryzbylowski, MD
SIS-12	Nutrition for Chronic Pain	2:40p – 3:30p	Level 4/ Nolita 3	Heather Tick, MD
PDM-08	Opioid Induced Constipation: The Science, the Struggle, and an Orally Administered Treatment Option* Sponsored by AstraZeneca	3:40p – 4:30p	Level 3/ Brera Ballroom	Orlando G. Florete, Jr, MD
AAPM-04	Evidence Based Medicine Under Attack! Use, Misuse, and Abuse of Clinical Practice Guidelines	4:40p – 5:30p	Level 3/ Gracia 1	Steven P. Stanos, DO
PEF-05	Pain Diagnostics: Clinical Pearls to Improve Common Tests for Pain	4:40p – 5:30p	Level 3/ Gracia 3	David M. Glick, DC, DAAPM, CPE, FASPE
SIS-13	Assessing and Managing Insomnia in Patients With Chronic Pain	4:40p – 5:30p	Level 4/ Nolita 1	Martin D. Cheatle, PhD
KEY-01	Keynote*	5:45p – 6:45p	Level 4/ Mont-Royal Ballroom	Michael R. Clark, MD, MPH, MBA Steven D. Passik, PhD Kevin L. Zacharoff, MD, FACIP, FACPE, FAAP
	Welcome Reception	6:45p – 9:00p	Level 4/ Exhibit Hall	

*Not certified for credit

THURSDAY

9.8

agenda

APP-01	The Role of the Advanced Practice Provider in the Acute Care Setting	7:00a – 7:50a	Level 3/ Gracia 3	Theresa Mallick-Searle, MS, NP-BC, ANP-BC
NAD-01	Hippocratic Oath: Does My Healthcare Provider Have My Best Interest at Heart?	7:00a – 7:50a	Level 4/ Mont-Royal Ballroom	Lisa M. McElhane, BS
PEF-06	The Neuroscience Behind Pain Education	7:00a – 7:50a	Level 3/ Gracia 5	Kathryn A. Schopmeyer, PT, DPT, CPE
PDM-09	Strengthening Your Pain Management Arsenal*	8:00a – 8:50a	Level 3/ Brera Ballroom	Rainer Vogel, MD
PDM-10	Opioid Induced Constipation: The Science, the Struggle, and an Orally Administered Treatment Option (Encore)* Sponsored by AstraZeneca	8:00a – 8:50a	Level 3/ Castellana Ballroom	Jeffrey A. Gudin, MD
APP-02	Naloxone Prescriptions for Overdose: Outside of Misuse and Abuse	9:00a – 9:50a	Level 3/ Gracia 3	Brett B. Snodgrass, FNP-C, CPE, FACPP, FAANP
PEF-07	Ain't Misbehavin': Decreasing and Managing Pain Patient Aberrant Behavior	9:00a – 9:50a	Level 3/ Gracia 5	Ted W. Jones, PhD, CPE
MAS-03	A Caress or a Slap? Understanding Sensory Amplification Systems in Chronic Pain	9:00a – 11:00a	Level 4/ Nolita 1	Charles E. Argoff, MD, CPE Daniel Clauw, MD
SIS-14	Pain Clinical Trials	9:00a – 11:00a	Level 4/ Nolita 3	Frank Breve, PharmD, MBA Errol M. Gould, PhD Marc Hoffman, MD Ernest A. Kopecky PhD, MBA Srinivas Nalamachu, MD Joseph V. Pergolizzi, MD Robert B. Raffa, PhD Robert Taylor, Jr, PhD
	Break/Exhibit Hall	10:00a – 10:30a		
APP-03	Complex Cases in Pain Management	10:30a – 11:20a	Level 3/ Gracia 3	Theresa Mallick-Searle, MS, NP-BC, ANP-BC
NAD-02	Pain Management Investigative Diaries	10:30a – 11:20a	Level 3/ Gracia 1	Marc S. Gonzalez, PharmD
WMH-01	Dysmenorrhea: Unlocking the Secrets of Chronic Menstrual Pain	10:30a – 11:20a	Level 3/ Gracia 5	Georgine M. Lamvu, MD, MPH, FACOG
SIS-15	In the Wake of the CDC Opioid Guidelines and the National Pain Strategy: Leveraging Pain Psychology and Platforms to Address the National Pain and Opioid Crises	10:30a – 11:50a	Level 4/ Mont-Royal Ballroom	Beth Darnall, PhD Sean C. Mackey, MD, PhD
POP-05	Here, There, and Everywhere: Linking into Social Media for Pain Practitioners (Part 1)	11:30a – 12:00p	Level 3/ Gracia 1	Barbara L. Kornblau, JD, OTR/L, CPE, DASPE
POP-06	Risk Tool to Qualify Patients for Take-Home Naloxone	11:30a – 12:00p	Level 3/ Gracia 3	Jeffrey Fudin, BS, PharmD, FCCP
PDM-11	Understanding Mechanism of Delivery in a Treatment for PHN* Sponsored by Depomed, Inc.	12:30p – 1:30p	Level 3/ Brera Ballroom	Charles E. Argoff, MD, CPE
PDM-12	Improving Patient Care: Focusing on Nausea and Vomiting From Opioid Therapy* Sponsored by DSI	12:30p – 1:30p	Level 3/ Castellana Ballroom	Faculty TBA
APP-04	Overview: Abuse Deterrent Formulations	1:40p – 2:30p	Level 3/ Gracia 3	Jeremy A. Adler, MS, PA-C

*Not certified for credit

THURSDAY

9.8

PEF-08	Meducating Pain Professionals: Interprofessional Education in Pain Management	1:40p – 2:30p	Level 3/ Gracia 5	Sondra M. Adkinson, PharmD, DAAPM, CPE, BSPH Mary Lynn McPherson, PharmD, MA, BCPS, CPE
MAS-04	The Mirror Has 2 Faces	1:40p – 3:40p	Level 4/ Nolita 1	Michael R. Clark, MD, MPH, MBA
SIS-16	The Medical Stasi: Is Risk Management for Controlled Substances Destroying the Provider-Patient Relationship?	1:40p – 3:40p	Level 4/ Mont-Royal Ballroom	Jennifer Bolen, JD Paul J. Christo, MD, MBA Douglas L. Gourlay, MD, MSc, FRCPC, FASAM Howard A. Heit, MD, FACP, FASAM Stephen J. Ziegler, PhD, JD
NAD-03	Common Sense, Education, and Ethics— The Foundation of a Good Medical Practice	2:40p – 3:30p	Level 3/ Gracia 1	Lisa M. McElhane, BS
SIS-17	Office Based Procedures for Primary Care Practitioners	2:40p – 3:30p	Level 4/ Nolita 3	Srinivas Nalamachu, MD
WMH-02	Interdisciplinary Management of Pelvic Pain: Bridging the Gap Between Primary Care and Specialty Referral	2:40p – 3:30p	Level 4/ Nolita 2	Jennifer M. Hah, MD, MS Ravi Prasad, PhD
PDM-13	The Importance of an Opioid Emergency Plan Includes Amplifying the Voice for Take-Home Naloxone* Sponsored by kaléo	3:40p – 4:30p	Level 3/ Castellana Ballroom	Faculty TBA
PDM-14	Teva Pharmaceuticals Sponsored Program*	3:40p – 4:30p	Level 3/ Brera Ballroom	Joseph P. Valenza, MD
APP-05	The Importance of Chart Documentation: Through the Eyes of a Chart Reviewer	4:40p – 5:30p	Level 3/ Gracia 3	Brett B. Snodgrass, FNP-C, CPE, FACPP, FAANP
NAD-04	Addiction: Drug Use Despite the Adverse Consequences	4:40p – 5:30p	Level 3/ Gracia 1	Marc S. Gonzalez, PharmD
WMH-03	Helping Providers Help Patients With Vulvodynia: Recommendations for Patient Care From the National Vulvodynia Registry	4:40p – 5:30p	Level 4/ Nolita 2	Georgine M. Lamvu, MD, MPH, FACOG
NAD-05	Abuse Deterrent Formulations: A Law Enforcement Perspective	5:40p – 6:30p	Level 4/ Mont-Royal Ballroom	Charles F. Cichon
PEF-09	The Five Coping Skills That Every Patient Needs	5:40p – 6:30p	Level 3/ Gracia 5	Ted W. Jones, PhD, CPE
SIS-18	Opioid “Induced” Hyperalgesia and Allodynia	5:40p – 6:30p	Level 3/ Gracia 1	R. Norman Harden, MD
SIS-19	Chronic Pain Patients Who Fail Standard Treatment: Identification and Strategies	5:40p – 6:30p	Level 3/ Gracia 3	Forest Tennant, MD, DrPH, FACPM, MPH
POS-01	Scientific Poster Session and Reception*	6:30p – 8:30p	Level 3/ Gracia 7	Christopher G. Gharibo, MD Srinivas Nalamachu, MD Joseph V. Pergolizzi, MD Robert B. Raffa, PhD Kevin L. Zacharoff, MD, FACIP, FACPE, FAAP

PCD-01	You're in Control or Urine Control: Clinical Pearls of Drug Testing Case Studies	7:00a – 7:50a	Level 3/ Gracia 3	Jeffrey Fudin, BS, PharmD, FCCP
PHM-01	A Gathering Storm: Are Perioperative Opioids Problematic?	7:00a – 7:50a	Level 3/ Gracia 1	Michael M. Bottros, MD
POS-02	Poster/Podium Presentations*	7:00a – 7:50a	Level 3/ Gracia 5	Srinivas Nalamachu, MD Joseph V. Pergolizzi, MD
PDM-15	Purdue Pharma L.P. Extended-Release Opioid Product Portfolio Options* Sponsored by Purdue Pharma L.P.	8:00a – 8:50a	Level 3/ Brera Ballroom	Faculty TBA
PDM-16	Opioid Induced Constipation: When Reliable and Rapid Relief Matters* Sponsored by Salix Pharmaceuticals	8:00a – 8:50a	Level 3/ Castellana Ballroom	Steven Simon, MD
APS-01	The Brain or the Body: What Is the Target for Pain Treatment?	9:00a – 9:50a	Level 4/ Nolita 3	Roger B. Fillingim, PhD
PHM-02	The Constipation Sensation That's Sweeping the Nation: Management of Opioid Induced Constipation	9:00a – 9:50a	Level 3/ Gracia 1	Mary Lynn McPherson, PharmD, MA, BCPS, CPE
SIS-20	Can Opioids Be Rationally Prescribed for Chronic Pain?	9:00a – 11:00a	Level 4/ Mont-Royal Ballroom	Charles E. Argoff, MD, CPE Roger Chou, MD Michael R. Clark, MD, MPH, MBA Brett R. Stacey, MD
	Break/Exhibit Hall	10:00a – 10:30a		
MDL-03	Managing the Risks of Prescribing Controlled Medications	10:30a – 11:20a	Level 3/ Gracia 1	Michael C. Barnes, JD, MIEP
NRO-01	Tea Party of the Damned	10:30a – 11:20a	Level 3/ Gracia 5	Gary W. Jay, MD, FAAPM, FACFEI
PCD-02	Trainwreck: Addressing Complex Pharmacotherapy With the Inherited Pain Patient	10:30a – 11:50a	Level 3/ Gracia 3	Douglas L. Gourlay, MD, MSc, FRCPC, FASAM Howard A. Heit, MD, FACP, FASAM
APS-02	Acupuncture Analgesia: Therapy or Sham?	11:30a – 12:00p	Level 4/ Nolita 3	Richard E. Harris, PhD, MS, Dipl Ac
POP-07	Here, There, and Everywhere: Linking into Social Media for Pain Practitioners (Part 2)	11:30a – 12:00p	Level 3/ Gracia 1	Barbara L. Kornblau, JD, OTR/L, CPE, DASPE
POP-08	The Science of Mindful Meditation	11:30a – 12:00p	Level 3/ Mont-Royal Ballroom	Sean Fargo
PDM-17	Teva Pharmaceuticals Sponsored Program*	12:30p – 1:30p	Level 3/ Brera Ballroom	Charles E. Argoff, MD, CPE
PDM-18	Moving Beyond Mu With Kappa Opioid Receptor Agonists— Leaving the Baggage Behind* Cara Therapeutics Sponsored Program	12:30p – 1:30p	Level 3/ The Chelsea	Michael J. Brennan, MD Joseph Stauffer, DO, MBA

*Not certified for credit

APS-03	Noninvasive Neuromodulatory Approaches to the Treatment of Chronic Pain	1:40p – 2:30p	Level 4/ Nolita 3	Vitaly Napadow, PhD, Lic Ac
NRO-02	Diagnosis and Treatment of Centralized Pain and Neuroinflammation	1:40p – 2:30p	Level 4/ Nolita 1	Forest Tennant, MD, DrPH, FACPM, MPH
MAS-05	Differential Diagnosis of Low Back Pain	1:40p – 3:40p	Level 3/ Gracia 3	David M. Glick, DC, DAAPM, CPE, FASPE
SIS-21	Pharmacogenomics: 3 Wise Men Discuss Effects on Holy Tablets	1:40p – 3:40p	Level 4/ Mont-Royal Ballroom	Charles E. Argoff, MD, CPE Jeffrey Fudin, BS, PharmD, FCCP Michael E. Schatman, PhD, CPE, DASPE
PCD-03	Nonpharmacologic Management of Chronic Pain	2:40p – 3:30p	Level 3/ Gracia 5	Mel Pohl, MD
PHM-03	Opioid Conversion Calculations	2:40p – 3:30p	Level 3/ Gracia 1	Mary Lynn McPherson, PharmD, MA, BCPS, CPE
	Exhibit Hall Closing Reception	3:30p – 4:30p	Level 4/ Exhibit Hall	
APS-04	Hands On or Hands Off? A Tour of Current Issues Impacting Spinal Manipulative Therapy for Spinal Pain	4:40p – 5:30p	Level 4/ Nolita 3	Steven Z. George, PT, PhD
NRO-03	Small Fiber Polyneuropathy: An Update	4:40p – 5:30p	Level 4/ Nolita 1	Charles E. Argoff, MD, CPE
SIS-22	Low Pressure Headaches: What Are You Missing?	4:40p – 5:30p	Level 3/ Gracia 5	Ian Carroll, MD, MS Theresa Mallick-Searle, MS, NP-BC, ANP-BC
APS-05	Neurochemical Imaging as a Probe of Chronic Pain and Its Treatment	5:40p – 6:30p	Level 3/ Gracia 3	Richard E. Harris, PhD, MS, Dipl Ac
NRO-04	Arachnoiditis: Diagnosis and Treatment	5:40p – 6:30p	Level 4/ Nolita 2	Forest Tennant, MD, DrPH, FACPM, MPH
PHM-04	Minimizing Pills and Maximizing Skills: Achieving Successful Opioid Cessation in Chronic Pain	5:40p – 6:30p	Level 3/ Gracia 1	Jennifer M. Hah, MD, MS Ravi Prasad, PhD
SIS-23	The Role of Special K in Pain Management	5:40p – 6:30p	Level 4/ Nolita 1	Abigail T. Brooks, PharmD, BCPS Courtney M. Kominek, PharmD, BCPS, CPE

SATURDAY

9.10

INT-01	To Hold or Not to Hold, That Is the Question: Antiplatelet and Anticoagulation Management for Interventional Spine and Pain Procedures	7:00a – 7:50a	Level 4/ Nolita 1	Abigail T. Brooks, PharmD, BCPS Courtney M. Kominek, PharmD, BCPS, CPE
MDL-04	Trends in Federal and State Policy and Their Impact on Pain Management	7:00a – 7:50a	Level 4/ Mont-Royal Ballroom	Michael C. Barnes, JD, MIEP
PAL-01	What's Your Preference...Up Your Butt? Under Your Tongue? Or Through Your Skin?	7:00a – 7:50a	Level 4/ Nolita 2	Rabia Atayee, PharmD Cara Brock, PharmD, CGP
SYM-03	Evolving Strategies for Chronic Pain Management: Targeting Multiple Pain Mechanisms to Improve Efficacy and Reduce Opioid Abuse Potential	8:00a – 9:00a	Level 3/ Brera Ballroom	Charles E. Argoff, MD, CPE Michael J. Brennan, MD
INT-02	Interventional Pain Management: Injections, Nerve Blocks, Pumps, and Spinal Cord Stimulation	9:00a – 9:50a	Level 4/ Nolita 1	Paul J. Christo, MD, MBA
PHM-05	Methadone and Marijuana: What's New and What's Not	9:00a – 9:50a	Level 4/ Mont-Royal Ballroom	Mary Lynn McPherson, PharmD, MA, BCPS, CPE Kathryn A. Walker, PharmD, BCPS, CPE
SIS-24	The Use of Viscosupplementation in FDA-Approved and Nonapproved Joints	9:00a – 9:50a	Level 4/ Nolita 3	Ramon L. Cuevas-Trisan, MD
VHA-01	Transformation of Chronic Pain within the Patient-Centered Medical Home: A Sustainable Stepwise Approach for Improved Functional Outcomes	9:00a – 11:00a	Level 4/ Nolita 2	Beth L. Dinoff, PhD Mary L. Jacobs, PhD, MSPH
	Break	10:00a – 10:30a		
INT-03	Innovative Interventional Approaches to Pain Management in the Elderly	10:30a – 11:20a	Level 4/ Nolita 1	Michael M. Bottros, MD
PAL-02	Speed Dating With the Pharmacy Ladies: Pain Management and Palliative Care	10:30a – 11:20a	Level 4/ Mont-Royal Ballroom	Mary Lynn McPherson, PharmD, MA, BCPS, CPE Kathryn A. Walker, PharmD, BCPS, CPE
SIS-25	The MEDD Myth: Practice and Research Implications	10:30a – 11:20a	Level 4/ Nolita 3	Jeffrey Fudin, BS, PharmD, FCCP Michael E. Schatman, PhD, CPE, DASPE
SIS-26	Into the Groove: Seducing the Anxiolytic Effects of Dance Music	10:30a – 11:50a	Level 4/ Yaletown 1	Joanne V. Loewy, DA, LCAT, MT-BC John F. Mondanaro, MA, LCAT, MT-BC Andrew R. Rossetti, MMT, LCAT, MT-BC

*Not certified for credit

SATURDAY

9.10

POP-09	Words That Do No Harm: The Unintended Nocebo Effect of Biochemical Language in Patient-Provider Interactions	11:30a – 12:00p	Level 4/ Nolita 3	Kathryn A. Schopmeyer, PT, DPT, CPE
POP-10	Taking the Road Less Traveled: Meeting Pain Patients Where They Are and Moving Forward Together	11:30a – 12:00p	Level 4/ Nolita 1	Barbara L. Kornblau, JD, OTR/L, CPE, DASPE
POP-11	Virtual Reality and Chronic Pain: The Future Has Arrived	11:30a – 12:00p	Level 4/ Mont-Royal Ballroom	Ted W. Jones, PhD, CPE
PDM-19	Collegium Pharmaceutical, Inc. Sponsored Program*	12:30p – 1:30p	Level 3/ Brera Ballroom	Faculty TBA
PAL-03	New Drugs in Pain Management and Palliative Care	1:40p – 2:30p	Level 4/ Nolita 1	Rabia Atayee, PharmD Mary Lynn McPherson, PharmD, MA, BCPS, CPE
PHM-06	Nonopioid Analgesics: Antidepressants, Adjuvant Therapies, and Muscle Relaxants	1:40p – 2:30p	Level 4/ Mont-Royal Ballroom	Kathryn A. Walker, PharmD, BCPS, CPE
VHA-02	Functional Restoration for Whole-Health and Well-Being Within the Patient Centered Medical Home	1:40p – 3:40p	Level 4/ Nolita 3	Jennifer L. Gansen, DPT Mary Elizabeth Hammons, PhD Michael S. Saenger, MD
INT-04	If Opioids Aren't the Answer, Then What Is the Question?	2:40p – 3:30p	Level 4/ Nolita 1	Sanford M. Silverman, MD
MDL-02	Embrace 2016 Practice Changes and Patient Education: Overview of Critical Pain Management Practice Issues	2:40p – 3:30p	Level 4/ Mont-Royal Ballroom	Jennifer Bolen, JD
SIS-27	The Silent Healthcare Epidemic: Counterfeit Medicine (Encore)	2:40p – 3:30p	Level 4/ Nolita 2	Jay Joshi, MD, DABA, DABA-PM, FABA-PM
SIS-28	Botulinum Toxins as Neuromodulators in Chronic Pain Management	2:40p – 3:30p	Level 4/ Yaletown 1	Ramon L. Cuevas-Trisan, MD
INT-05	Central Sensitization and Ketamine Infusions	3:40p – 4:30p	Level 4/ Nolita 1	Jay Joshi, MD, DABA, DABA-PM, FABA-PM
PAL-04	To Infinity and Beyond: Safe and Effective Opioid Titration Strategies	3:40p – 4:30p	Level 4/ Nolita 2	Mary Lynn McPherson, PharmD, MA, BCPS, CPE Kathryn A. Walker, PharmD, BCPS, CPE
PHM-07	Not for Human Consumption: New Drugs of Abuse and Their Detection	3:40p – 4:30p	Level 4/ Nolita 3	Abigail T. Brooks, PharmD, BCPS Courtney M. Kominek, PharmD, BCPS, CPE

*Not certified for credit

HEALTH

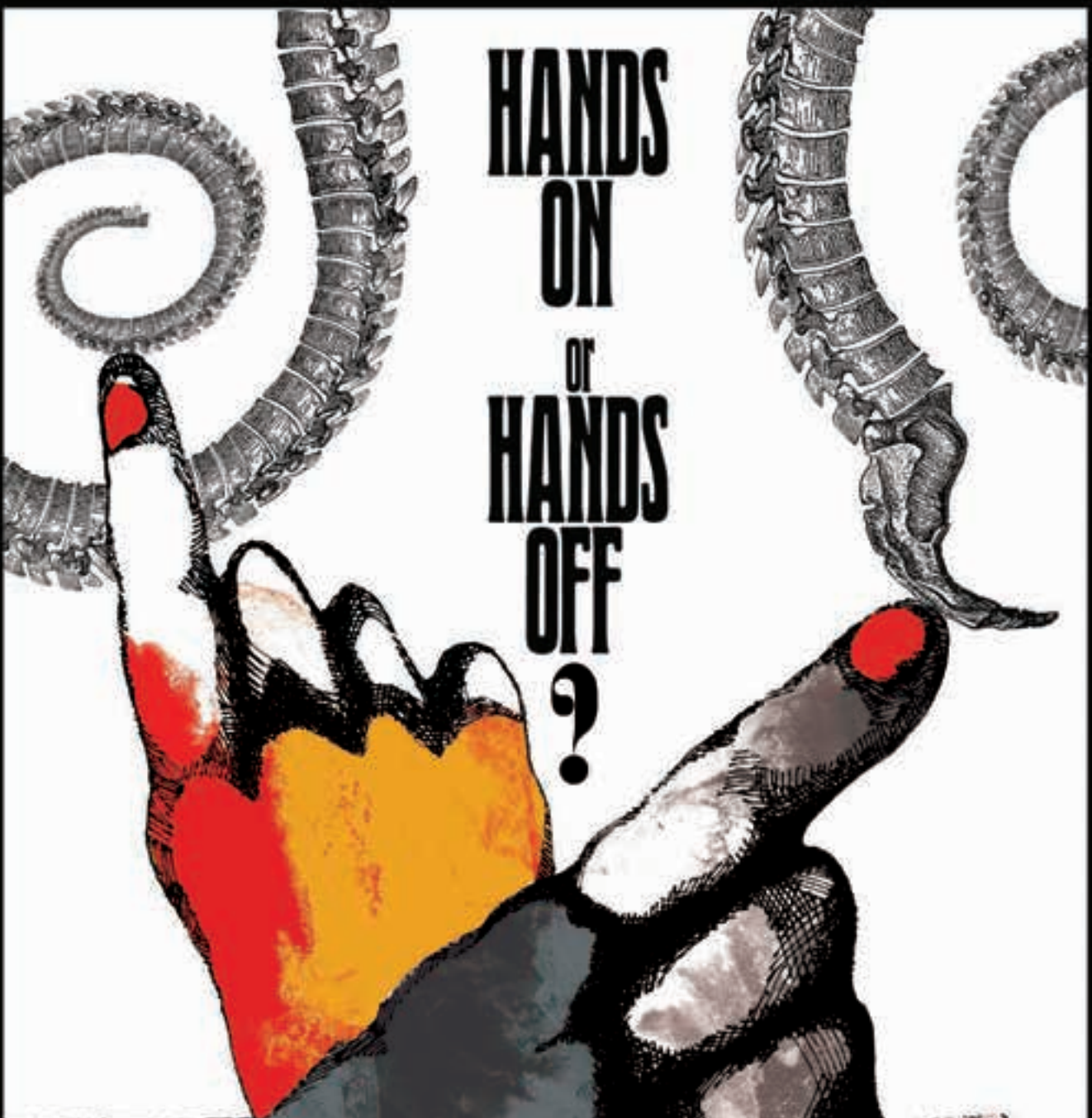


COACHING

tuesday

september 6

d.fossa 16



HANDS ON OR HANDS OFF ?

A tour of
current issues
impacting spinal
manipulative therapy
for spinal pain

Steven George

**Friday
September 9**

cfossa



FACULTY





JEFFREY GUDIN

Please note: Faculty disclosures are self-reported.

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Nothing to disclose

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Consultant/Independent Contractor: Egalet, Inc.,
Quest Diagnostics, Pernix
Speakers Bureau: AstraZeneca/Daiichi Sankyo, kaléo, Inc.,
Pernix, St. Jude Medical Neuromodulation System
Speakers Bureau/Consulting: Depomed, Inc.,
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Endo, Purdue, Quest, Grünenthal, Pfizer, Semnur
Grant/Research Support: Endo, Grünenthal, Forest
Speakers Bureau: Allergan, Depomed, Xenoport
Stock Shareholder: Pfizer, Depomed
Other/Royalty: Elsevier

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West Palm Beach, FL

Nothing to disclose

Dawn C. Buse, PhD
Associate Professor
Albert Einstein College of Medicine
Director
Behavioral Medicine
Montefiore Headache Center
Bronx, NY

Consultant/Independent Contractor: Eli Lilly
Grant/Research Support:
Allergan, Avanir Pharmaceuticals

Ian Carroll, MD, MS
Assistant Professor
Stanford University Medical Center
Palo Alto, CA

Nothing to disclose

Martin D. Cheatle, PhD
Associate Professor
Director
Pain and Chemical Dependency Program
Center for Studies of Addiction
Perelman School of Medicine
University of Pennsylvania
Philadelphia, PA

Consultant/Independent Contractor: Campbell Alliance
Grant/Research Support: Cordant Health
Speakers Bureau: Pharmacon

Roger Chou, MD
Associate Professor
Oregon Health & Science University
Portland, OR

Nothing to disclose

Paul J. Christo, MD, MBA
Associate Professor
Johns Hopkins University School of Medicine
Baltimore, MD

Consultant/Independent Contractor/Royalty:
Algiatry LLC, Media Work

Charles F. Cichon
Executive Director
National Association of
Drug Diversion Investigators
Lutherville, MD

Nothing to disclose

Michael R. Clark, MD, MPH, MBA
Vice Chair
Clinical Affairs
Johns Hopkins University School of Medicine
Director
Pain Treatment Programs
Johns Hopkins Medical Institutions
Baltimore, MD

Nothing to disclose

Daniel Clauw, MD
Professor
Anesthesiology, Medicine (Rheumatology),
and Psychiatry
University of Michigan
Ann Arbor, MI

Consultant/Independent Contractor: Abbott, Cerephex,
Eli Lilly, Forest Lab, Johnson & Johnson, Merck, Pfizer,
Samumed, Theravance, Tonix, UCB, Zynerba

David Cosio, PhD
Psychologist
University of Illinois College of Medicine
Jesse Brown Veterans Affairs Medical Center
Chicago, IL

Nothing to disclose

Lisa Creekmur, BSN, MINT
Chronic Pain Management Coach and Instructor
Take Courage Coaching
Bozeman, MT

Nothing to disclose

Ramon L. Cuevas-Trisan, MD
Affiliate Assistant Professor
University of Miami-Miller School of Medicine
Chief
Physical Medicine, Rehabilitation &
Pain Management Service
West Palm Beach VA Medical Center
West Palm Beach, FL

Nothing to disclose

Becky L. Curtis, PCC
Professional Certified Coach
International Coach Federation
Lexington, KY

Nothing to disclose

Beth Darnall, PhD
Clinical Associate Professor
Stanford School of Medicine
Palo Alto, CA

Nothing to disclose

Beth L. Dinoff, PhD
Clinical Psychologist
Director
Veterans Integrative Pain Services
Fayetteville, NC

Nothing to disclose

Sean Fargo
Chief Zen Officer & Director
Mindfulness Program Development
Wellbrain
Pleasant Hill, CA

Other/Royalty: Chief Zen Officer for WellBrain

Roger B. Fillingim, PhD
Distinguished Professor
University of Florida College of Dentistry
Gainesville, FL

Nothing to disclose

James R. Friction, DDS, MS
Professor
University of Minnesota
Minneapolis, MN
Senior Researcher Investigator
Health Partners
Bloomington, MN

Nothing to disclose

Jeffrey Fudin, BS, PharmD, FCCP
Adjunct Associate Professor
Western New England College of Pharmacy
Western New England University
Springfield, MA
Clinical Pharmacy Specialist, Residency Director
PGY-2 Pain & Palliative Care Pharmacy
Stratton VA Medical Center
Albany, NY

Consultant/Independent Contractor: Clarity, Endo,
KemPharm, Scilex Pharmaceuticals
Advisory Board/Speakers Bureau:
AstraZeneca, Depomed, Endo, kaléo,
Millennium Health, Pernix Therapeutics
Stock Shareholder: Remitigate LLC

Jennifer L. Gansen, DPT
Assistant Director & Supervisory Physical Therapist
Atlanta VA Health Care System
Decatur, GA

Nothing to disclose

Steven Z. George, PT, PhD
Associate Professor
University of Florida
Director
Doctor of Physical Therapy Program
University of Florida
Gainesville, FL

Nothing to disclose

David M. Glick, DC, DAAPM, CPE, FASPE
CEO & Medical Director
HealthQ2
Richmond, VA

Nothing to disclose

Marc S. Gonzalez, PharmD
Investigator
National Association of
Drug Diversion Investigators
Los Angeles, CA

Nothing to disclose

Debra B. Gordon, RN, DNP, FAAN
Teaching Associate
University of Washington
Co-Director
Integrated Pain Care Program
Harborview Medical Center
Seattle, WA

Consultant/Independent Contractor/Honoraria: Pacira

Errol M. Gould, PhD
Senior Director
Medical Affairs
Pernix Therapeutics
Morristown, NJ

Nothing to disclose

Douglas L. Gourlay, MD, MSc, FRCPC, FASAM
Educational Consultant
Former Director
Wasser Pain Centre
Toronto, Ontario

Nothing to disclose

Jeffrey A. Gudín, MD
Clinical Instructor
Icahn School of Medicine at Mount Sinai
New York, NY
Director
Pain and Palliative Care
Englewood Hospital and Medical Center
Englewood, NJ

Consultant/Independent Contractor:
 Quest, Purdue, Scilex, Collegium, Endo, AstraZeneca,
 Daiichi, Shionogi, Depomed
 Grant/Research Support: Purdue, Sentyln

Jennifer M. Hah, MD, MS
Instructor
Stanford University
Stanford, CA

Nothing to disclose

Robert Hall, MD
Corporate Medical Director
HeliosComp
Westerville, OH

Nothing to disclose

Mary Elizabeth Hammons, PhD
Psychologist
Atlanta VAMC
Decatur, GA

Nothing to disclose

R. Norman Harden, MD
Professor
Northwestern University
Chicago, IL

Nothing to disclose

Richard E. Harris, PhD, MS, Dipl Ac
Associate Professor
Chronic Pain and Fatigue
Research Center, Anesthesiology
University of Michigan
Ann Arbor, MI

Consultant/Independent Contractor/Grant/
 Research Support: Pfizer

Howard A. Heit, MD, FACP, FASAM
Assistant Clinical Professor
Georgetown University
Arlington, VA

Nothing to disclose

Phyllis L. Hendry, MD, FAAP, FACEP
Professor
Emergency Medicine and Pediatrics
Assistant Chair
Research, Department of Emergency Medicine
Jacksonville, FL

Nothing to disclose

Danielle Eaves Hernandez, BS, CCLS
Certified Child Life Specialist
Community Hospice of Northeast Florida
Jacksonville, FL

Nothing to disclose

Marc Hoffman, MD
Chief Medical Officer
Theorem Clinical Research
Long Grove, IL

Nothing to disclose

Mary L. Jacobs, PhD, MSPH
Staff Psychologist
VA Boston Healthcare System
Brockton, MA

Nothing to disclose

Gary W. Jay, MD, FAAPM, FACFEI
Chief Medical Officer
AdviseClinical
Raleigh, NC

Nothing to disclose

Ted W. Jones, PhD, CPE
Clinical Psychologist
Pain Consultants of East Tennessee
Knoxville, TN

Other/Royalty: Ethos Labs

Jay Joshi, MD, DABA, DABA-PM, FABA-PM
CEO and Medical Director
National Pain Centers
Vernon Hills, IL

Nothing to disclose

Colleen Kalynych, MSH, EdD
Associate Director
Research Administration
University of Florida
Jacksonville, FL

Nothing to disclose

Tea Party of the Damned

Friday
9.9

Gary Jay



Courtney M. Kominek, PharmD, BCPS, CPE
Clinical Pharmacy Specialist
Pain Management
Harry S. Truman Memorial Veterans' Hospital
Columbia, MO

Nothing to disclose

Ernest A. Kopecky, PhD, MBA
Vice President
Clinical Development
Head
Neuroscience
Collegium Pharmaceuticals, Inc.

Nothing to disclose

Barbara L. Kornblau,
JD, OTR/L, CPE, DASPE
Adjunct Professor
Florida A&M University
Tallahassee, FL
Health Policy Consultant
Coalition for Disability Health Equity
Arlington, VA

Nothing to disclose

Georgine M. Lamvu, MD, MPH, FACOG
Gynecologic Surgeon and Pelvic Pain Specialist
Veterans Administration Medical Center
Orlando, FL

Nothing to disclose

Alexis LaPietra, DO
Medical Director
Emergency Medicine Pain Management
St. Joseph's Regional Medical Center
Paterson, NJ

Nothing to disclose

Joanne V. Loewy, DA, LCAT, MT-BC
Associate Professor
Icahn School of Medicine at Mount Sinai
Director
The Louis Armstrong Center
for Music and Medicine
Beth Israel Medical Center
New York, NY

Nothing to disclose

Sean C. Mackey, MD, PhD
Redlich Professor
Anesthesiology, Perioperative and Pain
Medicine, Neurosciences, and Neurology
Stanford University Medical Center
Palo Alto, CA
Chief
Stanford University Pain Management Center
Redwood City, CA

Nothing to disclose

Theresa Mallick-Searle,
MS, NP-BC, ANP-BC
Nurse Practitioner
Pain Medicine
Stanford Health Care
Stanford, CA

Consultant/Independent Contractor/Speakers Bureau:
Allergan, Depomed

Darren McCoy, FNP-BC, CPE
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College of Nursing
University of Tennessee-Knoxville
Nurse Practitioner
Pain Consultants of East Tennessee
Knoxville, TN

Nothing to disclose

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President
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Lutherville, MD

Nothing to disclose

Mary Lynn McPherson,
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Professor and Executive Director
Advanced Post-Graduate Education in
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Baltimore, MD
Hospice and Palliative Care
Consultant Pharmacist
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Nothing to disclose

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Clinical Director
Mount Sinai Beth Israel
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Nothing to disclose

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Kansas City, KS
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International Clinical Research Institute
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Nothing to disclose

Vitaly Napadow, PhD, Lic Ac
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Director
Center for Integrative Pain Neuroimaging
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Nothing to disclose

Joseph V. Pergolizzi, MD
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Baltimore, MD
Senior Partner and Director of Research
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Naples, FL

Nothing to disclose

Mel Pohl, MD
Clinical Assistant Professor
University of Nevada School of Medicine
Medical Director
Las Vegas Recovery Center
Las Vegas, NV

Nothing to disclose

Ravi Prasad, PhD
Clinical Associate Professor
Stanford University
Stanford, CA

Nothing to disclose

Peter G. Pryzbylowski, MD
Interventional Pain Specialist
Relievis Pain Management Group
Cherry Hill, NJ

Nothing to disclose

Robert B. Raffa, PhD
Professor
Temple University
Philadelphia, PA

Nothing to disclose

Anna Ratka, PhD, PharmD, CPE
Professor
Chicago State University
Chicago, IL

Nothing to disclose

Frank L. Rice, PhD
President
Chief Scientist
Integrated Tissue Dynamics, LLC
Rensselaer, NY

Nothing to disclose

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Nothing to disclose

Michael S. Saenger, MD
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Atlanta, GA

Nothing to disclose

Michael E. Schatman, PhD, CPE, DASPE
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Foundation for Ethics in Pain Care
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Nothing to disclose

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Nothing to disclose

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Grant/Research Support:
Florida Medical Malpractice Joint Underwriters Association

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Affiliate Assistant Professor
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Nothing to disclose

Brett B. Snodgrass,
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Director
Clinical Operations
LifeLinc Pain
Memphis, TN

Consultant/Independent Contractor: McNeil
Pharmaceuticals, Purdue Pharmaceuticals
Speakers Bureau: Astra Zeneca, Depomed
Pharmaceuticals, Iroko Pharmaceuticals

Brett R. Stacey, MD
Professor
University of Washington
Medical Director
Center for Pain Relief
Seattle, WA

Consultant/Independent Contractor: Teva

Steven P. Stanos, DO
Medical Director
Swedish Health System
Seattle, WA

Consultant/Independent Contractor: AZ, Collegium,
Endo, MyMatrix, Pfizer, Daiichi Sankyo, Endo,
MyMatrixx, Purdue, Scillex
Grant/Research Support: Grünenthal

Robert Taylor, Jr, PhD
Executive Director of Operations
NEMA Research Inc.
Naples, FL

Nothing to disclose

Forest Tennant, MD, DrPH, FACPM, MPH
Editor
Practical Pain Management
West Covina, CA

Other/Royalty: Practical Pain Management
Speakers Bureau: Regensis Biomedical

Heather Tick, MD
Clinical Associate Professor
UW Medicine
Seattle, WA

Nothing to disclose

Allen J. Togut, MD
Thoracic Surgeon (retired)

Nothing to disclose

Kathryn A. Walker, PharmD, BCPS, CPE
Assistant Professor
University of Maryland School of Pharmacy
Baltimore, MD

Nothing to disclose

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University of Pennsylvania
Philadelphia, PA

Nothing to disclose

Kevin L. Zacharoff, MD, FACIP, FACPE, FAAP
Faculty
SUNY Stony Brook School of Medicine
Stony Brook, NY
Anesthesiologist
St Catherine of Siena Medical Center
Smithtown, NY

Nothing to disclose

Stephen J. Ziegler, PhD, JD
Associate Professor
Public Policy
Indiana University—Purdue University
Fort Wayne, IN

Consultant/Independent Contractor: Depomed
Other/Royalty: Drug & Health Policy Consulting, LLC



JEFFREY FUDIN



interdisciplinary management of pelvic pain:

bridging the gap between primary care and specialty referral

thurs
sept 8

**american
academy
of
pain
medicine**

r. norman harden
ravi prasad
steven stanos
heather tick

wednesday
september 7





d.fossá

**THE CDC'S PRESCRIBING
GUIDELINES AND THE
VEIL OF SECRECY**

WEDNESDAY

SEPTEMBER 7

JENNIFER BOLEN JEFFREY FUDIN STEVEN STANOS STEPHEN ZIEGLER

SATELLITE EVENTS

Non-CME Activities | **CME** Activities



SATELLITE EVENTS

PAINWeek would like to thank our corporate and nonprofit partners for their participation in this year's satellite events. **PAINWeek** is appreciative of the supportive role that members of this community continue to play in our efforts to provide frontline practitioners with quality educational programs. These satellite events are not part of the official **2016 PAINWeek National Conference** and are planned solely by the sponsoring organizations/companies.

These events include both certified and non-certified programs. Course descriptions for certified activities, faculty disclosures, and protocol for obtaining CE/CME credit will be provided by individual event organizers. Please contact the organizers for further details.

Seating is strictly limited for all events. Preference may be given to preregistrants. If you are registered, please still plan on arriving at the door no later than 15 minutes prior to start time to ensure that your seat is held for you. A limited number of meals or refreshments will be served where indicated.

Nonmedical professionals or members of industry may only be allowed to participate at the discretion of the program organizers. Typically organizers do not accommodate family members, office staff, or guests of health-care professionals.

There are no fees to attend any of these satellite events.

Information provided and opinions expressed have not involved any verification of the findings, conclusions, and opinions by PAINWeek. Opinions expressed by speakers do not necessarily reflect those of PAINWeek. No responsibility is assumed by PAINWeek for any injury and/or damage to persons or property as a matter of products liability, negligence or otherwise, or from any use or operation of any methods, products, instruction, or ideas contained in the material herein. Because of the rapid advances in the medical sciences, PAINWeek recommends that independent verification of diagnoses and medication dosages should be made by each healthcare professional.

Information provided was accurate as of press time. For the most up-to-date information please visit m.painweek.org.

NON-CME ACTIVITIES

(Not certified for credit)

PDM Programs

Product Theatre, Disease Awareness, and Medical Information
Events listed in chronological order.

Lunch PDM

**Guidelines, Practice, and Policy:
Separating the Myths From the Facts With OADP**
Sponsored by Purdue Pharma L.P.

Ellen Battista, NP; J. David Haddox, DDS, MD

Course code: PDM-O2

Tuesday/9.6 12:30p – 1:30p Level 3/**Brera Ballroom**

Lunch will be served.

Contact: Peter Justason, (203) 588-7851, peter.justason@pharma.com

Lunch PDM

**Clinical Dialogues:
What Is the Role of Buprenorphine in Chronic Pain?**
Sponsored by Endo Pharmaceuticals

Jeffrey Fudin, BS, PharmD, FCCP; Jeffrey A. Gudin, MD

Course code: PDM-O3

Tuesday/9.6 12:30p – 1:30p Level 3/**Castellana Ballroom**

Lunch will be served.

Contact: Kristin Alfieri-Waldie, (484) 216-6640, Alfieri-Waldie.Kristin@endo.com

Breakfast PDM

Teva Pharmaceuticals is pleased to be sponsoring 3 programs during the conference which will examine prescription opioids in the management of chronic pain.

Charles E. Argoff, MD, CPE

Course code: PDM-O5

Wednesday/9.7 8:00a – 8:50a Level 3/**Brera Ballroom**

Breakfast will be served.

Contact: Alison Labombarda, (973) 401-1654, alabombarda@hlxusa.com

Breakfast PDM

**Beyond Chronic Pain in the Opioid-Managed Patient:
Addressing Comorbid Sleep and Psychiatric Disorders**
Supported by Pernix Therapeutics

Jeremy A. Adler, MS, PA-C; Jeffrey Fudin, BS, PharmD, FCCP; Jay Joshi, MD, DABA, DABA-PM, FABA-PM

Course code: PDM-O6

Wednesday/9.7 8:00a – 8:50a Level 3/**Castellana Ballroom**

Breakfast will be served.

Contact: Samantha Libby-Cap, (860) 575-5360, slibbycap@pharmacomgroup.com

Lunch PDM

**Targeting Success: An Interactive Discussion of
a Next Generation Molecule**
Sponsored by Depomed, Inc.

Joseph Pergolizzi, MD; Steve Vacalis, DO

Course code: PDM-O7

Wednesday/9.7 12:30p – 1:30p Level 3/**The Chelsea**

Lunch will be served.

Contact: Allie Antonelle, (908) 766-2003, aantonelle@decileten.com

PDM

**Opioid Induced Constipation: The Science, the Struggle, and
an Orally Administered Treatment Option**
Sponsored by AstraZeneca

Orlando G. Florete, Jr, MD

Course code: PDM-O8

Wednesday/9.7 3:40p – 4:30p Level 3/**Brera Ballroom**

Refreshments will be served.

Contact: Phillip Lucas, (302) 885-8836, phillip.lucas@astrazeneca.com

PDM

Strengthening Your Pain Management Arsenal
Sponsored by Egalet

Rainer Vogel, MD

Course code: PDM-O9

Thursday/9.8 8:00a – 8:50a Level 3/**Brera Ballroom**

Refreshments will be served.

Contact: Terri Lawrence, (484) 259-7172, tlawrence@egalet.com

Breakfast PDM**Opioid Induced Constipation: The Science, the Struggle, and an Orally Administered Treatment Option (ENCORE)**

Sponsored by AstraZeneca

Jeffrey A. Gudin, MD

Course code: PDM-10**Thursday/9.8 8:00a – 8:50a** Level 3/**Castellana Ballroom****Breakfast will be served.**

Contact: Phillip Lucas, (302) 885-8836, phillip.lucas@astrazeneca.com

Lunch PDM**Understanding Mechanism of Delivery in a Treatment for PHN**

Sponsored by Depomed, Inc.

Charles E. Argoff, MD, CPE

Course code: PDM-11**Thursday/9.8 12:30p – 1:30p** Level 3/**Brera Ballroom****Lunch will be served.**

Contact: Allie Antonelle, (908) 766-2003, aantonelle@decileten.com

Lunch PDM**Improving Patient Care: Focusing on Nausea and Vomiting From Opioid Therapy**

Sponsored by DSI

Jeffrey A. Gudin, MD

Course code: PDM-12**Thursday/9.8 12:30p – 1:30p** Level 3/**Castellana Ballroom****Lunch will be served.**

Contact: Scott Wearley, (973) 944-2056, swearley@dsi.com

PDM**The Importance of an Opioid Emergency Plan Includes Amplifying the Voice for Take-Home Naloxone**

Sponsored by kaléo

Eric S. Edwards, MD, PhD; Jeffrey A. Gudin, MD;
Sanford M. Silverman, MD**Course code:** PDM-13**Thursday/9.8 3:40p – 4:30p** Level 3/**Castellana Ballroom****Refreshments will be served.**Contact: Samantha Libby-Cap, (860) 575-5360,
slibbycap@pharmacomgroup.com**PDM****Teva Pharmaceuticals is pleased to be sponsoring 3 programs during the conference which will examine prescription opioids in the management of chronic pain.**

Joseph P. Valenza, MD

Course code: PDM-14**Thursday/9.8 3:40p – 4:30p** Level 3/**Brera Ballroom****Refreshments will be served.**

Contact: Alison Labombarda, (973) 401-1654, alabombarda@hlxusa.com

Breakfast PDM**Purdue Pharma L.P. Extended-Release Opioid Product Portfolio Options**

Sponsored by Purdue Pharma L.P.

Faculty TBA

Course code: PDM-15**Friday/9.9 8:00a – 8:50a** Level 3/**Brera Ballroom****Breakfast will be served.**Contact: Amanda Stephens Hogan, (203) 588-7360,
Amanda.Stephens@pharma.com**Breakfast PDM****Opioid Induced Constipation: When Reliable and Rapid Relief Matters**

Sponsored by Salix Pharmaceuticals

Steven Simon, MD, RPh

Course code: PDM-16**Friday/9.9 8:00a – 8:50a** Level 3/**Castellana Ballroom****Breakfast will be served.**

Contact: Cassie Cognetta, (201) 799-4898, cassie.cognetta@prihcs.com

Lunch PDM**Teva Pharmaceuticals is pleased to be sponsoring 3 programs during the conference which will examine prescription opioids in the management of chronic pain.**

Sponsored by Teva Pharmaceuticals

Charles E. Argoff, MD, CPE

Course code: PDM-17**Friday/9.9 12:30p – 1:30p** Level 3/**Brera Ballroom****Lunch will be served.**

Contact: Alison Labombarda, (973) 401-1654, alabombarda@hlxusa.com

PLEASE JOIN US FOR A PRODUCT THEATER
BREAKFAST PRESENTATION AT
PAINWEEK® 2016

OPIOID-INDUCED CONSTIPATION

Friday, September 9, 2016

8:00 AM – 8:50 AM

The Cosmopolitan of Las Vegas

Castellana Ballroom, Level 3

Las Vegas, Nevada

Steven Simon, MD, RPh

This is a promotional event. CE/CME credit will not be available for this session.

In compliance with PhRMA guidelines, spouses or other guests are not permitted to attend company-sponsored programs.

This promotional educational activity is brought to you by Salix Pharmaceuticals and is not certified for continuing medical education. The speakers are presenting on behalf of Salix Pharmaceuticals and must present information in compliance with FDA requirements applicable to Salix Pharmaceuticals.

If you are licensed in any state or other jurisdiction (eg, VT, Wash. DC, ME, MN) or are an employee or contractor of any organization or government entity that limits or prohibits meals from pharmaceutical companies, please identify yourself so that you (and we) are able to comply with such requirements. Your name, the value, and the purpose of any educational item, meal, or other items of value you receive may be reported as required by state or federal law. Once reported, this information may be publicly accessible.

Thank you for your cooperation.

This Product Theater is neither sponsored by nor endorsed by PAINWeek®.

Lunch PDM

**Moving Beyond Mu With Kappa Opioid Receptor Agonists—
Leaving the Baggage Behind**

Supported by Cara Therapeutics

Joseph Stauffer, DO, MBA; Michael J. Brennan, MD

Course code: PDM-18

Friday/9.9 12:30p – 1:30p Level 3/**Castellana Ballroom**

Lunch will be served.

Contact: Samantha Libby-Cap, (860) 575-5360,
slibbycap@pharmacomgroup.com

Lunch PDM

Collegium Pharmaceutical, Inc. Sponsored Program

Sponsored by Collegium Pharmaceutical, Inc.

Faculty TBA

Course code: PDM-19

Saturday/9.10 12:30p – 1:30p Level 3/**Brera Ballroom**

Lunch will be served.

Contact: Lisa Grant, (415) 310-5706, lgrant@collegiumpharma.com

CME ACTiViTiEs

(Certified for credit)

SYMPOSIUM

**A Comprehensive Approach to the Safe Management of
Extended-Release/Long-Acting Opioids**

This educational activity is supported by an independent educational grant from the ER/LA Opioid Analgesic REMS Program Companies

Jointly provided by Global Education Group and Rockpointe

Please see: http://ce.er-la-opioidrems.com/lwgCEUI/remss/pdf/List_of_RPC_Companies.pdf for a listing of the member companies. This activity is intended to be fully compliant with the ER/LA Opioid Analgesics REMS education requirements issued by the US Food & Drug Administration

This program was planned in accordance with AANP CE Standards and Policies and the AANP Commercial Support Standard

Jeffrey A. Gudin, MD; Bill H. McCarberg, MD

Course code: SYM-O1

Tuesday/9.6 1:40p – 4:40p Level 3/**Gracia 3***

Refreshments will be served.

Contact: Paula Larson, (449) 539-4070, plarson@rockpointe.com
Go to p. 111 for course description.

SYMPOSIUM

**The Need for a Personalized Team Approach in Managing
Chronic Pain**

This activity is supported by an educational grant from Teva Pharmaceuticals

This activity is provided by Med Learning Group. This activity is co-provided by Ultimate Medical Academy/CCM

John A. Hopper, MD; Sanford M. Silverman, MD

Course code: SYM-O2

Wednesday/9.7 7:00a – 7:50a Level 3/**Gracia 5**

Refreshments will be served.

Contact: Lisa Dorin, (908) 229-6957, ldorin@medlearninggroup.com
Go to p. 111 for course description.

BREAKFAST SYMPOSIUM

Evolving Strategies for Chronic Pain Management: Targeting Multiple Pain Mechanisms to Improve Efficacy and Reduce Opioid Abuse Potential

This activity has been supported by an educational grant from Depomed, Inc.

This symposium is provided by North American Center for Continuing Medical Education, LLC, an HMP Communications Holdings Company

Charles E. Argoff, MD, CPE; Michael J. Brennan, MD

Course code: SYM-03

Saturday/9.10 8:00a – 9:00a Level 3/**Brera Ballroom**

Breakfast will be served.

Contact: Tanya Kenevich, (609) 630-6278, tkenevich@naccme.com
Go to p. 111 for course description.



Stop the carousel I want to get off

The
pressures
of
managing
chronic
pain
patients
in
clinical
practice

kevin zacharoff

Tuesday
September 6



d. fossa '16

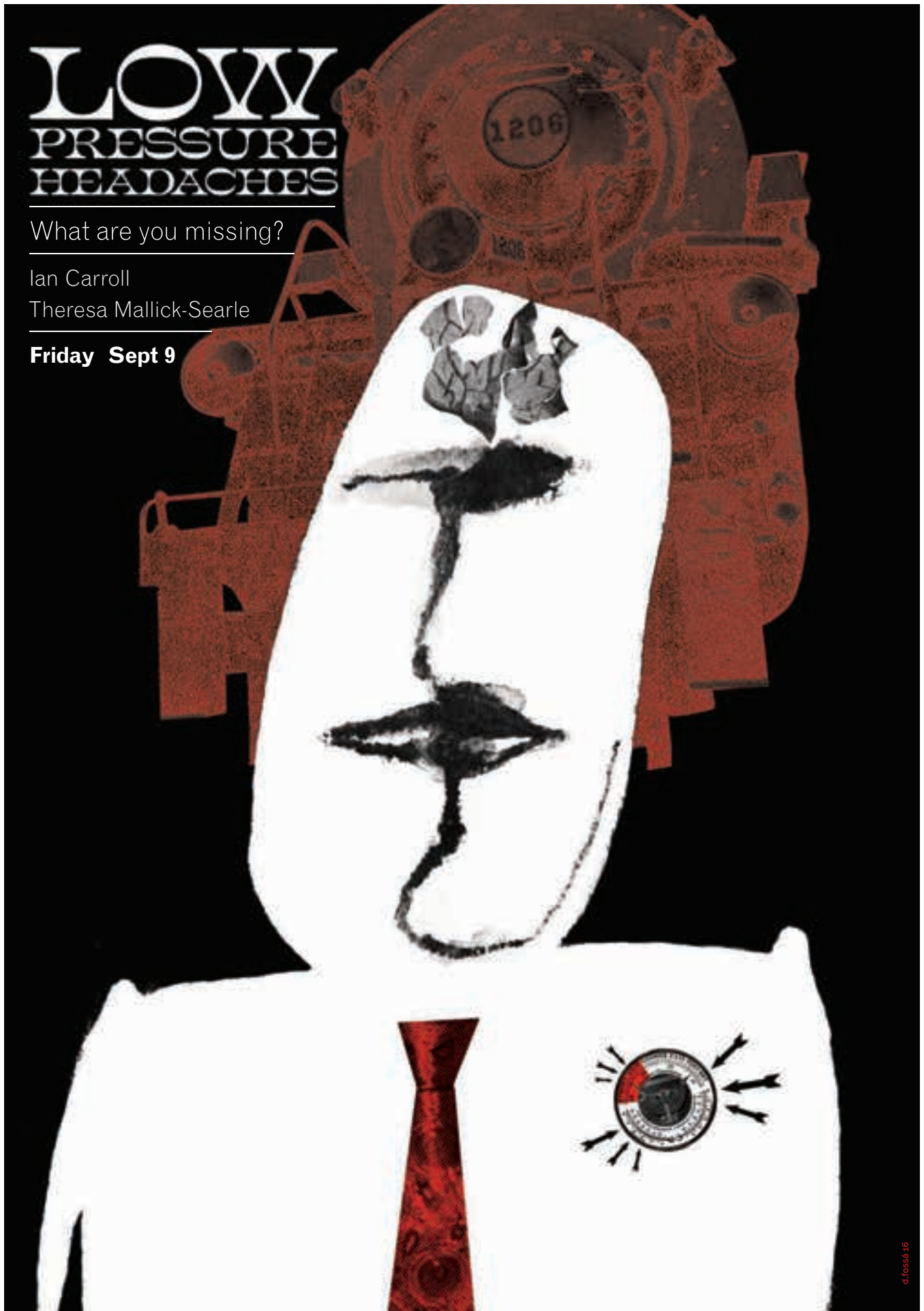
LOW PRESSURE HEADACHES

What are you missing?

Ian Carroll

Theresa Mallick-Searle

Friday Sept 9

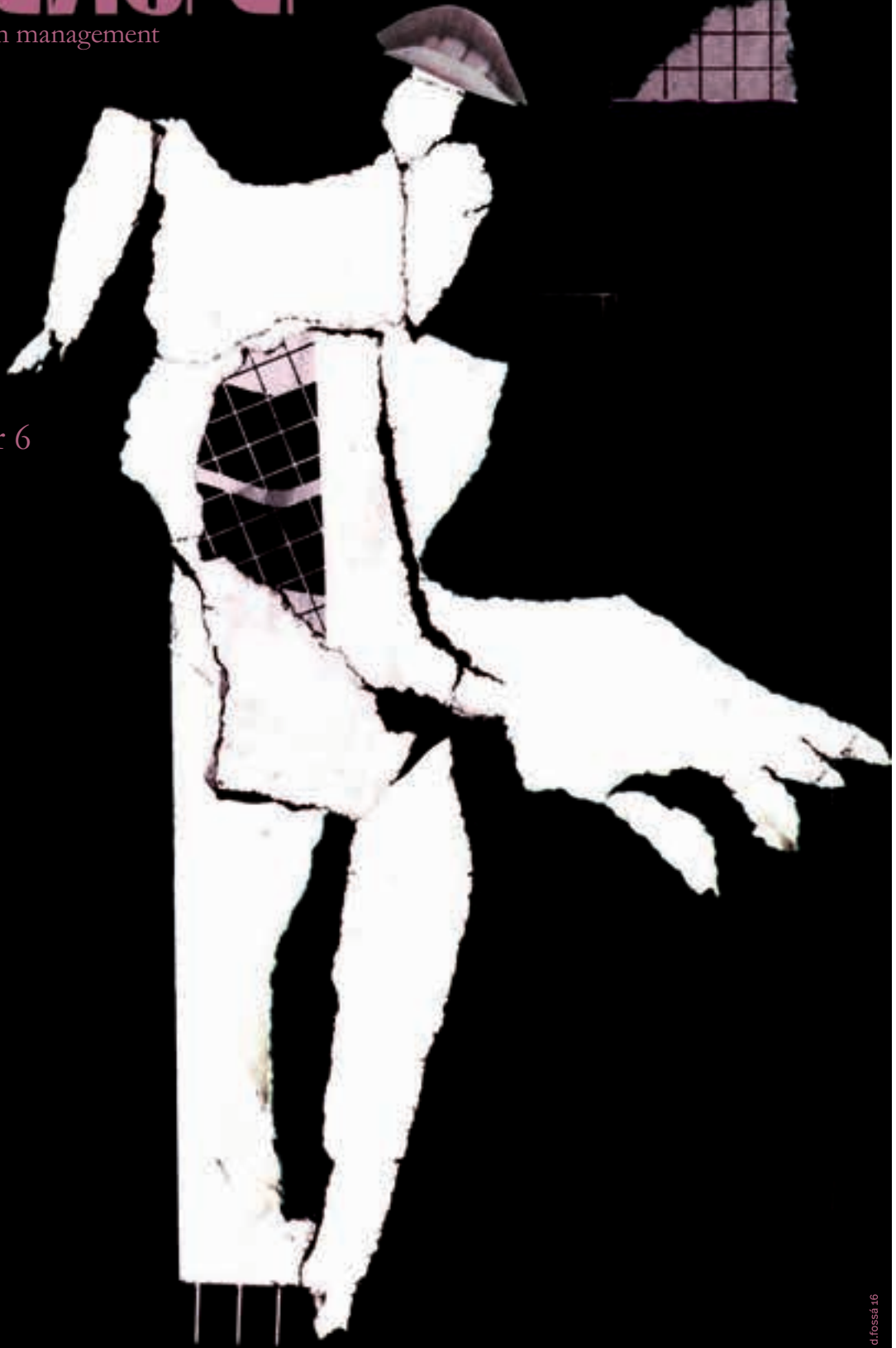


behavioral

pain management

dawn buse
david cosio

tuesday
september 6



d.fossa 16

masterclass series

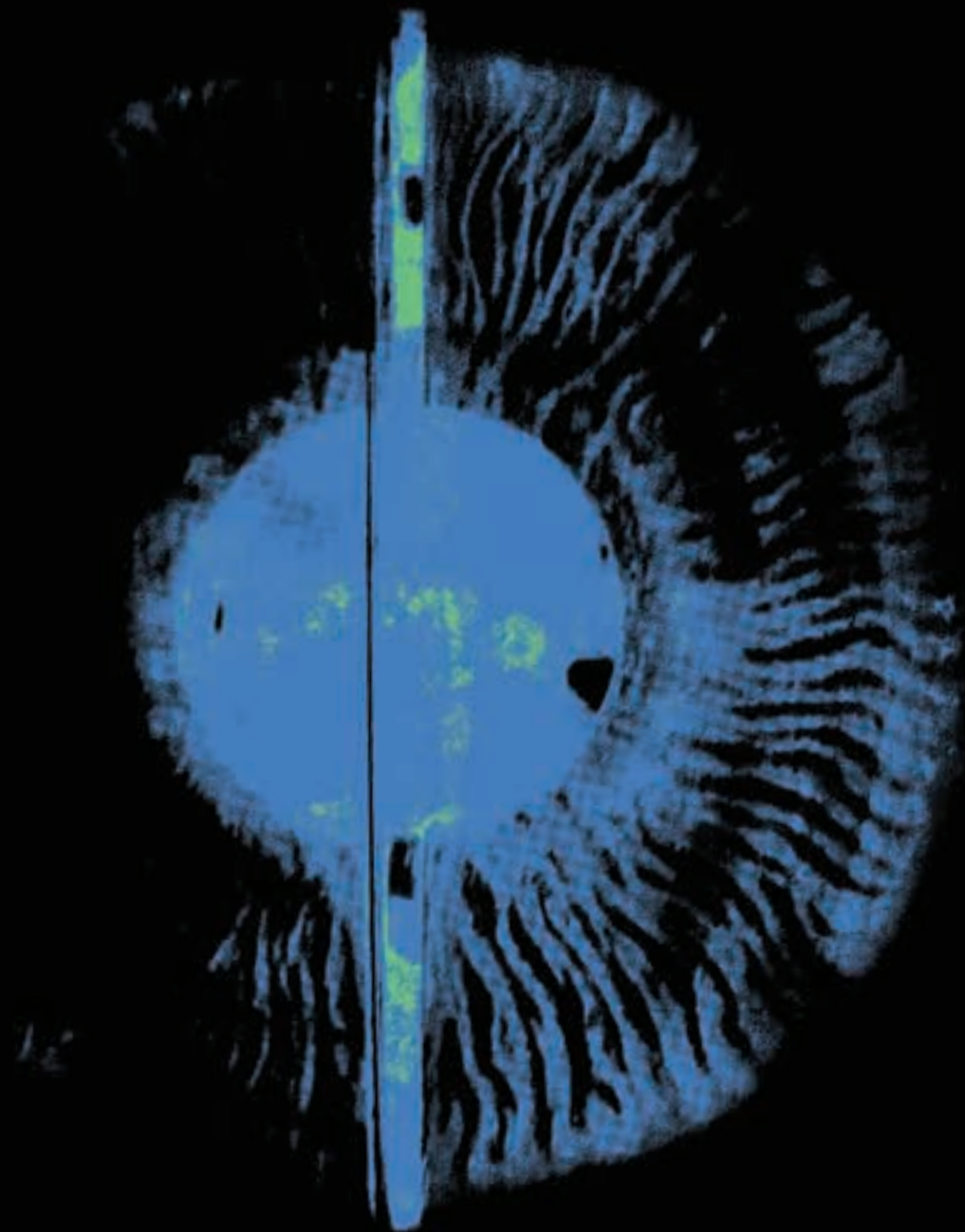
A CARESS OR A SLAP?

Understanding Sensory Amplification Systems in Chronic Pain

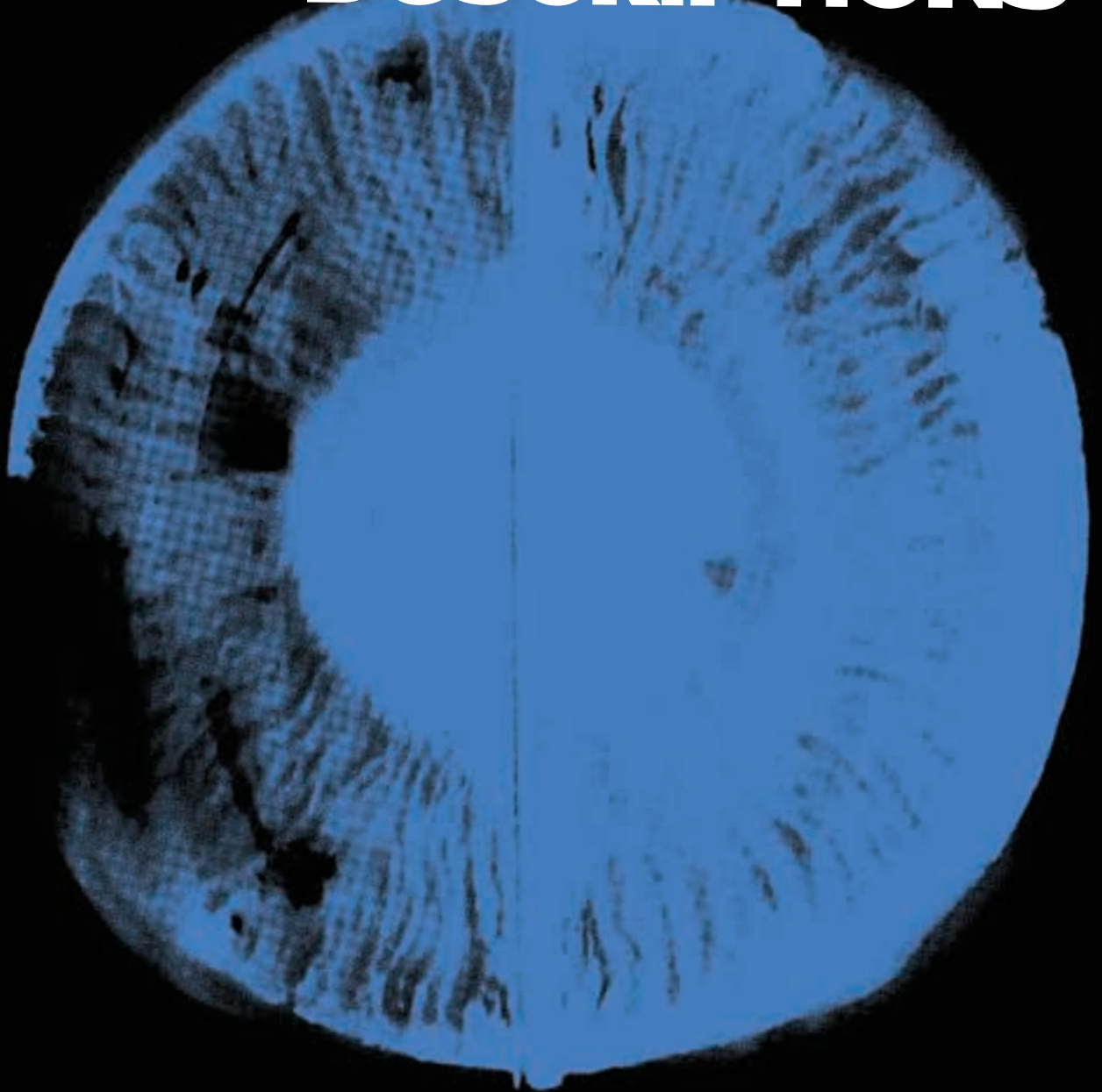
Charles Argoff Daniel Clauw THURS. 9.8



75



COURSE DESCRIPTiONS



TRACKS

AAPM

American Academy of Pain Medicine

ACU

Acute Pain Management

APP

Advanced Practice Provider

APS

American Pain Society

BHV

Behavioral Pain Management

CPS

Chronic Pain Syndromes

eMD

Pain Management in the ED

HCH

Health Coaching

iNT

Interventional Pain Management

MAS

Master Class

MDL

Medical/Legal

NAD

National Association of Drug Diversion Investigators

NRO

Neurology

PAL

Palliative Care

PCD

Pain and Chemical Dependency

PEF

Pain Educators Forum

PHM

Pharmacotherapy

POP

Pop-Up Course

POS

Scientific Poster Session*

PREPEF

Neuropathica Galactica

SiS

Special Interest Session

SYM

Symposium

VHA

Veterans Health Administration

WMH

Women's Health

*Not certified for credit

For the most up to date schedule,
possible room changes, and full AANP Rx hours,
please refer to m.painweek.org.

AAPM-O1 **It Takes a Village (Part 1): Caring for the Whole Patient From an Integrative Therapies Perspective**

Heather Tick, MD

Wednesday/9.7 9:00a – 9:50a

Level 3/Gracia 1

This session will explore research frontiers in pain medicine and the profound effect food has on inflammation, the immune system, and mood. Nutrient deficiencies associated with pain, holistic pain relief, and foods and vitamins as therapeutic agents will also be discussed.

Presented by the American Academy of Pain Medicine.

AAPM-O2 **It Takes a Village (Part 2): Caring for the Whole Patient With an Interdisciplinary Team**

Ravi Prasad, PhD

Wednesday/9.7 10:30a – 11:20a

Level 3/Gracia 1

This session will help clinicians understand the role of interdisciplinary care in pain management by identifying the components of the biopsychosocial model. Cases will be discussed, and a review of literature findings supporting multidisciplinary treatment approaches and the chronification of pain will be explored, as well as empirically validated treatments, addressing pain in outpatient settings, and more.

Presented by the American Academy of Pain Medicine.

AAPM-O3 **CRPS and New Developments in Fibromyalgia & Diabetic Neuropathy**

R. Norman Harden, MD

Wednesday/9.7 2:40p – 3:30p

Level 3/Gracia 1

This session will explore an interdisciplinary team approach for the treatment of pain and autonomic dysfunction and will look closely at chronic pain as a biopsychosocial disease. A pharmacotherapy guide for CRPS will be reviewed, along with a comparison of FM and MPS and treatments for diabetic neuropathy.

Presented by the American Academy of Pain Medicine.

AAPM-O4 **Evidence Based Medicine Under Attack! Use, Misuse, and Abuse of Clinical Practice Guidelines**

Steven P. Stanos, DO

Wednesday/9.7 4:40p – 5:30p

Level 3/Gracia 1

This session will examine the development of evidence based medicine (EBM), its evolution and associated methodologies. Recent EBM documents including the CDC Guideline for Opioid Management, AHRQ low back pain reviews, and practice decisions related to use of epidural injections in the state of Washington will be discussed. Clinicians will increase their knowledge about how EBM works, as well as how to critically assess potential use and monitor for bias.

Presented by the American Academy of Pain Medicine.

ACU-01

Case Based Challenges in Acute Pain Management*Debra B. Gordon, RN, DNP, FAAN***Wednesday/9.7 7:00a – 7:50a**Level 3/**Gracia 1**

Acute pain is associated with negative outcomes; therefore, efforts to prevent and control pain are necessary. Goals for acute postoperative pain management include reducing the incidence and severity of pain, particularly that which impacts patient function such as movement; minimizing side effects from analgesics; preventing postoperative complications; enhancing recovery; and preventing chronic pain if possible. The purpose of this session will be to discuss common challenges including pain assessment, opioid safety, and individualizing multimodal analgesia.

ACU-02

New Treatment Options for Managing Pain in the ED*Alexis LaPietra, DO***Wednesday/9.7 9:00a – 9:50a**Level 4/**Nolita 1**

EDs are searching for new ways to treat pain that are rapid, safe, and effective. The search for new options is being driven by the national outcry to decrease opioid prescribing, pressure to see patients faster, decrease ED length of stay, and prevent readmissions while still treating pain and suffering and obtaining positive patient satisfaction scores. This course will focus on new uses of old drugs, different routes of delivery, multimodal treatment, ED nerve blocks, nonopioids, and patient discharge education regarding nonpharmacologic pain management.

ACU-03

Acute Pain in Patients With Active Substance Use Disorder*Debra B. Gordon, RN, DNP, FAAN***Wednesday/9.7 10:30a – 11:20a**Level 4/**Nolita 1**

Management of acute pain following surgery or trauma requiring opioid treatment can be particularly challenging in patients with substance use disorders. This session will explore ways to optimize analgesic care, keep patients safe, and promote behavioral consequences that are just and equitable in patients with active heroin use during hospitalization.

ACU-04

Balancing Analgesia vs ORAEs in Postoperative Acute Pain: Consequences, Strategies, and New Approaches*Charles E. Argoff, MD, CPE***Wednesday/9.7 2:40p – 3:30p**Level 4/**Nolita 1**

This presentation will review the consequences of not adequately addressing postoperative acute pain, strategies for balancing analgesia against opioid related adverse events in this setting, and new approaches on the horizon. Postoperative acute pain continues to be undertreated in a large number of cases. This may be due to a wide variety of factors, notably drug related adverse events. Conventional opioids, for example, are widely employed for the management of moderate to severe acute pain. They function by binding to μ receptors and nonselectively activating 2 downstream pathways: the G protein pathway, associated with analgesia, and the β -arrestin pathway, associated with opioid related adverse events (ORAEs) and inhibition of G protein-mediated analgesia. ORAEs, including respiratory depression, are serious, pose a risk to patient safety, and limit dosing required for optimal analgesia. Consequences of suboptimal acute pain management are numerous and include prolonged opioid use, potential development of chronic pain, and increased morbidity, length of stay, time to discharge, and time before ambulation. Greater spotlight is needed on this unmet need, particularly in patient groups—the opioid tolerant, obese, respiratory compromised, elderly, and those with sleep apnea—at greater risk for undertreatment of acute postoperative pain, where prevalence and impact of adverse events is heightened. New therapeutic approaches have been developed in the past decade to address some of these issues, including use of multimodal therapy, reformulations in analgesics, innovations in drug delivery, and μ -GPS modulators, which are novel μ receptor modulators that differentially activate G protein while causing low β -arrestin recruitment to the μ receptor.

charles argoff
debra gordon
phyllis hendry
alexis lapietra
sophia sheikh

wednesday
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acute pain
management

APP-01

The Role of the Advanced Practice Provider in the Acute Care Setting*Theresa Mallick-Searle, MS, NP-BC, ANP-BC***Thursday/9.8 7:00a – 7:50a**Level 3/**Gracia 3**

Millions of patients each year suffer from acute pain as a result of trauma, illness, or surgery. Pain is the most common reason for admission to the emergency department (ED), comprising more than 40% of the over 100 million ED visits annually. The prevalence of intense acute pain is similarly high among patients undergoing surgery: in the United States, over 73 million surgical procedures are performed annually, and most patients report experiencing a high degree of pain postoperatively. Studies indicate that treatment of acute pain remains suboptimal due to attitudes and educational barriers on the part of clinicians and patients, as well as the intrinsic limitations of available therapies. Inadequate management of acute pain negatively impacts numerous aspects of patient health and may increase the risk of developing chronic pain. This presentation will review the differences between acute and chronic or persistent pain, while providing attendees with a multimodal treatment approach for the acute care setting. Emphasis will be placed on the role of the advanced practice provider.

APP-02

Naloxone Prescriptions for Overdose: Outside of Misuse and Abuse*Brett B. Snodgrass, FNP-C, CPE, FACPP, FAANP***Thursday/9.8 9:00a – 9:50a**Level 3/**Gracia 3**

Opioid emergencies have risen with the increase in prescribing of opioids. It is imperative that prescribers of opioids know when to coprescribe naloxone therapy to their patients. It goes beyond the patient suspected of misuse and abuse. This presentation will focus on the patients you might not consider at risk for an opioid overdose.

APP-03

Complex Cases in Pain Management*Theresa Mallick-Searle, MS, NP-BC, ANP-BC***Thursday/9.8 10:30a – 11:20a**Level 3/**Gracia 3**

Chronic pain affects 100 million US adults. It is the #1 reason people are out of work. It is the leading reason that people seek medical attention, costing the nation upwards of \$635 billion annually—more than heart disease, cancer, and diabetes combined. Given the burden of unmanaged pain in terms of human suffering, societal burden, and healthcare dollars spent, relieving pain has become a national priority. This case based lecture will define the pathophysiology of various pain generators, and provide a comprehensive overview of multimodal management of chronic/persistent and acute pain. The use of pharmacotherapy, nerve blocks, and behavioral management strategies will be emphasized. This lecture will examine the decision making involved in developing a treatment strategy for patients with complex pain diagnosis. Special emphasis will be placed on cancer pain, the patient with an addiction history, central pain, and neuropathic pain.

APP-04

Overview: Abuse Deterrent Formulations*Jeremy A. Adler, MS, PA-C***Thursday/9.8 1:40p – 2:30p**Level 3/**Gracia 3**

Although opioids remain an important tool in aiding the management of pain in the United States, the balance between the potential benefits and harms must be considered. Some specific harms are manifested in the abuse of opioids for nonmedical purposes. The primary access to prescribable opioids for abuse is through illegal diversion. Those abusing opioids may do so through a variety of mechanisms, including taking excessive doses, altering formulations, and changing the route of delivery. For example, an oral formulation may be modified and abused through nasal snorting or intravenous injection. The FDA has developed guidelines for a clinical study design for “abuse deterrent opioids” and has labeled a number of opioids with language that they are “abuse deterrent.” This session will review the FDA’s publication “Abuse Deterrent Opioids—Evaluation and Labeling: Guidance for Industry” as well as discuss many of the novel technologies developed and labeled specifically to minimize the likelihood of abuse, while retaining the potential benefits of opioids in the management of pain.

The Brain or the Body

What is the target for pain treatment?



Roger Fillingim

**Friday
September 9**

The Importance of Chart Documentation: Through the Eyes of a Chart Reviewer

Brett B. Snodgrass, FNP-C, CPE, FACPP, FAANP

Thursday/9.8 4:40p – 5:30p

Level 3/Gracia 3

Chart documentation is important in any practice, but even more so when working with chronic pain patients. The treatment of chronic pain management comes with increased potential for litigation. There are important steps that prescribers must take with their documentation to lessen that risk. As a case reviewer and expert witness, I will highlight important areas that should be documented, as well as what safe guards to use when using electronic medical records. What is being looked at? What is vital to every chronic pain chart? What must be included in your charts if they are ever called into question?

The Brain or the Body: What Is the Target for Pain Treatment?

Roger B. Fillingim, PhD

Friday/9.9 9:00a – 9:50a

Level 4/Nolita 3

Historically, pain has been viewed as a symptom of perturbations in the tissues of the body, such that effective treatments would address the damage to the affected body region and pain relief would ensue. However, both clinical experience and the scientific literature are replete with examples of such body based treatments failing to relieve pain. In recent years, accumulating evidence implicates changes in the structure and function of the brain as important contributors to the pathophysiology of chronic pain, with some thought leaders concluding that chronic pain is often a brain disease in its own right. This raises the question whether the brain or the body represents the best target for pain treatment. This course will present a conceptual model of chronic pain based on a continuum of peripheral vs central contributions. Examples of pain conditions and their location on the continuum will be provided, and assessment methods that can be used to determine where a given patient falls on the spectrum will be discussed. Then, an overview of treatment approaches whose mechanisms cover the spectrum from peripheral to central pain mechanisms will be provided, including pharmacological, behavioral/psychological, and neuromodulatory therapies. The session will conclude with a discussion of how to decide whether treatment for a given patient should target the brain or the body and how best to tailor treatment to the mechanisms underlying that patient's pain condition.

Presented by the American Pain Society.

Acupuncture Analgesia: Therapy or Sham?

Richard E. Harris, PhD, MS, Dipl Ac

Friday/9.9 11:30a – 12:00p

Level 4/Nolita 3

Acupuncture has been used for centuries to treat pain; however, multiple recent randomized controlled trials of acupuncture in chronic pain disorders have largely shown mixed findings. In most of these studies acupuncture is no better than sham/placebo. Moreover, many basic as well as clinical studies have indicated that analgesia following acupuncture treatment involves the body's own endogenous opioid system, which is also known to be a key factor in placebo analgesia. This raises the question: Is acupuncture simply a sham/placebo? During this presentation we will examine evidence from the animal basic science literature indicating that there may be some specific effects of acupuncture needling that differ from placebo analgesia. Also we will explore how translational approaches using quantitative sensory testing as well as functional and neurochemical imaging in humans have been used to suggest that acupuncture may specifically work by upregulating receptor activity and neurotransmitter release, both hallmarks of synaptic plasticity. These results indicate a disconnect between acupuncture clinical trials and basic/translational research. New approaches are clearly needed to bridge this gap. We will end by stepping back and entertaining the question of how relevant this information is for the treatment of chronic pain patients.

Presented by the American Pain Society.

Friday Sept. 9

Roger Fillingim Steven George
Richard Harris Vitaly Napadow



dfrossa

AMERICAN PAIN SOCIETY

*Vitaly Napadow, PhD, Lic Ac***Friday/9.9 1:40p – 2:30p**Level 4/**Nolita 3**

Recent advances in neuromodulation approaches have resulted in several promising applications for the treatment of various chronic pain disorders. This course will review several of the more popular applications, including transcranial direct current stimulation (tDCS), transcutaneous vagus nerve stimulation (tVNS), and transcranial magnetic stimulation (TMS). The neural mechanisms by which these neuromodulatory therapies access pain associated brain circuitries will also be reviewed, and neuroimaging evidence will demonstrate how these therapies might impact brain physiology. For instance, recent functional MRI (fMRI) research for applications of tVNS in migraine has demonstrated targeting of specific medullary nuclei and modulation of pontine raphe response to processing along the spinal trigeminal pathway in these patients. Finally, the side effect profile for different neuromodulatory approaches should be considered with respect to pharmacological approaches to chronic pain management.

*Presented by the American Pain Society.***Hands On or Hands Off? A Tour of Current Issues Impacting Spinal Manipulative Therapy for Spinal Pain***Steven Z. George, PT, PhD***Friday/9.9 4:40p – 5:30p**Level 4/**Nolita 3**

Manual therapy has long been used to treat spinal pain. Spinal manipulative therapy, in particular, has received special emphasis as many providers use it as a featured part of their practice. It has a favorable side effect profile, but there continues to be healthy debate on whether it is an effective option for pain relief compared to other treatment options. This presentation will review key aspects of the debate by differentiating between spinal manipulative therapy's ability to modulate nociception (largely through mechanistic studies) and having an impact on outcomes for those with acute or chronic spine pain (largely through clinical trials). A primary goal is to provide attendees with a better understanding of key components perpetuating this debate. The second half of the presentation will highlight future practice and research priorities that if implemented may lead to better defined information on how spinal manipulative therapy could be used to effectively provide pain relief.

*Presented by the American Pain Society.***Neurochemical Imaging as a Probe of Chronic Pain and Its Treatment***Richard E. Harris, PhD, MS, Dipl Ac***Friday/9.9 5:40p – 6:30p**Level 3/**Gracia 3**

Accumulating evidence suggests that widespread pain syndromes such as fibromyalgia display a generalized disturbance in central nervous system pain processing. Multiple lines of research have identified that the locus for many functional chronic pain disorders, including fibromyalgia, pelvic pain, and irritable bowel syndrome, is within the central nervous system, and the brain more specifically. Brain neuroimaging techniques have heralded a revolution in our understanding of chronic pain, as they have allowed researchers to noninvasively evaluate brain structure and function. In addition, growing interest has turned to proton magnetic resonance spectroscopy (1H-MRS), a noninvasive magnetic resonance imaging technique that can quantify the concentration of glutamate and GABA, the brain's main excitatory and inhibitory neurotransmitters, respectively, within the living human brain. During this presentation, we will explore the ability and utility of 1H-MRS to identify brain neurotransmitter concentrations in chronic pain patients. Moreover, we will examine how 1H-MRS may provide insight into the mechanism(s) of action of pharmacologic as well as nonpharmacologic therapies. A key question: Are alterations in neurotransmitter levels along the causal pathway for the development/maintenance of chronic pain, or are they simply a response to sustained peripheral input?

Presented by the American Pain Society.

BHV-01

Biobehavioral Management of Migraine*Dawn C. Buse, PhD***Tuesday/9.6 9:00a – 9:50a**Level 4/**Nolita 3**

There is strong evidence supporting the use of biobehavioral therapies for chronic pain conditions including fibromyalgia, migraine, and other forms of severe headache. Evidence based behavioral medicine treatments include cognitive behavioral therapy (CBT) and biobehavioral training. These techniques have demonstrated efficacy when learned and practiced correctly and may be used individually or in conjunction with pharmacological and other interventions. Migraine will be used as an example in this presentation; however, these techniques all have evidence for their use with chronic pain conditions and will also be applicable to chronic pain management. This workshop will review the well established approaches including include cognitive behavioral therapy, biofeedback, relaxation training, and stress management, as well as emerging therapies including acceptance and commitment therapy (ACT) and mindfulness based cognitive therapy (MBCT). The science supporting these therapies will be reviewed along with case examples and experiential learning where the audience will participate in diaphragmatic breathing and a guided visual imagery exercise so that they can either make referrals or teach these approaches themselves. Suggestions and resources for making successful referrals, finding and communicating with allied providers, and resources such as websites, apps, and books will also be reviewed.

BHV-02

Burnout! Recognize Symptoms, Enhance Resilience, and Improve Quality of Life*Dawn C. Buse, PhD***Tuesday/9.6 1:40p – 2:30p**Level 4/**Nolita 3**

Burnout has reached epidemic proportions among healthcare professionals and is especially high among those who care for patients with chronic pain and chronic painful conditions such as migraine and fibromyalgia. This course will review the definition and prevalence of burnout, review the risk factors for healthcare professionals, have participants take the Maslach Burnout Inventory, and review what the results may imply both professionally and personally. Then the course will review strategies for reducing stress, enhancing resilience, and improving quality of life. As well as improving satisfaction for healthcare professionals, these resilience enhancing strategies and healthy lifestyle practices also have benefits for patients.

BHV-03

The Gentle Art of Saying No: How to Establish Appropriate Boundaries With Chronic Pain Patients*David Cosio, PhD***Tuesday/9.6 2:40p – 3:30p**Level 4/**Nolita 3**

Effective pain management has been deemed a human right, but some chronic pain patients perceive that to mean they are entitled to opioid analgesics for prolonged pain control. In response to these expectations, providers may feel pressured to say “Yes” and continue prescribing opioids, thereby reinforcing the patient’s beliefs and reliance on medication. This has contributed to a dramatic rise in opioid analgesic misuse and deaths from prescription drug overdose. In fact, the CDC has identified opioid misuse as a “public health epidemic” and released new guidelines in March 2016. While a collaborative relationship is optimal for pain management, there may be times when a practitioner saying “No” is the best treatment. Many providers feel uncomfortable setting boundaries; however, boundary setting is important work because rights as a provider are also important. When reasonable limits are placed on a patient and the patient continues to step beyond those limits, it is imperative that providers maintain boundaries and be consistent in their message. Participants will learn about the gentle art of saying “No” and how to use a decision tree when making pain management decisions. Sample cases will be presented along with recommended treatment strategies.

David Cosio

**Tuesday
September 6**

**The
gentle
art
of
saying**

NO

**How to establish
appropriate
boundaries with
chronic
pain patients**



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a primer for chronic pain management and substance abuse disorders



**tues
sept 6**

david cosio

falling down the rabbit hole

BHV-04

Falling Down the Rabbit Hole:

A Primer for Chronic Pain Management and Substance Abuse Disorders

*David Cosio, PhD***Tuesday/9.6 4:40p – 5:30p**Level 4/**Nolita 3**

The field of pain management has undergone a circuitous adventure, much like a rabbit hole. As the economic, mental health, and medical consequences of prescribing opioid medications have mounted, the prevailing logic regarding the usefulness of prescribing opioids for chronic pain has shifted. The widespread dissemination of opiates and the lax safety measures placed on their storage has also led to an increase in nonmedical use. Given the high level of comorbidity between opioid use disorders and chronic pain, providers' decisions about how to address treatment with patients who may have or who have been diagnosed with substance use disorders are often complex. The new CDC guidelines will require providers to assess for risk of overdose or development of a substance use disorder, and to be keenly aware of their patients' pain levels and pain management strategies when working as part of a system where opioid medications may be prescribed. Participants will learn how patient and provider education programs and communication interventions may improve outcomes in pain management. Participants will also learn how to select candidates for opioid trials, assess for risk, and initiate opioid therapy, but only after exploring nonopioid and nonpharmacological strategies.

CPS-O1

Chronic Pain Prevention*James R. Friction, DDS, MS***Tuesday/9.6 7:00a – 7:50a**Level 3/**Gracia 3**

The Institute of Medicine stated in 2011 that one of the health professional's primary roles for chronic pain should be guiding, coaching, and assisting patients with day-to-day self-management of their pain condition and, along with National Institutes of Health, have established research involving self-management as one of the highest priority topics. A transformative care model integrates self-management training with evidence based treatments. The use of web based cognitive behavioral patient training programs with a telehealth coach therapist is an innovative strategy to improve the long-term outcomes of pain care. This approach can help patients make necessary changes in their life to reduce risk factors and promote protective factors while making the implementation affordable, rapidly deployed, scalable, and transferable to all settings and conditions. This presentation will provide the rationale, implementation, and outcomes associated with employing transformative care for chronic pain.

CPS-O2

Managing Odd Neuropathic Pain Disorders*Ignacio J. Badiola, MD; Martin D. Cheattle, PhD; Peter G. Pryzbylowski, MD; Peter Yi, MD***Tuesday/9.6 8:00a – 10:00a**Level 4/**Mont-Royal Ballroom**

There are a number of common neuropathic pain syndromes, such as complex regional pain syndrome, postherpetic neuralgia, and diabetic neuropathy, that have established diagnostic and treatment paradigms. There also are a number of neuropathic pain disorders that are as common but less understood and can be more challenging to the treating clinician. For example postthoracotomy pain syndrome is relatively common and is seen in approximately 50% of patients after thoracotomy. It is a chronic condition, and about 30% of patients still experience pain 4 to 5 years after surgery. Between 20% to 60% of women who undergo mastectomy for breast cancer develop postmastectomy pain syndrome. This multidisciplinary panel will review the prevalence, characteristics, and pathophysiology of these odd neuropathic pain disorders and discuss models for evaluation and treatment that include both pharmacologic and nonpharmacologic approaches.

CPS-O3

Transformative Care for Chronic Pain: Orofacial*James R. Friction, DDS, MS***Tuesday/9.6 10:30a – 11:20a**Level 4/**Nolita 3**

This course presents the basic principles of etiology, diagnosis, and management of orofacial pain using transformative care. Because orofacial structures have close association with eating, communication, sight, and hearing as well as forming the basis for appearance, self-esteem, and

pain management in the emergency department

phyllis hendry danielle eaves hernandez colleen kalynych alexis lapietra sophia sheikh

tuesday

september 6



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personal expression, persistent pain in this region can deeply affect an individual and significantly interfere with quality of life and ability to function. We will review diagnosis and management of the more common orofacial pain conditions and highlight advances in education, research, and patient care from risk assessment and prevention to early successful treatment of acute pain and interdisciplinary individualized transformative care. Explored will be the evidence behind treatment strategies for personalized transformative care ranging from self-management and pharmacology to physical medicine, splints, surgery, and interdisciplinary team management. It is hoped that this review will provide the clinician with broad perspective on the evolution of this field to the current scientific approach for prevention and management that helps the patient achieve a truly transformative experience.

CPS-O4 **Transformative Care for Chronic Pain: Myofascial**

James R. Friction, DDS, MS

Tuesday/9.6 5:40p – 6:30p

Level 4/**Nolita 1**

Several studies from both pain clinics and primary care have found that regional myofascial pain is the most common presenting pain condition. Yet the lack of awareness of it is surprising. Everyone, at some point in their lives, has experienced acute muscle pain associated with overuse or repetitive strain. However, when acute pain becomes chronic, patients and their healthcare providers can become confused and overlook myofascial pain to focus on comorbid pain conditions such as orthopedic and neuropathic pain. This lack of recognition and understanding often leads to mistreatment and progression of a simpler acute problem into a more complex chronic pain condition. Identifying and managing myofascial pain is relatively straight-forward, by integrating patient training on exercises and reducing repetitive strain with evidence based treatments such as physical medicine treatments. This course presents the basic principles of etiology, diagnosis, and management of myofascial pain for all healthcare professionals.

EMD-O1 **Child Life 101 for Emergency Departments and Emergency Care Providers: Using Nonpharmacologic Methods to Relieve and Manage Pain and Anxiety**

Phyllis L. Hendry, MD, FAAP, FACEP; Danielle Eaves Hernandez, BS, CCLS; Colleen Kalynych, MSH, EdD

Tuesday/9.6 7:00a – 7:50a

Level 3/**Gracia 1**

Pain is a common presenting complaint to emergency departments and EMS, and painful procedures are often necessary. Most EDs do not have child life specialists, psychologists, or other resources to assist patients in pain or during procedures. The majority of emergency care providers (physicians, nurses, and paramedics) are not trained in nonpharmacologic means of managing pain and anxiety. This course will discuss nonpharmacologic methods of relieving and managing pain in ED and prehospital/EMS settings. Although mainly used in children, many of these techniques and tools are helpful in adult patients.

EMD-O2 **Case Scenarios in ED Pain Management: Don't Let First Impressions Fool You!**

Phyllis L. Hendry, MD, FAAP, FACEP; Alexis LaPietra, DO

Tuesday/9.6 9:00a – 9:50a

Level 4/**Nolita 2**

Pain is a very common complaint in the emergency department (ED) yet it presents in various ways. The hectic nature of the ED is not always conducive to obtaining the "real story." ED practitioners can be misled by prehospital reports, triage notes, vital signs, past history, and personal biases. This course will present acute and chronic pain case scenarios that will highlight "near miss" patient safety features and lessons learned in patients of all ages.

EMD-O3 **How to Complete a Rapid Pain Assessment in a Busy ED**

Alexis LaPietra, DO; Sophia Sheikh, MD

Tuesday/9.6 10:30a – 11:20a

Level 4/**Nolita 2**

Pain is a component of up to 78% of ED presenting complaints yet most ED physicians have had minimal training related to pain recognition, assessment, and management. Adequate pain assessment is complex and requires time to determine the patient's past pain and medication history, current pain history, and pain intensity. ED providers are under pressure to recognize and treat pain while also dealing with overcrowding, a vast array of patient complaints, and

concerns over opioid addiction and overprescribing. This course will review critical components of a rapid ED pain assessment, the current status of pain scales in the ED, electronic medical record documentation of pain, and current literature.

EMD-O4 **Why Emergency Departments Love Ketamine**

Phyllis L. Hendry, MD, FAAP, FACEP; Sophia Sheikh, MD

Tuesday/9.6 4:40p – 5:30p

Level 4/**Nolita 2**

This course will discuss the use of ketamine in emergency departments (EDs) for the management of pain and procedural sedation in adults, children, and high risk populations. Ketamine has been used for years in pediatric procedural sedation and has now become the “go-to” drug for adult dissociative analgesia in ED, trauma, and prehospital settings and in patients with chronic opioid use or those at high risk for addiction.

HCH-O1 **Pain Management Coaching: Integrative and Complimentary Strategies for Complicated Pain**

Lesla R. Abney, BSN, MINT; Lisa Creekmur, BSN, MINT; Becky L. Curtis, PCC

Tuesday/9.6 1:40p – 2:30p

Level 4/**Nolita 2**

Pain management coaching is a systematized application of techniques, including motivational interviewing, that enable your patients to work through ambivalence and take action to change their lives. One of the primary components is education. Coaches teach skills to enable the patient to regain a sense of control and direction. Working with patients to implement the providers’ recommendations, coaches give support and tools to help the patient reframe their perspective hopelessness and safely navigate through the treacherous jungle of complicated pain.

HCH-O2 **How Pain Management Coaching Impacts Pain Outcomes**

Lesla R. Abney, BSN, MINT; Lisa Creekmur, BSN, MINT; Becky L. Curtis, PCC

Tuesday/9.6 2:40p – 3:30p

Level 4/**Nolita 2**

Perhaps the single most failure producing aspect of chronic pain is its inherent isolation. Add the medical hopelessness faced by many patients, and a perfect storm is created for chronic pain patients to fall permanently out of the workforce and fail to thrive. Pain management coaching provides the bridge between medical care and the patient’s innate will to survive. Pain management coaching pioneer Becky Curtis will share how the latest research on the brain and pain relate to relearning and pain management. Attendees will gain understanding of the role pain management coaching plays in reshaping the learned phenomenon of chronic pain, and how coached clients acquire knowledge and implement effective pain management strategies with the guidance of a coach.

INT-O1 **To Hold or Not to Hold, That Is the Question:**

Antiplatelet and Anticoagulation Management for Interventional Spine and Pain Procedures

Abigail T. Brooks, PharmD, BCPS; Courtney M. Kominek, PharmD, BCPS, CPE

Saturday/9.10 7:00a – 7:50a

Level 4/**Nolita 1**

Interventional spine and pain procedures continue to play an important role in the management of chronic pain for many patients. Pain procedures can result in improved function and better quality of life for patients, as well as pain medication sparing effects. With the aging American population and increasing polypharmacy, it is vital that clinicians working in an interventional pain procedure environment have an understanding of the complexity associated with antiplatelet and anticoagulant therapies, namely, which medications need to be held prior to a pain procedure and for how long? If anticoagulation is held, is bridging required? When should the patient resume therapy? All of these questions and more will be addressed in this presentation with a detailed review of the 2015 ASRA (American Society of Regional Anesthesia and Pain Medicine) guideline recommendations for anticoagulation and antiplatelet therapy in this unique patient population.

- INT-02 **Interventional Pain Management: Injections, Nerve Blocks, Pumps, and Spinal Cord Stimulation**
Paul J. Christo, MD, MBA
Saturday/9.10 9:00a – 9:50a Level 4/**Nolita 1**
 This presentation will highlight common procedures used for pain reduction, their evidence base, and a basic description of how each procedure is performed. We will primarily review epidural steroid injections, facet joint blocks and denervation, sacroiliac joint injections and denervation, myofascial pain, spinal cord stimulation, and intrathecal pumps.
- INT-03 **Innovative Interventional Approaches to Pain Management in the Elderly**
Michael M. Bottros, MD
Saturday/9.10 10:30a – 11:20a Level 4/**Nolita 1**
 Pain management in the elderly can be quite complex. The most common method of pain control in this population is pharmacotherapy. However, this patient population is becoming subject to the complex interactions and risks associated with polypharmacy. Hence, interventional strategies are increasingly being recognized as an important part of their multimodal pain management. In this session, we will explore unique and emerging interventional strategies for some of the most common pain complaints in the elderly.
- INT-04 **If Opioids Aren't the Answer, Then What Is the Question?**
Sanford M. Silverman, MD
Saturday/9.10 2:40p – 3:30p Level 4/**Nolita 1**
 The Centers for Disease Control and Prevention's new prescription guidelines strongly urge physicians to reduce their use of opioid analgesics in the treatment of chronic pain. Specifically, the guidelines outline a multidisciplinary approach that includes interventional pain management and limited use of immediate-release opioids instead of extended-release or long-acting opioids. This presentation will address the practical aspects of these recommendations and how frontline practitioners can contextualize this information to better manage their patients to restore functionality and quality of life.
- INT-05 **Central Sensitization and Ketamine Infusions**
Jay Joshi, MD, DABA, DABA-PM, FABA-PM
Saturday/9.10 3:40p – 4:30p Level 4/**Nolita 1**
 Central pain conditions are difficult to treat. What is worse, many central pain conditions are misdiagnosed or mistreated. Conditions such as depression, anxiety, trigeminal neuralgia, complex regional pain syndrome (CRPS), various neuropathies, phantom limb pain, postherpetic neuralgia, fibromyalgia, PTSD, and others can be very responsive to ketamine infusions. There have been many infusion protocols out there with variable results. We will discuss various conditions, the infusion, and the results we have seen.
- KEY-01 **Keynote***
Michael R. Clark, MD, MPH, MBA; Steven D. Passik, PhD; Kevin L. Zacharoff, MD, FACIP, FACPE, FAAP
Wednesday/9.7 5:45p – 6:45p Level 4/**Mont-Royal Ballroom**
 *This presentation is not certified for credit.
- MAS-01 **Neurogenic Thoracic Outlet Syndrome**
Allen J. Togut, MD
Tuesday/9.6 9:00a – 11:00a Level 4/**Yaletown 1**
 Neurogenic thoracic outlet syndrome (NTOS) is a chronic neuropathic illness that involves all or part of the brachial plexus. It is predominately a sensory disorder of pain and paresthesias, although it often includes motor dysfunction. Previous trauma(s) create the initial sensory injury of

A-delta and C-fibers. More recent trauma(s) aggravate the previous injury and impact the central nervous system. Not only is motor function impacted, but the traumas may cause radiation of sensory symptoms beyond the original dermatomes and central sensitization (complex regional pain syndrome II). The pain is unrelenting and grinds on the psyche, particularly if the patient hears or even senses "It's all in your head." The patient may lose his/her identity as a wage earner, parent, or spouse. Happiness and self-image are seriously affected. The effective physician needs to know how the illness has impacted the individual's life and how the individual copes. Recommended therapies must be based on a thorough psychosocial assessment as well as a clinical examination. A biopsychosocial approach is crucial in assessing and treating the patient with NTOS. This presentation will concentrate on 5 areas: 1) anatomy and etiology, 2) symptoms, 3) physical and neurological examination, 4) psychosocial, and 5) laboratory testing and management.

MAS-02 **When That Shark Bites: Classic Central Pain Syndromes**

Gary W. Jay, MD, FAAPM, FACFEI

Wednesday/9.7 1:40p – 3:40p

Level 3/**Gracia 5**

During this 2-hour Master Class, participants will learn the pathoetiology of central pain syndromes (CPS). Six specific CPS will be described and clinical aspects will be discussed: multiple sclerosis, Parkinson's disease, phantom limb pain, spinal cord injury, poststroke pain syndrome, and traumatic brain injury. Treatment of an individual CPS as well as the general problem of CPS will be discussed.

MAS-03 **A Caress or a Slap? Understanding Sensory Amplification Systems in Chronic Pain**

Charles E. Argoff, MD, CPE; Daniel Clauw, MD

Thursday/9.8 9:00a – 11:00a

Level 4/**Nolita 1**

Fibromyalgia has frequently been referred to as the most common chronic widespread pain disorder. Many investigators have viewed fibromyalgia as a central nervous system disorder of sensory amplification resulting in many symptoms including chronic pain. Recently, however, others have reported conditions affecting the peripheral nervous system in which chronic widespread pain sensory amplification has been reported. This session will focus on how various mechanisms underlying sensory amplification may be associated with various clinical phenotypes.

MAS-04 **The Mirror Has 2 Faces**

Michael R. Clark, MD, MPH, MBA

Thursday/9.8 1:40p – 3:40p

Level 4/**Nolita 1**

Pain and depression. Depression and pain. Are they the same or do they just "look" the same? Is one the chicken and one the egg? Both terms reflect more than just a single concept. They represent complex constructs that relate to and interact with one another. In order to appreciate all the angles, the practitioner must evaluate the patient from different perspectives. This course will review the formulation of both pain and depression in patients who present suffering from either one or both. The different natures of pain and/or depression as diseases of the body, vulnerabilities of capacities, reinforcements of choices, and outcomes of interpretation will be described. The underlying logics of these natures of suffering will be contrasted with an emphasis on prescribing comprehensive and tailored therapy regimens to promote a patient centered plan for rehabilitation and life satisfaction.

MAS-05 **Differential Diagnosis of Low Back Pain**

David M. Glick, DC, DAAPM, CPE, FASPE

Friday/9.9 1:40p – 3:40p

Level 3/**Gracia 3**

The prevalence of back pain continues in spite of the many treatments available, without any single treatment being a panacea. In routine clinical practice there has been a tendency of clinical examinations to become more cursory, largely influenced by increasing demands of time and arguably an over reliance upon technology. It has been suggested that the failure to adequately differentially diagnose the cause of back pain can account for clinical failures in treatment.

The purpose of this discussion is assist clinician in the development of a more specific problem focused examination that can enhance the differential diagnosis of specific pain generators, and

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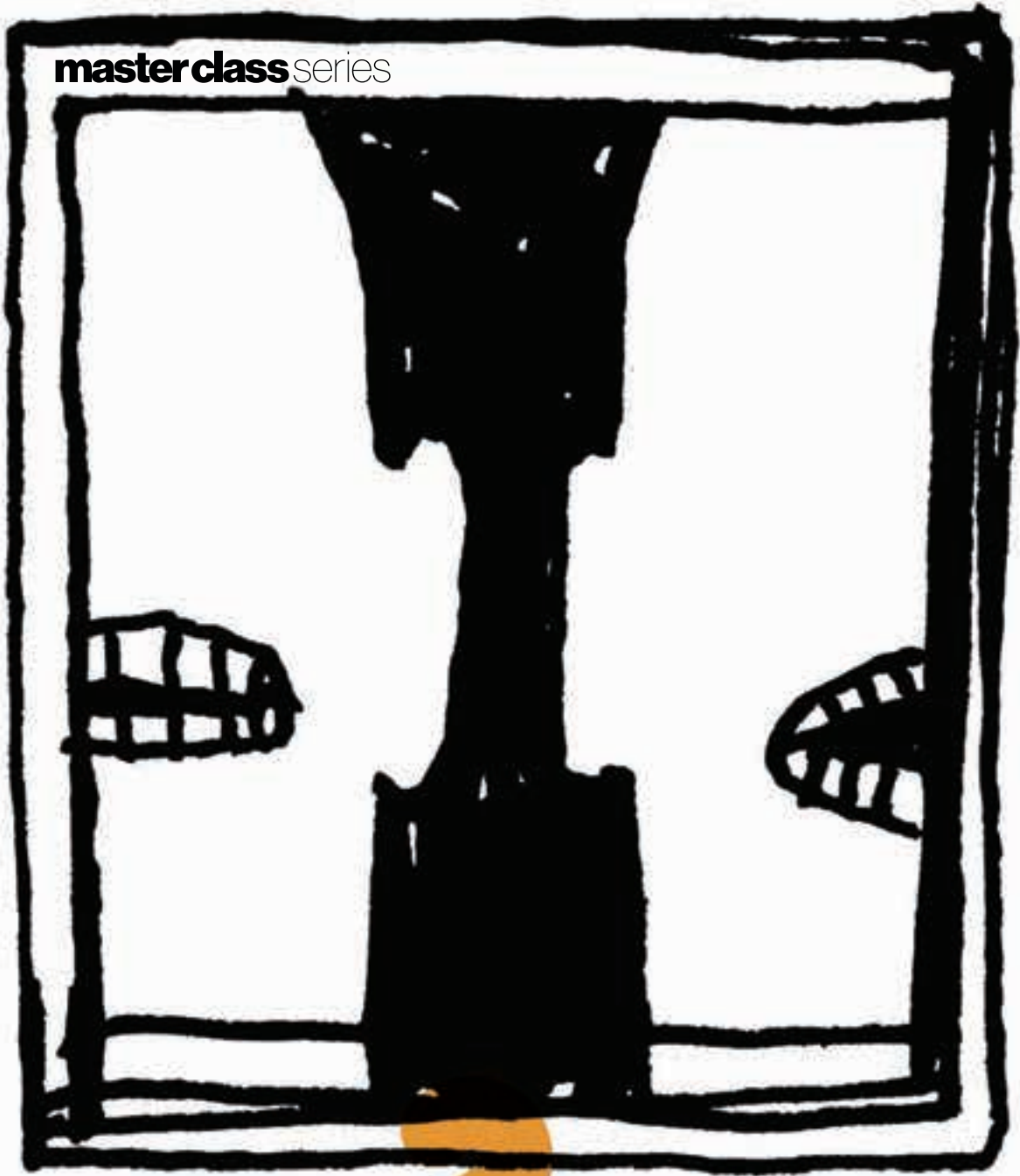
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wednesday september 7

masterclass series



the mirror has **2** faces
faces

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michael clark thursday september 8

therefore lead to more patient specific treatment. Attention will be given to considering all aspects of the examination, including physical assessment as well as imaging studies, and the ability to rationalize when pathologies seen on imaging studies may or may not be clinically significant. The importance of considering how failed treatments influence the differential diagnosis will also be discussed.

MDL-01

Winning the Game of Groans: Strategies and Tactics for Preserving the Pain Practitioner's Decision to Prescribe Controlled Medication

Jennifer Bolen, JD; Douglas L. Gourlay, MD, MSc, FRCPC, FASAM; Ted W. Jones, PhD, CPE; Darren McCoy, FNP-BC, CPE

Tuesday/9.6 9:00a – 12:00p

Level 2/**Condesa 8**

This hands-on workshop will instruct pain practitioners on key self-audit strategies and tactics to demonstrate and document patient evaluation and monitoring when prescribing controlled medication to treat pain. Using a combination of teaching methods, faculty will present not only the “what” of quality patient evaluation and monitoring, but also the “how to” of compliance and documentation strategies. Faculty and attendees will work through extensive case examples and various treatment puzzles to accomplish course objectives. This workshop is conducted by a unique combination of a physician, a nurse practitioner, a clinical psychologist, and a veteran attorney/medical practice consultant. In today’s environment of ever-increasing regulatory scrutiny over controlled medication, pain practitioners need to accurately and completely capture patient history, physical examination, risk evaluation, treatment plan, informed consent, treatment agreement, condition and medication monitoring, and other steps to demonstrate “prescribing for a legitimate medical purpose while acting in the usual course of professional practice.”

Note: This is an application-based activity; registration is limited to 40 learners, and there is a separate registration fee of \$175. Precourse materials will be made available prior to the program.

MDL-02

Embrace 2016 Practice Changes and Patient Education: Overview of Critical Pain Management Practice Issues

Jennifer Bolen, JD

Saturday/9.10 2:40p – 3:30p

Level 4/**Mont-Royal Ballroom**

Every day something new happens in pain management. One day it might be a change in a licensing board practice standards and the next day might bring new legislation on opioid overdose prevention. Whatever the case, pain management practitioners need a system to help keep themselves and their staff current on new prescribing regulations, patient education efforts, and reimbursement challenges. This course will examine critical pain management practice issues and offer practical guidance on staying current, compliant, and focused on providing quality pain relief.

MDL-03

Managing the Risks of Prescribing Controlled Medications

Michael C. Barnes, JD, MIEP

Friday/9.9 10:30a – 11:20a

Level 3/**Gracia 1**

The prescribers of opioid medications for pain and addiction are under heavy scrutiny from state regulators, law enforcement, and plaintiffs’ attorneys. With benzodiazepine related overdose deaths quadrupling between 2001 and 2013, and sedative induced impairment garnering increasing attention in communities, courts, and the media, scrutiny of the prescribing of all classes of controlled prescription medications is rapidly increasing. This session—led by an attorney whose practice focuses heavily on managing the risks of prescribing controlled prescription medications—will set forth best practices to protect patients from harm and providers from criminal and civil liability. The speaker will discuss methods to determine medical necessity, comply with the standard of care, implement safety precautions, and provide adequate documentation in the medical record.

Winter is coming...

Winning the Game of Groans

Strategies
and tactics
for preserving
the pain
practitioner's
decision to
prescribe
controlled
medication



Tuesday
September 6

Jennifer Bolen
Douglas Gourlay
Ted Jones
Darren McCoy

Thursday

September 8



N A D D I

National Association of Drug Diversion Investigators

Charles Cichon Marc Gonzalez Lisa McElhanev

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MDL-04 **Trends in Federal and State Policy and Their Impact on Pain Management**

Michael C. Barnes, JD, MIEP

Saturday/9.10 7:00a – 7:50a

Level 4/Mont-Royal Ballroom

In February 2016, President Obama expressed his compassion for people with pain loud and clear, saying, "If we go to doctors right now and say 'Don't overprescribe' without providing some mechanisms for people in these communities to deal with the pain that they have or the issues that they have, then we're not going to solve the problem, because the pain is real." Nevertheless, governors, members of Congress, and regulators are calling for aggressive government action that poses grave consequences for people with pain and their healthcare providers. The presentation will address the pressing policy issues affecting pain management. Also discussed will be recent federal action, including the CDC's opioid prescribing guidelines, and we'll look ahead to noteworthy federal and state level proposals. This course will examine the likely impact of legislation and regulations, looking at the current status, and predicted benefits, drawbacks, and unintended consequences of such efforts on the clinical management of pain.

NAD-01 **Hippocratic Oath:
Does My Healthcare Provider Have My Best Interest at Heart?**

Lisa M. McElhaney, BS

Thursday/9.8 7:00a – 7:50a

Level 4/Mont-Royal Ballroom

Moral, muddled, or malevolent? The United States life expectancy is currently 78.4 years, which means you mostly will be treated by a healthcare provider a bare minimum of 78 times throughout your lifetime. The unthought of challenge that individuals face: Does my healthcare provider have my best interest at heart? This presentation will reveal a number of actual case scenarios of healthcare providers who chose to ignore the ethics of the Hippocratic Oath. What were they thinking? The fallout from their actions varies from one victim to hundreds. See what their patients did not see. Instructor Lisa McElhaney is the National President of the National Association of Drug Diversion Investigators (NADDI) and a retired law enforcement officer who presents a fact filled lecture on the evils that lurk within the healthcare industry.

NAD-02 **Pain Management Investigative Diaries**

Marc S. Gonzalez, PharmD

Thursday/9.8 10:30a – 11:20a

Level 3/Gracia 1

This course will describe actual pain management investigations where prescribers knew or should have known that their prescribing would lead to significant diversion of drugs on the street. Cases will elucidate the 4 Ds—Dated, Duped, Dishonest, and Dumb. Prescribing for money, guns, street drugs, and sex has also resulted in the deaths of some of the prescriber's patients. The long-term effects of a rogue prescriber on a community at large and within the healthcare community as a result of these cases will be described. Methods to best curtail these behaviors to prevent the "chilling effect" on legitimate prescribers and their patients will be provided. Tools for empowering the prescribers and dispensers to know what their roles can be in preventing diversion in their communities will complete this course.

NAD-03 **Common Sense, Education, and Ethics—
The Foundation of a Good Medical Practice**

Lisa M. McElhaney, BS

Thursday/9.8 2:40p – 3:30p

Level 3/Gracia 1

"Oh no! Why are the police looking at me?" Conquer the fear of a potential civil or criminal investigation! Half the battle of keeping investigators away from the door of your medical practice is developing performance skills, self-confidence, and improving the foundation of your medical practice. In similar fashion, common sense should be applied in all aspects of your healthcare operations. Medical ethics can no longer be counted on to always provide a security blanket. Each provider must take personal responsibility for their own business and medical decisions, or suffer the consequences. Instructor Lisa McElhaney is the National President of the National Association of Drug Diversion Investigators (NADDI) and a retired law enforcement officer who presents a passionate lecture on the simple steps that every healthcare facility should implement as a prevention practice to keep their workplace less vulnerable, inside and out.

NAD-04 **Addiction: Drug Use Despite the Adverse Consequences**

Marc S. Gonzalez, PharmD

Thursday/9.8 4:40p – 5:30p

Level 3/Gracia 1

This session will describe the expanded definition of addiction, the process and daily symptoms of the disease, the distortion of cognition caused by craving, and the consequences of using. We will define the drug-specific circuits of the brain and its response to overstimulation of pleasure, sedation, and stimulation that stop working without the drug. Areas of the brain that are affected will be identified and described. When an addict stops using, it leads directly to boredom, anxiety, depression, and loss of energy because their brains have neuroadapted. This leads to a reward/pleasure system that assigns value to sensations, emotions, and thoughts, which sets the level of alertness/awareness/interest in the forebrain, regulating executive functions. Case examples of well known addicts will reinforce the mechanisms described based on their specific behaviors and ultimate demise.

NAD-05 **Abuse Deterrent Formulations: A Law Enforcement Perspective**

Charles F. Cichon

Thursday/9.8 5:40p – 6:30p

Level 4/Mont-Royal Ballroom

While the first generation of abuse deterrent formulations have reduced diversion, any advances in this technology that would further erode the street value of opioids and maintain access to the individuals who benefit from their relief would be welcomed. This presentation focuses on one Florida county from 2010 to 2015, including law enforcement oxycodone seizures; medical examiner oxycodone cause of death reports; NADDI members survey; pharmacy robberies; FDA actions; and abuse deterrent opioids and types of technology. While ADFs are not a guarantee that a dedicated abuser cannot tamper with the intended delivery mechanism and dose, making it more difficult may dissuade many from trying.

NRO-01 **Tea Party of the Damned**

Gary W. Jay, MD, FAAPM, FACFEI

Friday/9.9 10:30a – 11:20a

Level 3/Gracia 5

During this session, we will discuss migraine, specifically migraine with aura. Types of migrainous auras will be shown, and we will “deep dive” into the Alice in Wonderland Syndrome, a very specific and rare migrainous aura. Also to be discussed: evidence based medicine treatments to abort migraines and prevent them; how migraine with aura affects the output of creative individuals such as painters; and celebrities who experience(d) migraine.

NRO-02 **Diagnosis and Treatment of Centralized Pain and Neuroinflammation**

Forest Tennant, MD, DrPH, FACPM, MPH

Friday/9.9 1:40p – 2:30p

Level 4/Nolita 1

Chronic pain may centralize in the spinal cord and brain leaving the patient with constant, neuropathic pain. The mechanism of this development is microglial activation and neuroinflammation. Successful treatment usually requires a special pharmacologic regimen that includes analgesics, neuropathic agents, and agents which reduce neuroinflammation.

NRO-03 **Small Fiber Polyneuropathy: An Update**

Charles E. Argoff, MD, CPE

Friday/9.9 4:40p – 5:30p

Level 4/Nolita 1

Approximately 40 million people in the United States suffer from peripheral neuropathy and a growing subset of those appear to suffer from small fiber neuropathy. This presentation will review the causes and symptoms of small fiber neuropathy, a grossly underappreciated painful disorder that frequently is manifested by chronic widespread pain. Symptoms—burning and shooting pain, allodynia, and hyperesthesia—may result from myriad diseases, including diabetes, thyroid dysfunction, sarcoidosis, vitamin B12 deficiency, HIV, and neurotoxic medications, among others; however, often no specific cause is determined. Data about treatment specifically for small fiber

NEUROLOGY

Charles Argoff
Gary Jay
Forest Tennant

Friday
September 9



neuropathy remain sparse. Recent guidelines propose using antidepressants, anticonvulsants, opioids, topical therapies, and nonpharmacologic treatments. History and physical examination are primarily used to diagnose this condition. Functional neurophysiologic testing and intraepidermal nerve fiber density evaluation using skin biopsy should also be used to confirm the diagnosis, as many patients are misdiagnosed as having fibromyalgia and continue to experience pain. For up to 50% of patients, the diagnosis may, however, remain “idiopathic.” In this course, emphasis will be placed on determining the underlying etiology so that treatment can be tailored as much as possible, including management of associated neuropathic pain.

NRO-04 **Arachnoiditis: Diagnosis and Treatment**

Forest Tennant, MD, DrPH, FACPM, MPH

Friday/9.9 5:40p – 6:30p

Level 4/**Nolita 2**

Arachnoiditis is officially listed as a rare disease, but its estimated incidence has increased over about 400% in the past decade. Almost every pain practice has now encountered a case. Technically, the name implies an inflammatory disease of the arachnoid layer of the thecal sac or meninges. In most cases the underlying pathologic cause is neuroinflammation of the nerve roots of the cauda equina. Pain practitioners need to know the inciting causes, symptoms, physical signs, and MRI findings of arachnoiditis. A clinical protocol for treatment of this “most painful” of pain states has been developed and will be presented.

PAL-01 **What’s Your Preference...Up Your Butt? Under Your Tongue? Or Through Your Skin?**

Rabia Atayee, PharmD; Cara Brock, PharmD, CGP

Saturday/9.10 7:00a – 7:50a

Level 4/**Nolita 2**

Step right up and receive all the updates on alternative routes of administration to the oral and intravenous route. In this lively session the pharmacology of rectal, sublingual, topical, and subcutaneous routes of opioid therapy in the setting of palliative care will be discussed. For each alternative route, the burden-to-benefit ratio and the role of the palliative care pharmacist will be discussed.

PAL-02 **Speed Dating With the Pharmacy Ladies: Pain Management and Palliative Care**

Mary Lynn McPherson, PharmD, MA, BCPS, CPE; Kathryn A. Walker, PharmD, BCPS, CPE

Saturday/9.10 10:30a – 11:20a

Level 4/**Mont-Royal Ballroom**

Complex medication decisions are an integral part of treating patients with pain and palliative care. Pharmacists have a unique perspective on using these medications creatively and effectively. This session will flirt with tips and tricks on using medications appropriately for patients with chronic pain and those facing advanced diseases. Whether debriding a medication profile, aggressively treating symptoms, or strategizing a dosage formulation, it can be hard to commit to medication decisions. Two pharmacists will “speed date” their way through medication tips designed to impart highly important and little known medication facts that are important in pain management and palliative care practice.

PAL-03 **New Drugs in Pain Management and Palliative Care**

Rabia Atayee, PharmD; Mary Lynn McPherson, PharmD, MA, BCPS, CPE

Saturday/9.10 1:40p – 2:30p

Level 4/**Nolita 1**

Up to 100 new drugs and dosage formulations are approved every year by the Food and Drug Administration. Some of these are new molecular entities, while others are new formulations, new indications, generic drug approvals, or labeling revisions. Participants in this fast paced session will learn about new medications approved in 2015/2016 and their usefulness in treating pain and symptoms associated with advanced illness. Specifically, participants will learn the indication, any off-label uses, if the medication is a controlled substance, adverse effects, major drug interactions, dosing, clinical pearls, and financial implications. This is a MUST session for all practitioners who wish to remain cutting edge and prepared for questions from patients and other practitioners concerning new medications.

howard heit douglas gourlay

friday september 9



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TRAIN WRECK

addressing complex pharmacotherapy with the inherited pain patient

To Infinity and Beyond: Safe and Effective Opioid Titration Strategies*Mary Lynn McPherson, PharmD, MA, BCPS, CPE; Kathryn A. Walker, PharmD, BCPS, CPE***Saturday/9.10 3:40p – 4:30p**Level 4/**Nolita 2**

Opioids are the most powerful tool we have in our arsenal for the management of moderate to severe pain, yet great care and attention to detail in dosing is necessary to prevent patient suffering and death. This presentation is a “boots on the ground” approach to selecting, dosing, titrating, and converting bolus doses and basal infusions of opioids. Inappropriate determining and titrating basal infusion doses of opioids, especially for patients with an advanced illness, is a leading cause of opioid induced death. Practitioners often write inappropriate orders such as “titrate to comfort” with no regard for the pharmacokinetic parameters of specific opioids, which can result in “dose stacking” and often fatality. This presentation will cover how to calculate an appropriate starting infusion dose of an opioid, how to titrate the basal dose, including how quickly you can titrate, and the magnitude of the increase, and how to write the order correctly. Participants will also learn about the importance of a clinician bolus, including what it is, when it should be administered, how to determine the dose, the pharmacokinetic explanation of the clinician bolus, and how to use administration data to further guide dosing. The final portion of this amazing program will include guidance on switching from a parenteral basal/bolus opioid regimen to an alternate regimen including different opioids and different routes of administration. Every palliative care prescriber should attend this presentation!

You’re in Control or Urine Control: Clinical Pearls of Drug Testing Case Studies*Jeffrey Fudin, BS, PharmD, FCCP***Friday/9.9 7:00a – 7:50a**Level 3/**Gracia 3**

The science of drug testing in chronic pain has advanced rapidly over the past few years. Yet there is still confusion around optimal test choices, frequencies, and what test results actually provide. Today’s definitive drug testing technology can help to identify more than the simple “presence or absence” of drugs, such as possible drug-drug interactions, variations in individual metabolism that could impact medication efficacy or side effects, potential genetic variations in metabolism, and more. This case based session will focus on patient centered, guideline driven drug testing, and medical necessity documentation to support definitive drug testing. Attendees will participate and help to complete case studies with practical clinical resources that can be immediately incorporated into their practice setting.

Trainwreck: Addressing Complex Pharmacotherapy With the Inherited Pain Patient*Douglas L. Gourlay, MD, MSc, FRCPC, FASAM; Howard A. Heit, MD, FACP, FASAM***Friday/9.9 10:30a – 11:50a**Level 3/**Gracia 3**

The prescription drug problem in America has led to many guidelines and, in some cases, regulations aimed at stemming the tide of prescription drug abuse. Some are evidence based, but most are driven by fear and an overwhelming need to do “something.” Unfortunately, while these guidelines have offered suggestions of how to apply this information in a clinical context going forward, they provide little information as to the management of those patients who already exceed these current guidelines. This is where the concept of the “inherited patient” comes into play. Some of these patients are doing well while some are doing quite poorly. The undeniable fact is that as these guidelines are being exceeded, risk of a bad outcome increases while likelihood of achieving therapeutic goals decreases. This workshop will, through the use of representative cases, help participants to recognize irrational pharmacotherapy and, when necessary, address it through a combination of pharmacological as well as biopsychosocial frameworks.

Nonpharmacologic Management of Chronic Pain*Mel Pohl, MD***Friday/9.9 2:40p – 3:30p**Level 3/**Gracia 5**

Despite the increase in prescriptions of pain medication and interventional procedures to treat pain, there is scant evidence from population based research that these treatments have been successful in reducing pain associated functional impairment. This is because successful treatment

the
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pain
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presents

pain educators forum

sondra adkinson
michael clark
david glick
ted jones
mary lynn mcpherson
anna ratka
kathryn schopmeyer

wednesday/thursday
september 7–8



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of chronic pain requires a comprehensive approach that should include self-care, psychological, psychosocial, functional restorative, and alternative integrative approaches to complement medical treatments.

PEF-01

Pain Terminology: Knowing the Difference Makes a Difference!

David M. Glick, DC, DAAPM, CPE, FASPE; Mary Lynn McPherson, PharmD, MA, BCPS, CPE

Wednesday/9.7 7:00a – 7:50a

Level 3/**Gracia 3**

The Pain Educators Forum presents this course because there are so many different levels of practitioner experience with pain management. Specifically, inspiration came from someone who, after attending one of our courses, had a burning question for our faculty: "What do sodium channels have to do with pain?" Yikes!!! After attending this humorous, informative course you will definitely know the difference between paresthesia and dysesthesia, allodynia and hyperalgesia, and how sodium channels confer excitability on neurons in nociceptive pathways. In sum, you will be a fierce and worthy contestant on *Jeopardy!*

PEF-02

Pain Pathophysiology Unraveled

David M. Glick, DC, DAAPM, CPE, FASPE

Wednesday/9.7 9:00a – 9:50a

Level 3/**Gracia 3**

In order to successfully clinically manage pain, it is essential to begin with an understanding of the underlying mechanisms responsible for its generation. A skillful approach based upon better knowledge concerning the anatomical structures, pathways, and events that result in pain is more likely to lead to effective clinical management of pain. The discussion will include an overview of medication classes typically considered for pain and the pathways they affect.

PEF-03

Chronic Pain Assessment

Michael R. Clark, MD, MPH, MBA

Wednesday/9.7 10:30a – 11:20a

Level 3/**Gracia 3**

Effective clinical interviewing and pain assessment are critical to the appropriate diagnosis and management of pain. In this presentation, the clinician learns how to apply principles of effective communication and also ascertain how to evaluate available assessment tools.

PEF-04

Pain Therapeutics

Anna Ratka, PhD, PharmD, CPE

Wednesday/9.7 1:40p – 3:40p

Level 3/**Gracia 3**

Therapy of pain is a challenge and requires special approaches. This course, as part of the Pain Educators Forum, will build on information provided in other sessions and focus on the prevalence and impact of unrelieved pain, pathogenesis, and treatments of pain. Participants will learn about approaches and advances in therapy of common acute and chronic pain syndromes. Evidence based recommendations for pharmacotherapy of pain will be provided. Pain therapeutics will examine current trends in pain relief that can be implemented into practice.

PEF-05

Pain Diagnostics: Clinical Pearls to Improve Common Tests for Pain

David M. Glick, DC, DAAPM, CPE, FASPE

Wednesday/9.7 4:40p – 5:30p

Level 3/**Gracia 3**

Diagnostic testing is an integral component for the differential diagnosis. In routine clinical practice there has been a tendency for clinical examinations to become more cursory, largely influenced by increasing demands of time and patient expectations of technological advances. The end result may arguably lead to an overreliance on technology for basic clinical diagnosis. The purpose of this session is 2-fold. It is meant to provide a review and, for some, an introduction to basic structural and functional studies used for the diagnosis of pain related problems. Attention will also be given to the limitations of such studies and the importance of establishing clinical relevance to their findings. Factors that adversely affect clinical management potentially resulting in failed treatment will be discussed as well as best practices when utilizing such studies to help enhance clinical outcomes for treatment.

ain't misbehavin'

decreasing and managing pain patient aberrant behavior



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thursday
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ted jones

PEF-06

The Neuroscience Behind Pain Education*Kathryn A. Schopmeyer, PT, DPT, CPE***Thursday/9.8 7:00a – 7:50a**Level 3/**Gracia 5**

Pain science education has gained international praise as an underutilized clinical intervention for treating pain. Research supports teaching patients about pain using a neurophysiology framework, rather than explaining pain in biomedical or biomechanical terms. To “explain pain, not anatomy” is easier said than done. This course provides arguments for utilizing this type of education in the clinic and simplifies talking points to help busy clinicians feel more confident when teaching patients about pain.

PEF-07

Ain’t Misbehavin’: Decreasing and Managing Pain Patient Aberrant Behavior*Ted W. Jones, PhD, CPE***Thursday/9.8 9:00a – 9:50a**Level 3/**Gracia 5**

Practitioners routinely wrestle with the issue of medication aberrant behavior (MAB)—What should I do about this? Should I discharge the patient? Will I get in trouble if I don’t discharge this patient? Often there is no one right answer, and practitioners struggle with what to do in the face of a failed drug screen or some other evidence of MAB. This session will help prescribers decrease and prevent MAB in their practice as well as be more comfortable making clinical decisions when faced with MAB. The session will address such issues as universal precautions, assessing risk of MAB, clinical decision-making with regards to MAB, and deciding when to discontinue opioids. The session is designed to move practitioners from a simple “I’ll discharge anyone who does anything wrong” to a more balanced and clinically sound decision-making practice.

PEF-08

Meducating Pain Professionals: Interprofessional Education in Pain Management*Sondra M. Adkinson, PharmD, DAAPM, CPE, BSpH; Mary Lynn McPherson, PharmD, MA, BCPS, CPE***Thursday/9.8 1:40p – 2:30p**Level 3/**Gracia 5**

In clinical practice today, more often than not patients receive care from an interprofessional team. How can we best prepare students and practitioners to optimize working in an interprofessional environment? This presentation will review the definition of interprofessional education, what is meant and NOT meant by this definition, what evidence supports IPE practice and education, and proposed competencies. Strategies useful for developing and implementing an interprofessional education program will be reviewed, using a hands-on, interprofessional approach!

PEF-09

The Five Coping Skills That Every Patient Needs*Ted W. Jones, PhD, CPE***Thursday/9.8 5:40p – 6:30p**Level 3/**Gracia 5**

This session will teach participants the 5 core pain coping skills that all pain patients need: understanding, believing, calming, balancing, and coping. By knowing these skills providers will have a better idea of how they can plan treatment and intervene with patients more effectively. Participants will also learn how they can teach these skills to patients in individual sessions or in a group setting. By learning these core skills and simple ways to teach them to patients, providers can add to their treatment armamentarium in helping patients deal with their pain.

PHM-01

A Gathering Storm: Are Perioperative Opioids Problematic?*Michael M. Bottros, MD***Friday/9.9 7:00a – 7:50a**Level 3/**Gracia 1**

The United States is in the midst of a prescription drug crisis. Each year, over 100 million surgical procedures are performed in the US and routinely opioid use is prescribed for postoperative pain. While the recent CDC guidelines are geared towards outpatient chronic pain management, few concerns have been directed toward the postoperative setting as a potential source of this problem. In this lecture, we will examine the current opioid problem and the evidence suggesting that we should rethink how to care for these patients postoperatively.

A collage of images on a black background. At the top, a dark, stormy sky with white clouds. Below it, a hand holding a lit cigarette, with a trail of white dots behind it. In the center, a large, bright red question mark. Below the question mark, a surgical instrument, possibly a stapler, with a small white circle on its handle. The text 'Are perioperative opioids problematic?' is centered over the question mark.

Are perioperative opioids problematic?

d.fossá 16

Michael Bottros

A Gathering Storm

Friday September 9

PHM-02

The Constipation Sensation That's Sweeping the Nation: Management of Opioid Induced Constipation

Mary Lynn McPherson, PharmD, MA, BCPS, CPE

Friday/9.9 9:00a – 9:50a

Level 3/**Gracia 1**

Opioid therapy fairly predictably causes constipation, which can be a great source of distress for patients. Defined as a reduction in bowel movement frequency and increased straining, this adverse effect is so common that good practice dictates preventive therapies, not waiting to see if it develops. We will cover the pathogenesis of opioid induced constipation, mechanisms of action of common and newer laxatives, including the PAMORAs (peripherally acting mu opioid antagonists). This presentation promises to be a “moving” experience!

PHM-03

Opioid Conversion Calculations

Mary Lynn McPherson, PharmD, MA, BCPS, CPE

Friday/9.9 2:40p – 3:30p

Level 3/**Gracia 1**

Many patients receiving opioids will need to be switched from one opioid to another during therapy or at least from one dosage formulation or route of administration to another. During this session, practitioners learn to recognize clinical situations in which opioid switching would be appropriate. Attendees will also work on a problem set designed to sharpen their skills in opioid conversion calculation.

PHM-04

Minimizing Pills and Maximizing Skills: Achieving Successful Opioid Cessation in Chronic Pain

Jennifer M. Hah, MD, MS; Ravi Prasad, PhD

Friday/9.9 5:40p – 6:30p

Level 3/**Gracia 1**

Although long regarded as an appropriate standard of care for treating acute and cancer pain, the use of prescription opioids to treat chronic benign pain conditions has been highly controversial. The lack of empirical support in conjunction with the increased prevalence of prescription opioid abuse has subsequently led professional and regulatory boards, as well as the general public, to become more critical of physician prescribing practices. As a result, patients who were once prescribed high doses of opioid medication are now being told that they need to reduce or eliminate their reliance on this form of treatment. How can individuals successfully eliminate use of a substance that they have relied on for an extended period of time? A pain physician will review current literature related to the use of opioids and will discuss the medical challenges associated with weaning individuals off of this class of drug. A psychologist will then speak about the role of interdisciplinary treatment programs in facilitating opioid cessation while concurrently improving patients' functional outcomes. Emphasis will be placed on the critical role that psychological and behavioral interventions play in this process, and the evidence which supports their inclusion.

PHM-05

Methadone and Marijuana: What's New and What's Not

Mary Lynn McPherson, PharmD, MA, BCPS, CPE; Kathryn A. Walker, PharmD, BCPS, CPE

Saturday/9.10 9:00a – 9:50a

Level 4/**Mont-Royal Ballroom**

Methadone is a very useful opioid that indisputably requires careful attention to dosing and monitoring. In this fast paced presentation, participants will learn about the American Pain Society guidelines for the safe and effective use of methadone and how those guidelines should be applied for patients with an advanced illness. Using a case based approach, participants will explore methadone dosing in opioid naïve and opioid tolerant patients, how to adjust a calculated dose based on patient related variables (eg, comorbid conditions, concurrent drug therapy), and how to use methadone in an adjunctive role. As if that weren't controversial enough, participants will also learn about medical cannabis, including its proposed indications, mechanism of action, adverse effects, and role in management of patients with chronic noncancer pain or an advanced illness. Methadone and marijuana—all you need now is potato chips!

Not *for* Human Consumption



Abigail **Brooks**
Courtney **Kominek**

Saturday **September 10**

new drugs of abuse and their detection

PHM-06

Nonopioid Analgesics: Antidepressants, Adjuvant Therapies, and Muscle Relaxants

Kathryn A. Walker, PharmD, BCPS, CPE

Saturday/9.10 1:40p – 2:30p

Level 4/**Mont-Royal Ballroom**

Nonopioid analgesics are oftentimes considered first-line therapy for most chronic pain syndromes. A strong understanding of these agents' mechanism of action, pharmacokinetics, and toxicity profiles is paramount for today's pain practitioner. This course will provide an in-depth look at each of the agents within these drug classes, their potential role in pain management, and available data supporting their use. Additionally, clinically relevant monitoring pearls will be discussed.

PHM-07

Not for Human Consumption: New Drugs of Abuse and Their Detection

Abigail T. Brooks, PharmD, BCPS; Courtney M. Kominek, PharmD, BCPS, CPE

Saturday/9.10 3:40p – 4:30p

Level 4/**Nolita 3**

Designer drugs are structurally related to illegal psychoactive drugs and include cathinones (bath salts and flakka), synthetic cannabinoids (K2), piperazines (Molly), salvia, kratom, and desomorphine (krokodil). Often designer drugs are readily available on the Internet or in head shops and skirt regulation through the development of novel analogs and labeling the products "not for human consumption." These novel psychoactive substances are consumed typically by younger males via various routes and modes for their desirable effects; however, undesirable and even life-threatening reactions or death may occur. Additionally, designer drugs are often coingested with other psychoactive substances and may be metabolized through cytochrome P450 pathways leading to drug-drug interactions furthering the potential for harm. Management is normally with supportive measures and symptomatic care. Unfortunately, most of these agents are challenging to detect as they are not readily identified by immunoassay urine drug testing, though some may lead to false positives. More advanced testing with liquid or gas chromatography/mass spectroscopy is able to detect designer drugs but is limited due to its availability, cost, delay in results, and the ever-changing designer drug structures.

POP-01

14 Miles From Wisdom: Things I Learned By Accident

Becky L. Curtis, PCC

Tuesday/9.6 11:30a – 12:00p

Level 4/**Mont-Royal Ballroom**

In an instant, a rollover car accident left me partially paralyzed from the neck down and in constant burning nerve pain. I began a fateful journey into the personal realities and facts of chronic pain. In my quest for a cure I discovered that the best solutions for chronic pain are not surgeries, pills, or other passive therapies. What I learned by accident is that pain is an experience of the brain. And chronic pain is an experience that has been memorized and continually repeated to such an extent that it has overtaken the lives of over 116 million people in the United States alone. Presenting evidence based modalities I used to retrain my brain and decrease my chronic pain, I will show how brain research provides wisdom for communicating with patients. Words spoken inspire thoughts, thoughts impact emotions, and emotions define the pain experience. Learn how words either emphasize the negative aspects of a condition or focus on positive options and attitudes. Hear through the ears of a pain patient as I describe the power words have had in my own experience and in the recovery of people I coach every day.

POP-02

The Unstable Argument for Core Stabilization

Kathryn A. Schopmeyer, PT, DPT, CPE

Tuesday/9.6 11:30a – 12:00p

Level 4/**Nolita 1**

A common practice for treating chronic back pain includes core stabilization. There is strongly held belief in health care and fitness that back pain is related to the strength of core muscles. Where did this belief originate? Why is it so popular? What is the evidence supporting widespread use of this approach? This short course will explore the history of core stabilization and the current evidence that may change your opinion of this popular treatment approach.

POP-03

Aches, Pains, and Secondary Gains*Dawn C. Buse, PhD***Wednesday/9.7 11:30a – 12:00p**Level 4/**Mont-Royal Ballroom**

All types of healthcare professionals may encounter challenges and obstacles to patient outcomes despite providing optimized treatment plans and state-of-the-art care. These obstacles may come from a variety of barriers including the existence of secondary gains, low patient motivation, misalignment of goals, and miscommunication. This course will discuss secondary gains and define and provide examples of empirically supported clinical pearls to improving outcomes. We will discuss the use of motivational interviewing techniques to match treatment to patient readiness to change; a research review of medical communication and pearls to improve communication; the use of strategies to improve patient adherence and self-efficacy; and the encouragement of an internal locus of control. In addition to improving outcomes, these strategies are proven to reduce negative provider outcomes including burn-out, negative feedback, and legal issues such as malpractice. The strategies reviewed will lead to improved satisfaction for patients and providers alike.

POP-04

Clinical Conundrum: Catch-22 (Encore)*Gary W. Jay, MD, FAAPM, FACFEI***Wednesday/9.7 11:30a – 12:00p**Level 3/**Gracia 3**

We will discuss the difficulties in diagnosing and treating a patient with a significant neurological entity who develops a "Catch-22." This Catch-22 may prevent appropriate testing and therefore impede finding the correct diagnosis and treatment.

POP-05

**Here, There, and Everywhere:
Linking into Social Media for Pain Practitioners** (Part 1)*Barbara L. Kornblau, JD, OTR/L, CPE, DASPE***Thursday/9.8 11:30a – 12:00p**Level 3/**Gracia 1**

Social media presents many opportunities for pain practitioners to keep up with the pulse of what is happening in pain practice and pain policy. Thought leaders share valuable information via social media, and social media is one way patients obtain and share information about pain. This session looks at the use of social media in pain practice, discusses various vehicles of social media and how each can be used in pain practice, examines the benefits of social media for pain practitioners along with the potential pitfalls that social media may present. In short, this course will provide a road map to help navigate the benefits, burdens, and policies of social media for pain practitioners.

See POP-07 for Part 2.

POP-06

Risk Tool to Qualify Patients for Take-Home Naloxone*Jeffrey Fudin, BS, PharmD, FCCP***Thursday/9.8 11:30a – 12:00p**Level 3/**Gracia 3**

There are over 16,000 deaths per year associated with opioid induced respiratory depression and overdose. These occur in the substance abuse population and also in chronic pain patients who are legitimately receiving opioids. This interactive lecture will review unexpected and unanticipated risks of opioid therapy, including drug interactions that are not generally included in pharmacy software programs. Opportunities for collaboration between healthcare providers will be discussed, including current comparative state policies for naloxone standing orders, standardized procedures, and clinical documentation. Available software to assess risk and the validated RIOSORD tool—risk index for overdose or serious opioid induced respiratory depression—will be introduced to participants with an explanation of how they can be implemented by all clinicians to qualify patients for in-home naloxone. Attendees will leave with a foundation on how to best counsel patients and caregivers to mitigate against opioid induced risks in terms of preparedness for naloxone reversal in the home.

POP-07

Here, There, and Everywhere: Linking into Social Media for Pain Practitioners (Part 2)

Barbara L. Kornblau, JD, OTR/L, CPE, DASPE

Friday/9.9 11:30a – 12:00p

Level 3/**Gracia 1**

See POP-05 for course description.

POP-08

The Science of Mindful Meditation

Sean Fargo

Friday/9.9 11:30a – 12:00p

Level 3/**Mont-Royal Ballroom**

This presentation will examine the uses and benefits of adopting mindfulness therapies within the scope of a comprehensive treatment plan. For people with persistent pain, practicing mindfulness meditation can be helpful, with moderate effects seen in reducing pain intensity. Compared to normal medical care for pain, meditation also seems to improve other important aspects of life, such as depression, coping ability, quality of life and sleep, acceptance, and physical functioning. Compared to people who do not meditate, people with acute or short term pain who have had meditation training report less distress and more pain tolerance in the research laboratory. This presentation will define mindfulness and meditation, offer a guided practice addressing pain symptoms, and provide an overview of multimodal management of mindfulness therapy. Only secular, nonreligious forms of mindfulness will be discussed.

POP-09

Words That Do No Harm: The Unintended Nocebo Effect of Biochemical Language in Patient-Provider Interactions

Kathryn A. Schopmeyer, PT, DPT, CPE

Saturday/9.10 11:30a – 12:00p

Level 4/**Mont-Royal Ballroom**

Using “the right language” to trigger positive physiological responses in patients is a well-established practice based on robust placebo research. The nocebo effect is less studied but should be considered in pain care. Healthcare providers and educators try to help patients understand their painful conditions by describing anatomy or diagnosing common ailments like arthritis, impingement syndrome, or bulging discs. This approach can result in an unintended nocebo effect of increasing anxiety and fear-avoidance behavior. This pop-up course will highlight clinically relevant research focused on language commonly used in the clinic to explain pain from a biomechanical perspective and will outline the pitfalls of this approach. Learners will be presented with alternative word choices to create a therapeutic context.

POP-10

Taking the Road Less Traveled: Meeting Pain Patients Where They Are and Moving Forward Together

Barbara L. Kornblau, JD, OTR/L, CPE, DASPE

Saturday/9.10 11:30a – 12:00p

Level 4/**Nolita 1**

Leonard Kish called patient engagement the wonder drug of the 21st century. The Affordable Care Act requires it, and the evidence shows that people engaged in their own care, including those with chronic pain, experience improved health outcomes, lower costs, improved patient care, and decreased medical errors. Engaged individuals with chronic conditions are also more likely to adhere to treatment regimens. This session looks at the evidence that supports the benefits of patient engagement and the barriers pain patients often face. It provides specific strategies for pain practitioners to meet the need for increased patient engagement among pain patients. This session provides practical information about shared decision-making and tools for implementation. It provides suggested vehicles to encourage the provider and the pain patient to move forward together.

POP-11

Virtual Reality and Chronic Pain: The Future has Arrived

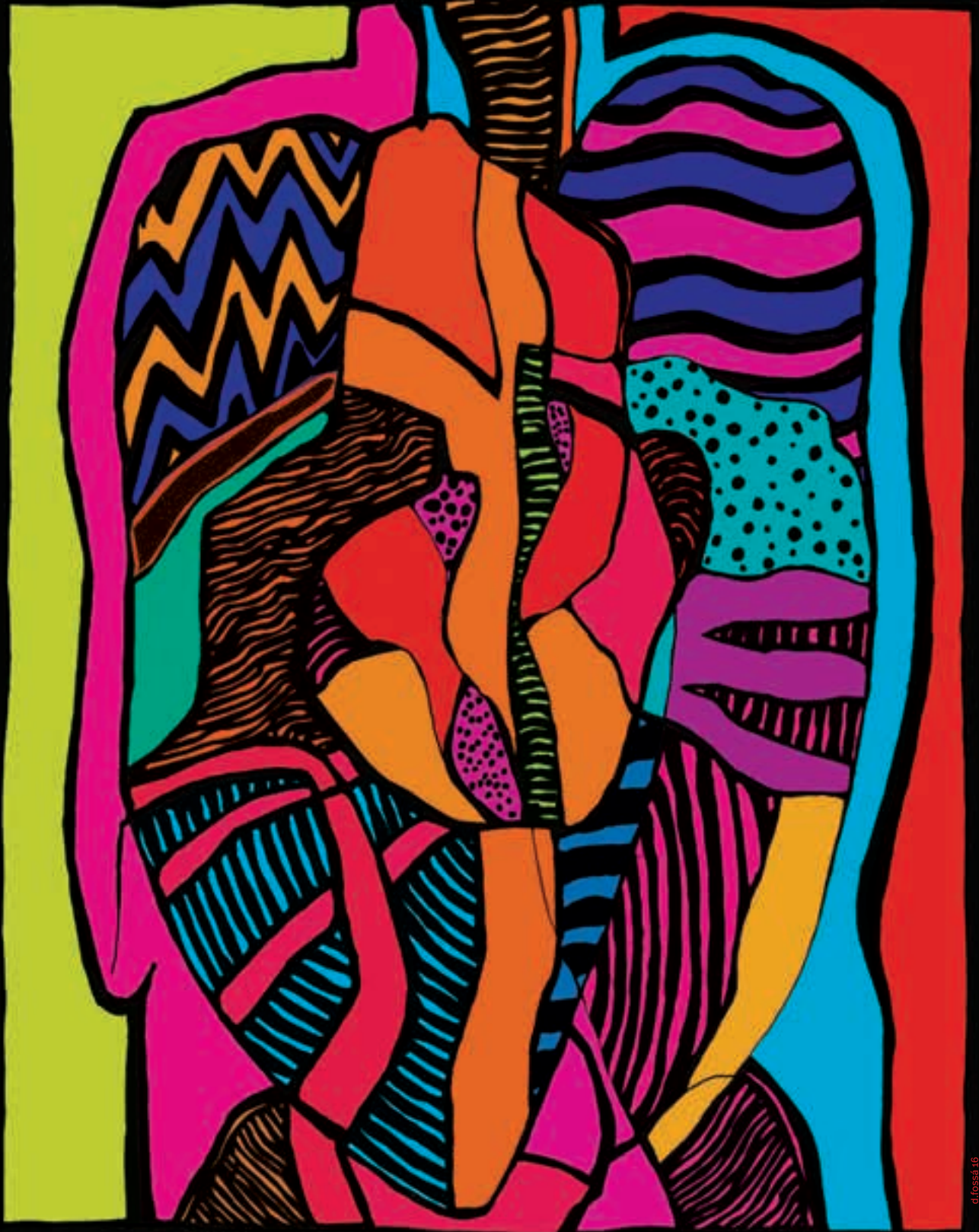
Ted W. Jones, PhD, CPE

Saturday/9.10 11:30a – 12:00p

Level 4/**Mont-Royal Ballroom**

Virtual reality (VR) has been used as a pain treatment technique in some settings for decades. However, the cost of the technology has traditionally been out of reach for almost all practitioners.

A cerebro-cosmic, interplanetary voyage through the pathogenesis and symptom analysis of pain



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Neuropathica Galactica

Sondra Adkinson Mary Lynn McPherson

Tuesday September 6

This has changed in the last year as the hardware has become affordable and the possibility of using VR in the treatment of pain in additional settings is now a possibility. This session will review the existing literature on the use of VR for pain. Then we will present the results of a recent clinical trial in the use of VR for chronic pain conditions. Finally, we will review some of the hardware and software options now available, and discuss the emerging options for frontline practitioners to help patients deal with pain without opioids.

POS-01 **Scientific Poster Session and Reception***

Co-Chairs: Srinivas Nalamachu, MD; Joseph V. Pergolizzi, MD
Christopher G. Gharibo, MD; Robert B. Raffa, PhD; Kevin L. Zacharoff, MD, FACIP, FACPE, FAAP

Thursday/9.8 6:30p – 8:30p

Level 3/**Gracia 7**

**This presentation is not certified for credit.*

POS-02 **Poster/Podium Presentations***

Co-Chairs: Srinivas Nalamachu, MD; Joseph V. Pergolizzi, MD

Friday/9.9 7:00a – 7:50a

Level 3/**Gracia 5**

This session presents posters selected for oral presentations.

**This presentation is not certified for credit.*

PREPEF-01 **Neuropathica Galactica**

Sondra M. Adkinson, PharmD, DAAPM, CPE, BSpH; Mary Lynn McPherson, PharmD, MA, BCPS, CPE

Tuesday/9.6 9:00a – 5:00p

Level 3/**Gracia 5**

Chronic pain affects over 100 million Americans, more people than those with cardiac disease, diabetes, and cancer combined! Savvy practitioners relish opportunities to participate in a “boots on the ground” all-day program such as this, taught by 2 highly skilled primary care pain practitioners who happen to be amazing educators! Participants will have ample opportunity to practice assessment skills, select and monitor nondrug and drug therapies, and determine which educational strategies to use with pain patients. This invaluable course will not only allow participants to implement patient care strategies the very next day back at work, but will prepare participants for licensing and credentialing exams in pain management/education.

Preregistration is required; onsite registration is not permitted. This course is limited to 60 participants to guarantee a high degree of active learning and interaction. Continental breakfast and box lunches will be provided.

SIS-01 **Physician Orders for Life Sustaining Treatment (POLST)**

Jeffrey A. Gudin, MD

Tuesday/9.6 7:00a – 7:50a

Level 4/**Nolita 1**

Most states have passed legislation to honor a type of advanced directive, commonly known as a POLST, for Physician Orders for Life Sustaining Treatment. It is basically a more detailed and specific DNR (do not resuscitate). Patients consistently report preferences to die peacefully at home but all too often end up dying in hospitals, with advanced medical interventions and an uncomfortable end. Most clinicians are not adequately prepared to address this issue. End-of-life care is about listening to patients and their families and engaging them in honest dialogue about options and outcomes—easy to say, but excruciatingly hard to do. This presentation will explore the economic and societal issues of end-of-life care for an aging society and encourage the use of an enduring set of medical orders guided by clinicians but chosen by patients and their families. This session will discuss POLST and ongoing research in the state of Oregon, which has proven that the POLST program more accurately conveys end-of-life preferences that are more likely followed by medical professionals. The POLST program has been a key vehicle in Oregon’s successful efforts to increase the effectiveness of advance care planning and decrease unwanted hospitalizations at the end-of-life.

SIS-02

Stop the Carousel I Want to Get Off: The Pressures of Managing Chronic Pain Patients in Clinical Practice

Kevin L. Zacharoff, MD, FACIP, FACPE, FAAP

Tuesday/9.6 10:30a – 11:20a

Level 4/**Mont-Royal Ballroom**

Controversies continue to exist regarding safe and appropriate management of people with chronic pain. The “pendulum has swung in the other direction” with respect to the utility, safety, and efficacy of the use of opioids as a key component of chronic pain treatment. It seems to be unclear to many what can rationally be offered to patients whose lives have been derailed by often debilitating chronic pain. This is further complicated by the “opioid epidemic” that has resulted in a dramatic increase in unintended deaths related to opioids, heroin, and now fentanyl. This presentation will detail many of the hurdles that exist in clinical practice trying to compassionately help and support patients while navigating the challenges and pressures of state and national guidelines, educational deficits, ethical dilemmas, and regulatory scrutiny. This discussion will include the fact that in many cases, clinicians have questioned whether or not it is worth the effort to try to conform to all of the constraints involved, especially in the face of decreased available resources and funding. Intended and unintended consequences of this exodus will be addressed, along with possible strategies for preventing it.

SIS-03

Clinical Conundrum: Catch-22

Gary W. Jay, MD, FAAPM, FACFEI

Tuesday/9.6 10:30a – 11:50a

Level 3/**Gracia 1**

We will discuss the difficulties in diagnosing and treating a patient with a significant neurological entity who develops a “Catch-22.” This Catch-22 may prevent appropriate testing and therefore impede finding the correct diagnosis and treatment.

SIS-04

Functional Pain Syndromes

Martin D. Cheatle, PhD; Peter G. Pryzbylowski, MD; Peter Yi, MD

Tuesday/9.6 1:40p – 3:40p

Level 4/**Nolita 1**

Functional pain syndromes (irritable bowel syndrome, fibromyalgia, interstitial cystitis, vulvodynia, etc) are commonly seen in primary care and by pain medicine practitioners. For example, fibromyalgia affects 5 million people and interstitial cystitis 8 million women per year, and the etiologies of these syndromes remain unknown. These syndromes are challenging, both diagnostically and in developing efficacious treatments. Patients who present with functional pain syndromes tend to have significant psychiatric comorbidities that further reduce their quality of life. It is critical that practitioners are versed in the assessment and management of these complex cases to avoid iatrogenic complications such as unneeded surgery and medication dependency and to improve clinical and functional outcomes. This multidisciplinary panel will review common functional pain syndromes, underlining theoretical pathophysiologies, diagnostic strategies, and effective interventions, including pharmacologic and nonpharmacologic approaches.

SIS-05

Managing Pain in Workers’ Compensation Claims

Robert Hall, MD

Tuesday/9.6 4:40p – 5:30p

Level 4/**Nolita 1**

Pain management is prevalent in the workers’ compensation industry as employees are treated for a workplace injury or illness. In managing an injured worker’s pain, there are many things to consider, from appropriate utilization of opioid analgesics to the potential impact of underlying comorbid conditions. This presentation will discuss the pain management issues to look for in a workers’ compensation claim, methods to help injured workers improve function, and the importance of collaboration in facilitating a successful return to work.

The Silent Healthcare Epidemic: Counterfeit Medicine*Jay Joshi, MD, DABA, DABA-PM, FABA-PM***Tuesday/9.6 5:40p – 6:30p**Level 4/**Nolita 2**

Counterfeiting is big business. In 2012, counterfeit auto parts accounted for \$4 billion in the US and \$12 billion globally; electrical parts were \$15 billion; personal care \$4 billion; aerospace & defense accounted for 520,000 counterfeit parts in the US, and >5% of wine sold on the secondary market is counterfeit. Those numbers pale in comparison to the pharmaceutical industry. >8% of the medical devices in circulation are counterfeit. Global sales of counterfeit products in the pharmaceutical industry alone accounted for \$431 billion in 2012 according to the World Health Organization. Counterfeit pharmaceuticals account for up to \$200 billion in losses per year alone. Counterfeit medications are a cause for decreased wellness, increased morbidity, and even deaths. According to the Business Action to Stop Counterfeiting and Piracy group (BASCAP), the global value of the counterfeit industry will grow to \$1.7 trillion in 2015 without any real solution in sight. The Drug Supply Chain Security Act (DSCSA) passed in 2013 mandated verification of the legitimacy of the drug product identifier down to the package level and enhanced detection and notification of illegitimate products in the drug supply chain. This session will discuss counterfeiting and what can be done.

Exercise as Medicine: How to Get Pain Patients Active Again*Peter A. Abaci, MD***Tuesday/9.6 5:40p – 6:30p**Level 4/**Nolita 3**

Chronic pain can lead to inactivity, functional impairments, and prolonged disability. Some of the potential secondary consequences of pain related avoidance of typical daily activities include unemployment, a loss of independence, and an increased risk of other chronic diseases including cardiovascular disease, diabetes, and obesity. The need to improve physical fitness and function with daily activities should be considered an essential component of addressing chronic pain as a public health epidemic. Helping pain patients become both more globally active and functional with symptomatic body parts can be difficult. Practitioners are often not trained in focusing on chronic pain and rehabilitation and may struggle in achieving long-term success. Understanding the complex central nervous system changes that take place in chronic pain syndromes and how exercise can positively counteract these changes is an important first step. Fear avoidance is often a significant barrier to progress, and learning specific steps to work past it can be critical. While each patient's own set of physical limitations and challenges are unique, there are certain core concepts of chronic pain rehabilitation that practitioners can employ to improve measurable outcomes.

If 6 Were 9: The CDC's Prescribing Guidelines and the Veil of Secrecy*Jennifer Bolen, JD; Jeffrey Fudin, BS, PharmD, FCCP; Steven P. Stanos, DO; Stephen J. Ziegler, PhD, JD***Wednesday/9.7 9:00a – 11:00a**Level 4/**Mont-Royal Ballroom**

On September 16, 2015, the Centers for Disease Control and Prevention (CDC) hosted a public webinar where they revealed a draft of their 12 prescribing guidelines for chronic pain. Due to technical difficulties, the entire process was repeated the following day. Concerns over the way the guidelines were introduced was raised by the pain community and, following a congressional inquiry, the CDC decided to offer an extended open comment period that resulted in over 4000 written responses. It is anticipated that the CDC guidelines will be finalized by the time PAINWeek convenes. Panelists will discuss the history of the guidelines as well as their concerns, both procedurally and substantively.

Why Skin Matters*Philip J. Albrecht, PhD; Charles E. Argoff, MD, CPE; Frank L. Rice, PhD***Wednesday/9.7 10:30a – 11:50a**Level 4/**Nolita 2**

Although many providers have experience in advising their patients to use topical analgesics for treatment of various types of acute and chronic pain conditions, there are new insights into just how important the skin is in evaluating and treating people with chronic pain. In this translational session, basic science data will be presented in a clinically relevant manner, describing how keratinocytes and other skin structures play an active role in the development of pain as well as potentially in identifying best treatments for patients. The results of several recently completed trials will be presented, and application of such knowledge to practice will be addressed.

PW NEXT Generation



the silent healthcare epidemic:

counterfeit medicine

jay joshi

tuesday september 6

encore saturday september 10

d. ross/f. sbf

SIS-10

If the Phone Doesn't Ring, It's Me: Communication and Pain Management*Kevin L. Zacharoff, MD, FACIP, FACPE, FAAP***Wednesday/9.7 1:40p – 2:30p**Level 4/**Mont-Royal Ballroom**

Fierce debates rage on about chronic pain. These include the utility of chronic opioid therapy, the value proposition of multidisciplinary approaches, reimbursement related issues, risk of aberrant drug related behaviors, along with many other questions related to assessment and treatment. Additionally, and unfortunately, education about chronic pain, one of the most prevalent medical conditions, remains poor or nonexistent for most clinicians in the majority of medical training programs, including the training of most if not all clinical disciplines. While many existing and familiar clinical strategies for managing other medical conditions can often be applied to chronic pain, educational deficits may often result in the lack of application of commonly accepted clinical tools and approaches, of which none are more important than dialogue and communication. This presentation will focus on the significant role of communication as an often forgotten yet supremely important component of assessment, treatment plan formulation, and management. It seems logical that if pain is one of the few medical conditions where the patient has a say in whether or not a treatment plan is successful, communication should be a consistent and omnipresent component of the healthcare provider and patient relationship.

SIS-11

Platelet Rich Plasma (PRP): Hoax or Hope?*Peter G. Pryzbylowski, MD***Wednesday/9.7 2:40p – 3:30p**Level 4/**Nolita 2**

The course will overview current believed mechanisms of actions surrounding platelet rich plasma (PRP) and how it is acquired from patients. It will describe current indications for use and possible side effects of its use. The literature as it stands will be reviewed in depth with specific time spent discussing the role PRP may play in interventional pain therapies.

SIS-12

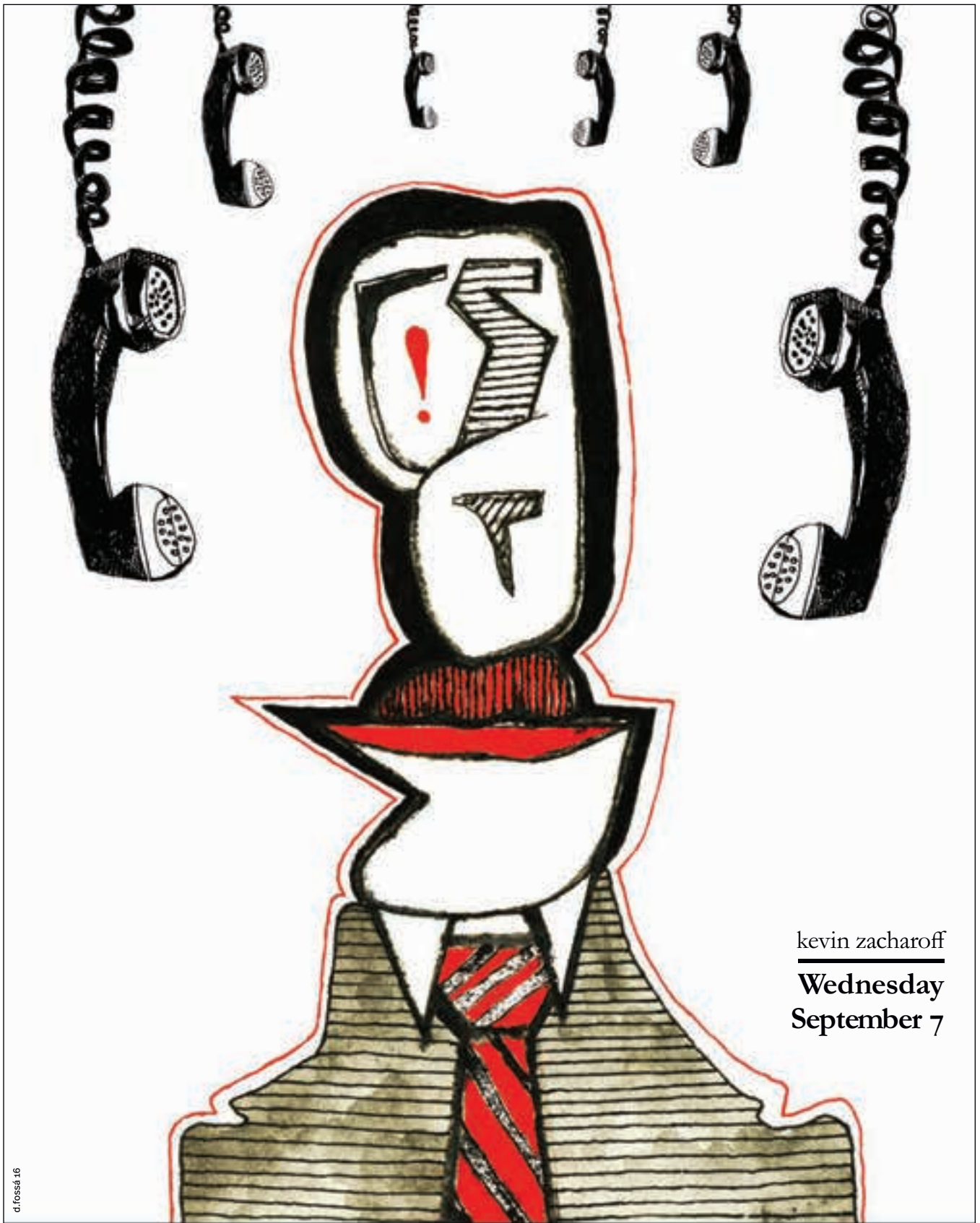
Nutrition for Chronic Pain*Heather Tick, MD***Wednesday/9.7 2:40p – 3:30p**Level 4/**Nolita 3**

In the age of modern medical miracles, it is easy to forget that we change our body chemistry every time we eat. The quality and composition of our food has the power to increase or decrease body-wide inflammation. Yet most medical schools have only a few hours of learning time devoted to a topic that has the potential to help every patient seen. The research evidence is robust for dietary interventions and improved health. The changes needed are simple, but not necessarily easy. Topics covered in this sessions will include the evidence, suggested interventions, and how to overcome barriers to change.

SIS-13

Assessing and Managing Insomnia in Patients With Chronic Pain*Martin D. Cheattle, PhD***Wednesday/9.7 4:40p – 5:30p**Level 4/**Nolita 1**

Patients suffering from chronic pain commonly experience comorbid problems that can further impair quality of life. These include psychological and medical comorbidities and fatigue and sleep disorders. Greater than 50% of patients with pain disorders experience sleep disturbance, with estimates as high as 70% to 80%. Experimental studies of healthy subjects and cross-sectional research in clinical populations have demonstrated that there is a strong relationship between sleep disturbance and pain, and that this relationship is reciprocal—pain disturbing sleep continuity/quality and poor sleep exacerbating pain. Chronic pain and sleep disorders independently have been demonstrated to contribute to psychiatric and medical morbidities, disability, and a significantly reduced quality of life. In spite of the persuasive literature on the deleterious effect of sleep on pain and pain on sleep, clinicians may not adequately assess and effectively treat sleep disorders in the pain population. This symposium will review the prevailing theories of this interrelationship, outline efficient and sensitive methods to assess sleep disorders, and discuss both pharmacologic and nonpharmacologic interventions to improve sleep quality in patients with chronic pain.



kevin zacharoff
Wednesday
September 7

d.fossa@16

if the phone doesn't ring, it's me

communication and pain management

Heather Tick

**Wednesday
September 7**



d.fossá

NUTRITION
for chronic pain

Platelet-
Rich
Plasma
Therapy

PRP
HOAX
or
HOPE?

Peter Pryzbylkowski

Wednesday
September 7



SIS-14

Pain Clinical Trials

Frank Breve, PharmD, MBA; Errol M. Gould, PhD; Marc Hoffman, MD; Ernest A. Kopecky PhD, MBA; Srinivas Nalamachu, MD; Joseph V. Pergolizzi, MD; Robert B. Raffa, PhD; Robert Taylor, Jr, PhD

Thursday/9.8 9:00a – 11:00a

Level 4/Nolita 3

The significance of investigational drugs can be identified by performing a variety of clinical studies. These studies can range from bench top to bedside and include various populations like pediatrics and geriatrics. This course will address the elements related to the clinical study of analgesics. Discussed will be new analgesic drugs; their mechanism of action; how to design a study around these characteristics; why trial design for these types of analgesics (and others) do not always mimic clinical practice; and pitfalls of analgesic trials. Issues surrounding some of the new regulatory requirements of analgesics, especially controlled substances, and the impact of these requirements on trial design will be presented. In addition, dissemination of data from analgesic clinical studies into the public domain will be covered. At the conclusion of the program, participants will have a comprehensive understanding of analgesic trial design and reporting.

SIS-15

In the Wake of the CDC Opioid Guidelines and the National Pain Strategy: Leveraging Pain Psychology and Platforms to Address the National Pain and Opioid Crises

Beth Darnall, PhD; Sean C. Mackey, MD, PhD

Thursday/9.8 10:30a – 11:50a

Level 4/Mont-Royal Ballroom

In this dynamic and interactive session, Drs. Darnall and Mackey will tag team content that will lead attendees through the recent and relevant political developments including the CDC opioid prescribing guidelines and recommendations from the National Pain Strategy (developed by a committee of 80 individuals chaired by Dr. Mackey). The underlying imperative is to treat pain differently, but how do we do that?

SIS-16

The Medical Stasi: Is Risk Management for Controlled Substances Destroying the Provider-Patient Relationship?

Jennifer Bolen, JD; Paul J. Christo, MD, MBA; Douglas L. Gourlay, MD, MSc, FRCPC, FASAM; Howard A. Heit, MD, FACP, FASAM; Stephen J. Ziegler, PhD, JD

Thursday/9.8 1:40p – 3:40p

Level 4/Mont-Royal Ballroom

Managing risk is an essential part of medical practice, particularly in light of the reported increase in morbidity and mortality associated with the use of opioids. Recent anecdotal data indicate that as a result of the "opioid crisis," patients are being told by their prescribers that they can no longer manage pain with opioids and must therefore find another healthcare provider. Consequently, healthcare professionals are now faced with the increased likelihood of inheriting patients. The moderated panel will discuss the many clinical, legal, and ethical challenges that are associated with terminating/discharging patients, inheriting a patient, and managing risk.

SIS-17

Office Based Procedures for Primary Care Practitioners

Srinivas Nalamachu, MD

Thursday/9.8 2:40p – 3:30p

Level 4/Nolita 3

Many common chronic pain conditions including headache, various types of musculoskeletal pain, and certain neuropathic pain conditions can be successfully treated with office based procedures. In this session, common office based procedures that can be performed to treat chronic pain will be discussed and demonstrated, with emphasis on the rationale for performing, as well as the methods to assess their efficacy. In addition, their role as part of a multimodal treatment program for an individual person with chronic pain will be discussed.



Co-chairs
Srinivas Nalamachu
Joseph Pergolizzi

Frank Breve
Errol Gould
Marc Hoffman
Robert Raffa
Robert Taylor, Jr

Pain Clinical Trials

**Thursday
September 8**

d.fossa.16

SIS-18

Opioid “Induced” Hyperalgesia and Allodynia*R. Norman Harden, MD***Thursday/9.8 5:40p – 6:30p**Level 3/**Gracia 1**

Prolonged exposure to opioids hypothetically activates a pro-nociceptive mechanism resulting in opioid induced hyperalgesia (OIH). Opioid hysteria doctors are causing payors and governing bodies to rush to bring the OIH concept into law and protocol, but are finding a lack of any scientific evidence for this process, at least in humans. The FDA is now requiring pharma to run extensive and expensive trials to demonstrate OIH associated with opioid therapy, but the construct is vaguely defined, the mechanisms are poorly understood, and the outcomes and methods for studying OIH are very poorly developed. In this session we will examine the state of the science surrounding OIH including terminology, technology/methodology, and existing evidence. I will also present a preliminary data set executed to determine practical, workable methods to study the phenomena, and its results. Our pilot study showed no trend toward development of OIH (by our quantitative definitions) beyond the hyperalgesia and allodynia that all pain patients develop as pain becomes chronic (AKA sensitization/augmentation), which was seen equally in our control group of subjects with the same diagnosis not taking opioids. Importantly, I will try to outline practical methods for future study.

SIS-19

Chronic Pain Patients Who Fail Standard Treatment: Identification and Strategies*Forest Tennant, MD, DrPH, FACPM, MPH***Thursday/9.8 5:40p – 6:30p**Level 3/**Gracia 3**

There is a group of intractable pain patients who have extensively accessed the pain treatment system only to be unable to find satisfactory pain relief. These patients have sought treatment at multiple academic centers and attempted numerous nonmedical, pharmacologic, and invasive interventions including surgery, implants, and intrathecal drugs. Our experience in a special unit for these patients will be presented. Only a few underlying painful conditions are found in this subgroup and patients tend to have profound genetic, metabolic defects and hormonal alterations. Special treatment regimens based on their unique clinical abnormalities have to be developed for these individuals.

SIS-20

Can Opioids Be Rationally Prescribed for Chronic Pain?*Charles E. Argoff, MD, CPE; Roger Chou, MD; Brett R. Stacey, MD***Friday/9.9 9:00a – 11:00a**Level 4/**Mont-Royal Ballroom**

As we acknowledge the recent increases in deaths and other negative outcomes associated with chronic opioid use, abuse, and overdose, we as clinicians are faced with very important questions: Can opioids be rationally prescribed for chronic pain? For whom? How? For how long? Recent CDC guidelines have been published regarding the use of chronic opioid therapy for noncancer pain FOR THE PRIMARY CARE PROVIDER. This course will not only describe the CDC guidelines but will also illustrate how these might be utilized in clinical practice. The weaknesses of the guidelines and their limitations will also be discussed. Faculty will also describe application of current guidelines to their own patients. This promises to be a lively interactive session.

SIS-21

Pharmacogenomics: 3 Wise Men Discuss Effects on Holy Tablets*Charles E. Argoff, MD, CPE; Jeffrey Fudin, BS, PharmD, FCCP; Michael E. Schatman, PhD, CPE, DASPE***Friday/9.9 1:40p – 3:40p**Level 4/**Mont-Royal Ballroom**

In this time during which the use of opioids for analgesia is being attacked by well-organized zealots, society is desperately seeking ways to make utilization of these medications safer and more effective. In a growing number of developed nations, genetic testing is being routinely utilized to determine which opioid is likely to provide the best choice for each patient. There have been excellent results reported in terms of prescription of the lowest possible dosage of an opioid with ideal analgesia—for individualized pain medicine. Unfortunately, the United States is lagging behind in pain pharmacogenomics, thereby perpetuating our 2 opioid crises: “abuse, overdose, and death” and “the swing of the pendulum to frank opiophobia and oliaoanalgesia.” In the first part of this comprehensive symposium, a PharmD will discuss the science behind

pharmacogenomics. This will be followed by a neurologist who will discuss practice issues associated with this scientific approach to opioid prescribing. Finally, a policy and bioethics specialist will discuss the conundrum of gaining insurance coverage for this cost-efficient yet currently expensive paradigmatic revision, along with some of the myriad ethical issues associated with pharmacogenomic testing in practice as well as research.

SIS-22

Low Pressure Headaches: What Are You Missing?

Ian Carroll, MD, MS; Theresa Mallick-Searle, MS, NP-BC, ANP-BC

Friday/9.9 4:40p – 5:30p

Level 3/**Gracia 5**

Low pressure headaches (LPH) are caused by low cerebral spinal fluid (CSF) pressure or volume and may be spontaneous or provoked. Although the suspected incidence of spontaneous intracranial hypotension (SIH) is rare, improved imaging and greater awareness have led to increased identification. Undiagnosed LPH can lead to years of painful, expensive, and unyielding diagnostics. Patients endure years of suffering as a result of inappropriate treatment and the stigma of chronic or even a suspicion of psychogenic pain. Practitioners struggle with the inability to diagnose or manage the patient's symptoms because of inadequate education. This presentation will review the clinical features of a low intracranial pressure headache, explore the unique patient history and imaging characteristics, and identify the proper treatment options available.

SIS-23

The Role of Special K in Pain Management

Abigail T. Brooks, PharmD, BCPS; Courtney M. Kominek, PharmD, BCPS, CPE

Friday/9.9 5:40p – 6:30p

Level 4/**Nolita 1**

Ketamine, known on the street as "special K," is a dissociative anesthetic with hallucinogenic properties and is classified as a controlled substance. Its unique mechanism as an N-methyl-D-aspartate (NMDA) receptor antagonist is thought to be responsible for many of the drug's most promising properties. Stimulation of the NMDA receptor results in central sensitization (wind up phenomenon), hyperalgesia, reduced sensitivity to opioids, and the development of opioid tolerance. This can result in allodynia, hyperalgesia, and prolonged pain response. Ketamine partially reverses the previously mentioned complications that can restore the effectiveness of opioids in various settings and often allows for reduced opioid doses and improved pain control. With the appropriate clinical knowledge and patient monitoring, ketamine at subanesthetic doses can play a role in the treatment of complex regional pain syndrome (CRPS), cancer pain, and even neuropathic or chronic pain refractory to typical treatment options. Depending on the clinical setting, ketamine can be administered via either intravenous or oral routes. Clinical monitoring is required to ensure that side effects, such as dysphoria, do not adversely impact the patient.

SIS-24

The Use of Viscosupplementation in FDA-Approved and Nonapproved Joints

Ramon L. Cuevas-Trisan, MD

Saturday/9.10 9:00a – 9:50a

Level 4/**Nolita 3**

Osteoarthritis (OA) is the fastest growing major health condition with symptomatic disease affecting approximately 46 million people in the US. Hyaluronic acid gives synovial fluid the viscous quality that helps to lubricate and absorb shock. Joints affected by OA have poorer quality and less hyaluronic acid in the joint fluid. Viscosupplementation—the injection of a synthetic version of hyaluronic acid into joints such as knees, shoulders, and hips—is thought to improve the viscosity of synovial fluid, resulting in smoother movement and reduced pain. FDA and non-FDA approved indications for various viscosupplements in the management of pain related to OA will be discussed. We will also present existing medical literature and pragmatic recommendations for the use of viscosupplementation for the management of symptomatic OA in large synovial joints.

SIS-25

The MEDD Myth: Practice and Research Implications

Jeffrey Fudin, BS, PharmD, FCCP; Michael E. Schatman, PhD, CPE, DASPE

Saturday/9.10 10:30a – 11:20a

Level 4/**Nolita 3**

For decades, the concept of morphine equivalent daily dosage (MEDD) or some variant thereof has been routinely utilized clinically (eg, for opioid rotation) as well as in research as a dependent variable. However, recently, the concept has been demonstrated to be a scientifically invalid

one. Irrespective, MEDD continues to be utilized, with many of the individuals dedicated to the eradication of opioid analgesia fully aware of their fraudulent behavior. In this symposium, the scientific basis of the MEDD myth will be explored, as well as its implications for clinical practice. Additionally, there will be a discussion of the need to discontinue the practice of conveniently yet invalidly “lumping together” opioid dosages in empirical investigation if the research that should be informing clinical practice is to be legitimate and valid. Finally, we will explore perhaps the most egregious use of MEDD, ie, as the basis of recently released opiophobic prescribing guidelines that are causing unnecessary distress to prescribers and patients suffering from pain alike.

SIS-26

Into the Groove: Seducing the Anxiolytic Effects of Dance Music

Joanne V. Loewy, DA, LCAT, MT-BC; John F. Mondanaro, MA, LCAT, MT-BC;
Andrew R. Rossetti, MMT, LCAT, MT-BC

Saturday/9.10 10:30a – 11:50a

Level 4/**Yaletown 1**

Pain and restrictions on movement are often inextricably linked. The pain of movement and the tendency to hold oneself still in order to avoid further pain can have a residually negative impact in a disease trajectory. Compelling research in music and medicine illuminates the therapeutic benefits of ‘coupling’ and movement in groove to heighten feelings of pleasure, build resilience, and extend one’s capacity to cope with pain and its ensuing anxiety and stress. The convergence of advancement in personal technology fosters heightened self-awareness of individuals to be active players in their own modulation of pain, and has substantiated that accessing the ‘groove’ in music is a tangible and enjoyable means of self-treatment. Music as an active resource, and most particularly groove’s hooks, can therapeutically impact those living with pain. We will explicate and ‘sample’ this idea through new research as evidenced and practiced by music therapists in the Louis Armstrong Center for Music and Medicine. In this eye- and ear-opening presentation, we will discuss: the applicability of groove-based music toward resilience and wellness in everyday life; entrainment and groove in the treatment of acute pain; and rhythmicity’s means to increasing fluidity in those living with the trauma of pain.

SIS-27

The Silent Healthcare Epidemic: Counterfeit Medicine (Encore)

Jay Joshi, MD, DABA, DABA-PM, FABA-PM

Saturday/9.10 2:40p – 3:30p

Level 4/**Nolita 2**

See SIS-06 for course description.

SIS-28

Botulinum Toxins as Neuromodulators in Chronic Pain Management

Ramon L. Cuevas-Trisan, MD

Saturday/9.10 2:40p – 3:30p

Level 4/**Yaletown 1**

The emerging role of botulinum toxins as chemical neuromodulators, specifically in the management of chronic intractable painful syndromes, will be presented. There is compelling evidence showing that toxins modulate chronic neurogenic inflammation, commonly expressed as peripheral sensitization leading to central sensitization with allodynia and hyperalgesia. Existing medical literature will be discussed. Several cases successfully managed with type A botulinum toxins will be discussed, including chronic intractable headaches of several etiologies (migraine, posttraumatic, postintracranial bleed, etc), occipital neuralgia, intractable facial pain, temporomandibular joint pain syndromes, postradiation fibrosis, and other focal painful syndromes (ie, distal limb ischemic pain seen in Raynaud’s phenomenon, temporal arteritis, and others).

SYM-01

A Comprehensive Approach to the Safe Management of Extended-Release/Long-Acting Opioids

Jeffrey A. Gudin, MD; Bill H. McCarberg, MD

Tuesday/9.6 1:40p – 4:40p

Level 3/**Gracia 3**

Chronic pain is a prevalent medical condition that has a significant clinical and societal impact. However, despite scientific advances in the diagnosis of chronic pain, large numbers of individuals remain inadequately treated. A comprehensive pain assessment can help determine the feasibility and appropriateness of analgesic therapy, which may include the use of opioid analgesics.

INTO THE GROOVE:

seducing
the anxiolytic
effects of
dance music

saturday

9.10.16

joanne loewy
john mondanaro
andrew rossetti

Although opioids can provide effective pain relief for many patients, their use for chronic pain relief remains controversial due to insufficient data regarding long-term efficacy, adverse events, and drug misuse, abuse, and addiction. Therefore, the challenge for clinicians is to balance the patient's need for adequate pain relief with these adverse effects. This activity is part of the FDA Risk Evaluation and Mitigation Strategy (REMS) to ensure that the benefits of extended-release and long-acting (ER/LA) opioid analgesics outweigh their risks. It will discuss the epidemiology and prevalence of chronic pain and opioid abuse, followed by a discussion of the clinical pharmacology of opioid analgesia and drug abuse and addiction. The rest of the discussion will focus on comprehensive pain assessment, determination if a patient is a candidate for opioids, initiation of opioid therapy, ongoing management of therapy with ER/LA opioid analgesics, and counseling of patients and their families on the safe use of ER/LA analgesics. It will conclude with a presentation of general and specific drug information about ER/LA opioids. This information is based on a series of presentations being given at regional pain management conferences throughout the US in 2016.

For accreditation information, refer to page 52.

SYM-02 **The Need for a Personalized Team Approach in Managing Chronic Pain**

John A. Hopper, MD; Sanford M. Silverman, MD

Wednesday/9.7 7:00a – 7:50a

Level 3/**Gracia 5**

Chronic pain is a public health problem of epidemic proportions. How to safely and effectively manage it and minimize the risk of opioid abuse and misuse is a clinical dilemma faced by primary care providers and specialists from nearly every discipline. The speakers will review evidence based guidelines for the assessment and management of patients with chronic pain, including evaluation of risk factors for abuse and incorporation of strategies for mitigating risk into management plans. Clinical trial data of extended-release/long-acting opioid formulations with abuse deterrent technology will be reviewed, and methods for enhancing patient-provider communication and the interdisciplinary management of patients with chronic pain will be discussed. There is a need for collaboration by all healthcare workers involved in the management of chronic pain to better manage patients, including assessing risks for and addressing opioid misuse. This satellite symposium at the 2016 PAINWeek Annual Meeting will educate practicing pain specialists, physicians, pharmacists, and/or nurses who are involved in the management of chronic pain.

For accreditation information, refer to page 52.

SYM-03 **Evolving Strategies for Chronic Pain Management: Targeting Multiple Pain Mechanisms to Improve Efficacy and Reduce Opioid Abuse Potential**

Charles E. Argoff, MD, CPE; Michael J. Brennan, MD

Saturday/9.10 8:00a – 9:00a

Level 3/**Brera Ballroom**

In recognition of the interrelated chronic pain and opioid epidemic, novel therapeutic development efforts are currently underway to better address the multiple mechanisms of pain while reducing abuse potential. Further, federal, state, and other organizations have implemented a variety of policies, guidelines, and programs aimed at supporting appropriate opioid prescription and reducing nonmedical use of opioids in patients with chronic pain. At the forefront of implementing chronic pain management efforts are primary care physicians (PCPs). This interactive symposium will provide PCPs education on safe opioid prescribing, the latest clinical trial data on newer pharmacologic options for chronic pain with reduced abuse potential, and strategies to overcome barriers to access.

For accreditation information, refer to page 53.

VHA-01 **Transformation of Chronic Pain within the Patient-Centered Medical Home: A Sustainable Stepwise Approach for Improved Functional Outcomes**

Beth L. Dinoff, PhD; Mary L. Jacobs, PhD, MSPH

Saturday/9.10 9:00a – 11:00a

Level 4/**Nolita 2**

This presentation will outline 3 sustainable stepwise approaches for providing chronic pain care within the patient centered medical home (PMH). Treatment of chronic pain is going through a systemic transformation (see 2016 National Pain Strategy from HHS and the 2009 VHA Stepped



georgine lamvu

**thursday
september 8**

dysmenorrhea

unlocking the secrets of chronic menstrual pain

c.fossa

Care Model). The biopsychosocial, multidisciplinary, stepped-care model provides a 3-step continuum of efficient pain care leading to the goal of sustainable functional improvement for the patient. Stepwise pain management increases patient access to evidence based treatment while reducing the potentially dangerous use of opioids. Authorizing staff to work at the peak of their licenses allows the PMH to utilize a variety of staff for managing chronic pain through shared medical appointments, case management, and educational instruction. Timely access to each step enhances multiple outcomes for patients with chronic pain, including focusing on improvements in functional status rather than changes in pain intensity, increasing dependence upon self-care strategies, and establishment of pathways for patient-provider agreement on opioid safety goals. Quality improvement examples, treatment guidelines, educational tools, enhanced sustainability and efficiency recommendations, and clinical process goals will be provided.

VHA-O2 **Functional Restoration for Whole-Health and Well-Being Within the Patient Centered Medical Home**

Jennifer L. Gansen, DPT; Mary Elizabeth Hammons, PhD; Michael S. Saenger, MD

Saturday/9.10 1:40p – 3:40p

Level 4/**Nolita 3**

This interactive course will instruct participants in how to begin implementation of an outpatient functional restoration program for chronic pain, ie, intensive integrated coaching for self-care for wellness. The model will be the Atlanta VA Health System's Empower Veterans Program (EVP). EVP help coach veterans with chronic pain to live a fuller life by moving toward their own wellness goals. The program features group experience supplemented with individual coaching. This functional rehabilitation quality improvement is part of a health system solution for pain management and plays an important part in turning off the faucet of the opioid epidemic. EVP will be explained in detail by members of the multidisciplinary team professionals who are directly involved with EVP, including a medical doctor, a psychologist, and a physical therapist. The presenters will address that high impact chronic pain is real, complex, and difficult to treat. As a result, even 10 weeks of evidence based cognitive behavioral therapy for chronic pain is only modestly effective.

WMH-01 **Dysmenorrhea: Unlocking the Secrets of Chronic Menstrual Pain**

Georgine M. Lamvu, MD, MPH, FACOG

Thursday/9.8 10:30a – 11:20a

Level 3/**Gracia 5**

Painful menstruation, or dysmenorrhea, is the most common gynecological pain condition, affecting 45% to 95% of menstruating women. In spite of its prevalence, it is often ignored and poorly treated because many healthcare providers and patients may consider pain a normal part of the menstrual cycle. This lecture will define the impact of this pain condition, our current knowledge about evaluation and management, and the potential long-term consequences of recurrent menstrual pain on quality of life, mood, and pain sensitivity as well as the risk of developing more chronic patterns of pain. The lecture will specifically emphasize recognition of chronic pain comorbidities associated with dysmenorrhea and development of treatment strategies that focus on the biopsychosocial model of pain management. At the end of the lecture, attendees should be able to: 1) classify disorders associated with menstrual pain; 2) describe the basic biology of the menstrual cycle; 3) learn neurobiologic changes that can occur in menstruating women with pain; and 4) formulate treatment plans based on specific patient characteristics. This lecture will be interactive using case scenarios, survey questions, and audience participation.

WMH-02 **Interdisciplinary Management of Pelvic Pain: Bridging the Gap Between Primary Care and Specialty Referral**

Jennifer M. Hah, MD, MS; Ravi Prasad, PhD

Thursday/9.8 2:40p – 3:30p

Level 4/**Nolita 2**

The prevalence of chronic pelvic pain in women aged 18 to 50 is around 15%. However, only one-third of these women seek medical care. Also, the average time from presentation to a primary care provider and appropriate specialty referral and diagnosis ranges from 3 to 7 years. Not only is it essential for primary care providers to recognize the broad differential diagnoses contributing to pelvic pain, but also to understand appropriate and prompt specialist referral. Furthermore, many of these conditions require ongoing interdisciplinary management for optimal outcomes. In order to enhance care, it

is essential for the primary care provider to appreciate the epidemiology, risks factors, and etiology of a spectrum of pelvic pain conditions in addition to relevant treatment options. In order to narrow the gap between current and optimal practice, a case based learning discussion will engage the audience to illustrate aspects of interdisciplinary management relevant to the treatment of pelvic pain.

WMH-03

Helping Providers Help Patients With Vulvodynia: Recommendations for Patient Care From the National Vulvodynia Registry

Georgine M. Lamvu, MD, MPH, FACOG

Thursday/9.8 4:40p – 5:30p

Level 4/**Nolita 2**

Chronic vulvar pain, or vulvodynia, is a prevalent pain disorder that affects nearly 14 million women in the US. Unfortunately a poor understanding of disease pathophysiology leads to less than 2% of women actually being properly diagnosed and treated. Treatment recommendations vary widely and few treatments have been shown to be truly effective. Clinicians and scientists now recognize that our inability to effectively treat this disease is in part due to heterogeneity of patient characteristics. This session will review the epidemiology of vulvodynia and our current understanding of disease physiology. The majority of the lecture will be spent on providing clinicians with an overview of how to incorporate biopsychosocial and physical patient characteristics into the evaluation and treatment of vulvar pain. Data from the National Vulvodynia Registry will be presented. The goal is that by the end of the lecture attendees will be able to: 1) classify vulvodynia patients in terms of factors (other than pain level and location) that may equally impact pain and patient well-being; 2) describe medical and nonmedical therapies available for treatment of vulvodynia; 3) incorporate patient characteristics and knowledge about treatment effects into more individualized and multimodal treatment plans. This lecture will be interactive using case scenarios, survey questions and audience participation.

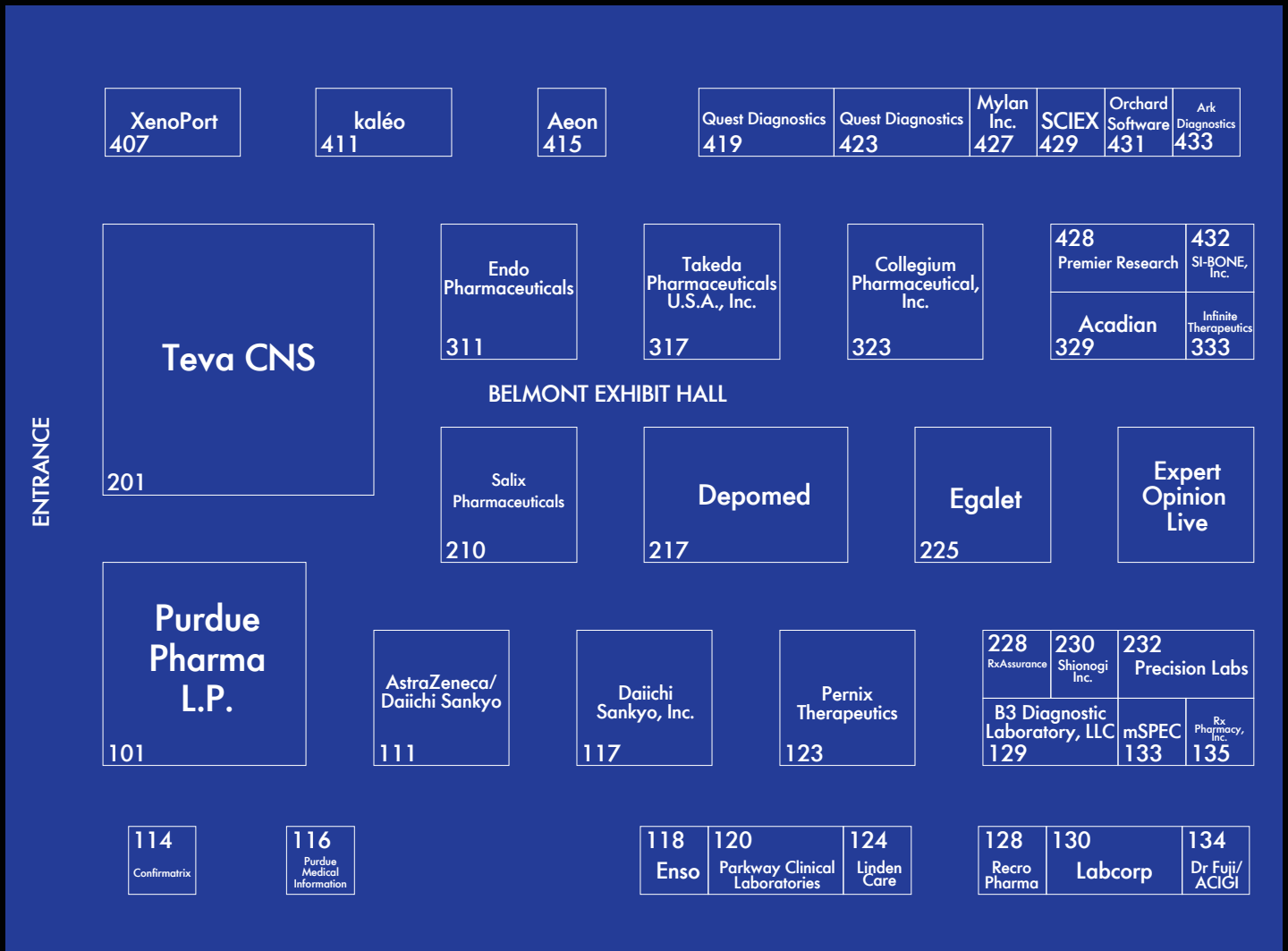


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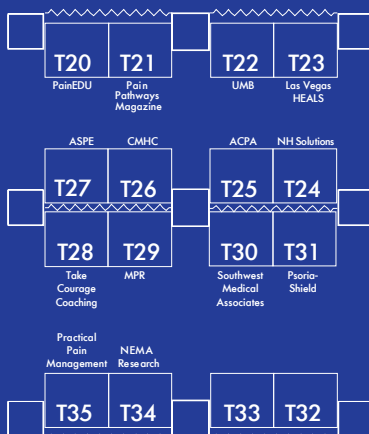
EXHIBIT HALL | SCHEDULE | DESCRIPTIONS



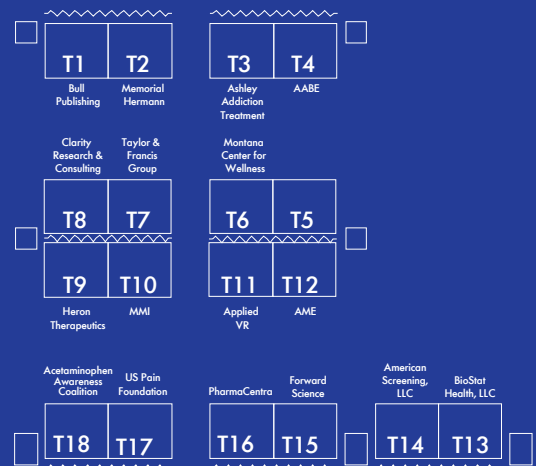
EXHIBIT HALL &



GRACIA COMMONS EXHIBIT ANNEX (Level 3)



BELMONT COMMONS EXHIBIT ANNEX (Level 4)



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WEDNESDAY/9.7

6:45p – 9:00p
Welcome Reception

THURSDAY/9.8

10:00a – 12:30p
2:30p – 5:00p

FRIDAY/9.9

10:00a – 12:30p

3:30p – 4:30p
Closing Reception

Please note: There are concurrent educational sessions taking place while the Exhibit Hall is open. Exhibit Hall hours are subject to change.

BOOTH	ORGANIZATION	DESCRIPTION
T4	THE ACADEMY OF APPLIED BIOELECTROPHYSIOLOGY www.microcurrent-training.com	Please visit our booth for more information.
329	ACADIAN DIAGNOSTIC LABORATORIES, LLC www.acadianlab.com	A highly accredited full service clinical reference lab that specializes in forensic toxicology in a clinical setting.
T18	ACETAMINOPHEN AWARENESS COALITION www.knowyourdose.org	The Acetaminophen Awareness Coalition (AAC) is made up of leading health, healthcare provider, and consumer organizations. The American Academy of Pediatrics, Centers for Disease Control and Prevention, and U.S. Food and Drug Administration serve as advisors to the Coalition. The goal of the AAC is to educate consumers and patients on the importance of knowing the ingredients in their medicines and following labeled directions to prevent unintentional acetaminophen overdose. Through outreach to healthcare providers, patients, and consumers, the AAC works to ensure that acetaminophen is used only as directed or labeled. The AAC is the official sponsor of the Know Your Dose campaign.
251	ADAPT PHARMA www.adaptpharma.com	Please visit our booth for more information.
241	AEGIS SCIENCES CORPORATION www.aegislabs.com	Aegis Sciences Corporation is a laboratory sciences company providing science-driven testing and consulting services for clients such as healthcare providers, pharmaceutical companies, professional and amateur sports organizations, leading college and university athletic programs, medical examiners, Fortune 500 corporations, and government agencies throughout the United States.
415	AEON CLINICAL LABORATORIES www.aeonclinical.com	Please visit our booth for more information.
345	ALERE TOXICOLOGY www.aleretoxicology.com	Alere™ Toxicology is committed to helping you develop a compliant drug testing program that improves patient outcomes, enhances patient safety, and protects your practice. Abiding by the highest standards of laboratory compliance, our goal is to provide clinicians with tools to help individualize therapy and optimize patient outcomes through customized testing.
339	ALTERNATIVE BIOMEDICAL SOLUTIONS www.altbio.com	Please visit our booth for more information.
T25	AMERICAN CHRONIC PAIN ASSOCIATION (ACPA) www.theacpa.org	Please visit our booth for more information.
T14	AMERICAN SCREENING, LLC www.americanscreeningcorp.com	American Screening, LLC is an ISO 13485 Certified Manufacturer/Distributor of FDA 510k, OTC, CLIA Waived, CE, & AU Certified Rapid Urine Drug Test Cups, Dip Cards, Saliva Drug Tests, Alcohol Tests, HCG, LH, H Pylori, Strep A, Flu A/B, FOB Chlamydia, HIV, HBV, HCV and other tests on request. Our rapid drug tests can be confirmed GC/MS at our SAMHSA Certified Lab. We sell worldwide to 27 countries. Our brands include: Reveal, Discover, Onescreen and Trucheck.
T27	AMERICAN SOCIETY OF PAIN EDUCATORS www.paineducators.org	The American Society of Pain Educators (ASPE) is a professional organization dedicated to improving pain management through the education and training of healthcare professionals to become Certified Pain Educators (CPEs). As the only organization focusing on pain educator training, the Society teaches healthcare professionals to serve as resources to educate their clinical peers, as well as patients, families, and caregivers, on ways to relieve pain by the safest means possible. ASPE members are the frontline practitioners when it comes to treating pain. They are "go to" resources in their practices and organizations, imparting evidence-based guidelines, translating care plans, and monitoring for safety, efficacy, and adherence. They are charged with delivering better health outcomes.
242	ANAZAOHEALTH CORPORATION www.anazaohealth.com	Please visit our booth for more information.

BOOTH	ORGANIZATION	DESCRIPTION
T 12	ANCILLARY MEDICAL EXPERTS (AME)	Please visit our booth for more information.
T 11	APPLIEDVR appliedvr.io	AppliedVR designs and distributes therapeutic VR content to healthcare providers. Based on 40 years of proven academic research, we transform the patient experience and create better outcomes. Initially, we focus on reducing pain and anxiety before, during, and after procedures. Part of Techstars Healthcare Accelerator, in partnership with Cedars-Sinai.
433	ARK DIAGNOSTICS, INC. www.ark-tdm.com	Please visit our booth for more information.
T 3	ASHLEY ADDICTION TREATMENT www.ashleytreatment.org	Please visit our booth for more information.
342	ASPEN MEDICAL PRODUCTS www.aspenmp.com	Aspen Medical Products is a leader in the development of innovative spinal braces for pain management, post-trauma stabilization, pre- and post-surgical stabilization and long-term patient care. Aspen's commitment to clinical research is unparalleled in the orthotics community and has directly impacted product development, providing unsurpassed motion restriction, superior comfort, and the most effective pain relieving braces on the market. The company makes more than 35 spinal orthotics options, including the award winning Vista® adjustable product lines that provide unsurpassed motion restriction, superior comfort, and an economic advantage, encouraging better patient compliance.
111	ASTRAZENECA AND DAIICHI SANKYO, INC. www.movantikhcp.com	AstraZeneca LP and Daiichi Sankyo, Inc. cordially invite you to visit our exhibit at Booth #111.
129	B3 DIAGNOSTIC LABORATORY, LLC www.b3diagnosticlaboratory.com	B3 Diagnostic Laboratory is a premier clinical laboratory specializing in advanced technology and science based solutions. We have created a comprehensive approach in understanding and positively affecting the management of toxicology services. B3 is recognized nationwide for client focused customer service and setting new industry standards in providing timely, accurate results allowing our clients to act quickly in planning treatment. Our team of industry professionals includes account management support, expert toxicologists, innovative scientists focused on research and assay development ensuring the highest level of care and client satisfaction and compliance. At B3 we are dedicated to excellence and improving health.
T 13	BIOSTAT HEALTH, LLC www.biostathealth.com	BioStat Health, LLC Is a full service marketing company offering customized testing solutions to meet the needs of our clients. This includes: Toxicology, Pharmacogenetics, and Health & Wellness blood testing. For quality service and convenience, BioStat Health will coordinate supplies and materials needed for testing as well as offer guaranteed customer service and expert support with one phone call. All of our laboratories utilize only the latest technology and the highest sensitivity testing methods.
448	THE BFF www.thebff.com	Please visit our booth for more information.
T 1	BULL PUBLISHING www.bullpub.com	Just released, The Opioid-Free Pain Relief Kit: 10 Simple Steps to Ease Your Pain by Dr. Beth Darnall, Pain Psychologist, Stanford University. Pick up a free review copy at our booth while quantities last! Taking the CDC guidelines into account, this brand new book gives your patients a road map and skills to help them self-manage their pain, so they need less medication. We also have copies of the highly acclaimed Less Pain, Fewer Pills. Living a Healthy Life With Chronic Pain is now available in a new Spanish translation.
T 26	CARDIOMETABOLIC HEALTH CONGRESS www.cardiometabolicehealth.org	Please visit our booth for more information.

BOOTH	ORGANIZATION	DESCRIPTION
451	CDC FOUNDATION: ONE AND ONLY CAMPAIGN www.oneandonlycampaign.org	Please visit our booth for more information.
247	CHEMWARE, LLC www.chemware.com	Please visit our booth for more information.
T8	CLARITY RESEARCH & CONSULTING www.clarityscience.com	Clarity Science is a leading international scientific research organization that performs rigorous research in the field of health care across a myriad of therapeutic areas. We conduct institutional review board (IRB)-approved clinical research studies with the utmost integrity—adhering to the highest standards of scientific excellence—to produce quality, reliable, and validated results.
323	COLLEGIUM PHARMACEUTICAL, INC. www.collegiumpharma.com	Collegium Pharmaceutical, Inc. is a specialty pharmaceutical company developing and commercializing next generation, abuse deterrent products for patients suffering from chronic pain.
143	COMPUGROUP MEDICAL www.cgm.com/us	Please visit our booth for more information.
114	CONFIRMATRIX LABORATORY, INC www.confirmatrixlabs.com ALPHA GENOMIX www.alphagenomix.com	Confirmatrix Laboratory, Inc. is an independent laboratory in Lawrenceville, Georgia, specializing in providing comprehensive clinical quantitative urine and oral fluid drug testing, medication monitoring, and support services. In addition, Confirmatrix provides time saving, economical, and accurate on-site/point of collection analysis for drugs of abuse, therapeutic drugs, employment drug screening, and occupational health testing. We are committed to quality testing with a guaranteed turnaround time of 24 hours. Confirmatrix Laboratory prides itself on individualized customer service based on the unique needs of your organization.
135	CURE RX PHARMACY, INC. www.curerxpharmacy.com	Please visit our booth for more information.
117	DAIICHI SANKYO, INC. www.dsi.com	Daiichi Sankyo, Inc. is a member of the Daiichi Sankyo Group and is focused on the development of cardiovascular, pain, and oncology therapies. We currently market therapies in hypertension, dyslipidemia, diabetes, thrombosis, stroke prevention, acute coronary syndrome, opioid induced constipation, and metastatic melanoma.
217	DEPOMED www.depomed.com	Please visit our booth for more information.
134	DR FUJI / ACIGI www.fujichair.com	Please visit our booth for more information.
446	DRUGSCAN www.drugscan.com	Please visit our booth for more information.
440	DRUG TESTING PROGRAM MANAGEMENT www.dtpm.com	Please visit our booth for more information.
225	EGALET www.egalet.com	Please visit our booth for more information.
311	ENDO PHARMACEUTICALS www.endo.com	Endo Pharmaceuticals Inc. is focused on developing and delivering high-value branded pharmaceutical products that meet the unmet needs of patients. Endo Pharmaceuticals is an operating company of Endo International plc (NASDAQ: ENDP) (TSX: ENL), a global specialty healthcare company focused on improving patients' lives while creating shareholder value.
118	ENSO www.cur.me	Enso is an electronic band-aid that delivers high frequency neuromodulation (HFN) to relieve back pain with a push of a button. HFN devices are traditionally implanted by orthopedic surgeons as an effective alternative to opioids, but require an invasive surgical procedure. Enso is the first convenient, topical form of HFN that physicians can easily prescribe to their patients.

BOOTH	ORGANIZATION	DESCRIPTION
T 15	FORWARD SCIENCE www.forwardscience.com	Please visit our booth for more information.
240	GENOTOX LABORATORIES www.genotoxlabs.com	Genotox Laboratories is a CLIA-certified reference laboratory based in Austin, Texas, that takes an innovative approach to laboratory services. With top of the line technology, Genotox Laboratories combines pharmacogenetic analysis and toxicology drug screenings to enable physicians to provide individualized treatment for each patient.
449	GENOVA DIAGNOSTICS www.gdx.net	Genova Diagnostics is a leading clinical laboratory applying systems based testing approaches to the diagnosis, treatment, and prevention of complex chronic disease. Genova specializes in clinical laboratory services with actionable information.
340	GENSCO LABORATORIES www.genscolabs.com	Gensco Laboratories is an innovator of pharmaceutical products and the development of patented delivery systems. As a healthcare partner, the company is in continual pursuit of novel and effective therapies that improve health. Gensco Laboratories is an FDA regulated and licensed pharmaceutical manufacturer that is dedicated to developing "Next Generation" solutions in healthcare.
245	GULFSTREAM DIAGNOSTICS www.gulfdiagnostics.com	Please visit our booth for more information.
249	HALYARD HEALTH www.halyardhealth.com	Formerly part of Kimberly-Clark, Halyard Health is a medical technology company focused on preventing infection, eliminating pain, and speeding recovery. Solutions for chronic pain include COOLIEF® Cooled Radiofrequency (RF) Treatment, a revolutionary technology that uses cooled RF energy to safely treat the sensory nerves causing pain, providing up to 24 months of relief.
439	HAMILTON ROBOTICS www.hamiltoncompany.com	Please visit our booth for more information.
T 9	HERON THERAPEUTICS www.herontx.com	Please visit our booth for more information.
336	HOSPIRA, A PFIZER COMPANY www.pfizer.com	Please visit our booth for more information.
250	HRMD MANAGEMENT www.hrmdmanagement.com	Please visit our booth for more information.
333	INFINITE THERAPEUTICS www.infinitymassagechairs.com	The Infinity Riage features the most advanced 3D massage technology on the market and an L-shaped roller track to deliver unmatched stress relief. Users can also control the chair from their Apple™ or Android™ devices with the Infinity Riage app. The 3D Infinity Riage provides the ultimate massage every time.
237	INSYS THERAPEUTICS www.insysrx.com	Please visit our booth for more information.
137	ITELAGEN LLC www.itelagen.com	ITelagen® redefines healthcare IT for pain management practices by providing PainCare™ for NextGen® EHR, a fully integrated technology, uniquely designed to meet the complexity and documentation needs of pain management physicians. Paincare™ delivers tools, templates, and workflows specific to the needs of pain management, developed with the help of leading physicians and EHR experts, and is part of a total solution including unlimited onsite and remote technical support for all staff, implementation, and secure hosting of patient data. ITelagen becomes the single point of contact for the IT and pain management EHR infrastructure.
411	KALÉO www.kaleopharma.com evzio.com	Please visit our booth for more information.

BOOTH	ORGANIZATION	DESCRIPTION
130	LABCORP-MEDTOX www.labcorp.com	Please visit our booth for more information.
T23	LAS VEGAS HEALS www.lasvegasheals.org	Please visit our booth for more information.
124	LINDEN CARE LLC www.lindencare.com	Please visit our booth for more information.
349	MEDITOUCH EHR www.healthfusion.com	Please visit our booth for more information.
T2	MEMORIAL HERMANN parc.memorialhermann.org	Please visit our booth for more information.
343	MERCEDES MEDICAL www.mercedesmedical.com	Please visit our booth for more information.
T10	METABOLIC MEDICAL INSTITUTE www.mmimedicine.com	Metabolic Medical Institute, Inc. (MMI) is a medical organization dedicated to promoting health and prevention of disease by providing premium, university and science based education to health professionals and researchers. MMI provides educational courses through conferences, workshops, online courses, fellowships, and certification programs. MMI educational courses are affiliated with leading universities and taught by Nobel-prize winning scientists, expert clinicians, and researchers. Programs are held to the highest standards of academic rigor and train practitioners in the methods of metabolic, functional, preventive, and integrative medicine, an approach that uncovers the deeper causes of disease and reveals the uniqueness of each patient.
438	MILLENNIUM HEALTH www.millenniumhealth.com	Millennium Health is a leading health solutions company that delivers accurate, timely, and clinically actionable information to inform the right treatment decisions for each patient at the right time. Millennium offers a comprehensive suite of services to better tailor patient care.
248	MOLECULAR DIAGNOSTICS CONSULTANTS www.moleculardiagnosicsconsultants.com	Please visit our booth for more information.
T6	THE MONTANA CENTER FOR WELLNESS & PAIN MANAGEMENT OF KALISPELL REGIONAL HEALTHCARE www.krh.org	The Montana Center for Wellness & Pain Management is designed to bring together leading healthcare providers in an effort to deliver the best possible care to those suffering from chronic pain. Our providers, and those with whom we work closely, are uniquely skilled in interventional pain management, medical pain management, physical therapy, chiropractic, mental health, massage therapy, acupuncture, naturopathic medicine, psychology/counseling, addiction medicine, and yoga therapy/gentle movement. The benefits of this approach are immeasurable to the quality and effectiveness of our patient care.
T29	MONTHLY PRESCRIBING REFERENCE (MPR) www.empr.com	Please visit our booth for more information.
133	MSPEC GROUP www.mspeccgroup.com	Please visit our booth for more information.
427	MYLAN INC. www.mylan.com	Please visit our booth for more information.
T34	NEMA RESEARCH INC www.nemaresearch.com	Please visit our booth for more information.
T24	NH SOLUTIONS www.vinevera.com	Please visit our booth for more information.
348	NOBLE MEDICAL, INC. www.noblemedical.com	Please visit our booth for more information.

BOOTH	ORGANIZATION	DESCRIPTION
350	NOVA INNOVATIONS www.novainnovations.net	Please visit our booth for more information.
445	OMEGA BIO-TEK, INC. www.omegabiotek.com	Please visit our booth for more information.
149	OMNIPLUS PHARMACY www.omnipluspharmacy.com	Please visit our booth for more information.
431	ORCHARD SOFTWARE CORP. www.orchardsoft.com	Orchard Software is a leader in the laboratory information system industry and offers a variety of informatics solutions. Orchard's products are installed in all sizes of physician groups, clinics, hospitals, reference labs, and pain management centers. Decision support rules based on medications prescribed and detected analytes enhance productivity, ensure quality results, and improve consistent reporting. Business intelligence enables compliance monitoring and reporting of inconsistent findings to document compliance and corrective action. In addition, analytics support risk stratification for identifying abuse potential. Orchard serves more than 1,400 laboratories across the country helping them to improve efficiency, reduce errors, and enhance integration.
T20	PAINEDU www.painedu.org	PainEDU is a leading educational website for healthcare providers to enhance understanding of pain management through interviews, articles, interactive tools, and teaching resources. Registered users have access to valuable resources and risk management tools including the widely used Screener and Opioid Assessment for Patients with Pain (SOAPP®) and the Current Opioid Misuse Measure (COMM®). PainEDU is part of the Inflexxion Pain Suite, which includes PainACTION (www.painaction.com), a self-management resource for individuals in chronic pain, and PainCAS (www.paincas.com), a web based clinical tool for assessing pain and opioid risk in chronic pain patients.
341	PAIN MEDICINE NEWS www.painmedicineneeds.com	Pain Medicine News (PMN), the best-read pain publication in the United States according to Kantar Media, is mailed 10 times annually to 45,179 pain treating physicians. This newspaper offers extensive coverage of pain related presentations at major clinical meetings and feature articles on topics relevant to practicing physicians. PMN also presents in-depth clinical and educational reviews written by thought leaders, as well as cutting-edge practice management articles.
T21	PAIN PATHWAYS www.painpathways.org	Please visit our booth for more information.
120	PARKWAY CLINICAL LABORATORIES www.parkwayclinical.com	Parkway Clinical Laboratories (PCL) is a CAP accredited, national CLIA certified laboratory performing routine and esoteric diagnostic testing. PCL is primarily focused on serving addiction and pain management specialists, performing urine and saliva based substance abuse screening and quantitative confirmation utilizing state of the art LC/MS/MS methodology. We offer a comprehensive test menu for LC/MS/MS analysis, which includes but is not limited to various controlled prescription medications, Z class sedatives, hypnotics, antidepressants, ecstasy, bath salts, and K2-spice. Finalized reports are available within 48 hours of specimen receipt, via a secure web portal, fax, email, courier service, or EMR interface.
123	PERNIX THERAPEUTICS www.pernixtx.com	Please visit our booth for more information.

BOOTH	ORGANIZATION	DESCRIPTION
145	PHAMATECH LABORATORIES AND DIAGNOSTICS www.phamatech.com	Phamatech offers a wide range of individual drug tests and profiles to help you specify medically necessary monitoring for each patient's specific needs and to further enhance your compliant medication monitoring and risk management testing program. We are a CAP, SAMHSA, CLIA, and FUDT certified laboratory. Phamatech offers numerous cost efficient and diverse UDT and pharmacogenetics testing options. Phamatech is also a manufacturer of CLIA waived instant diagnostic devices for use in clinical and home settings. Use of these devices, along with clinical laboratory testing, ensures reliable, accurate, qualitative, and quantitative medication monitoring and risk management testing results.
T16	PHARMACENTRA, LLC www.pharmacentra.com	Please visit our booth for more information.
436	PHYSICIAN COMPOUNDING ALLIANCE www.physiciancompoundingalliance.com	A point of care compounded pain creams dispensing program. We can tremendously improve practice income and standard of patient care with our unique turn key program.
T35	PRACTICAL PAIN MANAGEMENT www.practicalpainmanagement.com	Please visit our booth for more information.
347	PRACTICE PARTNERS IN HEALTHCARE www.practicepartners.org	Practice Partners is a developer, manager, and minority equity partner of single and multispecialty ambulatory surgery centers. We specialize in the development of start-up centers and the optimization turn-around of existing centers, in partnerships with physicians and with physician/hospital joint ventures. We deliver success-proven expertise with no development fees.
232	PRECISION LABS www.urinalysislabs.com	Precision Labs is a licensed reference lab that focuses on urinalysis, primarily through industry Gold Standard LC MS/MS technology. We offer unparalleled scientific expertise, customized integration solutions, and industry leading professionals whom educate and service the needs of physicians, medical practices, and treatment facilities.
428	PREMIER RESEARCH www.premier-research.com	Premier Research is a leading clinical development service provider that helps highly innovative biotech and specialty pharma companies transform breakthrough ideas into reality. The company has a wealth of experience in the execution of global, regional, and local clinical development programs with a special focus on addressing unmet needs in areas such as analgesia, CNS, oncology, pediatric, and rare disease. Premier Research operates in 84 countries and employs 1,000 professionals, including a strong international network of clinical monitors and project managers, regulatory, data management, statistical, scientific, and medical experts. They are focused on smart study design for advanced medicines that allow life-changing treatments.
346	PROOVE BIOSCIENCES www.proove.com	Please visit our booth for more information.
T31	PSORIA-SHIELD www.psoriashield.com	Please visit our booth for more information.
101	PURDUE PHARMA L.P. www.purduehcp.com	Please visit our booth for more information.
116	PURDUE PHARMA MEDICAL INFORMATION www.purduehcp.com	Please visit our booth for more information.
236	PURDUE PHARMA, OADP www.purduehcp.com	Please visit our booth for more information.
243	QUANTUM ANALYTICS www.lqa.com	Please visit our booth for more information.

BOOTH	ORGANIZATION	DESCRIPTION
419 & 423	QUEST DIAGNOSTICS www.questdiagnostics.com	Please visit our booth for more information.
128	RECRO PHARMA www.recropharma.com	Recro Pharma, Inc. is a specialty pharmaceutical company developing nonopioid therapeutics for the treatment of pain, initially for acute post-operative pain. Two product candidates are in mid to late stage clinical trials for the management of acute post-operative pain: IV/IM meloxicam, a proprietary, long-acting preferential COX-2 inhibitor, and intranasal dexmedetomidine, a selective alpha-2 adrenergic agonist demonstrating sedative, analgesic, and anxiolytic properties.
344	REGENESIS BIOMEDICAL www.regenesishbio.com	Regenesis Biomedical is a medical device company dedicated to improving human welfare through the research, design, manufacture, and sale of energy based medical products and services that alleviate pain, restore health, and improve quality of life. We offer the Provant Therapy System, which is electromagnetic energy. Provant is safe, nondrug pain management. As a company we value a pioneering spirit, excellence, respect, family, integrity, compassion, and dedication.
228	RXASSURANCE www.rxassurance.com	RxAssurance is a digital health company offering software solutions for patient engagement, outcomes data collection, and clinical decision support for physicians and large organizations. Our pain medication management platform, OpiSafe, helps doctors and patients better manage the complexity of prescribing opioid medications safely. We assure full CDC guideline adherence by performing baseline assessments and risk stratification, generating provider-patient agreements, following patients daily, tracking random UAs, and performing automated daily PDMP checks. Using OpiSafe saves doctors time and motion, helps them provide safe and effective care, mitigates potential liability, and generates billable event codes to earn appropriate reimbursement for pain management.
210	SALIX PHARMACEUTICALS www.salix.com	Please visit our booth for more information.
429	SCIEX www.sciex.com	SCIEX helps improve the world by enabling scientists and laboratory analysts to find answers to complex analytical challenges they face in basic research, drug discovery, and development, in addition to food and environmental testing, forensics, and clinical research and diagnostics. As part of SCIEX, SCIEX Diagnostics brings the power, flexibility, reliability, and accuracy of mass spectrometry to clinical testing laboratories. SCIEX Diagnostics offers an expanding portfolio of mass spectrometry solutions and assays for in vitro diagnostic use, enabling customers to deliver high-quality results to clinicians who make decisions affecting patient care.
230	SHIONOGI INC. www.shionogi.com	Shionogi & Co., Ltd., is a Japanese pharmaceutical company with a 138-year history discovering and developing innovative therapies. Shionogi Inc., the U.S. based subsidiary of Shionogi & Co., Ltd., continues this focus on the development and commercialization of high quality medicines that protect the health and well-being of the patients we serve. The company currently markets products in several therapeutic areas including women's health, anti-infectives, pain, and cardiovascular diseases. Our pipeline is focused on infectious disease, pain, CNS, and oncology.

BOOTH	ORGANIZATION	DESCRIPTION
432	SI-BONE, INC. www.si-bone.com	SI-BONE pioneered the use of the iFuse Implant System®, a minimally invasive surgical (MIS) device indicated for fusion of the sacroiliac (SI) joint. The triangular implant is designed specifically to stabilize and fuse the heavily loaded SI joint. More than 20,000 procedures have been performed with the iFuse Implant System—the method of choice for SI joint fusion. Multiple published studies have documented procedure safety and effectiveness. The iFuse System is intended for sacroiliac joint fusion for conditions including SI joint dysfunction that is a direct result of SI joint disruptions and degenerative sacroiliitis.
151	SMARTOX www.smartox.com	SMARTOX® is a dedicated provider of innovative and competitively priced drug screen products and services. Our drug screening products include point of collection urine cups, urine dip tests, oral fluid tests, and the exclusive Intelligent Fingerprinting™ drug test. SMARTOX® drug screen products are designed for use in clinics, hospitals, probation and parole departments, pre-employment and corporate settings, schools, rehabilitation centers, drug courts, jails, and treatment centers. SMARTOX® is committed to serving customers with drug testing products that offer advanced technology and exceptional results.
T30	SOUTHWEST MEDICAL ASSOCIATES www.smalv.com	Please visit our booth for more information.
147	SORE NO MORE www.sorenomore.com	Sore No More is a fast acting, natural pain relieving gel that begins to work immediately once massaged onto affected areas. Our special blend of 6 natural plant extracts in combination with menthol, capsaicin, and witch hazel will get rid of pain the natural way with its unique heating and cooling ingredients.
141	STRYKER www.stryker.com	Stryker is one of the world's leading medical technology companies and, together with our customers, we are driven to make health care better. The company offers a diverse array of innovative products and services in Orthopaedics, Medical and Surgical, and Neurotechnology and Spine that help improve patient and hospital outcomes. Stryker is active in over 100 countries around the world.
T28	TAKE COURAGE COACHING www.takecouragecoaching.com	Please visit our booth for more information.
317	TAKEDA PHARMACEUTICALS U.S.A., INC. www.takeda.us	Please visit our booth for more information.
T7	TAYLOR & FRANCIS GROUP www.taylorandfrancisgroup.com	Please visit our booth for more information.
201	TEVA CNS www.tevausa.com	Please visit our booth for more information.
244	THERMO FISHER www.thermofisher.com	Please visit our booth for more information.
246	THERMO FISHER SCIENTIFIC www.thermofisherscientific.com	Please visit our booth for more information.
444	TOTAL MEDICAL MANAGEMENT SOLUTIONS www.tmms.care	Please visit our booth for more information.

BOOTH	ORGANIZATION	DESCRIPTION
337	UCP BIOSCIENCES www.ucpbiosciences.com	UCP Biosciences, Inc is a leading manufacturer supplying most comprehensive FDA approval, OTC/CLIA Waived drug test products including AMP, BAR, BZO, BUP, COC, EDDP, MET, MTD, MDMA, morphine, OPI2000, OXY, PCP, PPX, THC. Other products include saliva drug tests, saliva alcohol, urine alcohol, EtG, bath salts, K2/spice, tramadol, fentanyl, ketamine, methaqualone, ritalin, APAP, LSD, zolpidem, clonazepam, 6-acetylmorphine, hydrocodone/hydromorphone, and cotinine. Our new Cup Scanner can automatically recognize DOA cup type and completes cup scanning in ~30 seconds. It is highly sensitive to faint lines formed by colloidal gold, and provides powerful image processing capability on scanning the results in DOA Cups.
T22	UNIVERSITY OF MARYLAND INTERDISCIPLINARY MASTER OF SCIENCE PALLIATIVE CARE (UMB) www.graduate.umaryland.edu	Please visit our booth for more information.
T17	US PAIN FOUNDATION www.uspainfoundation.org	Please visit our booth for more information.
450	VISION DIAGNOSTICS, INC.	Vision Diagnostics Inc. is introducing a new second generation of automated adulterant reagents. The reagents detect "stealth" type oxidants for several weeks improving detection by confirmatory labs. The automated specific gravity detects both dilution and salts (including baking soda, liquid drain openers, and potassium nitrite) and eliminates hazardous ingredients. All reagents including creatinine, pH, and glyceralsdehyde are in plug & play instrument-specific bar-coded packaging. The new creatinine is has a reporting range up to 500 mg/dL and users report superior on-board stability. All reagents are liquid stable and ready-to-use.
442	WATERS CORPORATION www.waters.com	Please visit our booth for more information.
407	XENOPORT www.xenoport.com	Please visit our booth for more information.



Restoring Hope, Rebuilding Lives

Located in Atlanta, Shepherd Center is a not-for-profit hospital specializing in medical treatment, research and rehabilitation for people with spinal cord or brain injury. A 152-bed facility accredited by the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities (CARF), Shepherd Center is ranked by U.S. News & World Report as one of the top 10 best rehabilitation hospitals in the nation!

We are currently seeking a full-time Clinical Psychologist/Pain Psychologist to work with pain patients with SCI, ABI and other neuromedical conditions. Qualifications include a PhD or PsyD from an APA-approved program in Clinical Psychology and successful completion of a one or two year postdoctoral fellowship/residency, or similar work experience in a health-related psychology position; Psychologist in the State of Georgia or eligible for licensure in Georgia; specialty training in pain management, health/rehabilitation/medical psychology; inpatient hospital experience. Experience working with inpatient settings and interdisciplinary treatment teams is preferred.

We understand that patients are going through more than just recovery from an injury; they are learning a new way of life.

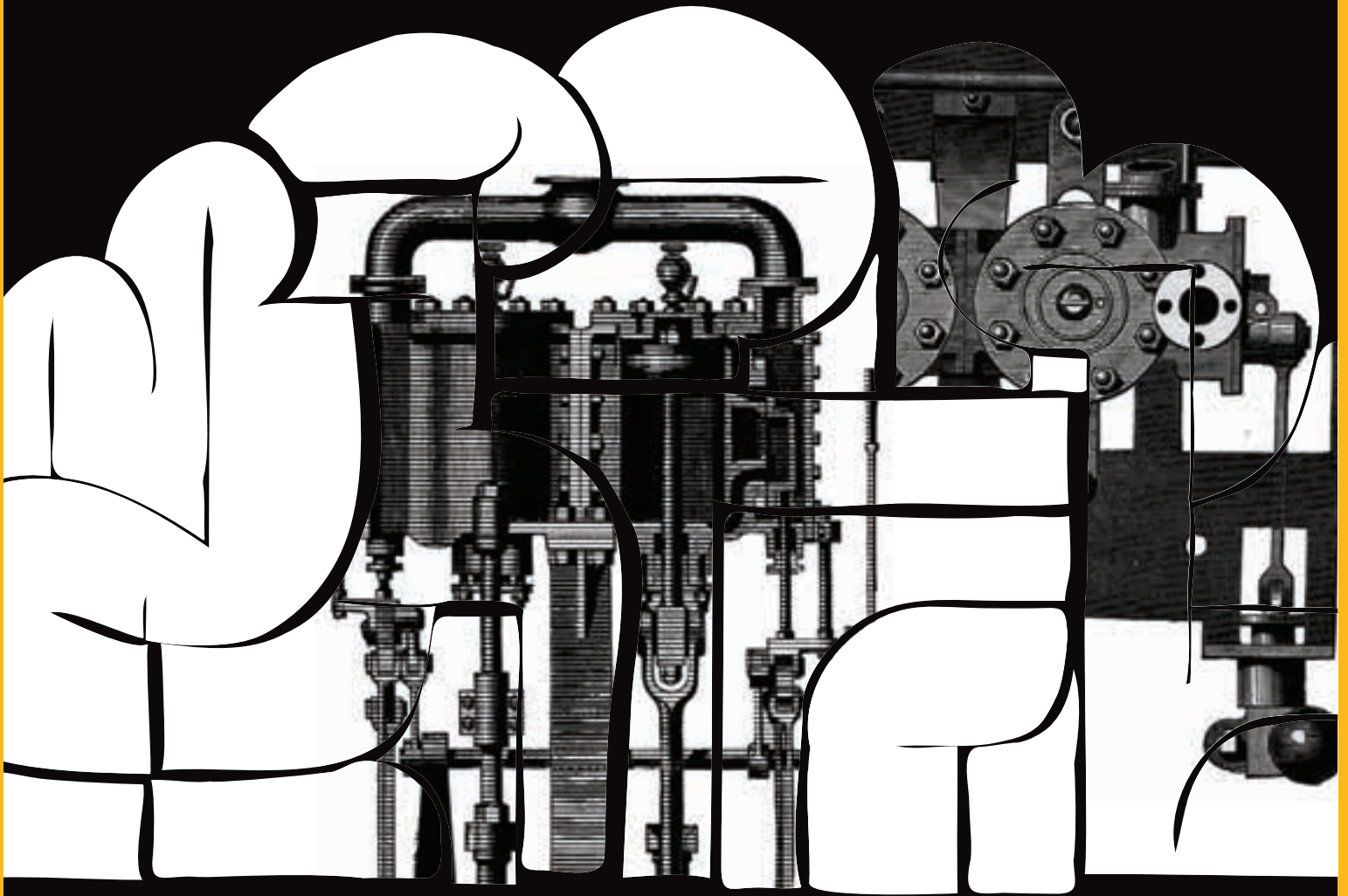
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GRALISE® (gabapentin) tablets

Rx Only

BRIEF SUMMARY OF FULL PRESCRIBING INFORMATION

This does not include all the information needed to use GRALISE safely and effectively. See full Prescribing Information for GRALISE.

INDICATIONS AND USAGE

- GRALISE is indicated for the management of postherpetic neuralgia.
- GRALISE is not interchangeable with other gabapentin products because of differing pharmacokinetic profiles that affect the frequency of administration.

DOSAGE AND ADMINISTRATION

- GRALISE should be titrated to an 1800 mg dose taken orally, once-daily, with the evening meal. GRALISE tablets should be swallowed whole. Do not crush, split, or chew the tablets. For recommended titration schedule, see DOSAGE AND ADMINISTRATION in full Prescribing Information.
- If GRALISE dose is reduced, discontinued, or substituted with an alternative medication, this should be done gradually over a minimum of 1 week or longer (at the discretion of the prescriber).
- Renal impairment: Dose should be adjusted in patients with reduced renal function. GRALISE should not be used in patients with CrCl less than 30 mL/min or in patients on hemodialysis.

CONTRAINDICATIONS

GRALISE is contraindicated in patients with demonstrated hypersensitivity to the drug or its ingredients.

WARNINGS AND PRECAUTIONS

GRALISE is not interchangeable with other gabapentin products because of differing pharmacokinetic profiles that affect the frequency of administration.

The safety and effectiveness of GRALISE in patients with epilepsy has not been studied.

Suicidal Behavior and Ideation

Antiepileptic drugs (AEDs), including gabapentin, the active ingredient in GRALISE, increase the risk of suicidal thoughts or behavior in patients taking these drugs for any indication. Patients treated with any AED for any indication should be monitored for the emergence or worsening of depression, suicidal thoughts or behavior, and/or any unusual changes in mood or behavior.

The increased risk of suicidal thoughts or behavior with AEDs was observed as early as one week after starting drug treatment with AEDs and persisted for the duration of treatment assessed.

Table 1: Risk by Indication for Antiepileptic Drugs (Including gabapentin, the active ingredient in GRALISE) in the Pooled Analysis

Indication	Placebo Patients with Events Per 1000 Patients	Drug Patients with Events Per 1000 Patients	Relative Risk: Incidence of Events in Drug Patients/Incidence in Placebo	Risk Difference: Additional Drug Patients with Events Per 1000 Patients
Epilepsy	1.0	3.4	3.5	2.4
Psychiatric	5.7	8.5	1.5	2.9
Other	1.0	1.8	1.9	0.9
Total	2.4	4.3	1.8	1.9

The relative risk for suicidal thoughts or behavior was higher in clinical trials for epilepsy than in clinical trials for psychiatric or other conditions, but the absolute risk differences were similar for the epilepsy and psychiatric indications.

Anyone considering prescribing GRALISE must balance the risk of suicidal thoughts or behavior with the risk of untreated illness. Epilepsy and many other illnesses for which products containing active components that are AEDs (such as gabapentin, the active component in GRALISE) are prescribed, are themselves associated with morbidity and mortality and an increased risk of suicidal thoughts and behavior. Should suicidal thoughts and behavior emerge during treatment, the prescriber needs to consider whether the emergence of these symptoms in any given patient may be related to the illness being treated.

Patients, their caregivers, and families should be informed that GRALISE contains gabapentin, which is also used to treat epilepsy and that AEDs increase the risk of suicidal thoughts and behavior and should be advised of the need to be alert for the emergence or worsening of the signs and symptoms of depression, any unusual changes in mood or behavior, or the emergence of suicidal thoughts, behavior, or thoughts about self-harm. Behaviors of concern should be reported immediately to healthcare providers.

Withdrawal of Gabapentin

Gabapentin should be withdrawn gradually. If GRALISE is discontinued, this should be done gradually over a minimum of 1 week or longer (at the discretion of the prescriber).

Tumorigenic Potential

In standard preclinical *in vivo* lifetime carcinogenicity studies, an unexpectedly high incidence of pancreatic acinar adenocarcinomas was identified in male, but not female, rats. The clinical significance of this finding is unknown.

In clinical trials of gabapentin therapy in epilepsy comprising 2,085 patient-years of exposure in patients over 12 years of age, new tumors were reported in 10 patients, and pre-existing tumors worsened in 11 patients, during or within 2 years after discontinuing the drug. However, no similar patient population untreated with gabapentin was available to provide background tumor incidence and recurrence information for comparison. Therefore, the effect of gabapentin therapy on the incidence of new tumors in humans or on the worsening or recurrence of previously diagnosed tumors is unknown.

Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS)/Multiorgan Hypersensitivity

Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS), also known as Multiorgan Hypersensitivity, has been reported in patients taking antiepileptic drugs, including GRALISE. Some of these events have been fatal or life-threatening. DRESS typically, although not exclusively, presents with fever, rash, and/or lymphadenopathy in association with other organ system involvement, such as hepatitis, nephritis, hematological abnormalities, myocarditis, or myositis sometimes resembling an acute viral infection. Eosinophilia is often present. Because this disorder is variable in its expression, other organ systems not noted here may be involved.

It is important to note that early manifestations of hypersensitivity, such as fever or lymphadenopathy, may be present even though rash is not evident. If such signs or symptoms are present, the patient should be evaluated immediately. GRALISE should be discontinued if an alternative etiology for the signs or symptoms cannot be established.

Laboratory Tests

Clinical trial data do not indicate that routine monitoring of clinical laboratory procedures is necessary for the safe use of GRALISE. The value of monitoring gabapentin blood concentrations has not been established.

ADVERSE REACTIONS

Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

In clinical trials in patients with postherpetic neuralgia, 9.7% of the 359 patients treated with GRALISE and 6.9% of 364 patients treated with placebo discontinued prematurely due to adverse reactions.

In the GRALISE treatment group, the most common reason for discontinuation due to adverse reactions was dizziness.

Table 2: Treatment-Emergent Adverse Reaction Incidence in Controlled Trials in Neuropathic Pain Associated with Postherpetic Neuralgia (Events in at Least 1% of all GRALISE-Treated Patients and More Frequent Than in the Placebo Group)

Body System – Preferred Term	GRALISE N = 359 %	Placebo N = 364 %
Ear and Labyrinth Disorders		
Vertigo	1.4	0.5
Gastrointestinal Disorders		
Diarrhea	3.3	2.7
Dry mouth	2.8	1.4
Constipation	1.4	0.3
Dyspepsia	1.4	0.8
General Disorders		
Peripheral edema	3.9	0.3
Pain	1.1	0.5
Infections and Infestations		
Nasopharyngitis	2.5	2.2
Urinary tract infection	1.7	0.5
Investigations		
Weight increased	1.9	0.5
Musculoskeletal and Connective Tissue Disorders		
Pain in extremity	1.9	0.5
Back pain	1.7	1.1
Nervous System Disorders		
Dizziness	10.9	2.2
Somnolence	4.5	2.7
Headache	4.2	4.1
Lethargy	1.1	0.3

The following adverse reactions with an uncertain relationship to GRALISE were reported during the clinical development for the treatment of postherpetic neuralgia. Events in more than 1% of patients but equally or more frequently in the GRALISE-treated patients than in the placebo group included blood pressure increase, confusional state, gastroenteritis, viral herpes zoster, hypertension, joint swelling, memory impairment, nausea, pneumonia, pyrexia, rash, seasonal allergy, and upper respiratory infection.

Postmarketing and Other Experience with Other Formulations of Gabapentin

In addition to the adverse experiences reported during clinical testing of gabapentin, the following adverse experiences have been reported in patients receiving other formulations of marketed gabapentin. These adverse experiences have not been listed above and data are insufficient to support an estimate of their incidence or to establish causation. The listing is alphabetized: angioedema, blood glucose fluctuation, breast enlargement, elevated creatine kinase, elevated liver function tests, erythema multiforme, fever, hyponatremia, jaundice, movement disorder, Stevens-Johnson syndrome.

Adverse events following the abrupt discontinuation of gabapentin immediate release have also been reported. The most frequently reported events were anxiety, insomnia, nausea, pain, and sweating.

DRUG INTERACTIONS

In vitro studies were conducted to investigate the potential of gabapentin to inhibit the major cytochrome P450 enzymes (CYP1A2, CYP2A6, CYP2C9, CYP2C19, CYP2D6, CYP2E1, and CYP3A4) that mediate drug and xenobiotic metabolism using isoform selective marker substrates and human liver microsomal preparations. Only at the highest concentration tested (171 mcg/mL; 1mM) was a slight degree of inhibition (14% to 30%) of isoform CYP2A6 observed. No inhibition of any of the other isoforms tested was observed at gabapentin concentrations up to 171 mcg/mL (approximately 15 times the C_{max} at 3600 mg/day).

Hydrocodone

Coadministration of gabapentin immediate release (125 mg and 500 mg) and hydrocodone (10 mg) reduced hydrocodone C_{max} by 3% and 21%, respectively, and AUC by 4% and 22%, respectively. The mechanism of this interaction is unknown. Gabapentin AUC values were increased by 14%; the magnitude of the interaction at other doses is not known.

Antacid (containing aluminum hydroxide and magnesium hydroxide)

An antacid containing aluminum hydroxide and magnesium hydroxide reduced the bioavailability of gabapentin immediate release by approximately 20%, but by only 5% when gabapentin immediate release was taken 2 hours after the antacid. It is recommended that GRALISE be taken at least 2 hours following the antacid (containing aluminum hydroxide and magnesium hydroxide) administration.

Drug/Laboratory Test Interactions

False positive readings were reported with the Ames-N-Multistix SG[®] dipstick test for urine protein when gabapentin was added to other antiepileptic drugs; therefore, the more specific sulfoisalicylic acid precipitation procedure is recommended to determine the presence of urine protein.

USE IN SPECIFIC POPULATIONS

Pregnancy Category C: GRALISE should be used during pregnancy or in women who are nursing only if the benefits clearly outweigh the risks. See full Prescribing Information for more information about use of GRALISE in pregnancy.

Pediatric Use

The safety and effectiveness of GRALISE in the management of postherpetic neuralgia in patients less than 18 years of age has not been studied.

Geriatric Use

The total number of patients treated with GRALISE in controlled clinical trials in patients with postherpetic neuralgia was 359, of which 63% were 65 years of age or older. The types and incidence of adverse events were similar across age groups except for peripheral edema, which tended to increase in incidence with age.

Renal Impairment

GRALISE is known to be substantially excreted by the kidney. Dosage adjustment is necessary in patients with impaired renal function. GRALISE should not be administered in patients with CrCl between 15 and 30 or in patients undergoing hemodialysis. [see *Dosage and Administration in Full Prescribing Information*].

DRUG ABUSE AND DEPENDENCE

The abuse and dependence potential of GRALISE has not been evaluated in human studies.

OVERDOSAGE

Acute oral overdoses of gabapentin immediate release in humans up to 49 grams have been reported. In these cases, double vision, slurred speech, drowsiness, lethargy and diarrhea were observed. All patients recovered with supportive care.

Gabapentin can be removed by hemodialysis. Although hemodialysis has not been performed in the few overdose cases reported, it may be indicated by the patient's clinical state or in patients with significant renal impairment.





Bring 24-hour relief into their routine

GRALISE is the **only once-a-day** gabapentinoid that offers Night to Day control of PHN pain¹



- Patients receiving GRALISE experienced significant pain reduction vs placebo beginning Week 1 and continuing throughout the 10-week study ($P < 0.05$)^{2,3}
- Average daily pain score reduction for GRALISE was -2.1 vs -1.6 with placebo ($P = 0.013$)²

Study Design: Patients from 89 investigative sites participated in this randomized, double-blind, parallel design, placebo-controlled, multicenter clinical trial. The study period included a 1-week baseline period, followed by randomization and a 2-week titration to a once-daily dose of 1800 mg G-GR or matched placebo, followed by an 8-week maintenance-dose period, followed by a 1-week dose-tapering period. 452 patients were randomized, with 221 receiving 1800 mg of GRALISE and 231 receiving placebo.²

Primary endpoint: change in the baseline observation carried forward (BOCF) average daily pain score from the baseline week to Week 10 of the efficacy treatment period.²

Learn more today at www.Gralise.com

INDICATIONS AND USAGE

GRALISE is indicated for the management of postherpetic neuralgia (PHN). GRALISE is not interchangeable with other gabapentin products because of differing pharmacokinetic profiles that affect the frequency of administration.

IMPORTANT SAFETY INFORMATION

ADVERSE REACTIONS

The most common side effects were dizziness (10.9%) and somnolence (4.5%).

USE IN SPECIFIC POPULATIONS

Reductions in GRALISE dose should be made in patients with age-related compromised renal function.

WARNINGS AND PRECAUTIONS

Suicidal Behavior and Ideation

Antiepileptic drugs (AEDs) including gabapentin, the active ingredient in GRALISE, increase the risk of suicidal thoughts or behavior in patients taking these drugs for any indication. Patients treated with any AED for any indication should be monitored for the emergence or worsening of depression, suicidal thoughts or behavior, and/or any unusual changes in mood or behavior.

For more information about GRALISE, please see Brief Summary on the following page.

References: 1. GRALISE [prescribing information]. Newark, CA: Depomed Inc.; December 2012.

2. Sang CN, Sathyanarayana R, Sweeney M. Gastroretentive gabapentin (G-GR) formulation reduces intensity of pain associated with postherpetic neuralgia (PHN). *Clin J Pain*. 2013;29:281-288.

3. Argoff CE, Chen C, Cowles VE. Clinical development of a once-daily gastroretentive formulation of gabapentin for treatment of postherpetic neuralgia: an overview. *Expert Opin Drug Deliv*. 2012;9:1147-1160.