



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-theclock, 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 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 and Brief Summary, including BOXED WARNING, on the following pages.



NUCYNTA ER
TAPENTADOL
EXTENDED-RELEASE

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 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 mg³* 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

940

OF COMMERCIALLY
INSURED PATIENTS.

PREFERRED FOR UNITEDHEALTH GROUP AND SILVERSCRIPT/ CVS CAREMARK PART D PLANS¹

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.

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 Pharmocother. 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.

^{*}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 state- or 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.

[‡]Source: MMIT 2.0, May 2015.

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 Gl 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.

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

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 (≥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.

Please see Brief Summary, including BOXED WARNING, on the following pages.







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, longterm 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 extendedrelease 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 (CO_2) 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 a 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 ≥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 ≥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 oxymorphone. 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 overthe-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 physicallydependent patient, an abstinence syndrome may occur. Some or all of the following can characterize this syndrome: restlessness, lacrimation, rhinorrhea, yawning, perspiration, chills, piloerection, 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 overdosage 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.

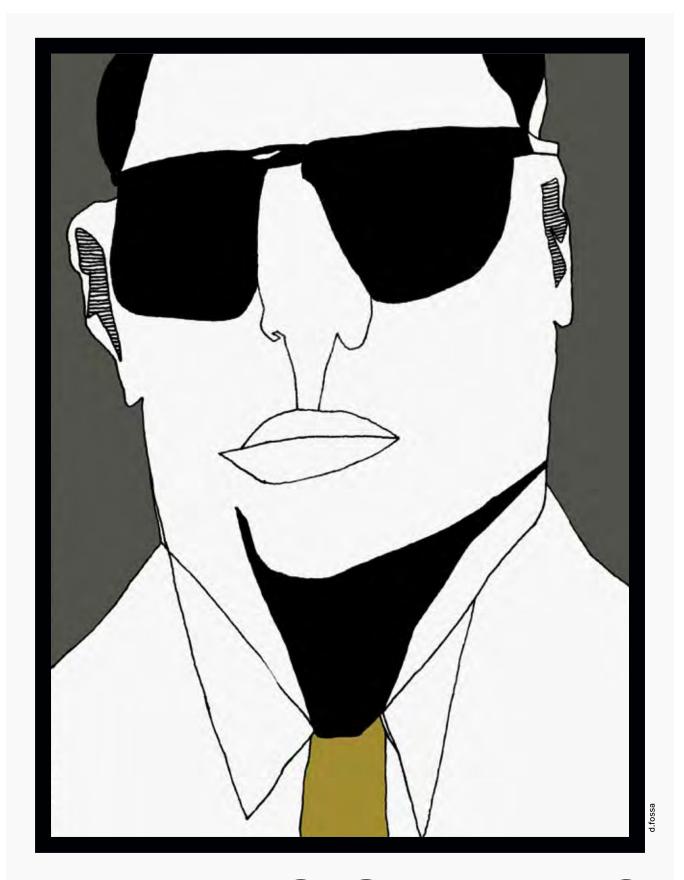
Treatment of Overdose

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.



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wednesday 9.9

PW'15

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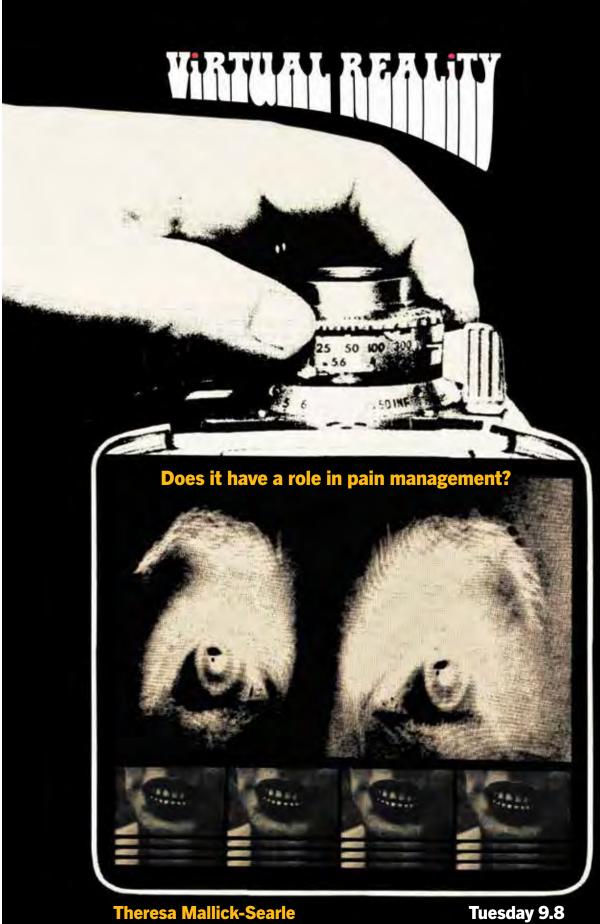
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Information provided was accurate as of press time. For the most up-to-date information please visit m.painweek.org. Any and all changes made subsequently regarding dates, times, courses, and faculty will also be reflected in *PAINWeek Daily News*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

1



Tuesday 9.8

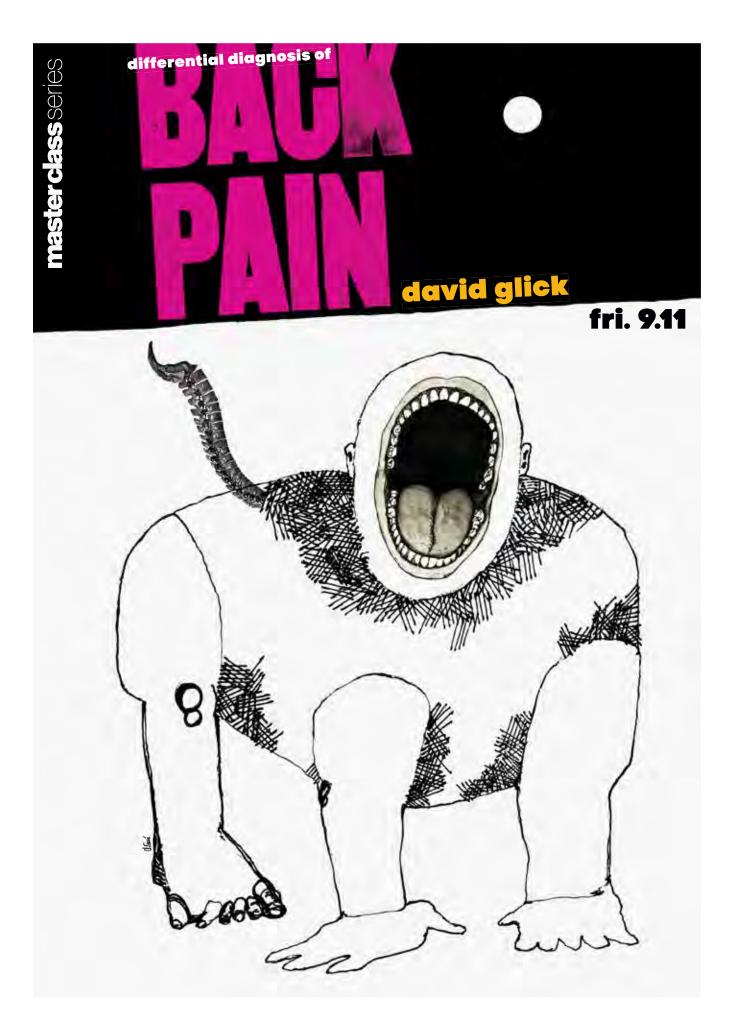
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Everything you need to know about PAINWeek on your smartphone, tablet, or laptop.

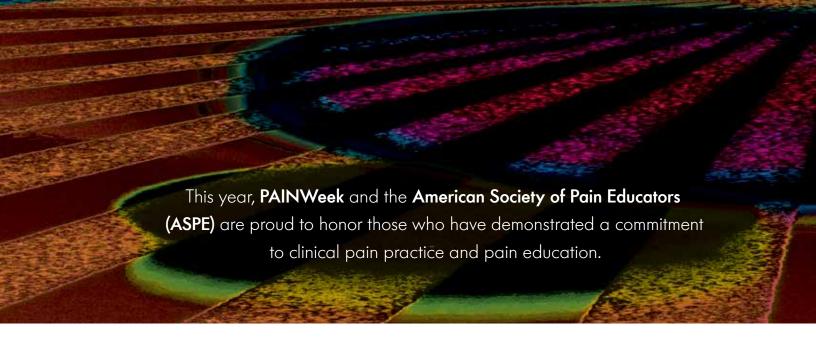


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- Link to session slides
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PAINWEEK PRACTITIONER OF THE YEAR

Kelvin B. **Burton**

MD

Dr. Kelvin B. Burton is the founder of Total Care Family Medicine in Douglasville and Temple, both in Georgia. His staff consists of psychologist Dr. Barry Keaton, 3 certified nurse practitioners, and 12 wonderful employees. Dr. Burton received his BS in biology from Morehouse College in Atlanta Georgia in 1984, his MD from the University of Iowa in 1988. He completed his family medicine residency in 1993 at Jacksonville Naval Hospital in Florida. He was honorably discharged as a Lieutenant Commander in 1995 after having served for 8 years, the highlight of which was his involvement in the entire Desert Shield/Desert Storm war. Dr. Burton has practiced primary care medicine in the West Georgia area for 20 years. He began delivering pain care after moonlighting in several emergency rooms and seeing firsthand the great need for chronic pain care management. Dr. Burton is married to Carol and they have 6 children. He firmly believes that the best way to honor patients is through faith, compassion, competency, and understanding. To achieve this, consideration should be made for the physical, emotional, and spiritual well-being of the patient. He feels that these attributes should be the cornerstone of any medical practice, and he is committed to delivering effective and quality healthcare to his patients.

"PAINWeek has been instrumental in keeping my practice on the cutting edge of pain management for my patients," said Dr. Burton. "It has helped me, along with my staff psychologist, to confidently develop an efficient and effective pain management program that elevates the care delivered

to our clients suffering with pain. PAINWeek has also been an important vehicle for me to educate my staff providers. It is extremely informative, exposes us to leaders in the field of pain management on a personal level, and stimulates us to practice sound, competent, and logical pain care. It would be difficult to imagine my practice without the influence of PAINWeek!"

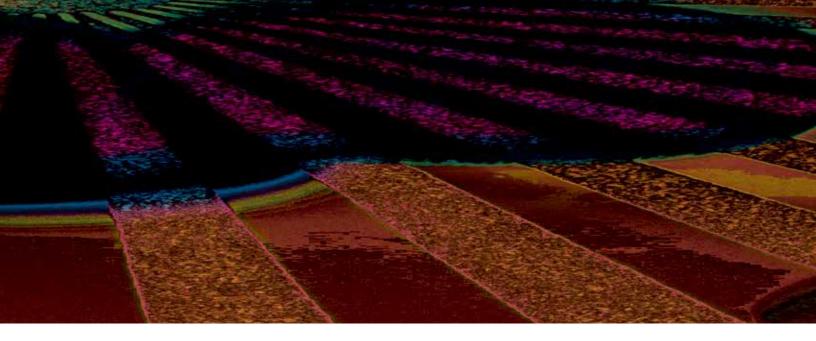
Sponsored by Teva Pharmaceuticals

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.



PAIN PALLIATIVE CARE PRACTITIONER OF THE YEAR

ASPE PAIN EDUCATOR OF THE YEAR

Tanya J. **Uritsky**PharmD, BCPS

Dr. Uritsky is a Clinical Pharmacy Specialist in pain management and palliative care at the Hospital of the University of Pennsylvania. For the past 5 years, she has been practicing in the inpatient setting and serves as the Palliative Care Pharmacist on the palliative care service. She also serves as a Pain Management Specialist within the pharmacy department and throughout the hospital. Additionally, she works in consultation with the inpatient hospice. She serves as a preceptor for pharmacy and medical students and residents, and trainees in other healthcare professions as represented on the palliative care service. She is a lecturer in pharmacology and therapeutics at the University of Pennsylvania School of Nursing. Dr. Uritsky received her Doctor of Pharmacy degree from the University of Maryland, Baltimore. She completed an ASHP-accredited Pharmacy Practice Residency at Union Memorial Hospital and an ASHP-accredited Specialty Residency in Pain and Palliative Care through the University of Maryland School of Pharmacy, both in Baltimore.

Sponsored by Xpress Laboratories

Paul Gileno

Founder, U.S. Pain Foundation

After a work injury left him with degenerative disc disease, failed back syndrome, and complex regional pain syndrome, Paul Gileno created U.S. Pain Foundation—a grassroots nonprofit organization to connect, inform, empower, and advocate for the pain community. It now has over 65,000 members with representation in every state. He empowers those suffering with pain and helps the general public better understand the toils and trials those with pain endure.

Among his contributions to advancing awareness: the pain warrior bracelet initiative; the INvisible Project, a national campaign of photography and stories (seen here at PAINWeek) illustrating the struggles and resilience of those with pain; Act 11-169 legislation, which has had a direct benefit on the medical care residents living with chronic pain receive.

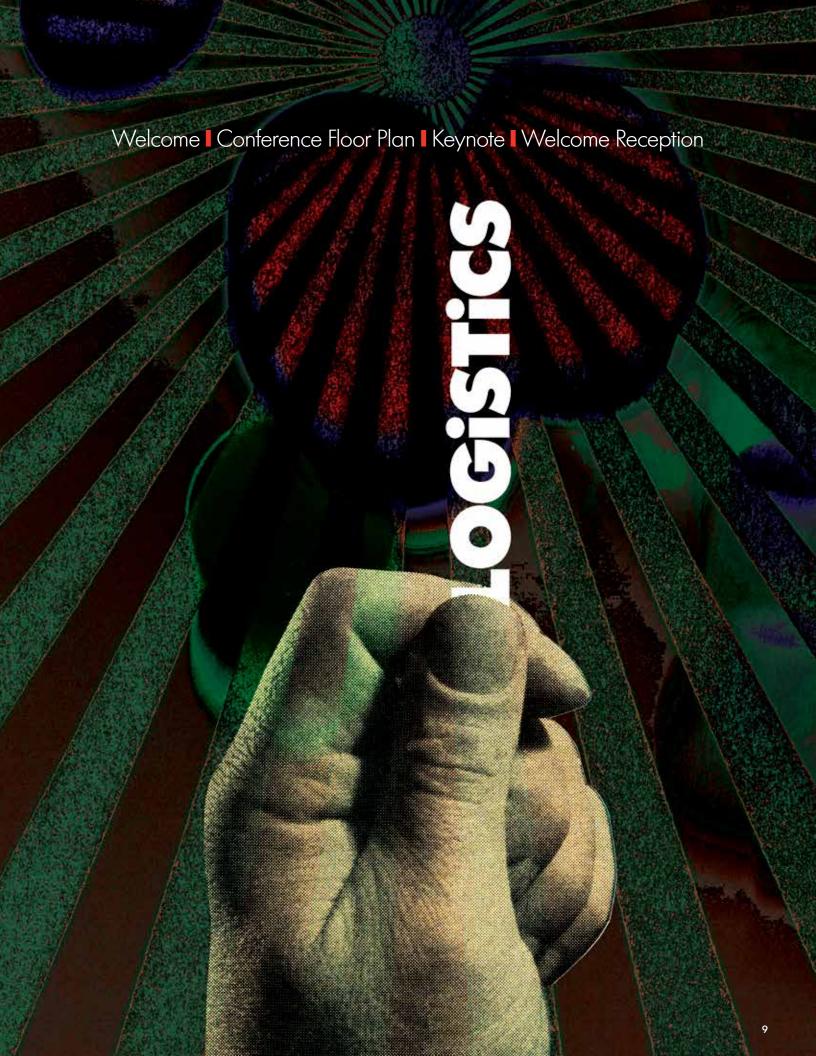
Paul is on the PainPathways magazine Advisory Board and sits on numerous steering committees and advisory committees that focus on patient care and access. In May 2014, he was the recipient of the Grünenthal USA Unsung Hero Award for his stellar work in pain policy initiatives and significant contributions to advancing the social awareness of pain and suffering.

clinical conundrum:



the pertinent negative

THE P LEART.







MELCOME DEAR PAINWEEK DELEGATES:

To our new and returning participants, we extend a warm welcome!

This year marks the 9th annual **PAINWeek National Conference**. Over the next 5 days, you'll have the opportunity to select from the most comprehensive curriculum of certified pain education available, with approximately 150 CE/CME hours of instruction! We're confident that you'll return from the week with new tools and skills to enhance your effectiveness as a pain practitioner, and we appreciate your participation in the collaborative journey that is PAINWeek.

In January of this year, the National Institutes of Health released a report¹ detailing urgently needed steps that practitioners should take to provide more effective pain care and to respond to the burgeoning problem of prescription medication and heroin abuse. The NIH concluded that many healthcare providers are poorly prepared to manage chronic pain, observing that "...clinical decision-making for long-term opioid therapy is complex and requires individualized benefit—risk assessments; opioid selection and dose initiation and titration strategies; integration of risk assessment and mitigation strategies; and consideration of alternative, nonopioid therapies."

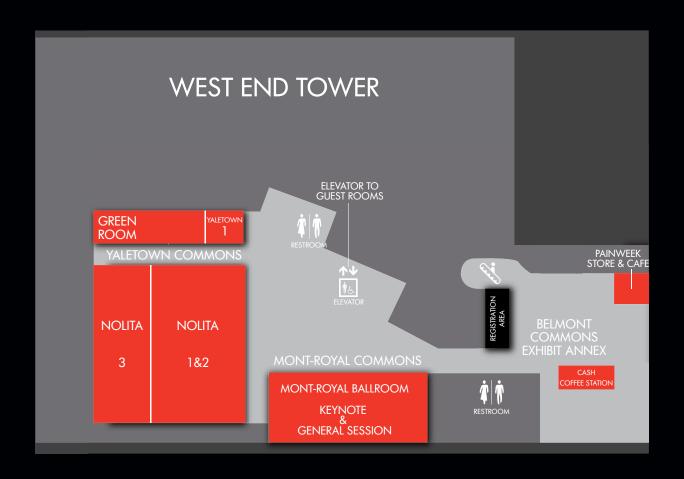
As the largest US pain conference for frontline practitioners, PAINWeek offers the best opportunity to improve your grounding in pain assessment and diagnosis, your skills in medication risk evaluation and mitigation, and your ability to provide individualized multimodal treatment for your patients. In reviewing this Program Guide, you'll see much that is new at the conference this year. We welcome the American Headache Society and the American Society of Addiction Medicine and their respective programs, and we are excited to present new course tracks from the American Academy of Pain Medicine, the American Pain Society, and the National Association of Drug Diversion Investigators. The American Society of Pain Educators presents its 10th Pain Educators Forum that now includes "Neuropathica Galactica," a limited attendance workshop and practice based expedition in assessment, patient education, and treatment planning.

PAINWeek 101, offered on Monday evening, is a special opportunity for new participants to orient and prepare for the conference experience. First timers and veterans alike are invited to our **Keynote Presentation** on Wednesday, followed by refreshments and the opportunity to network with colleagues at the **Welcome Reception** in the Exhibit Hall.

Through the years, PAINWeek has evolved to much more than a single event, and as a conference participant, you're automatically included in the platform of pain education that now includes our regular electronic and print communications and our content-rich website. We encourage you to make full use of these opportunities to learn, grow, and improve. Welcome to PAINWeek, and enjoy the experience!

Chou R, Turner JA, Devine EB, et al. The effectiveness and risks of long-term opioid therapy for chronic pain: a systematic review for a National Institutes of Health Pathways to Prevention Workshop. Ann Intern Med. 2015;162(4):276-286.

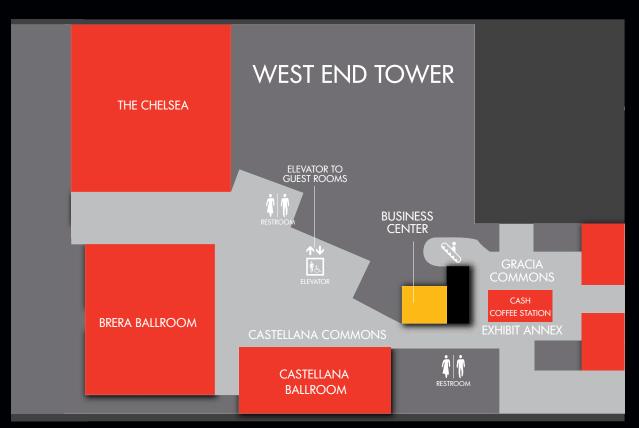
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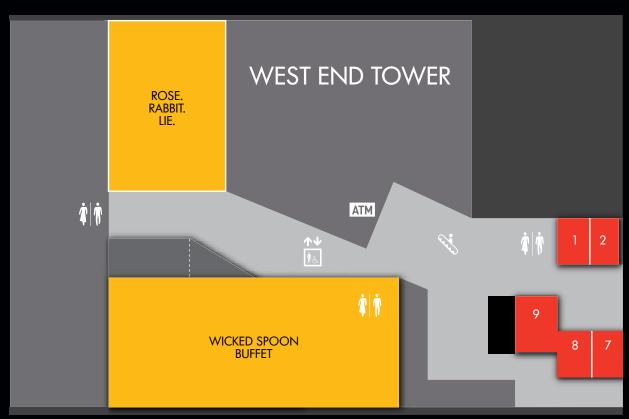
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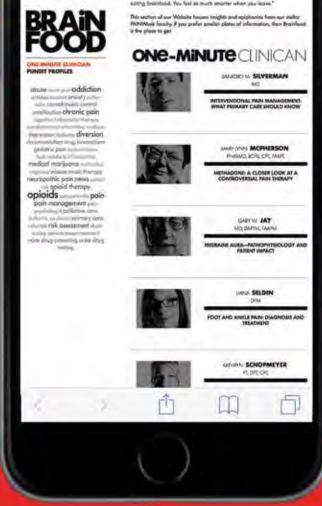


LEVEL2





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



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Charles Argoff

Pastram or Prescriptions?

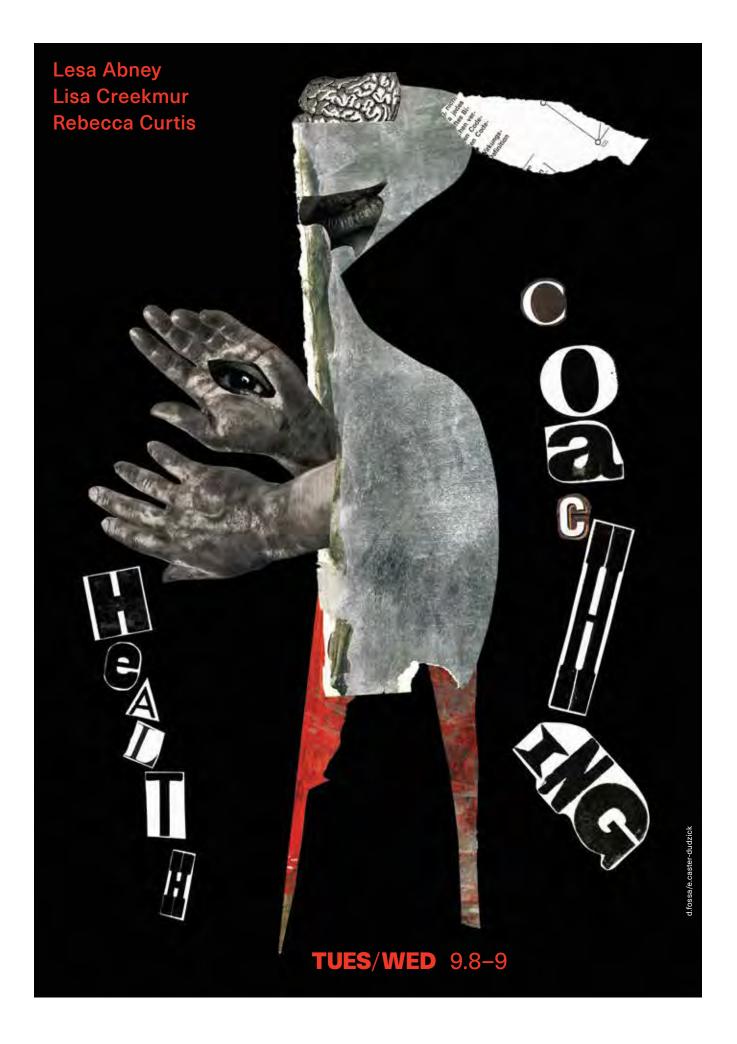
the deli can wait...

we need more and better pain practitioners NOW!

Wed 9.9 5:30p-6:30p

Level 4 Mont-Royal Ballroom







TUESDAY

CAM-01	Biofeedback and Chronic Pain: Making the Connection	7:00 a - 7:55 a	Level 4/ Nolita 3	Anthony A. Whitney, MS, LHMC, BCB
SIS-O1	3-Way Street: When Acute Pain Becomes Chronic	7:00 a - 7:55 a	Level 4/ Mont-Royal Ballroom	Kevin L. Zacharoff, MD, FACIP, FACPE, FAAP
sis-35	Motivating Your Patients in Pain Towards Physical Therapy	7:00 a – 7:55 a	Level 4/ Nolita 2	Kathryn Schopmeyer, PT, DPT, CPE
SIS-05	Connecting the Anatomical Dots for Common Pain Syndromes: An Overview of Injection Techniques for Frontline Practitioners	7:00 a – 8:55 a	Level 4/ Yaletown 1	Michael K. Perry, CRNA
SIS-O2	State Dosage Thresholds and Their Potential Impacts on Pain and Overdose Prevention	8:00 a – 8:55 a	Level 4/ Mont-Royal Ballroom	Jeffrey Fudin, PharmD, FCCP Stephen J. Ziegler, PhD, JD
sis-34	Improving Pain Management HCAHPS Scores	8:00 a – 8:55 a	Level 4/ Nolita 2	Jeffrey A. Gudin, MD Cynthia F. Knorr-Mulder, MSN, BCNP, NP-C
sis-36	Combating One Public Health Crisis With Another: Patients' Response to DEA Rescheduling of Opioids	8:00 a – 8:55 a	Level 4/ Nolita 3	Barbara L. Kornblau, JD, OTR/L, CPE, DASPE
CAM-02	Nutrition and Pain: Rules for Success	9:00 a – 9:55 a	Level 4/ Nolita 3	Hal S. Blatman, MD, DAAPM, ABIHM
sis-03	Is That Medicine Real or Counterfeit?	9:00 a - 9:55 a	Level 4/Nolita 2	Jay Joshi, MD
NRP-01	Demystifying Pain Management: One Case at a Time	9:00 a – 10:55 a	Level 4/ Nolita 1	Theresa Mallick-Searle, MS, RN-BC, ANP-BC
sis-04	Let No Man Write My Epitaph: Managing Chronic Pain in the Patient With Addiction	9:00 a – 12:00 p	Level 4/ Mont-Royal Ballroom	Melissa Durham, PharmD Steven Richeimer, MD Harriet Rossetto, LCSW
PREPEF	Neuropathica Galactica (Note: This course is limited to 60 learners. Preregistration is required; onsite registration is not permitted.)	9:00 a – 5:00 p	Level 3/ Gracia 5	Christopher M. Herndon, PharmD, BCPS, CPE Mary Lynn McPherson, PharmD, BCPS, CPE, FASPE
	Break	10:00 a - 10:20 a		
BHV-01	The Biopsychosocialspiritual Impact of Chronic Pain in Adolescence	10:20 a – 11:10 a	Level 4/ Nolita 2	Melissa E. A. Geraghty, PsyD
MDL-O1	Embrace 2015 Practice Changes and Patient Education: Overview of Critical Pain Management Issues	10:20 a – 12:10 p	Level 3/ Gracia 3	Jennifer Bolen, JD
BHV-02	Depression and Suicidal Behavior With Pain and Concomitant Substance Abuse Disorders	11:15 a – 12:10 p	Level 4/ Nolita 2	Martin D. Cheatle, PhD

CAM-03	Mind-Body Connection: It's Not Just in Your Head!	11:15 a – 12:10 p	Level 4/ Nolita 3	Anthony A. Whitney, MS, LHMC, BCB
NRP-02	Opioid Rotation: An Effective Technique in Reducing Opioid Dose and Mitigating Risk	11:15 a – 12:10 p	Level 4/ Nolita 1	Richard L. Talusan, DNP, FNP-BC, NEA-BC
SYM-O1	Comprehensive Pain Management: Uncovering and Addressing Opioid-Induced Constipation	12:00 p - 1:30 p	Level 3/ Brera Ballroom	Charles E. Argoff, MD, CPE Jeffrey A. Gudin, MD Anthony J. Lembo, MD
CAM-04	High-Density Platelet-Rich Plasma and Stem Cell Prolotherapy for Musculoskeletal Pain	1:35 p - 2:30 p	Level 4/ Nolita 3	Donna Alderman, DO
NRP-03	Safe Opioid Precribing: From Genomics to Disposal	1:35 p – 2:30 p	Level 4/ Nolita 1	Brett B. Snodgrass, MSN, APRN, FNP-C
sıs-37	Perception vs Reality: An Overview of Epidural Steroids	1:35 p - 2:30 p	Level 4/ Nolita 2	Jay Joshi, MD
MAS-01	Neurogenic Thoracic Outlet Syndrome	1:35 p – 3:30 p	Level 4/Yaletown 1	Allen J. Togut, MD
CAM-05	Identifying and Unlocking Myofascial Pain	2:35 p - 3:30 p	Level 4/Nolita 3	Hal S. Blatman, MD, DAAPM, ABIHM
NRP-04	The Complex Pain Patient: Addiction, Obesity, and the Elderly	2:35 p - 3:30 p	Level 4/ Nolita 1	Brett B. Snodgrass, MSN, APRN, FNP-C
HCH-01	Outside the Box: Rethinking Pain Management Paradigms	3:35 p - 4:30 p	Level 4/ Nolita 3	Lesa Abney, RN-BC, NC-BC Lisa Creekmur, BSN, RN, NC-BC, CPH&WC Rebecca L. Curtis, PCC
REG-O1	It's NOT Vulvodynia: It's Lichen Sclerosus! Have You Missed this Diagnosis?	3:35 p - 4:30 p	Level 4/Nolita 2	Barbara L. Kornblau, JD, OTR/L, CPE, DASPE
sis-06	Virtual Reality: Does It Have a Role in Pain Management?	3:35 p - 4:30 p	Level ₄ / Mont-Royal Ballroom	Theresa Mallick-Searle, MS, RN-BC, ANP-BC
вну-оз	"It Could Be Worse" and Other Things NOT to Say to Patients With Chronic Pain	4:35 p - 5:25 p	Level 4/ Nolita 2	Melissa E. A. Geraghty, PsyD
HCH-O2	The Pain Management Coaching Toolbox	4:35 p - 5:25 p	Level 4/ Nolita 3	Lesa Abney, RN-BC, NC-BC Lisa Creekmur, BSN, RN, NC-BC, CPH&WC Rebecca L. Curtis, PCC
NRP-05	Opioid Monitoring at a Nurse Practitioner Managed Clinic	4:35 p - 5:25 p	Level 4/ Nolita 1	Richard L. Talusan, DNP, FNP-BC, NEA-BC

WEDNESDAY



sis-07	PDMPs: A Nail in Search of a Hammer	7:00 a - 7:55 a	Level 4/Yaletown 1	Matthew P. Foster, PharmD
SYM-02	Multimodal Approaches to the Treatment of Mixed Pain: What Is New?	7:00 a – 7:55 a	Level 3/ Gracia 5	Oscar de Leon-Casola, MD
PDM-01	An Extended-Release Oral Hydrocodone Bitartrate Therapy*	8:00 a - 8:55 a	Level 3/ Castellana Ballroom	Michael J. Brennan, MD Joseph V. Pergolizzi, MD
PDM-02	The Treatment of PHN: Unmet Needs Still Exist*	8:00 a – 8:55 a	Level 3/ Brera Ballroom	Gregory L. Holmquist, PharmD, CPE
MSK-01	Osteoarthritis	9:00 a - 9:55 a	Level 4/Nolita 3	Steven P. Stanos, DO
PEF-O1	Pain Terminology: Knowing the Difference Makes a Difference!	9:00 a – 9:55 a	Level 4/ Nolita 1	David M. Glick, DC, DAAPM, CPE, FASPE Mary Lynn McPherson, PharmD, BCPS, CPE, FASPE
sis-08	Complex Regional Pain Syndrome: Prevention, Assessment, and Treatment	9:00 a – 10:55 a	Level 3/ Gracia 7	Russell L. Bell, MD Martin D. Cheatle, PhD Peter G. Pryzbylkowski, MD Peter Yi, MD
SIS-1O	Pain Clinical Trials	9:00 a – 10:55 a	Level 4/ Mont-Royal Ballroom	Frank Breve, PharmD, MBA Errol M. Gould, PhD Marc Hoffman, MD Srinivas Nalamachu, MD Joseph V. Pergolizzi, MD Robert B. Raffa, PhD Robert Taylor, Jr, PhD
	Break	10:00 a - 10:20 a		
sym-03	Essential Tools for Treating the Patient in Pain™ Anatomy of Ouch: The Pathophysiology of Pain	10:20 a – 11:10 a	Level 3/ Gracia 1	Charles E. Argoff, MD, CPE
нсн-оз	Outside the Box: Rethinking Pain Management Paradigms (Encore)	10:20 a – 11:10 a	Level 4/ Nolita 3	Lesa Abney, RN-BC, NC-BC Lisa Creekmur, BSN, RN, NC-BC, CPH&WC Rebecca L. Curtis, PCC
PEF-O2	Pain Pathophysiology Unraveled	10:20 a - 11:10 a	Level 4/Nolita 1	David M. Glick, DC, DAAPM, CPE, FASPE
MDL-02	Get Your Specimens in Order: The Impact of Changes to the Clinical Laboratory Fee Schedule	10:20 a – 12:10 p	Level 3/ Gracia 3	Jennifer Bolen, JD
нсн-о4	The Pain Management Coaching Toolbox (Encore)	11:15 a – 12:10 p	Level 4/ Nolita 3	Lesa Abney, RN-BC, NC-BC Lisa Creekmur, BSN, RN, NC-BC, CPH&WC Rebecca L. Curtis, PCC
мѕк-оз	Whiplash	11:15 a – 12:10 p	Level 3/ Gracia 5	James Matthew Elliott, PT, PhD
PEF-03	Chronic Pain Assessment	11:15 a – 12:10 p	Level 4/ Nolita 1	Michael R. Clark, MD, MPH, MBA
SYM-04	Essential Tools for Treating the Patient in Pain™	11:15 a – 12:10 p	Level 3/ Gracia 1	Armando Villarreal, MD



PDM-03	Targeting Success: An Interactive Discussion of a Next Generation Molecule*	12:15 p – 1:30 p	Level 3/ The Chelsea	Gregory L. Holmquist, PharmD, CPE Joseph V. Pergolizzi, MD Steve Vacalis, DO
sis-09	The Groundhog Day Phenomenon	1:35 p – 2:30 p	Level 4/ Mont-Royal Ballroom	Kevin L. Zacharoff, MD, FACIP, FACPE, FAAP
SIS-12	The Tyranny of "Shoulds"	1:35 p – 2:30 p	Level 3/Gracia 5	Steven D. Passik, PhD
SYM-05	Essential Tools for Treating the Patient in Pain™ Strategies for Success With Chronic Opioid Therapy	1:35 p – 2:30 p	Level 3/ Gracia 1	Farshad Ahadian, MD
MSK-O2	Assessing and Managing Acute and Chronic Low Back Pain	1:35 p – 3:30 p	Level 3/ Gracia 3	Russell L. Bell, MD Martin D. Cheatle, PhD Peter G. Pryzbylkowski, MD Peter Yi, MD
PEF-04	Pain Therapeutics	1:35 p – 3:30 p	Level 4/Nolita 1	Tanya Uritsky, PharmD, BCPS
MSK-04	Fibromyalgia	2:35 p – 3:30 p	Level 4/Nolita 3	Steven P. Stanos, DO
SIS-11	Pain Management in Workers' Compensation: Overview of Spend, Utilization, and Treatment Guidelines	2:35 p - 3:30 p	Level 3/ Gracia 5	Matthew P. Foster, PharmD
sis-13	Who's On First? Pain Specialists Discuss Their Approaches to Pain Management	2:35 p – 3:30 p	Level 4/ Mont-Royal Ballroom	Charles E. Argoff, MD, CPE Michael R. Clark, MD, MPH, MBA Gary E. Kaplan, DO, ABFP, DABPM, FAAMA Srinivas Nalamachu, MD Sanford M. Silverman, MD
	Break	3:35 p - 4:30 p		
PDM-04	Conversations That Matter: Addressing Challenging Topics in the Exam Room*	3:35 p - 4:30 p	Level 3/ Castellana Ballroom	Laura Cooley, PhD Paul Gileno Richard Payne, MD Bob Twillman, PhD, FAPM
PEF-05	Pain Diagnostics: Clinical Pearls to Improve Common Tests for Pain	4:35 p - 5:25 p	Level 4/ Nolita 1	David M. Glick, DC, DAAPM, CPE, FASPE
SIS-14	The Bulletproof Prescriber	4:35 p - 5:25 p	Level 4/ Nolita 3	Marc S. Gonzalez, PharmD Steve Louie, JD
syм-06	Essential Tools for Treating the Patient in Pain™ Understanding and Treating Neuropathic Pain	4:35 p - 5:25 p	Level 3/ Gracia 1	Charles E. Argoff, MD, CPE
KEY-O1	Keynote*	5:30 p – 6:30 p	Level 4/ Mont-Royal Ballroom	Charles E. Argoff, MD, CPE Michael R. Clark, MD, MPH, MBA Kevin L. Zacharoff, MD, FACIP, FACPE, FAAP
-	Welcome Reception*	6:30 p – 9:00 p	Level 4/Belmont Ballroo	

THURSDAY



FIN-01	Pain-Free Insights of Public Equity Investing*	7:00 a - 7:55 a	Level 4/Yaletown 1	Samuel Dedio
sis-1 <u>5</u>	Current Evidence-Based Guidelines for the Use of Ultrasound in Pain	7:00 a - 7:55 a	Level 3/ Gracia 7	Michael M. Bottros, MD
sis-16	Understanding DEA Requirements for Electronic Prescribing of Controlled Substances	7:00 a - 7:55 a	Level 3/ Gracia 1	Sean P. Kelly, MD
sis-32	Controversies in Pain Medicine Fudin vs Gudin: The Gloves Come Off!	7:00 a – 7:55 a	Level 3/ Gracia 5	Jeffrey Fudin, PharmD, FCCP Jeffrey A. Gudin, MD
PDM-05	Opioid-Induced Constipation: The Science, the Struggle, and an Orally Administered Treatment Option*	8:00 a – 8:55 a	Level 3/ Brera Ballroom	Gerald M. Sacks, MD
рдм-06	Prioritizing the Patient in the Opioid Debate: A Roundtable Discussion*	8:00 a - 8:55 a	Level 3/ Castellana Ballroom	TBA
NAD-01	Rx Abuse and Diversion: The Scope of the Problem in 2015	9:00 a - 9:55 a	Level 4/ Mont-Royal Ballroom	Lisa M. McElhaney, BS
POD-01	Diagnosis and Treatment of Superimposed Chronic Lower Extremity Nerve Entrapment in Patients With Metabolic Disease	9:00 a – 9:55 a	Level 4/ Nolita 3	Stephen L. Barrett, DPM, MBA
sis-19	The Imperfect Solution	9:00 a - 9:55 a	Level 3/ Gracia 1	Kevin L. Zacharoff, MD, FACIP, FACPE, FAAP
MAS-03	Shaken—Not Stirred: Minor Traumatic Brain Injury and Concussion	9:00 a – 10:55 a	Level 3/ Gracia 7	Gary W. Jay, MD, FAAPM
	Break/Exhibits	10:00 a - 10:20 a		
NAD-02	Scammers, Shammers, and Thieves	10:20 a – 11:10 a	Level 4/ Mont-Royal Ballroom	Marc S. Gonzalez, PharmD
sis-17	Controversies in Pain Medicine X = The Unknown: Widespread Pain	10:20 a – 11:10 a	Level 3/ Gracia 1	Charles E. Argoff, MD, CPE Gary E. Kaplan, DO, ABFP, DABPM, FAAMA
MDL-03	Focus on Changes in Billing/Coding Clinical Laboratory: Roll With the Changes and Learn How to Keep Payors Out of Your Bank Account	10:20 a – 12:10 p	Level 3/ Gracia 3	Jennifer Bolen, JD
PEF-06	Talking (and Perhaps Listening to) Patients With Pain: A Primer	10:20 a – 12:10 p	Level 4/ Nolita 1	Martin D. Cheatle, PhD Michael E. Schatman, PhD, CPE, DASPE
POD-02	Morton's Neuritis	11:15 a – 12:10 p	Level 4/Nolita 3	Andrew Rader, DPM
REG-02	Regional Pain Syndromes: When Sex Hurts	11:15 a – 12:10 p	Level 3/ Gracia 5	Georgine Lamvu, MD, MPH, FACOG
sis-18	Facet Joint Pain: Advances in Diagnosis and Treatment	11:15 a – 12:10 p	Level 3/ Gracia 1	Michael M. Bottros, MD

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PDM-07	Understanding Abuse-Deterrent Opioid Technologies*	12:15 p – 1:30 p	Level 3/ Brera Ballroom	Michael J. Brennan, MD Jeffrey A. Gudin, MD
PDM-08	Opioid-Induced Constipation*	12:15 p – 1:30 p	Level 3/ Castellana Ballroom	Steven Simon, MD
NAD-03	Opioid Overdose Strategies: Are They Working?	1:35 p – 2:30 p	Level 4/ Mont-Royal Ballroom	Lisa M. McElhaney, BS
PEF-07	Risk Assessment: What It Is and How to Use It	1:35 p - 2:30 p	Level 4/ Nolita 1	Ted W. Jones, PhD, CPE
SIS-20	Hurts So Good: Examining the Crossroads of Pain and Pleasure	1:35 p - 2:30 p	Level 4/ Nolita 3	Michael R. Clark, MD, MPH, MBA
MAS-02	Integrative Pain Management	1:35 p – 3:30 p	Level 3/ Gracia 7	Gary E. Kaplan, DO, ABFP, DABPM,
pef-08	Adult Learning: Not for the Faint of Heart	2:35 p – 3:30 p	Level 4/ Nolita 1	Kashelle Lockman, PharmD Mary Lynn McPherson, PharmD, BCPS, CPE, FASPE
POD-03	"Underneath the Radar" Lower Extremity Pain Generators— Diagnosis and Treatment	2:35 p - 3:30 p	Level 4/ Nolita 3	Stephen L. Barrett, DPM, MBA
SIS-21	Suspicion: What Should I Do if I Think My Patient Is Diverting, Abusing, or Both?	2:35 p - 3:30 p	Level 4/ Mont-Royal Ballroom	Kevin Barnard Jennifer Bolen, JD Stephen J. Ziegler, PhD, JD
	Break/Exhibits	3:35 p - 4:30 p		
PDM-09	Overview of Emerging Technologies: Opioids with Labeled Abuse-Deterrent Properties and Claims (OADP)*	3:35 p - 4:30 p	Level 4/ Mont-Royal Ballroom	TBA
PDM-10	Salix Pharmaceuticals Product Theatre*	3:35 p - 4:30 p	Level 3/ Castellana Ballroom	Steven Simon, MD
NAD-04	Addiction and Drug Histories: A Cop's Eye View From the Street to the Clinician's Office	4:35 p - 5:25 p	Level 3/ Gracia 3	Marc S. Gonzalez, PharmD
PEF-09	Creating a Treatment Plan for Higher Risk Patients: A Case Based Approach	4:35 p - 5:25 p	Level 4/ Nolita 1	Ted W. Jones, PhD, CPE
REG-03	Regional Pain Syndromes: Simplifying the Gender Specific Complexities of Female Chronic Pelvic Pain	4:35 p - 5:25 p	Level 3/ Gracia 5	Georgine Lamvu, MD, MPH, FACOG
POS-O1	Scientific Poster Session and Reception*	7:00 p - 9:00 p	Level 3/ The Chelsea	

FRIDAY

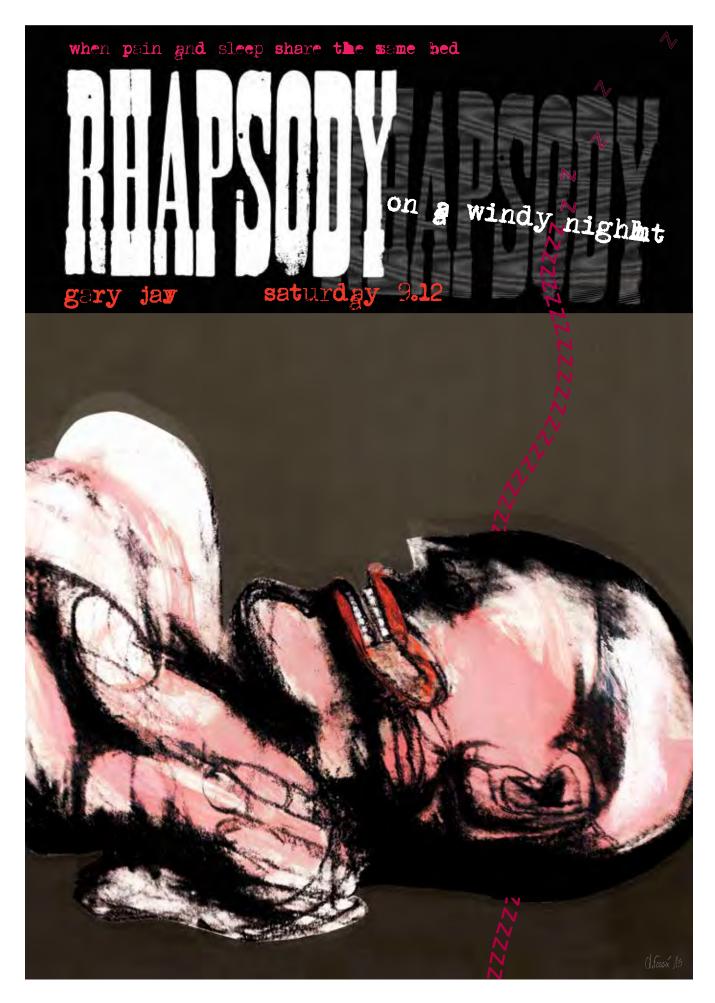
APS-O1	Why Does It Hurt to Get Old and What Can We Do About It?	7:00 a - 7:55 a	Level 3/ Gracia 1	Roger B. Fillingim, PhD
POS-O2	Poster/Podium Presentations*	7:00 a - 7:55 a	Level 3/ Gracia 5	Srinivas Nalamachu, MD Joseph V. Pergolizzi, MD
SIS-22	Visceral Pain	7:00 a - 7:55 a	Level 3/ Gracia 3	Paul J. Christo, MD, MBA
SIS-23	Chronic Pain Patients Who Fail Standard Opioid Dosages	7:00 a - 7:55 a	Level 4/ Mont-Royal Ballroom	Forest Tennant, MD, DrPH, FACPM, MPH
PDM-11	Opioid Emergencies: The Stakes Couldn't Be Higher. The Case for Naloxone*	8:00 a – 8:55 a	Level 3/ Castellana Ballroom	Eric Edwards, MD, PhD Jeffrey A. Gudin, MD Mark A. Kallgren, MD Bob A. Rappaport, MD
PDM-12	FDA NSAID Safety Update and Pain Management Options*	8:00 a – 8:55 a	Level 3/ Brera Ballroom	Christopher Gharibo, MD
NRO-01	The Neurological Examination: An Overview	9:00 a - 9:55 a	Level 4/ Nolita 3	Charles E. Argoff, MD, CPE
sis-28	Medical Cannabinoids: An Update on What You Need to Know for Your Practice	9:00 a - 9:55 a	Level 4/ Mont-Royal Ballroom	Michael E. Schatman, PhD, CPE, DASPE
AHS-O1	Comprehensive Migraine Education Program (Part 1)	9:00 a – 10:55 a	Level 3/ Gracia 7	Frank Andrasik, PhD Sheena K. Aurora, MD Andrew C. Charles, MD Richard B. Lipton, MD Matthew Robbins, MD, FAHS
	Break/Exhibits	10:00 a - 10:20 a		
PHM-O1	Update on Methadone Safety and Efficacy Guidelines	10:20 a - 11:10 a	Level 3/ Gracia 1	Mary Lynn McPherson, PharmD, BCPS, CPE, FASPE
REG-04	Regional Pain Syndromes: Neck and Back	10:20 a - 11:10 a	Level 4/Nolita 3	Srinivas Nalamachu, MD
MDL-04	A Legal Perspective on Practicing Medicine and Offering Ancillary Services: When Wearing 2 Hats May Cause You Problems Beyond a "Glamour Don't"	10:20 a – 12:10 p	Level 3/ Gracia 3	Jennifer Bolen, JD
SIS-24	Exit from the Dark Side: The Inherited Patient on Polypharmacy, Including Opioids	10:20 a – 12:10 p	Level 4/ Yaletown 1	Douglas L. Gourlay, MD, MSc, FRCPC, FASAM Howard A. Heit, MD, FACP, FASAM
APS-O2	Assessment of Pain in Older Adults	11:15 a – 12:10 p	Level 4/ Nolita 1	Keela A. Herr, PhD, RN, AGSF, FAAN
PHM-02	When What Goes Up, Must Come Down: Practical Considerations for Opioid Tapering	11:15 a – 12:10 p	Level 3/ Gracia 1	Lee Kral, PharmD, BCPS, RPh, CPE Tanya Uritsky, PharmD, BCPS
PDM-13	Kappa Opioid Agonists - Moving Beyond Mu*	12:15 p - 1:30 p	Level 3/ Castellana Ballroom	Michael J. Brennan, MD Gregory Holmquist, PharmD, CPE Joseph Stauffer, DO, MBA

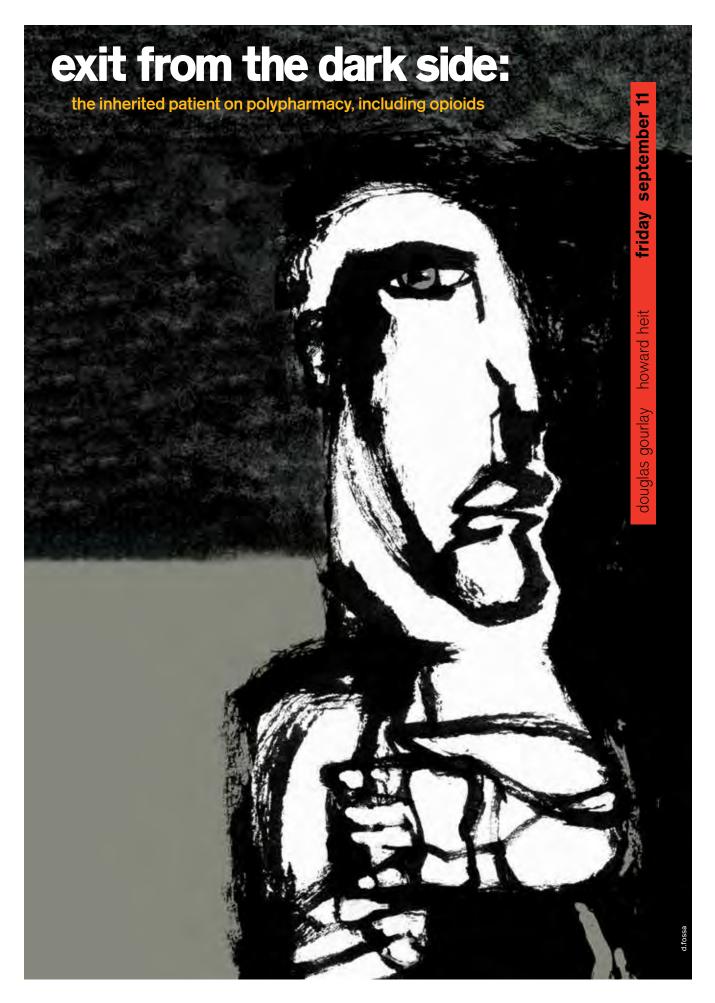
PDM-14	Re-examining the Complexities of Chronic Pain Management: Diverse Risk Factors and Risk Reduction Strategies for the Misuse of Prescription Opioids*	12:15 p = 1:30 p	Level 3/ Brera Ballroom	Charles E. Argoff, MD, CPE Jeffrey A. Gudin, MD W. Clay Jackson, MD, DipTh
APS-03	Pharmacologic and Nonpharmacologic Geriatric Pain Management	1:35 p - 2:30 p	Level 4/ Nolita 1	Manney C. Reid, MD, PhD
NRO-02	Peripheral Neuropathies	1:35 p – 2:30 p	Level 4/ Nolita 3	Natalie H. Strand, MD
рнм-03	Opioid Conversion Calculations	1:35 p - 2:30 p	Level 3/ Gracia 1	Mary Lynn McPherson, PharmD, BCPS, CPE, FASPE
AHS-O2	Comprehensive Migraine Education Program (Part 2)	1:35 p = 3:30 p	Level 3/ Gracia 7	Frank Andrasik, PhD Sheena K. Aurora, MD Andrew C. Charles, MD Richard B. Lipton, MD Matthew Robbins, MD, FAHS
MAS-04	Differential Diagnosis of Back Pain	1:35 p – 3:30 p	Level 3/ Gracia 3	David M. Glick, DC, DAAPM, CPE, FASPE
APS-04	Addressing Pain and Depression Together in Late Life	2:35 p - 3:30 p	Level 4/ Nolita 1	Jordan F. Karp, MD
NRO-03	Small Fiber Neuropathies	2:35 p - 3:30 p	Level 4/ Nolita 3	Charles E. Argoff, MD, CPE
SIS-25	Clinical Conundrum: The Pertinent Negative	2:35 p – 3:30 p	Level 3/ Gracia 5	Gary W. Jay, MD, FAAPM
	Break/Exhibits	3:35 p - 4:30 p		
PDM-15	Opioid-Induced Constipation: The Science, the Struggle, and an Orally Administered Treatment Option* (Encore)	3:35 p - 4:30 p	Level 4/ Mont-Royal Ballroom	Srinivas Nalamachu, MD
APS-05	Will Physicians Be Managing Pain With Smartphones in the 21st Century?	4:35 p - 5:25 p	Level 4/ Nolita 1	Manney C. Reid, MD, PhD
РНМ-О4	Naloxone Kudos vs Kinetics: A Debate on Emergency Response and Comparative Routes of Administration (IN, IM, Auto-IM)	4:35 p - 5:25 p	Level 3/ Gracia 1	Abigail T. Brooks, PharmD Jeffrey Fudin, PharmD, FCCP Courtney M. Kominek, PharmD
sis-26	Hormones and Pain Care	4:35 p - 5:25 p	Level 3/ Gracia 7	Forest Tennant, MD, DrPH, FACPM, MPH

SATURDAY

ASAM-01	Medical Aspects of Marijuana: How Would the Packet Insert Read?	7:00 a - 7:55 a	Level 4/Nolita 1	llene R. Robeck, MD
РНМ-05	Pharmacokinetic and Pharmacodynamic Drug Interactions	7:00 a - 7:55 a	Level 3/ Gracia 1	Christopher M. Herndon, PharmD, BCPS, CPE
REG-05	Regional Pain Syndromes: Knee and Hip	7:00 a – 7:55 a	Level 3/ Gracia 5	Srinivas Nalamachu, MD
ASAM-02	Nonpharmacologic Management of Pain	8:00 a - 8:55 a	Level 4/Nolita 1	Mel Pohl, MD
PAL-O1	As Different as Black & White? Chronic Pain and Palliative Care	8:00 a – 8:55 a	Level 4/ Nolita 3	Lee Kral, PharmD, BCPS, RPh, CPE Tanya Uritsky, PharmD, BCPS
рнм-06	Nonopioid Analgesics: Antidepressants, Adjuvant Therapies, and Muscle Relaxants	8:00 a - 8:55 a	Level 3/ Gracia 1	Christopher M. Herndon, PharmD, BCPS, CPE
INT-01	Pain Medicine Economics: Ancillary Services to Ensure Practice Solvency	9:00 a – 9:55 a	Level 3/ Gracia 5	Orlando G. Florete, Jr, MD
NRO-04	Diagnosis and Management of Central Pain	9:00 a - 9:55 a	Level 3/ Gracia 7	Forest Tennant, MD, DrPH, FACPM, MPH
PAL-O2	"Let it Go! Let it Go!" Pruning Medications in Advanced Illness	9:00 a – 10:55 a	Level 4/ Nolita 3	Holly M. Holmes, MD Kashelle Lockman, PharmD Mary Lynn McPherson, PharmD, BCPS, CPE, FASPE
	Break	10:00 a - 10:20 a		
SIS-27	Opioid-Induced Hyperalgesia	10:20 a – 11:10 a	Level 4/ Mont-Royal Ballroom	Sanford M. Silverman, MD
SIS-29	Stem Cell Therapy: The Future of Pain Management	10:20 a – 11:10 a	Level 4/ Nolita 1	Orlando G. Florete, Jr, MD
sis-30	When My Guitar Gently Weeps: Music as Therapy for Chronic Pain	10:20 a – 12:10 p	Level 3/ Gracia 3	Joanne V. Loewy, DA, LCAT, MT-BC John F. Mondanaro, MA, LCAT, MT-BC, CCLS Andrew R. Rossetti, MMT, LCAT, MT-BC
INT-02	Differential Diagnosis of Low Back Pain	11:15 a – 12:10 p	Level 4/Nolita 1	Arnold J. Weil, MD
PAL-03	New Drugs and Drug News in Pain Management and Palliative Care	11:15 a – 12:10 p	Level 4/Nolita 3	Rabia S. Atayee, PharmD Mary Lynn McPherson, PharmD, BCPS, CPE, FASPE
sis-31	Big Data or Ball of Confusion? Technology in Pain Management	11:15 a – 12:10 p	Level 4/ Mont-Royal Ballroom	Kevin L. Zacharoff, MD, FACIP, FACPE, FAAP

SYM-07	Chronic Pain:	12:00 p - 1:30 p	Level 3/	Charles E. Argoff, MD, CPE
	Discussions and Debates Around Responsible Opioid Prescribing		Brera Ballroom	Michael J. Brennan, MD Jeffrey A. Gudin, MD
asam-03	Buprenorphine in Patients With Chronic Pain and Opioid SUD	1:35 p - 2:30 p	Level 4/ Nolita 1	Mark A. Weiner, MD
INT-04	Management of Low Back Pain: Interventional Options	1:35 p - 2:30 p	Level 4/ Nolita 3	Arnold J. Weil, MD
INT-03	The Role of Combined Electrochemical Treatment for Chronic Pain Conditions	1:35 p – 3:30 p	Level 3/ Gracia 3	Cindy R. Cernak, DPM Robert H. Odell, MD, PhD
MAS-05	Patient Centered Urine Drug Testing: A Case Based Approach	1:35 p – 3:30 p	Level 4/ Yaletown 1	Douglas L. Gourlay, MD, MSc, FRCPC, FASAM Howard A. Heit, MD, FACP, FASAN
PAL-04	Let's Order Lunch Off the Beer's List and Other Flagrant Medication Decisions in Advanced Illness	2:35 p - 3:30 p	Level 4/ Nolita 3	Kashelle Lockman, PharmD Mary Lynn McPherson, PharmD, BCPS, CPE, FASPE
sıs-33	Rhapsody on a Windy Night: When Pain and Sleep Share the Same Bed	2:35 p - 3:30 p	Level 3/ Gracia 5	Gary W. Jay, MD, FAAPM
ASAM-04	Alcohol Use Disorder and Chronic Pain	3:35 p - 4:30 p	Level 4/Nolita 1	Michael F. Weaver, MD, FASAM
PAL-05	"Is Opioid Use the Same in Palliative Care or Does Everybody Get a Morphine Drip?"	3:35 p - 4:30 p	Level 4/ Nolita 3	Rabia S. Atayee, PharmD
РНМ-07	Could Levorphanol Levitate Above Methadone Misadventure?	3:35 p - 4:30 p	Level 3/ Gracia 5	Abigail T. Brooks, PharmD Jeffrey Fudin, PharmD, FCCP Courtney M. Kominek, PharmD





An overview for first-time conference attendees on the curriculum, faculty, satellite programs, and more.

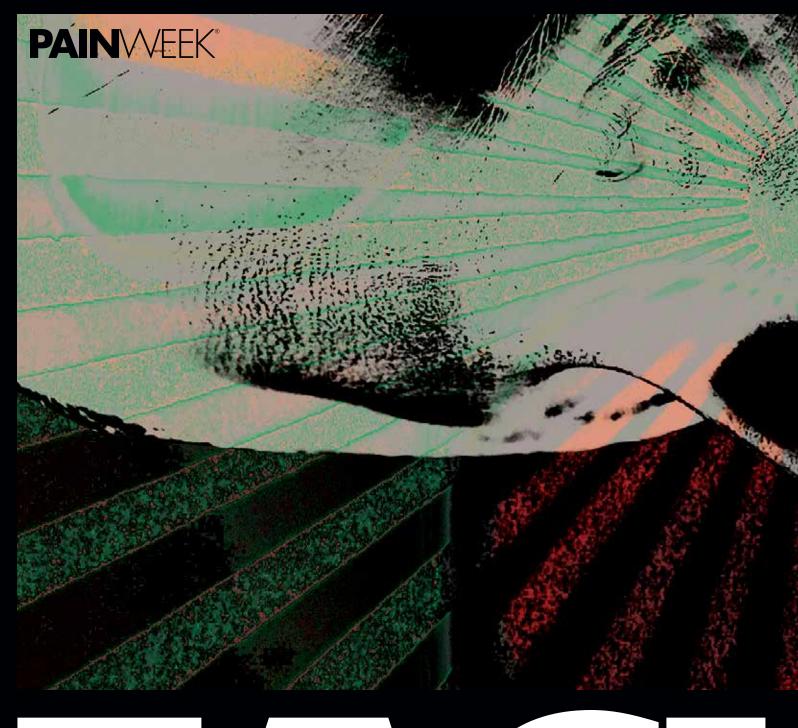


Monday/9.7

6:00**p**-8:00**p**

LEVEL 4 Nolita 1









Kevin Barnard

Regional Compliance Director H. D. Smith Wholesale Drug Carson, CA

Disclosure not submitted

Stephen L. Barrett, DPM, MBA

Adjunct Professor

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Glendale, AZ Medical Director

US Neuropathy Centers

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Nothing to disclose

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Nothing to disclose

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Legal Side of Pain Knoxville, TN

Consultant/Independent Contractor: Alere Toxicology Plc; eLab Solutions Corporation; kaléo, Inc.; Quest Diagnostics Incorporated Speakers Bureau: eLab Solutions Corporation; Quest Diagnostics Incorporated

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Assistant Professor

Founding Director of the Acute Pain Service

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Nothing to disclose

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President and CEO

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Nothing to disclose

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Clinical Pharmacy Specialist

Pain Management

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Pharmacy/Physical Medicine & Rehabilitation
Minneapolis, MN

Nothing to disclose

Cindy Cernak, DPM

Podiatric Surgeon

Weill Foot & Ankle Institute
Des Plaines, IA

Nothing to disclose

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Professor and Director

Headache Research and Treatment Program UCLA – David Geffen School of Medicine Department of Neurology Los Angeles, CA

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Martin D. Cheatle, PhD

Clinical Assistant Professor

Psychology in Psychiatry

Director

Pain and Chemical Dependency Program Center for Studies of Addiction Perelman Schools of Medicine University of Pennsylvania Psychiatry/Center for Studies of Addiction Philadelphia, PA

Consultant/Independent Contractor:

Campbell Alliance Health

Grant/Research Support: Cordant Healthcare **Honoraria**: Nektar Therapeutics; Zogenix, Inc.

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Associate Professor

Johns Hopkins University School of Medicine Baltimore, MD

Host

"Aches and Gains" Radio Program

Consultant/Independent Contractor: Egalet Corporation; Golen Harris; Purdue Pharma L.P.; Trevena, Inc.



Michael R. Clark, MD, MPH, MBA

Vice Chair

Clinical Affairs

Johns Hopkins University School of Medicine

Pain Treatment Programs
Johns Hopkins Medical Institutions
Department of Psychiatry and
Behavioral Sciences
Baltimore, MD

Nothing to disclose

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Instructor, Coach

Take Courage Coaching Bozeman, MT

Nothing to disclose

Rebecca L. Curtis, PCC

Instructor, Coach

Take Courage Coaching Bozeman, MT

Nothing to disclose

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USC School of Pharmacy Department of Clinical Pharmacy

Clinical Pharmacist

USC Pain Center Los Angeles, CA

Nothing to disclose

James Matthew Elliott, PT, PhD

Assistant Professor

Northwestern University Feinberg School of Medicine Chicago, IL

Consultant/Independent Contractor, Ownership/ Investment Interests: Pain ID, LLC Grant/Research Support: National Institutes of Health

Roger B. Fillingim, PhD

Professor and Director

University of Florida Gainesville, FL

Consultant/Independent Contractor, Stock Shareholder: Clinical Research Services at Algynomics, Inc.

Orlando G. Florete, Jr, MD

Medical Director

Institute of Pain Management Jacksonville, FL

Consultant/Independent Contractor: MD Medical, Inc.; Rego Medical Consultants

Matthew P. Foster, PharmD

Assistant Clinical Professor University of Florida Gainesville, FL

Clinical Pharmacy Manager

Helios Clinical Services Tampa, FL

Consultant/Independent Contractor:

Iroko Pharmaceuticals, LLC

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Adjunct Associate Professor

Western New England College of Pharmacy Western New England University Springfield, MA

Director

PGY2 Pharmacy Pain Residency Samuel Stratton VA Medical Center, Pharmacy Albany, NY

Consultant/Independent Contractor: AstraZeneca; kaléo, Inc.; Millennium Health; Zogenix, Inc. Speakers Bureau: AstraZeneca; kaléo, Inc.; Millennium Health

Stock Shareholder: Remitigate (owner)

Other/Royalty: Practical Pain Management (developed online opioid calculator; no financial support)

Melissa E. A. Geraghty, PsyD

Professional Health Psychologist

Rago & Associates
Private Practice
Naperville, IL

Nothing to disclose

David M. Glick, DC, DAAPM, CPE, FASPE Evans Army Community Hospital, Fort Carson Primary Care Colorado Springs, CO

Nothing to disclose

Marc Gonzalez, PharmD

Pharmaceutical Diversion Consultants, LLC DoD Consultant

Education & Training Coordinator NADDI

Tarzana, CA

Nothing to disclose

Errol M. Gould, PhD

Director

Medical Affairs Pernix Therapeutics Philadelphia, PA

Consultant/Independent Contractor, Stock Shareholder, Other/Royalty: PERNIX Therapeutics

Douglas L. Gourlay,

MD, MSc, FRCPC, FASAM

Educational Consultant and Former Director Pain and Chemical Dependency Division Wasser Pain Centre Toronto, Ontario, Canada

Nothing to disclose

Jeffrey A. Gudin, MD

Director

Englewood Hospital and Medical Center Pain Management Center Englewood, NJ

Consultant/Independent Contractor:

Charleston Laboratories, Inc.; Egalet Corporation; Insys Therapeutics, Inc.; kaléo, Inc.; KemPharm, Inc.; SCILEX Pharmaceuticals, Inc.

Speakers Bureau: AstraZeneca; Depomed, Inc., Iroko Pharmaceuticals, LLC; kaléo, Inc.; Purdue Pharma L.P.; Teva Pharmaceuticals USA; Valeant Pharmaceuticals International, Inc.; Xenoport, Inc.

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Assistant Clinical Professor

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Consultant/Independent Contractor: Millennium Health

Christopher M. Herndon,

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Scott Air Force Base and Southern Illinois Healthcare Foundation Family Medicine, 375th Medical Group Belleville, IL

Nothing to disclose

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Professor and Chair

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Nothing to disclose

Marc Hoffman, MD

Chief Medical Officer

Theorem Clinical Research Scientific & Medical Affairs Long Grove, IL

Nothing to disclose

Holly M. Holmes, MD

Associate Professor

University of Texas MD Anderson Cancer Center Houston, TX

Nothing to disclose

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Nothing to disclose

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Nothing to disclose

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Grant/Research Support: Pfizer Inc; Reckitt Benckiser Group plc

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douglas gourlay howard heit

saturday september 12

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Consultant/Independent Contractor: Alder

Biopharmaceuticals Inc; Allergan; Autonomic Technologies, Inc.; Avanir Pharmaceuticals, Inc.; Boston Scientific Corporation; Bristol-Myers Squibb Company; Colucid Pharmaceuticals, Inc.; Dr. Reddy's Laboratories Ltd.; electroCore LtC; eNeura Inc.; Labrys Biologics, Inc.; Merck & Co., Inc.; Novartis; Teva Pharmaceuticals USA; Vedanta Biosciences

Grant/Research Support: Migraine Research Foundation; National Headache Foundation; National Institutes of Health

Honoraria: Alder Biopharmaceuticals Inc.; Allergan; American Headache Society; Autonomic Technologies, Inc.; Avanir Pharmaceuticals, Inc.; Boston Scientific Corporation; Bristol-Myers Squibb Company; Colucid Pharmaceuticals, Inc.; Dr. Reddy's Laboratories Ltd.; electroCore LIC; eNeura Inc.; Labrys Biologics, Inc.; Merck & Co, Inc.; Novartis; Teva Pharmaceuticals USA; Vedanta Biosciences

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Nothing to disclose

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Nothing to disclose

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Vice President

NADDI

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Nothing to disclose

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Kansas City, KS

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International Clinical Research Institute Overland Park, KS

Nothing to disclose

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Nothing to disclose

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Vice President, Clinical Research and Advocacy

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Medical Affairs San Diego, CA







steve passik

wednesday 9.9



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Nothing to disclose

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Consultant/Independent Contractor: DNE SEAL

External Fixation

Speakers Bureau: CE Lasers; DNE SEAL External Fixation;

Organogenesis

Stock Shareholder: Fuse Medical

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Consultant/Independent Contractor: Depomed, Inc.; Grünenthal; Inspirion Pharmaceuticals, LLC; Iroko Pharmaceuticals, LLC; Johnson & Johnson Services, Inc.; Mallinckrodt Pharmaceuticals; Pfizer Inc; Purdue Pharma L.P.; Trevena, Inc.; Vyrix Pharmaceuticals, Inc. Honoraria: Depomed, Inc.; Grünenthal; Inspirion Pharmaceuticals, LLC; Iroko Pharmaceuticals, LLC; Johnson & Johnson Services, Inc.; Mallinckrodt Pharmaceuticals; Pfizer Inc; Purdue Pharma L.P.; Trevena, Inc. Speakers Bureau: Depomed, Inc.

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Disclosure not submitted

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Nothing to disclose

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Nothing to disclose

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Editor-in-Chief: Practical Pain Management

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Philadelphia, PA

Nothing to disclose

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Faculty Clinical Instructor

SUNY Stony Brook School of Medicine

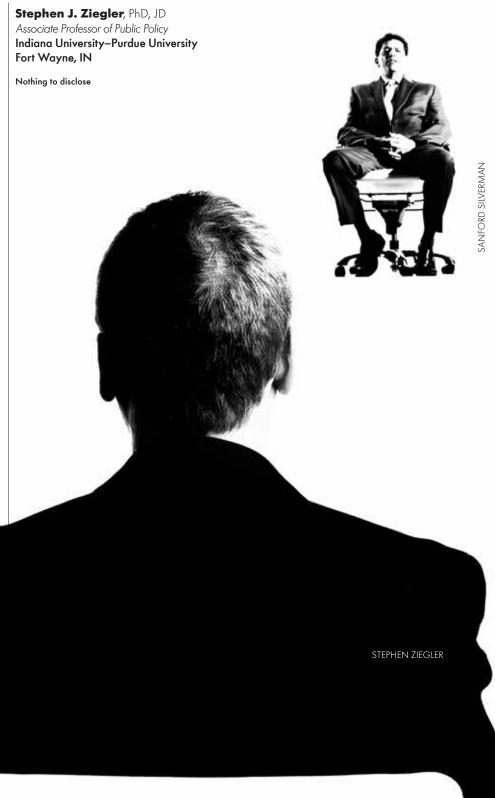
Stony Brook, NY

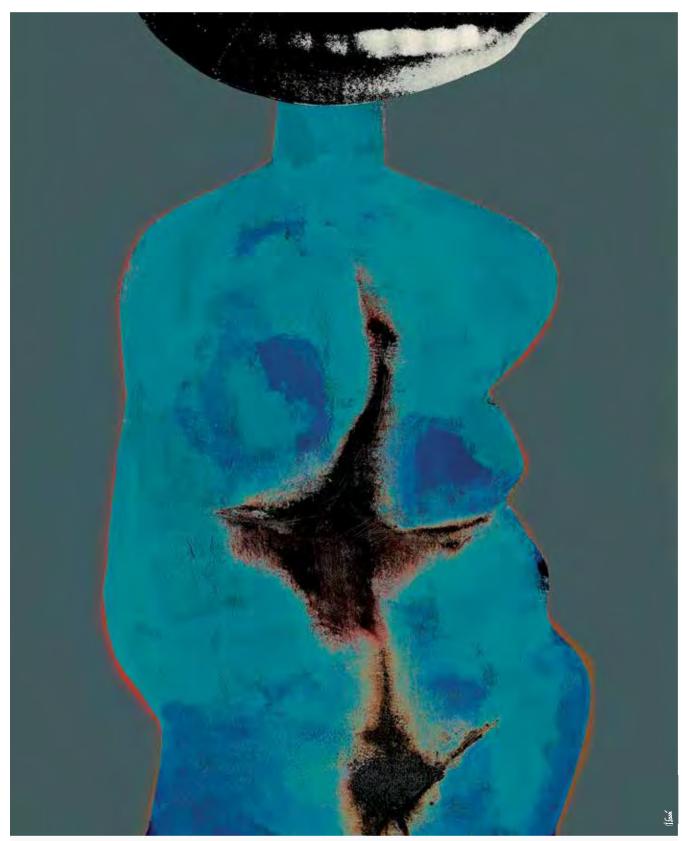
Director of Medical Affairs

Inflexxion Inc.

Newton, MA

Nothing to disclose





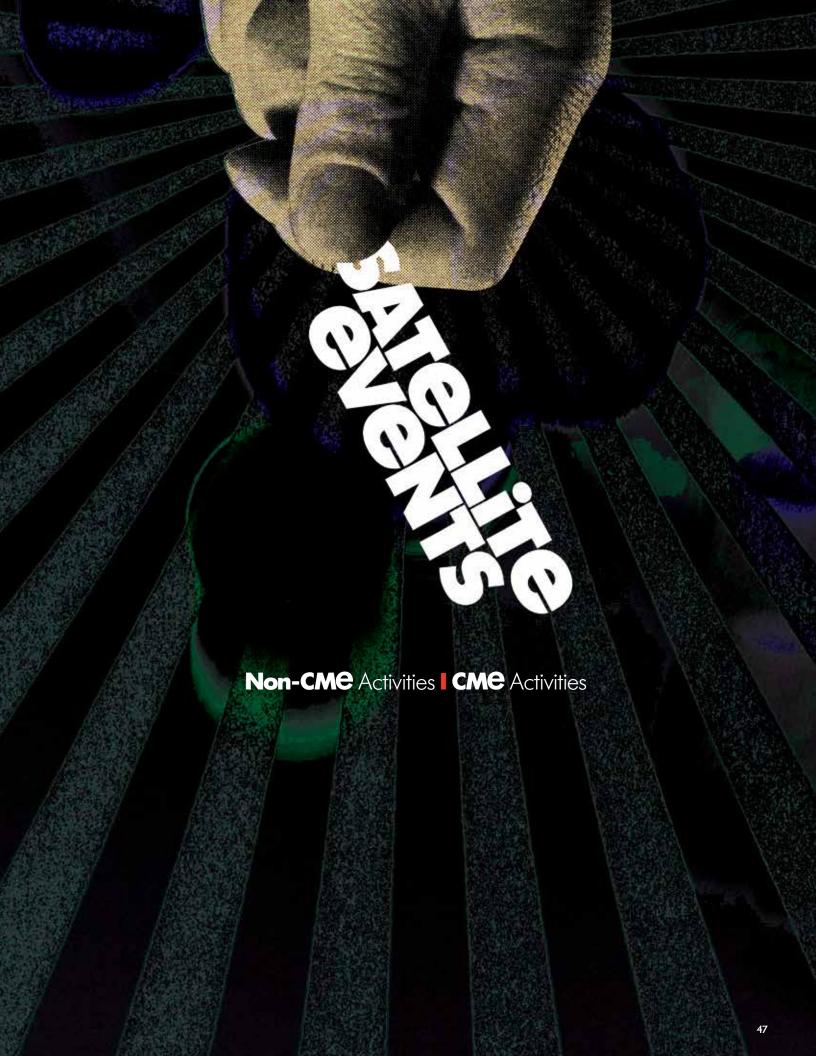
It's NOT Vulvodynia:

It's Lichen Sclerosus!

Have You Missed This Diagnosis?

Barbara Kornblau

Tuesday 9.8





PAINWeek would like to thank our corporate and nonprofit partners for their participation in this year's satellite events. PAINWeek values its partnerships with these organizations and 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 2015 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 10 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 educational activities.

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.

1

Breakfast PDM

An Extended-Release Oral Hydrocodone Bitartrate Therapy Sponsored by Purdue Pharma L.P.

Michael Brennan, MD; Joseph V. Pergolizzi, MD

Course Code: PDM-O1

Wednesday/9.9 8:00a - 8:55a Level 3/Castellana Ballroom

Breakfast will be served.

Contact: Alexandra Martinez, (203) 588–7311, Alexandra.Martinez@pharma.com

2

Breakfast PDM

The Treatment of PHN: Unmet Needs Still Exist Sponsored by Depomed, Inc.

Gregory L. Holmquist, PharmD, CPE

Course Code: PDM-02

Wednesday/9.9 8:00a - 8:55a Level 3/Brera Ballroom

Breakfast will be served.

Contact: Amy Imhoff, (510) 744-8519, achang@depomed.com

3

Lunch PDM

Targeting Success: An Interactive Discussion of a Next Generation Molecule

Sponsored by Depomed, Inc.

Gregory L. Holmquist, PharmD, CPE; Joseph V. Pergolizzi, MD; Steve Vacalis, DO

Course Code: PDM-03

Wednesday/9.9 12:15p - 1:30p Level 3/The Chelsea

Lunch will be served.

Contact: Amy Imhoff, (510) 744–8519, achang@depomed.com



PDM

Conversations that Matter: Addressing Challenging Topics in the Exam Room

Sponsored by Teva Pharmaceuticals

Laura Cooley, PhD; Paul Gileno; Bob Twillman, PhD; Richard Payne, MD

Course Code: PDM-04

Wednesday/9.9 3:35p - 4:30p Level 3/Castellana Ballroom

Refreshments will be served.

Contact: Jaimee Reggio, (312) 729-4276, jreggio@golin.com



Breakfast PDM

Opioid-Induced Constipation: The Science, the Struggle, and an Orally Administered Treatment Option

Sponsored by AstraZeneca

Gerald M. Sacks, MD

Course Code: PDM-05

Thursday/9.10 8:00a - 8:55a Level 3/Brera Ballroom

Breakfast will be served.

Contact: Annalisa Torrente-Haney, (302) 885–7843, Annalisa.Torrente@AstraZeneca.com



Breakfast PDM

Prioritizing the Patient in the Opioid Debate: A Roundtable Discussion

Supported by an educational grant from Pernix Therapeutics

Faculty to be announced

Course Code: PDM-06

Thursday/9.10 8:00a - 8:55a Level 3/Castellana Ballroom

Breakfast will be served.

Contact: Angela Casey, (203) 323-5945, acasey@pharmacomgroup.com.



Lunch PDM

Understanding Abuse-Deterrent Opioid Technologies

Sponsored by Teva Pharmaceuticals

Michael Brennan, MD; Jeffrey A. Gudin, MD

Course Code: PDM-07

Thursday/9.10 12:15p - 1:30p Level 3/Brera Ballroom

Lunch will be served.

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

8

Lunch PDM

Opioid-Induced Constipation

Sponsored by Salix Pharmaceuticals

Steven Simon, MD

Course Code: PDM-08

Thursday/9.10 12:15p - 1:30p Level 3/Castellana Ballroom

Lunch will be served.

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

9

PDM

Overview of Emerging Technologies: Opioids with Labeled Abuse-Deterrent Properties and Claims (OADP)

Sponsored by Purdue Pharma L.P.

Faculty to be announced

Course Code: PDM-09

Thursday/9.10 3:35p - 4:30p Level 4/Mont-Royal Ballroom

Refreshments will be served.

Contact: Alexandra Martinez, (203) 588-7311, Alexandra.Martinez@pharma.com

10

PDN

Salix Pharmaceuticals Product Theatre

Sponsored by Salix Pharmaceuticals

Steven Simon, MD

Course Code: PDM-10

Thursday/9.10 3:35p - 4:30p Level 3/Castellana Ballroom

Refreshments will be served.

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

11

Breakfast PDM

OPIOID EMERGENCIES: The Stakes Couldn't Be Higher. The Case for Naloxone

Sponsored by kaléo, Inc.

Moderator: Eric Edwards, MD, PhD

Faculty: Jeffrey A. Gudin, MD; Mark A. Kallgren, MD;

Bob A. Rappaport, MD

Course Code: PDM-11

Friday/9.11 8:00a - 8:55a Level 3/Castellana Ballroom

Breakfast will be served.

Contact: Angela Casey, (203) 323–5945, acasey@pharmacomgroup.com

12

Breakfast PDM

FDA NSAID Safety Update and Pain Management Options

Sponsored by Iroko Pharmaceuticals, LLC

Christopher Gharibo, MD

Course Code: PDM-12

Friday/9.11 8:00a - 8:55a Level 3/Brera Ballroom

Breakfast will be served.

Contact: Richard Dudek, (267) 546-1642, rdudek@iroko.com

13

Lunch PDM

Kappa Opioid Agonists - Moving Beyond Mu

Sponsored by Cara Therapeutics

Michael Brennan, MD; Gregory Holmquist, PharmD, CPE;

Joseph Stauffer, DO, MBA

Course Code: PDM-13

Friday/9.11 12:15p - 1:30p Level 3/Castellana Ballroom

Lunch will be served.

Contact: Geoff Birkett, (484) 467-1285, geoffbirkett@comcast.net

14

Lunch PDN

Re-examining the Complexities of Chronic Pain Management: Diverse Risk Factors and Risk Reduction Strategies for the Misuse of Prescription Opioids

Sponsored by Indivior PLC

Charles E. Argoff, MD, CPE; Jeffrey A. Gudin, MD;

W. Clay Jackson, MD, DipTh

Course Code: PDM-14

Friday/9.11 12:15p - 1:30p Level 3/Brera Ballroom

Lunch will be served.

Contact: Jamie Cahiwat, (212) 462–7802, IndiviorReg@complete-mc.com

15

PDN

Opioid-Induced Constipation: The Science, the Struggle, and an Orally Administered Treatment Option (Encore)

Sponsored by AstraZeneca

Srinivas Nalamachu, MD

Course Code: PDM-15

Friday/9.11 3:35p - 4:30p Level 4/Mont-Royal Ballroom

Refreshments will be served.

Contact: Annalisa Torrente-Haney, (302) 885–7843,

Annalisa.Torrente@AstraZeneca.com

A BREAKFAST PDM (PRODUCT, DISEASE AWARENESS, AND MEDICAL INFORMATION) PROGRAM HELD DURING THE PAINWEEK® 2015 NATIONAL CONFERENCE



PRIORITIZING THE PATIENT

in the Opioid Debate

A ROUNDTABLE DISCUSSION

PROGRAM DESCRIPTION

As the nation struggles with prescription opioid abuse, misuse, and diversion, clinicians, the FDA, and pharmaceutical industry are under pressure to develop and prescribe medications with abuse-deterrent technologies that do not directly benefit patients, but target "unintended" uses. In the rush to "make everything abuse-deterrent," the chronic pain patient has been lost in the discussion. The long-term efficacy of opioid analgesics for chronic pain has also been hotly debated due to the lack of good long-term evidence in this patient population. However, the needs of the chronic pain patient are often lost in this debate. In addition, we will address other clinical needs of chronic pain patients, such as disturbed sleep.

Please join us for a panel discussion where pain management and addiction specialists, a regulatory expert, and patient advocate will evaluate whether or not pain patients' needs are being prioritized in the opioid debate.

THURSDAY, SEPTEMBER 10, 2015

8:00 AM to 9:00 AM

Castellana Ballroom, Level 3 The Cosmopolitan of Las Vegas • Las Vegas, Nevada

This PDM program is neither sponsored by nor endorsed by PAINWeek® and does not offer CE/CME credits

Consistent with reporting obligations, including but not limited to the Federal Physician Payment Sunshine Act, Pernix Therapeutics is required to publicly disclose all items of value provided to healthcare providers. By attending this PDM program, you are accepting the disclosure of the cost of the meal.

Healthcare providers licensed in Massachusetts, Minnesota, or Vermont are welcome to participate in this PDM program, but we regret that healthcare providers from these states may not partake in the meal due to state law prohibitions.

Supported by an educational grant from Pernix Therapeutics



Opioid-Induced Constipation





The Cosmopolitan of Las Vegas

Castellana Ballroom, Level 3 Las Vegas, Nevada



Steven Simon, MD

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 governmental 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®.

Please visit Salix booth #117.



Product under license from Progenics Pharmaceuticals

A breakfast PDM (Product, Disease Awareness, and Medical Information) program held during the PAINWeek® 2015 National Conference

OPIOID EMERGENCIES

The Stakes Couldn't Be Higher



The Case for Naloxone

MODERATOR

Eric Edwards, MD, PhD

Chief Medical Officer and Vice President Research & Development kaleo, Inc.

Richmond, Virginia

FACULTY

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Director

Pain Management and Wellness Center Englewood Hospital and Medical Center Englewood, New Jersey

Mark A. Kallgren, MD

Medical Director, Pain Medicine Oregon Anesthesiology Group, PC Portland, Oregon

Bob A. Rappaport, MD

Former Director

Division of Anesthesia, Analgesia, and Addiction Products

Center for Drug Evaluation and Research US Food and Drug Administration

Prescription opioid deaths have reached epidemic levels in the United States. A large proportion of opioid emergencies in patients prescribed opioids for pain are unintentional, resulting in life-threatening opioid-induced respiratory depression (OIRD). Please join us for a PDM program where our faculty panel will discuss epidemiology, provide guidance on how to identify and communicate with at-risk patients, as well as discuss naloxone prescription in clinical practice to help reduce morbidity and mortality by reversing life-threatening OIRD.

Friday, September 11, 2015

8:00 AM to 9:00 AM

Castellana Ballroom, Level 3

The Cosmopolitan of Las Vegas • Las Vegas, Nevada

This PDM program is neither sponsored by nor endorsed by PAINWeek® and does not offer CE/CME credits

Kaléo is committed to comply with all federal and state reporting requirements and laws and will disclose the cost of this meal if required. Given this meal is supported by kaléo, before partaking in this meal offering, all Healthcare Practitioners should ensure it is permissible to do so given the governing laws and standards that apply to their practice of medicine. Healthcare Practitioners licensed in the states of Vermont and Minnesota may attend the program but may not partake in the meal.





1

LUNCH SYMPOSIUM

Comprehensive Pain Management: Uncovering and Addressing Opioid-Induced Constipation

This activity is supported by an educational grant from AstraZeneca

This activity is provided by Global Education Group and Integritas Communications

Charles E. Argoff, MD, CPE; Jeffrey A. Gudin, MD; Anthony J. Lembo, MD

Course Code: SYM-O1

Tuesday/9.8 12:00p - 1:30p Level 3/Brera Ballroom

Lunch will be served.

Contact: Barbara Jean Wynne, (201) 535–4941, bjwynne@integritasgrp.com

2

SYMPOSIUM

Multimodal Approaches to the Treatment of Mixed Pain: What Is New?

This live activity is supported by an independent educational grant from Depomed, Inc.

Jointly provided by Postgraduate Institute for Medicine and Miller Medical Communications, LLC

Oscar de Leon-Casasola, MD

Course Code: SYM-O2

Wednesday/9.9 7:00a - 7:55a Level 3/Gracia 5

Coffee will be served.

Contact: Maria DelCegno, (212) 661–7400, maria.delcegno@millermeded.com

3

SYMPOSIUM SYM-03 to SYM-06

Essential Tools for Treating the Patient in Pain™

PAINWeek 2015: AAPM Essential Tools for Treating the Patient in Pain™ is supported through educational grants from Depomed, Inc., the American Academy of Pain Medicine Foundation, and Iroko Pharmaceuticals, LLC, as of 8/4/15.

Farshad Ahadian, MD; Charles E. Argoff, MD; Aramando Villareal, MD

Wednesday/9.9 Level 3/Gracia 1

SYM-03 Anatomy of Ouch: The Pathophysiology of Pain 10:20a - 11:10a

SYM-04 The Science Behind Marijuana as an Analgesic

11:15**a** – 12:10**p**

SYM-05 Strategies for Success With Chronic Opioid Therapy

1:35P - 2:30P

SYM-o6 Understanding and Treating Neuropathic Pain

4:35P - 5:25P

Following participation at the American Academy of Pain Medicine's Essential Tools for Treating the Patient in PainTM sessions, attendees will receive an email containing a unique link where each learner can access online evaluations and meeting materials (presentation slides). Completing evaluations through the online evaluation process is the only way to receive your CME certificate(s). Please note that ONLY ACCME CME credits are provided for AAPM sessions; nursing and pharmacy credits are not provided. Certificates will be available immediately following the completion of both the individual session and overall activity evaluation. Learners will be able to print their own certificate(s) at their convenience. For assistance, please send a detailed email to the AAPM member services department at info@painmed.org. Please note evaluations and requests for credit and presentation downloads MUST be completed no later than October 31, 2015.

Accreditation: The American Academy of Pain Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Contact: Jennifer Westlund, (847) 375-4893, info@painmed.org



LUNCH SYMPOSIUM

Chronic Pain: Discussions and Debates Around Responsible Opioid Prescribing

This activity is supported by an educational grant from Teva CNS

This activity is provided by Global Education Group and Integritas Communications

Charles E. Argoff, MD, CPE; Michael Brennan, MD; Jeffrey A. Gudin, MD

Course Code: SYM-07

Saturday/9.12 12:00p - 1:30p Level 3/Brera Ballroom

Lunch will be served.

Contact: Matt Wong, (646) 350-0902, mwong@integritasgrp.com







COMPREHENSIVE PAIN MANAGEMENT

UNCOVERING AND ADDRESSING OPIOID-INDUCED CONSTIPATION

SEPTEMBER 2015

11:30 AM — 12:00 PM Lunch 12:00 PM — 1:30 PM Symposiu

BRERA BALLROOM LEVEL 3

The Cosmopolitan Las Vegas • Las Vegas, Nevada





Charles E. Argoff, MD

Professor of Neurology Albany Medical College Director, Comprehensive Pain Center Albany Medical Center Albany, New York



Jeffrey A. Gudin, MD

Clinical Instructor, Anesthesiology Mount Sinai University School of Medicine New York, New York Director, Pain Management and Palliative Care Englewood Hospital and Medical Center Englewood, New Jersey



Anthony J. Lembo, MD Associate Professor of Medicine Director, GI Motility Laboratory

Associate Professor of Medicine Director, Gl Motility Laboratory Harvard Medical School Beth Israel Deaconess Medical Center Boston, Massachusetts





ns.

TARGET AUDIENCE

The educational design of this activity addresses the needs of pain specialists and other health care providers involved in the treatment of patients with opioid-induced constipation (OIC).

EDUCATIONAL OBJECTIVES

After completing this activity, the participant should be better able to:

- Evaluate baseline bowel habits, risk factors for OIC development, and ongoing changes in bowel function in patients on long-term opioid therapy
- Implement a prophylactic treatment plan to address OIC concurrent with the initiation of opioid therapy
- Analyze current pharmacotherapies for OIC based on mechanisms of action and data on efficacy and safety
- Tailor treatment regimens for patients experiencing OIC according to symptom severity, post treatment responses, and patient preferences
- Collaborate with primary care and other providers to ensure that opioid-treated patients are routinely assessed for changes in bowel habits

This program was planned in accordance with AANP CE Standards and Policies and AANP Commercial Support Standard. This satellite symposium is neither sponsored by nor endorsed by PAINWeek®.

PHYSICIAN ACCREDITATION STATEMENT

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Global Education Group (Global) and Integritas Communications. Global is accredited by the ACCME to provide continuing medical education for physicians.

*This CME/CE activity complies with all requirements of the federal Physician Payment Sunshine Act.
If a reportable event is associated with this activity, the accredited provider managing the program will provide the appropriate physician data to the Open Payments database.

PHYSICIAN CREDIT DESIGNATION

Global Education Group designates this live activity for a maximum of 1.5 AMA PRA Category 1 Gedits. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

PHARMACIST CONTINUING EDUCATION



Global Education Group is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. Global Education Group designates this continuing education activity for 1.5 contact hour(s)

(0.15 CEUs) of the Accreditation Council for Pharmacy Education.
(Universal Activity Number - 0530-9999-15-058-L01)

This is a knowledge-based activity.

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

NURSE PRACTITIONER CONTINUING EDUCATION



Global Education Group is approved as a provider of nurse practitioner

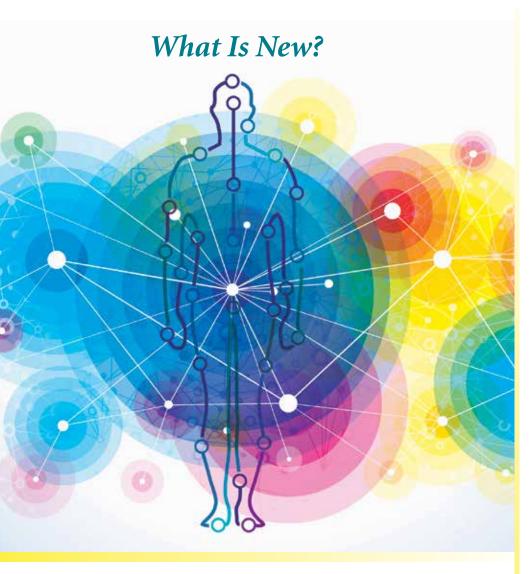
continuing education by the American Association of Nurse Practitioners: AANP Provider Number 1101021. This program has been approved for 1.5 contact hours of continuing education (which includes TBD hours of pharmacology).

This activity is jointly provided by Global Education Group and Integritas Communications.

This activity is supported by an educational grant from AstraZeneca.

MULTIMODAL APPROACHES

TO THE TREATMENT OF MIXED PAIN



Two ways to register

ONLINE AT www.MillerMedEd.com/PAINWeek2015
CALL TOLL-FREE 1-866-872-5840

On-site registration may be available, space permitting. Pre-registration does not guarantee seating. Arrive early, seating is limited!

Wednesday September 9, 2015

7:00 AM — 8:00 AM

Gracia Ballroom 5, Third Level The Cosmopolitan of Las Vegas Las Vegas, Nevada

Refreshments will be served.

PROGRAM CHAIR

Oscar de Leon-Casasola, MD

Professor of Anesthesiology and Medicine Senior Vice-Chair for Clinical Affairs School of Medicine and Biomedical Sciences University at Buffalo Chief, Pain Medicine and Professor of Oncology Roswell Park Cancer Institute Buffalo, New York

AMA Credit Designation

This activity has been approved for *AMA PRA Category 1 Credit*(s)TM.

Pharmacist Credit Designation

This activity is eligible for ACPE credit, see final CPE activity announcement for specific details.

Nursing Credit Designation

This activity is eligible for ANCC credit, see final CNE activity announcement for specific details.

This satellite symposium is neither sponsored by nor endorsed by PAINWeek®.

Jointly provided by Postgraduate Institute for Medicine and Miller Medical Communications, LLC.





This live activity is supported by an independent educational grant from Depomed, Inc.





11:30 AM **BRERA BALLROOM LEVEL 3** The Cosmopolitan of Las Vegas • Las Vegas, Nevada

MAIN EVENT

CUNICAL





This activity is jointly provided by Global Education Group and Integritas Communications.

This satellite symposium is neither sponsored nor endorsed by PAINWeek. This program was planned in accordance with AANP CE Standards and Policies and AANP Commercial Support Standard.



CHRONIC PAIN

DISCUSSIONS & DEBATES AROUND RESPONSIBLE OPIOID PRESCRIBING



CHARLES E. MICHAEL J. JEFFREY A. Brennan, MD Gudin, MD





TARGET AUDIENCE

The educational design of this activity addresses the needs of pain specialists, primary care providers, and other clinicians involved in opioid-based management of chronic pain.

EDUCATIONAL OBJECTIVES

After completing this activity, the participant should be better able to:

- Assess candidates for chronic opioid therapy via comprehensive clinical interviews, reviews of the medical history, physical exam, and stratification of risks for drug misuse and abuse
- Discuss the clinical profiles of current and emerging prescription opioid analgesics, including abuse-deterrent formulations
- Initiate opioid trials for patients with functionally impairing chronic pain severe enough to require around-the-clock, long-term therapy
- Tailor opioid-based regimens founded on evaluations of analgesia, functional goals, side effects, and risk evaluation and mitigation strategy (REMS)-compliant principles for patient monitoring and documentation
- Engage in open dialogues with patients with chronic pain about actively participating in a care plan, adhering to the treatment regimen, and safely using prescription opioid analgesics

PHYSICIAN ACCREDITATION STATEMENT

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Global Education Group (Global) and Integritas Communications. Global is accredited by the ACCME to provide continuing medical education for physicians.

This CME/CE activity complies with all requirements of the federal Physician Payment Sunshine Act. If a reportable event is associated with this activity, the accredited provider managing the program will provide the appropriate physician data to the Open Payments database.

Physician Credit Designation

Global Education Group designates this live activity for a maximum of 1.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Pharmacist Accreditation Statement



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

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

Credit Designation

Global Education Group designates this continuing education activity for 1.5 contact hour(s) (0.15 CEUs) of the Accreditation Council for Pharmacy Education. (Universal Activity Number - 0530-9999-15-056-L01-P)

This is a knowledge-based activity.

Nurse Practitioner Continuing Education



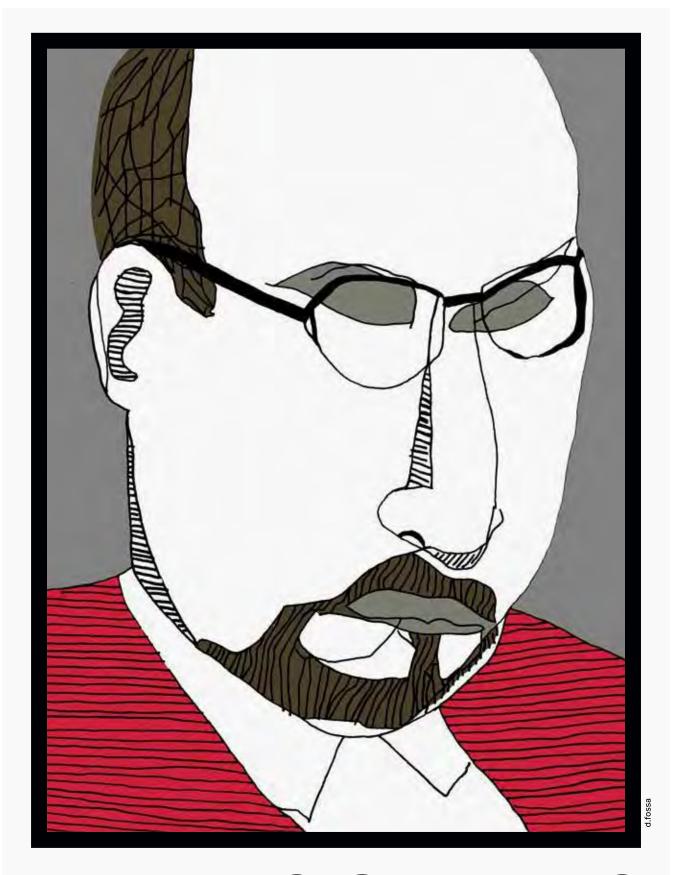
AMP American Association of NURSE PRACTITIONERS

Global Education Group is approved as a

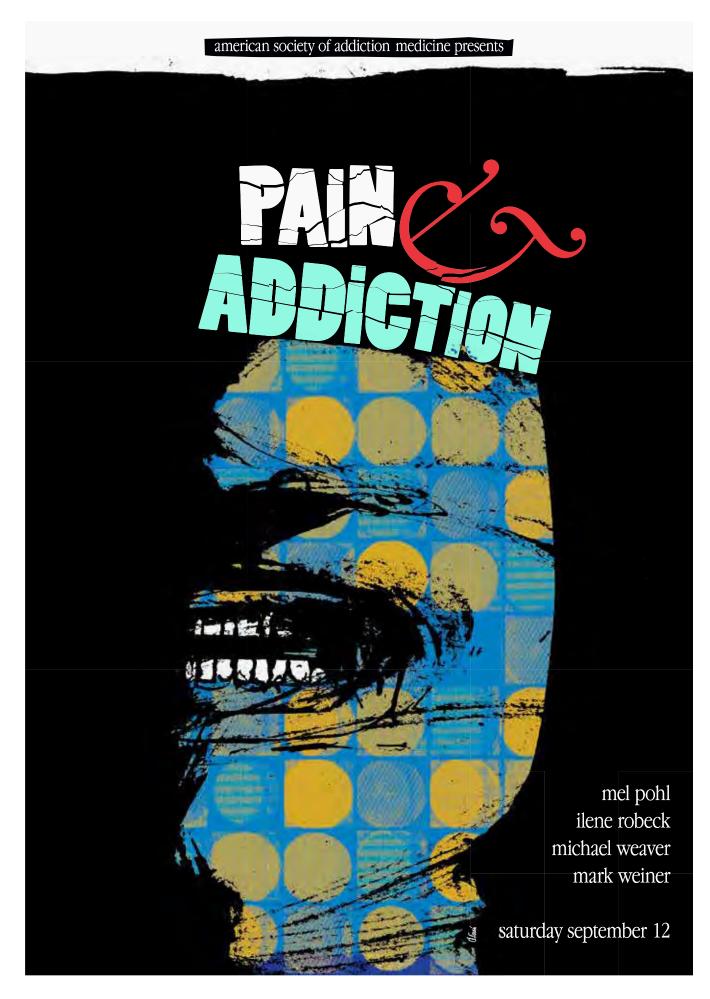
education by the American Association of Nurse Practitioners: AANP Provider Number 1101021. This program has been approved for 1.5 contact hours of continuing education.

This CME/CE activity complies with all requirements of the federal Physician Payment Sunshine Act and as such, this activity is eligible for Sunshine Act Reporting. Additional information is required to be collected from participants. If you are planning on participating in the meal, please indicate so on the evaluation and provide your NPI number

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



WHERE DOES IT HURT?





AHS

American Headache Society

APS

American Pain Society

ASAM

American Society of Addiction Medicine

BHV

Behavioral Pain Management

CAM

Complementary & Alternative Medicine

HCH

Health Coaching

iNT

Interventional Pain Management

Key

Keynote

MAS

Master Class

MDL

Medical/Legal

MSK

Musculoskeletal Pain Conditions

NAD

National Association of Drug Diversion Investigators

NRO

Neurology

NRP

Nurse Practitioner

PAL

Palliative Care

PDM

Product, Disease, & Medical Information Program

Pef

Pain Educators Forum

PHM

Pharmacotherapy

POD

Podiatric Pain Syndromes

POS

Scientific Poster Session

PREPEF

Neuropathica Galactica

Reg

Regional Pain Syndromes

SiS

Special Interest Session

SYM

Symposium



AHS-01 Comprehensive Migraine Education Program (Part 1)

Frank Andrasik, PhD; Sheena K. Aurora, MD; Andrew C. Charles, MD; Richard B. Lipton, MD; Matthew Robbins, MD, FAHS

Friday/9.11 9:00a - 10:55a

Level 3/Gracia 7

The Chronic Migraine Education Program (CMEP) was developed by the American Headache Society®. CMEP includes new advances and addresses acute and preventive treatment options. In addition, the CMEP highlights epidemiologic data on the scope and distribution of migraine with an emphasis on chronic migraine, practical methods for diagnosing chronic migraine, and recent insights into the mechanisms of the disorder setting the stage for improving treatment outcomes for this most disabling of headache disorders. The CMEP is designed to provide a comprehensive understanding of migraine with an emphasis on chronic migraine as well as to better diagnose and treat these serious problems. Part 1 of this program will cover diagnosis of chronic migraine, risk factors and prognosis of chronic migraine, neurobiology of chronic migraine, and behavioral and psychological aspects of migraine.

AHS-02 Comprehensive Migraine Education Program (Part 2)

Frank Andrasik, PhD; Sheena K. Aurora, MD; Andrew C. Charles, MD; Richard B. Lipton, MD; Matthew Robbins, MD, FAHS

Friday/9.11 1:35p - 3:30p

Level 3/Gracia 7

Part 2 of this program will cover preventative pharmacotherapy for chronic migraine and advances in acute treatment of chronic migraine.

APS-O1 Why Does It Hurt to Get Old and What Can We Do About It?

Roger B. Fillingim, PhD

Friday/9.11 7:00a - 7:55a

Level 3/Gracia 1

Pain represents arguably the most prevalent and costly public health condition in the United States, affecting 100 million adults and costing over \$500 billion annually. While pain affects individuals throughout the lifespan, older adults are at increased risk for chronic pain and pain related disability and transitioning from acute to chronic pain. Given the "graying" of the population, older adults will represent an increased proportion of patients seeking care for chronic pain; therefore, understanding age related influences on pain is critical for providing optimal pain management. This presentation will briefly review how aging influences the prevalence and impact of chronic pain. Then, biological and psychosocial factors that contribute to chronic pain among older adults will be discussed. For example, increasing evidence suggests that aging produces changes in pain modulation that may explain increases in chronic pain prevalence in older adults. In addition, age related influences on inflammation, brain structure and function, sleep quality, cognitive and affective processes, and social factors all contribute to chronic pain among older adults. Potential treatment strategies that may improve pain in older adults by targeting these mechanisms will then be presented. These issues will be fleshed out using a case example of an older adult with osteoarthritis, which will include discussion of how multiple biopsychosocial factors should be considered in developing a comprehensive treatment plan.

APS-02 Assessment of Pain in Older Adults

Keela A. Herr, PhD, RN, AGSF, FAAN

Friday/9.11 11:15a - 12:10p

Level 4/Nolita 1

This course provides an overview of current best practice recommendations for assessment of pain in older adults. Approaches identified as effective in gathering assessment information from those who are cognitively intact and those with cognitive impairment, including reliable and valid tools, will be discussed. Gaps in assessment knowledge that guide current and future research will be identified. Evidence-based resources to support effective assessment practices will be shared.

APS-03 Pharmacologic and Nonpharmacologic Geriatric Pain Management

Manney C. Reid, MD, PhD

Friday/9.11 1:35p - 2:30p

Level 4/Nolita 1

Friday 9.11



The American Pain Society presents



Roger Fillingim Keela Herr Jordan Karp Manney Reid

Management of pain in later life is often complicated by age related physiologic changes; sensory and cognitive impairments; polypharmacy; and multimorbidity, particularly chronic conditions such as disorders of gait and balance, and kidney, lung, and cardiovascular disease. Both nociceptive and neuropathic pain are common and often coexist in this age group, further complicating management. Guidelines and consensus statements provide useful information regarding the assessment and management of later life pain. There is a broad consensus around the need to intervene aggressively using a multimodal approach that includes both pharmacologic and nonpharmacologic treatments. This approach is supported by the fact that pain relief constitutes one of the most commonly endorsed goals of older adults. Dr. Reid will review guideline recommendations for the management of chronic pain in the older adult and present data on both the safety and efficacy of commonly prescribed pharmacologic agents to include the role of opioids as treatment for chronic noncancer pain. His presentation will also cover common nonpharmacologic approaches to include self-management education and the evidence underlying these modalities. Finally, Dr. Reid will review various approaches to delivering pain care to include collaborative models that have been successfully employed in the primary care setting.

APS-O4 Addressing Pain and Depression Together in Late Life

Jordan F. Karp, MD

Friday/9.11 2:35p - 3:30p

Level 4/Nolita 1

The links between chronic pain and depression are well established. Both conditions: 1) are risk factors for the other's onset, 2) interfere with each other's treatment response, 3) worsen the negative experience or "bothersomeness" of the other disorder, 4) mutually slow rates of remission, and 5) may increase the risk of the other's recurrence. In late-life, these conditions increase the risk of suicide, polypharmacy, physical deconditioning and disability, cognitive impairment, and worsened caregiver burden. A shared biology (eg, similar neurotransmitter perturbation and psychology—learned help-lessness, low self-efficacy—support a unified approach to treatment. Rationally developed and tested age-specific interventions targeting these linked conditions are sorely needed. This talk will focus on the epidemiology and screening for these conditions and rationally selected treatments that address both depression and chronic pain that are specific for older adults. Treating these chronic conditions as linked may minimize the stigma of depression treatment and improve treatment acceptability.

APS-05 Will Physicians Be Managing Pain With Smartphones in the 21st Century?

Manney C. Reid, MD, PhD

Friday/9.11 4:35p - 5:25p

Level 4/Nolita 1

In recent years, mobile devices such as smartphones have become increasingly lightweight, affordable, user-friendly, and widely used by individuals of all age groups, including elderly individuals. In combination with targeted prompts to record subjective states (eg, pain levels), these devices offer near continuous sampling capability for variables such as daily activity level, stress, mood, social networks, and sleep habits. Moreover, without any input from the individual, mobile phones can automatically collect information about time, location, voice quality as a measure of stress, and even the people around the individual. Many mobile phones have built-in accelerometers that can generate data on movement (pace, gait, distance) and sleep patterns. These devices along with associated applications (apps) have the potential to measurably improve patient care through more effective monitoring of treatment outcomes, enhanced patient-provider communication, and by providing new ways to deliver treatment. In this presentation, Dr. Reid will review published research examining the role of pain apps, review barriers and facilitators to their use in practice, and highlight knowledge gaps about the role of mHealth in pain care.

ASAM-O1 Medical Aspects of Marijuana: How Would the Packet Insert Read?

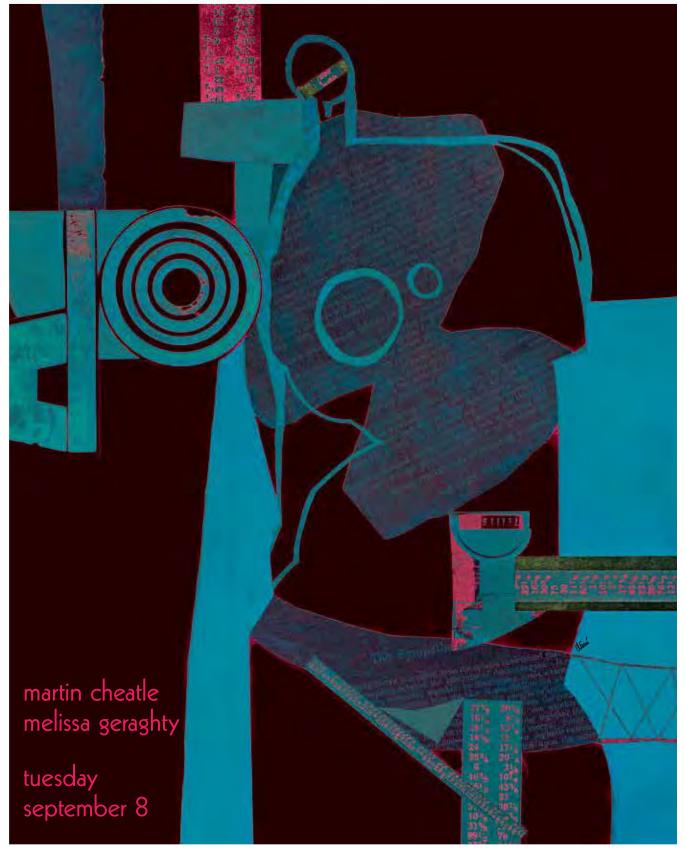
llene R. Robeck, MD

Saturday/9.12 7:00a - 7:55a

Level 4/Nolita 1

This presentation reviews what clinicians need to know when their patients are using marijuana either medically or recreationally. It is not a discussion of whether marijuana should be legal, illegal, or viewed as medicine. With the growing number of patients using marijuana, however, it is important to understand how patients may present with a marijuana related medical problem. It is also important to understand how to counsel patients related to marijuana and safety issues for them and their family.

behavioral pain management



ASAM-02 Nonpharmacologic Management of Pain

Mel Pohl, MD

Saturday/9.12 8:00a - 8:55a

Level 4/Nolita 1

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

ASAM-03 Buprenorphine in Patients With Chronic Pain and Opioid SUD

Mark A. Weiner, MD

Saturday/9.12 1:35p - 2:30p

Level 4/Nolita 1

The goal of this presentation is to educate practitioners in identifying problematic opioid use in their patients and to assist practitioners in the appropriate strategies for discontinuing opioids. Primary care physicians, as well as addiction medicine and pain management specialists, will be able to identify problematic opioid use, unintended consequences of opioid misuse, and to appropriately withdraw patients from chronic opioid medications. Additionally, the rehabilitative care of patients once opioids are withdrawn will be addressed.

ASAM-04 Alcohol Use Disorder and Chronic Pain

Michael F. Weaver, MD, FASAM

Saturday/9.12 3:35p - 4:30p

Level 4/Nolita 1

Why should clinicians care if their patients drink? Dr. Weaver will discuss the consequences of alcohol use disorder (AUD), including its impact on pain management. Screening methods for alcohol use with patients and brief intervention strategies for patients who drink will be introduced, including some motivational interviewing techniques to help clinicians address alcohol use with patients in a tactful manner. Also discussed will be how to refer for treatment of AUD and different treatment options available to patients.

BHV-01 The Biopsychosocialspiritual Impact of Chronic Pain in Adolescence

Melissa E. A. Geraghty, PsyD

Tuesday/9.8 10:20a - 11:10a

Level 4/Nolita 2

The effects of chronic pain in adolescence are diverse, influencing every facet of an adolescent's life. Literature on chronic pain often focuses on pediatric or adult populations and does not lend information on how to provide evidence-based treatment for adolescents in chronic pain. Adolescence itself is a diverse group due to differences in biology, psychological functioning, social interactions, and spirituality. This presentation discusses the biopsychosocialspiritual impact of chronic pain in the adolescent population. The psychological component is emphasized most.

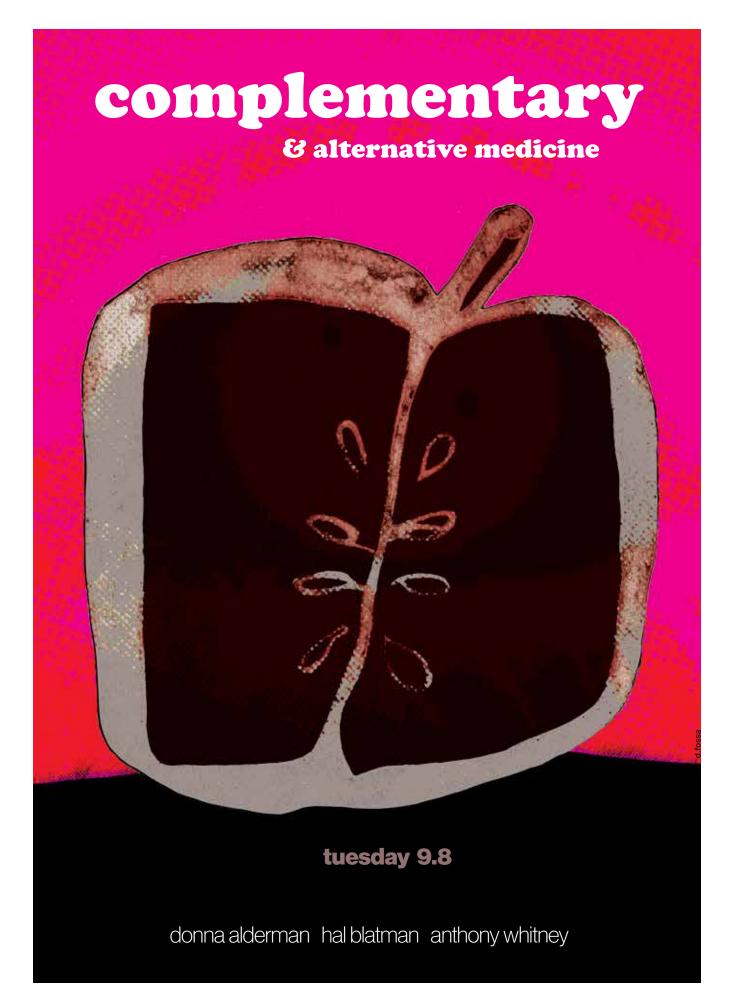
BHV-02 Depression and Suicidal Behavior With Pain and Concomitant Substance Abuse Disorders

Martin D. Cheatle, PhD

Tuesday/9.8 11:15a - 12:10p

Level 4/Nolita 2

Studies have demonstrated a strong association between depression and pain, indicating that pain patients are more likely to be depressed than patients without pain. There is also evidence suggesting an elevated prevalence of suicidal ideation in patients with chronic pain, with one systematic review revealing that the risk of successful suicide was doubled in patients with chronic pain as compared to nonpain controls. Patients suffering from substance use disorders (SUD) have comparable rates of depression and suicidal behavior. The patient with pain and a SUD is particularly susceptible to becoming suicidal. This presentation will review the current conceptual model of depression and suicidal ideation in patients with chronic pain and history of SUD and examine possible mediators, outline risk assessment strategies, and discuss interventions to mitigate risk of suicide in this vulnerable population.



BHV-03 "It Could Be Worse" and Other Things NOT to Say to Patients With Chronic Pain

Melissa E. A. Geraghty, PsyD

Tuesday/9.8 4:35p - 5:25p

Level 4/Nolita 2

This presentation discusses the etiquette of working with patients with chronic pain and physical disabilities. The pain culture is engulfed with many incorrect assumptions that drastically hinder the treatment of this population. Many patients with chronic pain report that their struggles are often dismissed by medical professionals, family members, friends, and coworkers. This presentation focuses on how to properly support patients in chronic pain by examining what not to say and what not to assume. Clinical case examples will be provided.

CAM-O1 Biofeedback and Chronic Pain: Making the Connection

Anthony A. Whitney, MS, LHMC, BCB

Tuesday/9.8 7:00a - 7:55a

Level 4/Nolita 3

The management of chronic pain has many attributes that distinguish it from almost all other medical conditions. An important characteristic of pain is that, unlike hypertension, diabetes, and other chronic medical conditions, the patient contributes to the process of defining a successful treatment outcome. Another question that often arises is the paradigm of "cure" in terms of chronic pain treatment. Unfortunately, there may often be a number of misalignments between patients and their healthcare providers, including incongruity of goals and expectations about treatment and the likelihood and/or prospect of a curative outcome. This presentation will explore issues that often arise in clinical practice. Recommendations for avoiding common pitfalls in clinical practice will be offered in a way intended to be constructive, provocative, and meaningfully beneficial to healthcare providers and their patients with chronic pain.

CAM-02 Nutrition and Pain: Rules for Success

Hal S. Blatman, MD, DAAPM, ABIHM

Tuesday/9.8 9:00a - 9:55a

Level 4/Nolita 3

Pain is one of the most common reasons for which patients seek medical care. Nutrition is often considered when counseling patients, and it takes a high level of conviction to motivate people to change. Patients with chronic fatigue, fibromyalgia, and a myriad of pain conditions are much more dramatically affected by nutrition than most of us appreciate. A successful plan can be explained through 3 rules that need to be followed.

CAM-03 Mind-Body Connection? It's Not Just in Your Head!

Anthony A. Whitney, MS, LHMC, BCB

Tuesday/9.8 11:15a - 12:10p

Level 4/Nolita 3

Relaxation training, meditation, and biofeedback are just a few of the mind-body connection based treatment options gaining increased attention, but what are they and should they be incorporated in the treatment of chronic pain? Generally it is far more acceptable to receive and/or participate in treatment when the problems involve the body (broken bones, knee replacement, heart attack, etc), but if the problems involve the mind or, even worse, emotions, getting or accepting treatment is often far more difficult. The treatment of chronic pain includes significant challenges for all involved, especially when considering chronic pain's impact on the brain, cognition, and emotional regulation. This course will analyze struggles both patients and providers often experience when attempting to integrate the mind-body connection into the treatment of chronic pain. Several short exercises/demonstrations will be presented to increase attendees awareness and understanding of the mind-body connection. Clinical case examples will be reviewed to increase awareness of the potential benefits produced when incorporating mind-body based treatments early in the management of chronic pain rather than when they are used as a last resort. It is not "Mind over matter" but rather that "The mind does matter."

CAM-O4 High-Density Platelet-Rich Plasma and Stem Cell Prolotherapy for Musculoskeletal Pain

Donna Alderman, DO

Tuesday/9.8 1:35p - 2:30p

Level 4/Nolita 3

Prolotherapy is an injection treatment that stimulates musculoskeletal healing, resolving pain. Used clinically since the 1930s, prolotherapy has a high success rate and a low risk profile. Newer forms of this treatment involve the use of autologous platelet-rich plasma and stem cell sources, such as autologous adipose and bone marrow. This lecture will discuss basics of prolotherapy, how these advanced forms work, and why prolotherapy improves connective tissue and joint pain, as well as supporting medical literature.

CAM-O5 Identifying and Unlocking Myofascial Pain

Hal S. Blatman, MD, DAAPM, ABIHM

Tuesday/9.8 2:35p - 3:30p

Level 4/Nolita 3

Muscle, fascia, radiating myofascial pain, prolotherapy, trigger point injections, and the use of compounding pharmacy take on new meaning with a more up-to-date understanding of anatomy based on new techniques of fascia sparing dissection. The very tissue that was discarded in anatomy lab is the most important generator of pain and proprioception in the body. This presentation illustrates the connection between injury to fascia and how this interacts with the nervous and immune systems to create most of the pain for which our patients seek care.

FIN-01 Pain-Free Insights of Public Equity Investing*

Samuel Dedio

Thursday/9.10 7:00a - 7:55a

Level 4/Yaletown 1

Join Sam Dedio, founder and Chief Investment Officer at Patrumin Investors, for an insightful discussion about investing in the US equity markets and a review of some painful investment lessons he's learned. Mr. Dedio will share personal insights and discuss the following topics: long-only investing vs hedge funds, asset allocation, bottom-up investing, style investing and smallcaps, understanding investment management fees of popular investment choices, behavioral aspects of professional investing, and a behind-the-scenes look at how accounts are managed at private wealth management firms. Mr. Dedio will also provide a summary and review of long-term performance in the equity markets—the data always surprises investors! He will conclude his discussion with some of his favorite investment themes, trends, and ideas. Mr. Dedio has over 25 years of experience navigating the turbulent markets as an analyst and portfolio manager for Standard & Poor's, Ernst & Young, Deutsche Asset Management, and Julius Baer. He has managed billions of dollars for institutional and individual clients, managed a 5-star, US smallcap mutual fund, and has been featured on CNBC, Fox, Bloomberg and CNN.

HCH-01 Outside the Box: Rethinking Pain Management Paradigms

Lesa Abney, RN-BC, NC-BC; Lisa Creekmur, BSN, RN, NC-BC, CPH&WC; Rebecca L. Curtis, PCC

Tuesday/9.8 3:35p - 4:30p

Level 4/Nolita 3

Some of the greatest discoveries come not from finding better answers, but from asking better questions. In today's pain management world, the focus tends to be on answers to problems providers face most, when perhaps the best solutions can be found in asking better questions. Pain management coach Becky Curtis will identify many of the old questions we have been asking and why they often fail, while explaining why pain management coaching may be a new answer to questions we have yet to ask.

HCH-02 The Pain Management Coaching Toolbox

Lesa Abney, RN-BC, NC-BC; Lisa Creekmur, BSN, RN, NC-BC, CPH&WC; Rebecca L. Curtis, PCC

Tuesday/9.8 4:35p - 5:25p

Level 4/Nolita 3

In this session we seek to take some of the mystery out of the pain management coaching process. The session will include live demonstrations of the process of pain-management coaching with commonly used techniques, such as MI, positive psychology, and CBT.

^{*}This presentation is not certified for credit.

HCH-03 Outside the Box: Rethinking Pain Management Paradigms (Encore)

Lesa Abney, RN-BC, NC-BC; Lisa Creekmur, BSN, RN, NC-BC, CPH&WC; Rebecca L. Curtis, PCC

Wednesday/9.9 10:20a - 11:10a Level 4/Nolita 3

HCH-O4 The Pain Management Coaching Toolbox (Encore)

Lesa Abney, RN-BC, NC-BC; Lisa Creekmur, BSN, RN, NC-BC, CPH&WC; Rebecca L. Curtis, PCC

Wednesday/9.9 11:15a - 12:10p Level 4/Nolita 3

INT-01 Pain Medicine Economics: Ancillary Services to Ensure Practice Solvency

Orlando G. Florete, Jr, MD

Saturday/9.12 9:00a - 9:55a

Level 3/Gracia 5

The ability to maintain a profitable pain management practice relying on the traditional source of income by direct patient care is becoming more difficult. Cuts in reimbursement on office visits and procedures as well as increasing overhead expenses make it difficult to maintain a viable practice. In order to increase revenue stream, pain practitioners must adopt nontraditional ancillary services including practice modification such as creation of an ancillary concierge practice, wellness program, clinical research program, and medico-legal work. Providing an in-house high complexity drug testing laboratory; medication dispensing; having a physical therapy and durable medical equipment programs; and acquiring ownership in surgical and diagnostic centers are other means to increase income. Decreasing cost by streamlining the practice, joining a group purchase organization, and taking advantage of the federal government's program in meeting the meaningful use criteria in the electric health record provide other means of increasing the practice's bottom line. Incorporating these different programs may be more than enough to sustain a viable private practice for years to come.

INT-02 Differential Diagnosis of Low Back Pain

Arnold J. Weil, MD

Saturday/9.12 **11:15a - 12:10p**

Level 4/Nolita 1

This presentation will cover the common differential diagnoses of low back pain: orthopedic conditions including musculoskeletal, discogenic, osseous, and nerve related entities.

INT-03 The Role of Combined Electrochemical Treatment for Chronic Pain Conditions

Cindy R. Cernak, DPM; Robert H. Odell, MD, PhD

Saturday/9.12 1:35p - 3:30p

Level 3/Gracia 3

Combined electrochemical treatment (CET) uses local anesthetics combined with a computerized electronic signal treatment (EST) to mitigate or eliminate pain, allodynia, numbness, and other symptoms of neuropathic pain. The electronic signal generator uses sophisticated communications level technology to produce and deliver medium frequency signal energy in continually varying sequential and random patterns via specialty electrodes. This alternation of sequential and random signal delivery eliminates neuron accommodation. EST has profound anti-inflammatory and other physiologic effects—cellular membrane repair, increase in intracellular metabolism, diffusion of hydrogen ion concentration to reduce tissue acidosis, regeneration of axons, and support of the immune system. These effects occur by using the principles of physics rather than pharmacology.

INT-04 Management of Low Back Pain: Interventional Options

Arnold J. Weil, MD

Saturday/9.12 **1:35p - 2:30p**

Level 4/Nolita 3

This presentation will cover the management of low back pain, in particular the interventional injection procedures. Treatment options including epidural injections, radiofrequency lesioning, spinal cord stimulation, and intradiscal stem cell injections will be discussed.



Neurogenic Thoracic Outlet Syndrome

Allen Togut

Tuesday September 8

KEY-O1 Keynote

Charles E. Argoff, MD, CPE; Michael R. Clark, MD, MPH, MBA; Kevin L. Zacharoff, MD, FACIP, FACPE, FAAP

Wednesday/9.9 5:30p - 6:30p

Level 4/Mont-Royal Ballroom

MAS-01 Neurogenic Thoracic Outlet Syndrome

Allen J. Togut, MD

Tuesday/9.8 1:35p - 3:30p

Level 4/Yaletown 1

Neurogenic thoracic outlet syndrome (NTOS) is a chronic neuropathic pain 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: anatomy and etiology, symptoms, physical and neurological examination, psychosocial, and laboratory testing and management.

Please note that this course is limited to 50 participants; preregistration is required.

MAS-02 Integrative Pain Management

Gary E. Kaplan, DO, ABFP, DABPM, FAAMA

Thursday/9.10 1:35p - 3:30p

Level 3/Gracia 7

This 2-hour master class is devoted to redefining chronic pain and depression as a neuroinflammatory disease and presenting a new model of integrated medical care. The cost for the treatment of chronic pain conditions exceeds one half trillion dollars a year. The conventional approach to the treatment of chronic pain has more failures than successes. The conventional approach to chronic pain has also resulted in an epidemic of opioid addiction and abuse in the US. Depression and chronic pain are comorbid in over 50% of the cases. This comorbidity results in even worse treatment outcomes. Underlying our failure is a misunderstanding of the illness we are treating. Chronic pain and depression are in fact not diseases so much as symptoms, symptoms of a neuroinflammatory disease of multiple and compounding etiologies central sensitization syndrome or CSS. The first hour will be devoted to understanding the pathophysiology of neuroinflammatory disease; the second will focus on treatment strategies based on our understanding of the neurophysiology of CSS. Successful treatment of CSS requires the integration of conventional therapies with functional medicine and complementary and alternative therapies. Through case presentations we will discuss how to perform a comprehensive integrative medical workup and then create a comprehensive integrated medical treatment program to achieve total recovery for our patients.

MAS-03 Shaken—Not Stirred: Minor Traumatic Brain Injury and Concussion

Gary W. Jay, MD, FAAPM

Thursday/9.10 9:00a - 10:55a

Level 3/Gracia 7

Is a concussion really a minor traumatic brain Injury (mTBI)? This will be discussed, along with the clinical aspects of concussion, postconcussion syndrome, and mTBI. The pathophysiology of concussion and mTBI will be discussed in detail, along with treatment options.

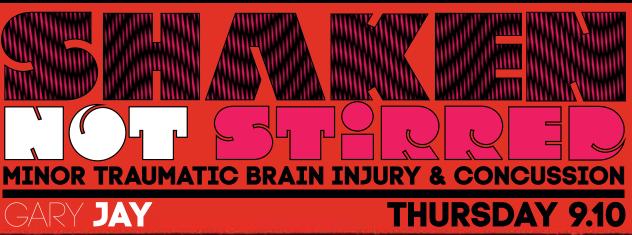
MAS-04 Differential Diagnosis of Back Pain

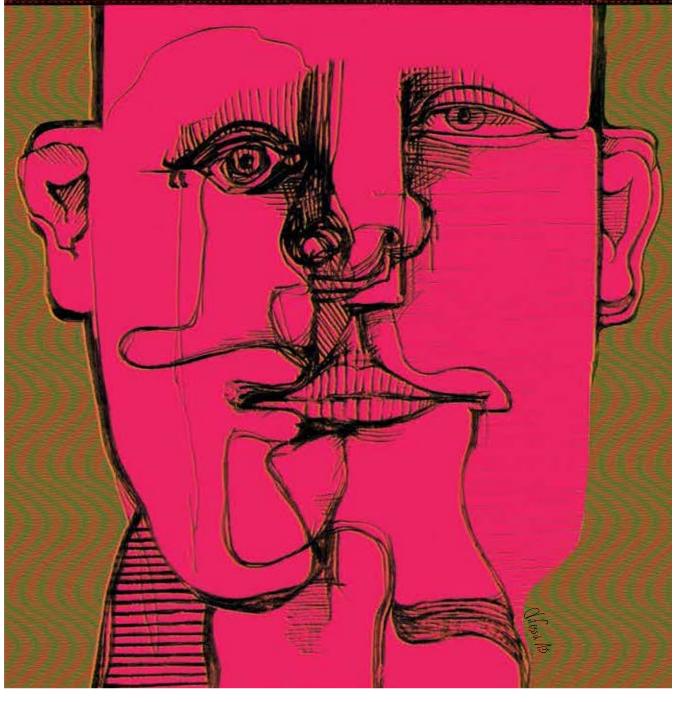
David M. Glick, DC, DAAPM, CPE, FASPE

Friday/9.11 1:35p - 3:30p

Level 3/Gracia 3

master class series





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 overreliance on 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 to assist clinicians in the development of a more specific problem focused examination that can enhance the differential diagnosis of specific pain generators, and 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.

MAS-05 Patient Centered Urine Drug Testing: A Case Based Approach

Douglas L. Gourlay, MD, MSc, FRCPC, FASAM; Howard A. Heit, MD, FACP, FASAM

Saturday/9.12 1:35p - 3:30p

Level 4/Yaletown 1

Urine drug testing (UDT) is playing an increasing role in the management of risk in clinical care. Unfortunately, drug testing in general suffers from several shortcomings, especially when called upon to identify problematic use of controlled substances, including drug diversion. UDT is the preferred tool in patient centered care. It can offer clinicians valuable insight into the identification, treatment, and monitoring of their patients while providing objective data in risk evaluation and minimization strategies necessary for responsible clinical care. Using a model of case based discussion, these issues will be examined.

Please note that this course is limited to 50 participants; preregistration is required.

MDL-01 Embrace 2015 Practice Changes and Patient Education: Overview of Critical Pain Management Issues

Jennifer Bolen, JD

Tuesday/9.8 10:20a - 12:10p

Level 3/Gracia 3

Every day something new happens in pain management. One day it might be a change in a licensing board practice standards and the next 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.

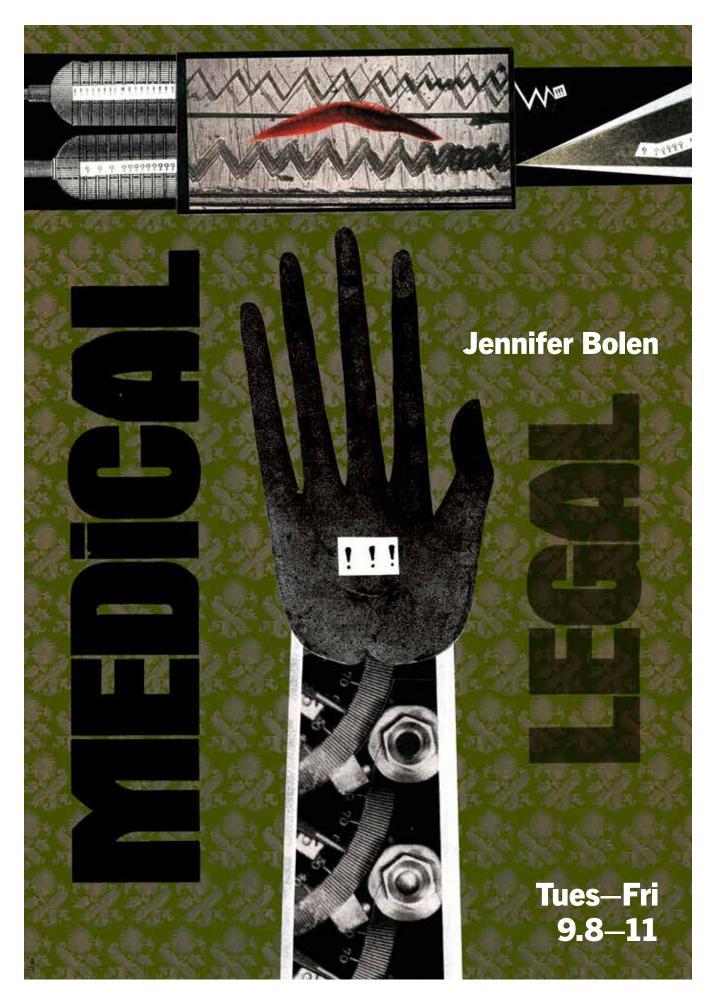
MDL-02 Get Your Specimens in Order: The Impact of Changes to the Clinical Laboratory Fee Schedule

Jennifer Bolen, JD

Wednesday/9.9 10:20a - 12:10p

Level 3/Gracia 3

Staying current and compliant contributes to quality patient care and reimbursement practices that maximize practice revenue and minimize the potential of the devastating financial consequences associated with inappropriate billing and coding practices. In 2015, enforcement arms of both commercial and government healthcare benefit plans are focused on reviewing reimbursement claims for clinical laboratory services. Much of the focus is the result of skyrocketing healthcare costs for these services in 2013/2014. Medicare's concern over potential fraud and abuse in the clinical laboratory area, and in particular drugs of abuse testing, is reflected in the 2015 Clinical Laboratory Fee Schedule (CLFS). In addition, payors continue to change coverage policies and are increasingly focused on medical record documentation to spell out why the patient is being testing, which drugs are to be tested based on the patient's individual medical situation and treatment needs, and how the physician uses the results of the drug test in the ongoing care of the patient. Physicians need a game plan to understand the 2015 CLFS, payor policies, and forthcoming changes to drugs of abuse testing. They also need a game plan to ensure that the medical record not only supports the decision to prescribe a controlled medication, but also supports claims for reimbursement of laboratory services. This course will examine the steps physicians should take to ensure proper medical record documentation to support claims for reimbursement of laboratory services and controlled substance prescribing decisions.



Focus on Changes in Billing/Coding Clinical Laboratory: Roll With the Changes and Learn How to Keep Payors Out of Your Bank Account

Jennifer Bolen, JD

Thursday/9.10 10:20a - 12:10p

Level 3/Gracia 3

During this lecture, attendees will learn to 1) identify the basic structure of 2015 CPT codes and relate them to the 2 major forms of drugs-of-abuse testing, presumptive and definitive; 2) compare 2015 CPT codes to 2015 G-Codes and further coding guidance published by CMS, and identify the critical differences in billing clinical laboratory services to commercial and government plans; and 3) identify recently released coverage determinations and medical policies governing clinical laboratory, and explore how these changes—draft and final—are likely to impact clinical laboratory during the balance of 2015 and into 2016. With all the pressure to solve the opioid overdose problem, the stakes in clinical laboratory are higher than ever and go well beyond upcoming financial challenges in this industry. This lecture will help physicians stay in control of laboratory claims for reimbursement while offering patients continued access to quality pain management.

MDL-04 A Legal Perspective on Practicing Medicine and Offering Ancillary Services: When Wearing 2 Hats May Cause You Problems Beyond a "Glamour Don't"

Jennifer Bolen, JD

Friday/9.11 10:20a - 12:10p

Level 3/Gracia 3

When Jane Doe walks into a medical practice, she expects her physician to competently evaluate her and order services that are medically necessary and appropriate to her individual healthcare needs. If her physician wears 2 hats and offers healthcare services such as clinical laboratory, pharmacy, or durable medical equipment, Jane Doe may be agreeable to accepting those additional services from her physician, but she has a right to know about her physician's financial interest in the offered services and whether to commit her resources to him. Today, physicians are battling declining reimbursement and bringing ancillary services into their practices to shore up the viability of their business operations. Physicians should work with their attorneys to ensure legal viability of contemplated and existing ancillary services and examine the legality of vendor relationships tied to these services. Physicians should also consider whether their core medical practice will be negatively impacted because of the effort required to make ancillary services successful. And, ancillary services may require education and even additional credentialing to ensure care standards are current. Disaster looms for those who fail to appreciate what it means to wear "2 hats" in the provision of both medical and Department of Health services to the patient.

MSK-01 Osteoarthritis

Steven P. Stanos, DO

Wednesday/9.9 9:00a - 9:55a

Level 4/Nolita 3

Pain and dysfunction related to osteoarthritic conditions are common in the pain clinician's practice. This lecture will review pathophysiology of osteoarthritis including an update on recent work related to central sensitization as an underlying contributor to osteoarthritic pain. The course will use case examples to help explore common arthritic conditions of the shoulder, knee, and hip including assessment and treatment considerations, both pharmacologic and nonpharmacologic. Pharmacologic overview will include a discussion of recent changes in FDA warnings for NSAIDs related to risk for cardiovascular and neurological adverse events, ie, heart attack and stroke.

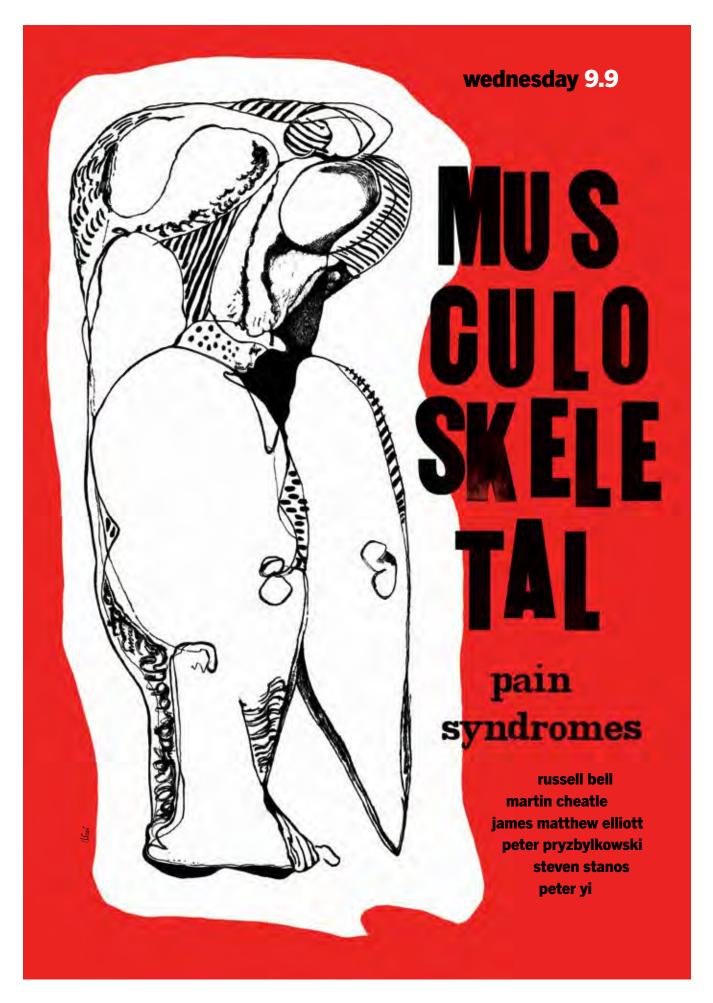
MSK-02 Assessing and Managing Acute and Chronic Low Back Pain

Russell L. Bell, MD; Martin D. Cheatle, PhD; Peter G. Pryzbylkowski, MD; Peter Yi, MD

Wednesday/9.9 1:35p - 3:30p

Level 3/Gracia 3

Low back pain is the most common type of pain condition that presents to both primary care physicians and pain medicine practitioners. The lifetime prevalence rate of low back pain in the United States has been estimated as up to 70% to 80%. A significant subgroup of acute pain patients will go on to develop chronic low back pain. Chronic low back pain is associated with significant rates of disability and corresponding healthcare costs and suffering to individuals. It is imperative that both acute and chronic low back pain be efficiently and effectively assessed and treated, avoiding iatrogenic complications from mismanagement and improving clinical and economic outcomes. This



multidisciplinary panel will review the underlying mechanisms of low back pain and discuss the current guidelines and models for evaluating and treating acute and chronic low back pain, including pharmacologic, nonpharmacologic, CAM, and interventional strategies.

MSK-03 Whiplash

James Matthew Elliott, PT, PhD

Wednesday/9.9 11:15a - 12:10p

Level 3/Gracia 5

Over 4 million patients are treated in US emergency medicine departments annually for whiplash as the result of a motor vehicle collision. Most individuals recover spontaneously, but 25% will continue to suffer in the long term. In the vast majority of cases, structural damage on objective imaging is rarely associated with symptoms, and there remains little evidence towards the most effective management of chronic whiplash. The prevailing opinion remains that poor functional recovery is largely influenced by social, psychological, and behavioral factors, not biological. While this may be the case in some, our preliminary data and previous work are at odds with this position. We have demonstrated the rapid and early expression of muscle degeneration, signs of disturbed descending control, and muscle weakness, which correlates with severe-pain-related disability. The long-term goals of our interdisciplinary research programs are to improve outcomes in whiplash associated disorders, but before this can be realized, it is crucial we, and all stakeholders, understand the biopsychological mechanisms underlying poor functional recovery. This new knowledge will set the stage for future studies investigating more objective assessments and the development of informed interventions that avoid stigmatization of the individual with whiplash as having purely, what some would say, a psychosomatic pathology.

MSK-04 Fibromyalgia

Steven P. Stanos, DO

Wednesday/9.9 2:35p - 3:30p

Level 4/Nolita 3

Fibromyalgia, a complex and sometimes misunderstood condition, remains a challenge from a diagnostic and treatment standpoint. From muscular rheumatism, fibrositis, to fibromyalgia, history has helped to shape our understanding of this now recognized central pain state. This course will review diagnostic criteria, recent pathophysiology, and comprehensive management principles that can be applied at the pain clinician clinic. Besides a strong evidence base for pharmacotherapy, this presentation will help to better highlight nonpharmacologic interventions that may help improve outcomes for chronic pain suffers presenting across a wide spectrum of presentations.

NAD-01 Rx Abuse and Diversion: The Scope of the Problem in 2015

Lisa M. McElhaney, BS

Thursday/9.10 9:00a - 9:55a

Level 4/Mont-Royal Ballroom

Pharmaceutical drug abuse has been occurring for decades across the globe and is a growing national epidemic. Addiction, overdoses, and deaths involving nonmedical prescription drug use, especially narcotic pain relievers, have risen dramatically over the last decade. This presentation presents findings that illustrate the scope and seriousness of the prescription drug abuse epidemic. The attendee will be presented with the history of pharmaceutical drug abuse, current trends, various methods of diversion, and steps to identify drug seekers.

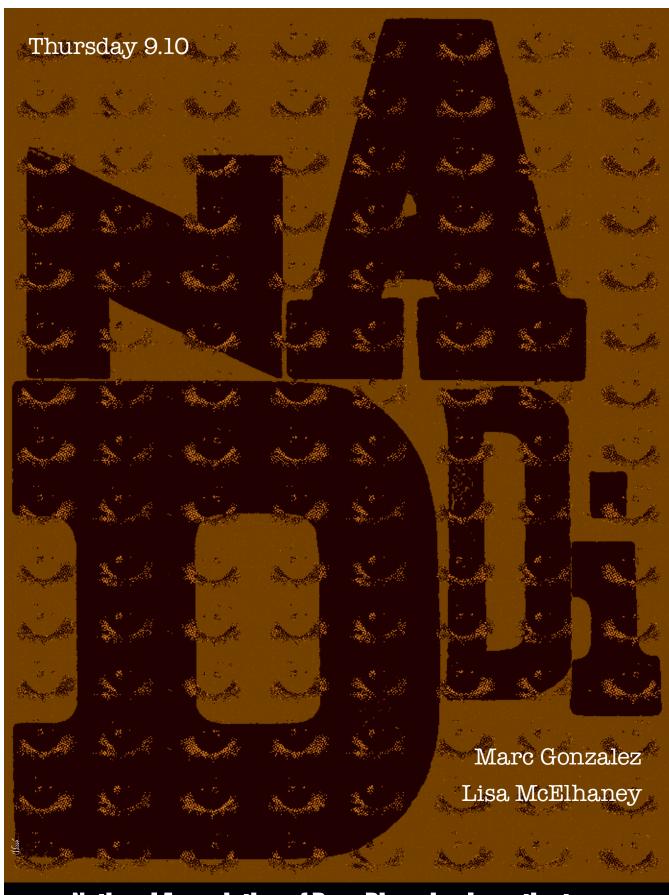
NAD-02 Scammers, Shammers, and Thieves

Marc S. Gonzalez, PharmD

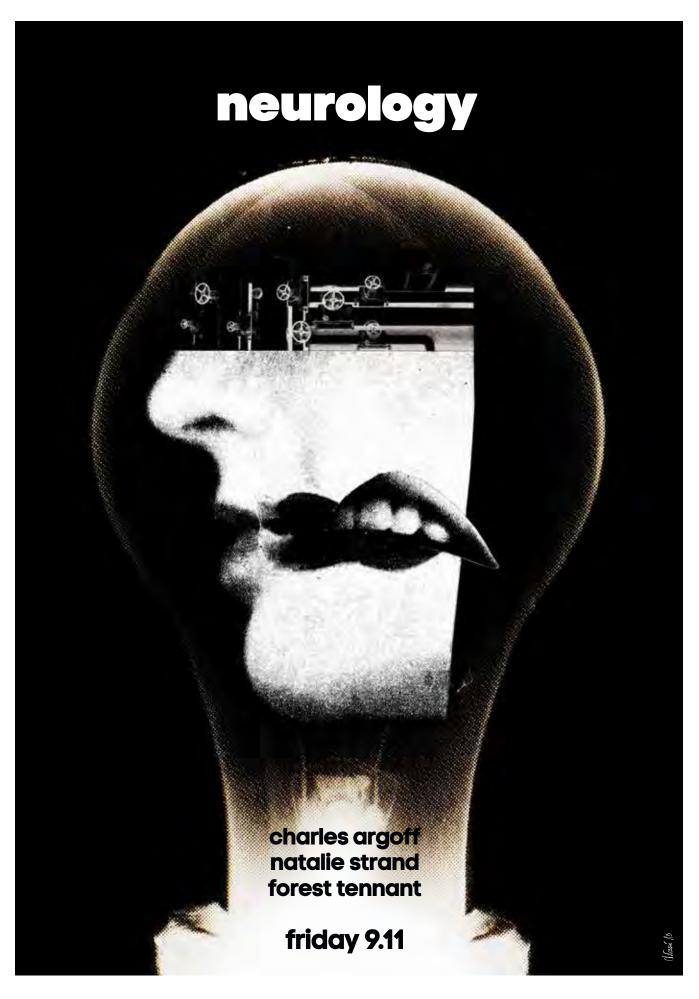
Thursday/9.10 10:20a - 11:10a

Level 4/Mont-Royal Ballroom

So many times, regulatory, the public, and even healthcare professionals think that rogue doctors are the main suppliers of pharmaceutical drugs to the illicit market—better known as pharmaceutical diversion. Take a trip to the dark side where a former law enforcement officer and healthcare professional elucidates the little known yet highly significant sources of illicit pharmaceutical markets. Methods will be discussed to create a partnership with healthcare professionals and law enforcement so that much of this criminal activity can be shut down.



National Association of Drug Diversion Investigators



NAD-03 Opioid Overdose Strategies: Are They Working?

Lisa M. McElhaney, BS

Thursday/9.10 1:35p - 2:30p

Level 4/Mont-Royal Ballroom

Deaths from drug overdose have risen steadily over the past 2 decades and currently outnumber deaths from car accidents in the United States. Many state and federal initiatives have been implemented in the past few years aimed at reducing pharmaceutical drug dependence, overdoses, and death. But are they working? The role of the healthcare practitioner is paramount in addressing this very challenging issue. This block of instruction will present the attendee with an overview of the existing problem, approaches to a solution, and resources available to them as practitioners.

NAD-04 Addiction and Drug Histories: A Cop's Eye View From the Street to the Clinician's Office

Marc S. Gonzalez, PharmD

Thursday/9.10 4:35p - 5:25p

Level 3/Gracia 3

A former law enforcement officer and healthcare professional will review aspects and mechanisms of addiction and why addicts continue to exhibit aberrant behaviors, despite knowing they will have negative consequences. In an effort to better appreciate the manifestations of previous drug use in patients, the presenter will review drugs of abuse that patients may have used in the past, which have lasting effects. Attendees will learn to develop treatment plans and consider a consult outside their scope of practice.

NRO-01 The Neurological Examination: An Overview

Charles E. Argoff, MD, CPE

Friday/9.11 9:00a - 9:55a

Level 4/Nolita 3

Many chronic pain patients are referred to neurologists to assess their history and detect aberrations that may be the source of their pain. This course provides an overview of the typical neurological exam, covering general appearance, posture, motor and sensory systems, reflexes, coordination, and differentiating peripheral from central nervous system lesions, and identifying other neurological abnormalities.

NRO-02 Peripheral Neuropathies

Natalie H. Strand, MD

Friday/9.11 1:35p - 2:30p

Level 4/Nolita 3

The pathophysiology of peripheral neuropathies will be reviewed in detail. We will review the anatomy of the nervous system to better understand peripheral neuropathies. We will go over the clinical presentation of painful peripheral neuropathies and pay particular attention to the criteria that differentiate one neuropathy from another. We will also review the most common causes, best diagnostic tools, and best treatments for painful peripheral neuropathy.

NRO-03 Small Fiber Neuropathies

Charles E. Argoff, MD, CPE

Friday/9.11 2:35p - 3:30p

Level 4/Nolita 3

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 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 Diagnosis and Management of Central Pain

Forest Tennant, MD, DrPH, FACPM, MPH

Saturday/9.12 9:00a - 9:55a

Level 3/Gracia 7

This presentation will primarily focus on the clinical recognition of centralized pain and the essential need to direct treatment at this condition regardless of its basic cause. Central pain is the classic term applied to a brain disease or injury such as a stroke in which pain was a sequelae. Two other categories of pain are now known to also be centralized: 1) pain that arises intrinsically such as fibromyalgia and 2) pain via centralization from a peripheral injury such as lumbar spine degeneration. Regardless of category, centralized pain syndromes are characterized by microglial activation, neuroinflammation, and excess sympathetic discharge, overstimulation of hypothalamic-pituitary-adrenal axis, fatigue, depression, insomnia, and sensitization to painful stimuli. While there are disease specific treatments such as milnacipran for fibromyalgia or anti-inflammatory agents for rheumatoid arthritis, all centralized pain syndromes require a treatment regimen that will require therapeutic agents that enter and act upon the central nervous system. Some metabolic and hormonal compounds are biomarkers for centralized pain syndromes, and they are helpful in diagnosis and monitoring of treatment. Patients who have peripheral as well as central disease must have both equally treated, as studies show that peripheral treatment may improve the central component.

NRP-01 Demystifying Pain Management: One Case at a Time

Theresa Mallick-Searle, MS, RN-BC, ANP-BC

Tuesday/9.8 9:00a - 10:55a

Level 4/Nolita 1

Chronic pain affects 100 million US adults. It is the number one 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 drain, and healthcare dollars spent, relieving pain has become a national priority. This case based presentation will define the pathophysiology of various pain generators and provide a comprehensive overview of multimodal management of chronic and acute pain. The use of pharmacotherapy, nerve blocks, and behavioral management strategies will be emphasized. Topics discussed herein will prepare the advanced practice provider to expertly problem solve complex case studies in pain management. Special emphasis will be placed on cancer pain, the patient with an addiction history, central pain, and neuropathic pain.

NRP-02 **Opioid Rotation:**

An Effective Technique in Reducing Opioid Dose and Mitigating Risk

Richard L. Talusan, DNP, FNP-BC, NEA-BC

Tuesday/9.8 11:15a - 12:10p

Level 4/Nolita 1

There is evidence that a dose of at least 100 mg of morphine equivalent dose per day (MEDD) puts patients at much higher risk of opioid related complication than doses below 100 mg MEDD. Reducing the total daily dose of opioids among patients at very high doses of opioids (>200 mg MEDD) or among patients on around the clock dosing of short acting opioids can reduce risk as well and may improve overall quality of chronic pain management. One technique in reducing dose is opioid rotation.

NRP-03 Safe Opioid Precribing: From Genomics to Disposal

Brett B. Snodgrass, MSN, APRN, FNP-C

Tuesday/9.8 1:35p - 2:30p

Level 4/Nolita 1

Safe opioid prescribing is of utmost importance to the busy nurse practitioner. What does it all mean? Where does it fall in the treatment course? These answers and further education will be provided in this session. A look into pharmacogenomics, interpreting urine drug testing, treatment of withdrawal, safe disposal of opioids, and proper naloxone prescribing will be covered.



NRP-04 The Complex Pain Patient: Addiction, Obesity, and the Elderly

Brett B. Snodgrass, MSN, APRN, FNP-C

Tuesday/9.8 2:35p - 3:30p

Level 4/Nolita 1

At times, a nurse practitioner may be asked to take over management of a complex pain treatment case from another provider. Whether the case involves a patient who has been displaced due to natural disaster, a patient with multiple health comorbidities, or a patient on a high dose medication regimen, the NP must decide whether the case is one that can be handled within the protocols and/or state regulations of his/her own practice setting, and whether extra assistance may be needed to promote patient safety. This session introduces participants to some of the complex situations in which they may find themselves while treating patients with pain. The session will cover methods each participant may find useful to simplify complex pain management situations and to identify resources upon which the NP may call for further assistance. At the end of this session, participants will be able to calculate the potency of a complex opioid regimen via a web based tool and identify a rational method of simplifying a complex pain medication regimen.

NRP-05 Opioid Monitoring at a Nurse Practitioner Managed Clinic

Richard L. Talusan, DNP, FNP-BC, NEA-BC

Tuesday/9.8 4:35p - 5:25p

Level 4/Nolita 1

About 100 million Americans suffer from chronic pain. The use of prescription opioid medications has skyrocketed since 2000 and has resulted in a significant increase in opioid related complications including opioid addiction, opioid related overdose deaths, and opioid diversion. The monitoring of prescription opioid use among patients on chronic opioid therapy has become a key aspect of clinical care for these patients. A nurse practitioner managed opioid monitoring clinic (OMC) was developed at the Department of Veterans Affairs' Las Vegas Southern Nevada Healthcare System to assist primary care providers in the monitoring of patients at high risk for opioid abuse and misuse. The OMC uses evidenced-based interventions such as frequent screening utilizing urine drug screens, state prescription drug monitoring databases, and frequent office visits to help identify opioid abuse and misuse.

PAL-01 As Different as Black & White? Chronic Pain and Palliative Care

Lee Kral, PharmD, BCPS, RPh, CPE; Tanya Uritsky, PharmD, BCPS

Saturday/9.12 **8:00a - 8:55a**

Level 4/Nolita 3

Depending on the patient's clinical situation, pain and symptom management do not always have the same goals of care and management principles. Patients with severe illness may have different requirements and needs than those living with chronic noncancer pain. Some principles overlap and some diverge and practitioners may need to work in the "gray" areas. The presenters each primarily practice in areas of pain management with differing focus—palliative care or chronic noncancer pain management. This presentation will cover the similarities and differences in therapeutic management of palliative care patients compared to patients with chronic noncancer pain. Patient cases will be used to compare and contrast. Topics include management of neuropathic pain, constipation, intrathecal pumps, and more.

PAL-02 "Let it Go! Let it Go!" Pruning Medications in Advanced Illness

Holly M. Holmes, MD; Kashelle Lockman, PharmD; Mary Lynn McPherson, PharmD, BCPS, CPE, FASPE

Saturday/9.12 **9:00a - 10:55a**

Level 4/Nolita 3

Medication therapy plays a critically important role in the management of pain and nonpain symptoms in patients with advanced illnesses. Often, however, medications are continued due to clinical inertia or a misperception concerning continued medication benefit. It is vitally important that practitioners be able to evaluate the medication regimen of a patient with an advanced illness, assess the benefits and burdens of drug therapy, and make an informed decision on whether or not to continue the medication. Another very important consideration is how to have this sensitive conversation with patients, families, and caregivers who may assign a degree of hope to continued medication therapies. Participants in this program will learn about a 5 step process to review a medication regimen, systematically recommend deprescribing, and use an empathetic approach when discussing these interventions with the patient and other interested parties.

Pain Palliative Care



Rabia Atayee Holly Holmes Lee Kral Kashelle Lockman Tanya Uritsky Mary Lynn McPherson

Saturday 9.12

PAL-03 New Drugs and Drug News in Pain Management and Palliative Care

Rabia S. Atayee, PharmD; Mary Lynn McPherson, PharmD, BCPS, CPE, FASPE

Saturday/9.12 11:15a - 12:10p

Level 4/Nolita 3

Step right up and receive all the "hot off the press" news and updates on medications in the pain and palliative care settings. In this lively session, new medications, indications of existing medications, and updates on toxicities will be presented. For each new medication, the burden-to-benefit ratio and the role of the medication in caring for patients with pain or advanced illness will be discussed.

PAL-O4 Let's Order Lunch Off the Beer's List and Other Flagrant Medication Decisions in Advanced Illness

Kashelle Lockman, PharmD; Mary Lynn McPherson, PharmD, BCPS, CPE, FASPE

Saturday/9.12 **2:35p - 3:30p**

Level 4/Nolita 3

The American Geriatrics Society (AGS) "Beers Criteria for Potentially Inappropriate Medication Use in Older Adults" is an often cited resource regarding the selection of medications for older adults and is frequently used to guide therapeutic decision-making. The purpose of these criteria is to provide guidance regarding medications considered to be "potentially inappropriate" in general or in specific disease states, drugs requiring dosage adjustment in renal impairment, and drug-drug interactions. Medications are frequently used to manage pain and nonpain symptoms in older patients with advanced illness, and this frequently involves selection of medications considered to be potentially inappropriate per the Beers criteria. The guidelines clearly state that the intended application is for use in all ambulatory care and institutionalized settings of care for patients over 65, with the exception of hospice and palliative care. However the guidelines offer prudent advice even in this clinical setting. The purpose of this presentation is to summarize the 2015 AGS Beers Criteria, and using a case based approach explore the benefits and burdens of medications on the list when used in the context of advanced illness.

"Is Opioid Use the Same in Palliative Care or Does Everybody Get a Morphine Drip?"

Rabia S. Atayee, PharmD

Saturday/9.12 3:35p - 4:30p

Level 4/Nolita 3

The opioid pendulum continues to sway from one side to the other. There is a belief that palliative care is overprescribing and chronic pain is underprescribing opioids. This evidenced-based presentation will review the pharmacology, management of side effects, and alternative routes of administration of opioids in the context of safe and effective prescribing in pain and palliative care settings. The goal of the presentation and audience discussion is to find the middle ground for the opioid pendulum regardless of the setting.

PDM-01 An Extended-Release Oral Hydrocodone Bitartrate Therapy*

Michael J. Brennan, MD; Joseph V. Pergolizzi, MD

Wednesday/9.9 8:00a - 8:55a

Level 3/Castellana Ballroom

Please check m.painweek.org for more information on this program.

*This presentation is not certified for credit.

PDM-02 The Treatment of PHN: Unmet Needs Still Exist*

Gregory L. Holmquist, PharmD, CPE

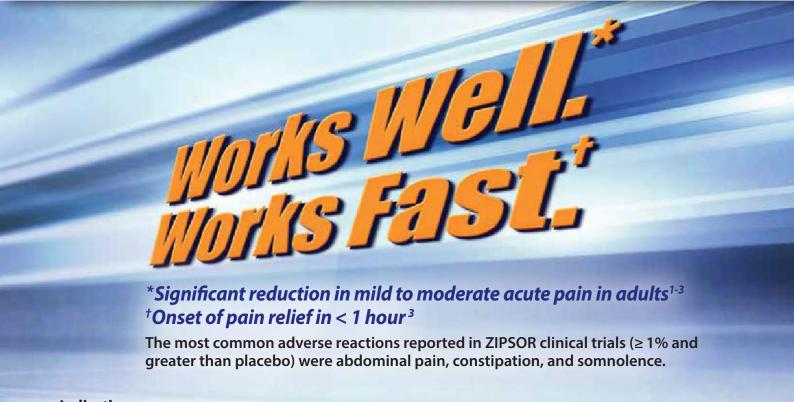
Wednesday/9.9 8:00a - 8:55a

Level 3/Brera Ballroom

Please check m.painweek.org for more information on this program.

*This presentation is not certified for credit.





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).

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 (5.1)].
- ZIPSOR is contraindicated for the treatment of perioperative pain in the setting of coronary artery bypass graft (CABG) surgery [see Contraindications (4)].

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 (5.2)].

Please see adjacent page for Brief Summary of Prescribing Information. Full Prescribing Information and Medication Guide are available at www.ZIPSOR.com.

References: 1. Riff DS, Ducker S, Gottlieb I, et al. Diclofenac potassium liquid-filled soft gelatin capsules in the management of patients with postbunionectomy pain: a phase III, multicenter, randomized, double-blind, placebo-controlled study conducted over 5 days. Clin Ther. 2009;31(10):2072-2085. **2.** Daniels SE, Baum DR, Clark F, et al. Diclofenac potassium liquid-filled soft gelatin capsules for the treatment of postbunionectomy pain. Curr Med Res Opin. 2010;26(10):2375-2384. **3.** ZIPSOR [package insert]. Newark, CA: Depomed, Inc.; 2012.





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Contraindications

ZIPSOR is contraindicated in patients with known hypersensitivity to diclofenac or bovine protein and in patients who have experienced asthma, urticaria, or other allergic reactions after taking aspirin or other NSAIDs. ZIPSOR should be discontinued immediately and emergency medical attention sought if an anaphylactoid reaction occurs as severe, rarely fatal, reactions 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.

Warnings and Precautions

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.

ZIPSOR can lead to onset of new hypertension or worsening of preexisting hypertension, either of which may contribute to the increased incidence of cardiovascular events. Blood pressure should be monitored closely during the initiation of ZIPSOR treatment and throughout the course of therapy. NSAIDs may diminish the antihypertensive activity of thiazides, loop diuretics, ACE inhibitors, and ARBs.

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.

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.

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.

Adverse Reactions

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

Drug Interactions

Concomitant administration of ZIPSOR and aspirin is not generally recommended because of the potential for increased adverse effects including increased GI bleeding. Concomitant use of anticoagulants and ZIPSOR has a risk of serious GI bleeding higher than users of either drug alone.

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).

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.

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.

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].



PDM-03 Targeting Success: An Interactive Discussion of a Next Generation Molecule*

Gregory L. Holmquist, PharmD, CPE; Joseph V. Pergolizzi, MD; Steve Vacalis, DO

Wednesday/9.9 12:15p - 1:30p

Level 3/The Chelsea

Please check m.painweek.org for more information on this program.

*This presentation is not certified for credit.

PDM-04 Conversations That Matter: Addressing Challenging Topics in the Exam Room*

Laura Cooley, PhD; Paul Gileno; Richard Payne, MD; Bob Twillman, PhD, FAPM

Wednesday/9.9 3:35p - 4:30p

Level 3/Castellana Ballroom

Please check m.painweek.org for more information on this program.

*This presentation is not certified for credit.

PDM-05 Opioid-Induced Constipation: The Science, the Struggle, and an Orally Administered Treatment Option*

Gerald M. Sacks, MD

Thursday/9.10 8:00a - 8:55a

Level 3/Brera Ballroom

Please check m.painweek.org for more information on this program.

*This presentation is not certified for credit.

PDM-06 Prioritizing the Patient in the Opioid Debate: A Roundtable Discussion*

Thursday/9.10 8:00a - 8:55a

Level 3/Castellana Ballroom

Please check m.painweek.org for more information on this program.

*This presentation is not certified for credit.

PDM-07 Understanding Abuse-Deterrent Opioid Technologies*

Michael J. Brennan, MD; Jeffrey A. Gudin, MD

Thursday/9.10 12:15p - 1:30p

Level 3/Brera Ballroom

Please check m.painweek.org for more information on this program.

*This presentation is not certified for credit.

PDM-08 Opioid-Induced Constipation*

Steven Simon, MD

Thursday/9.10 12:15p - 1:30p

Level 3/Castellana Ballroom

Please check m.painweek.org for more information on this program.

*This presentation is not certified for credit.

Overview of Emerging Technologies: Opioids with Labeled Abuse-Deterrent Properties and Claims (OADP)*

Thursday/9.10 3:35p - 4:30p

Level 4/Mont-Royal Ballroom

Please check m.painweek.org for more information on this program.

*This presentation is not certified for credit.

PDM-10 Salix Pharmaceuticals Product Theatre*

Steven Simon, MD

Thursday/9.10 3:35p - 4:30p

Level 3/Castellana Ballroom

Please check m.painweek.org for more information on this program.

*This presentation is not certified for credit.

PDM-11 Opioid Emergencies: The Stakes Couldn't Be Higher. The Case for Naloxone*

Eric Edwards, MD, PhD; Jeffrey A. Gudin, MD; Mark A. Kallgren, MD; Bob A. Rappaport, MD

Friday/9.11 8:00a - 8:55a

Level 3/Castellana Ballroom

Please check m.painweek.org for more information on this program.

*This presentation is not certified for credit.

PDM-12 FDA NSAID Safety Update and Pain Management Options*

Christopher Gharibo, MD

Friday/9.11 8:00a - 8:55a

Level 3/Brera Ballroom

Please check m.painweek.org for more information on this program.

*This presentation is not certified for credit.

PDM-13 Kappa Opioid Agonists – Moving Beyond Mu*

Michael J. Brennan, MD; Gregory Holmquist, PharmD, CPE; Joseph Stauffer, DO, MBA

Friday/9.11 12:15p - 1:30p

Level 3/Castellana Ballroom

Please check m.painweek.org for more information on this program.

*This presentation is not certified for credit.

PDM-14 Re-examining the Complexities of Chronic Pain Management: Diverse Risk Factors and Risk Reduction Strategies for the Misuse of Prescription Opioids*

Charles E. Argoff, MD, CPE; Jeffrey A. Gudin, MD; W. Clay Jackson, MD, DipTh

Friday/9.11 12:15p - 1:30p

Level 3/Brera Ballroom

Please check m.painweek.org for more information on this program.

*This presentation is not certified for credit.

Opioid-Induced Constipation: The Science, the Struggle, and an Orally Administered Treatment Option (Encore)*

Srinivas Nalamachu, MD

Friday/9.11 3:35p - 4:30p

Level 4/Mont-Royal Ballroom

Please check m.painweek.org for more information on this program.

*This presentation is not certified for credit.

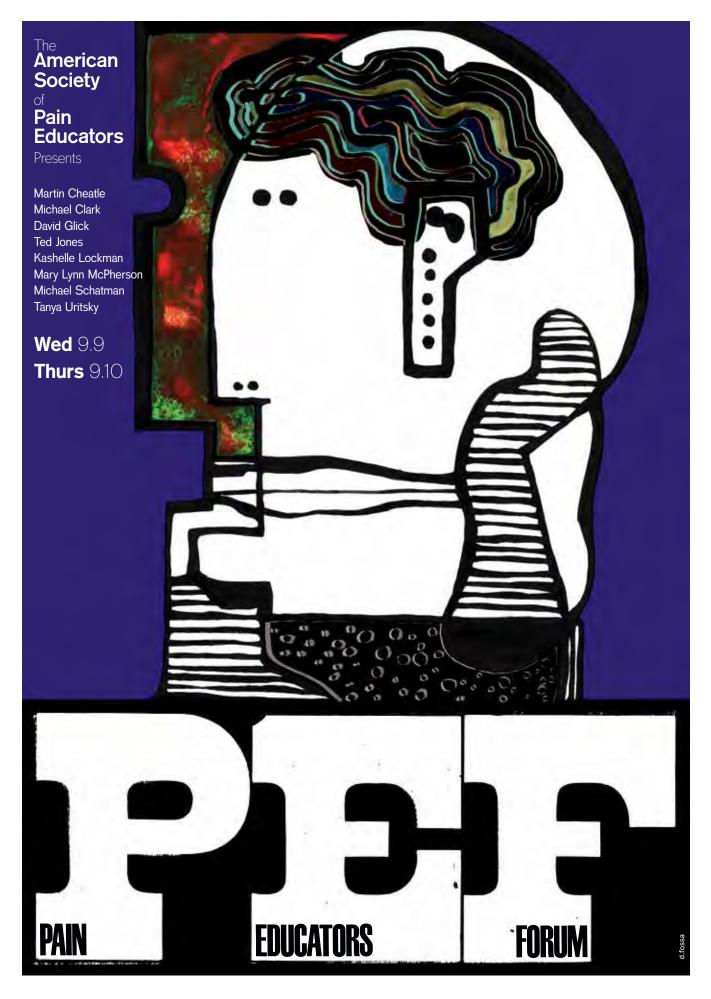
PREPEF Neuropathica Galactica

Christopher M. Herndon, PharmD, BCPS, CPE; Mary Lynn McPherson, PharmD, BCPS, CPE, FASPE

Tuesday/9.8 9:00a - 5:00p

Level 3/Gracia 5

Chronic pain affects over 100 million Americans, more 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, selecting and monitoring nondrug and drug therapies, and 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.

PEF-01 Pain Terminology: Knowing the Difference Makes a Difference!

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

Wednesday/9.9 9:00a - 9:55a

Level 4/Nolita 1

The Pain Educators Forum decided to present 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 Jeopardy! contestent.

PEF-O2 Pain Pathophysiology Unraveled

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

Wednesday/9.9 10:20a - 11:10a

Level 4/Nolita 1

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/9.9 11:15a - 12:10p

Level 4/Nolita 1

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

Tanya Uritsky, PharmD, BCPS

Wednesday/9.9 1:35p - 3:30p

Level 4/Nolita 1

Pain Therapeutics will provide the participant with succinct reviews of the pathogenesis and evidence-based treatment recommendations for commonly encountered acute and chronic pain syndromes including perioperative management, chronic low back, osteoarthritis, fibromyalgia, and painful diabetic peripheral neuropathy. Building on other sessions within the Pain Educators Forum, Pain Therapeutics will deliver succinct and clinically applicable pearls readily incorporable into primary care practice.

PEF-05 Pain Diagnostics: Clinical Pearls to Improve Common Tests for Pain

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

Wednesday/9.9 4:35p - 5:25p

Level 4/Nolita 1

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 upon 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.

PEF-06 Talking (and Perhaps Listening to) Patients With Pain: A Primer

Martin D. Cheatle, PhD; Michael E. Schatman, PhD, CPE, DASPE

Thursday/9.10 10:20a - 12:10p

Level 4/Nolita 1

Patients suffering from chronic pain are complex and commonly have multiple medical and psychiatric comorbidities which makes it challenging for clinicians to effectively and efficiently communicate with them, especially in a time pressured clinic setting. Effective communication between clinicians and patients provides the foundation for developing a collaborative therapeutic relationship, enhancing adherence to prescribed interventions, and improving patient satisfaction. The first part of this symposium will focus on the imperative of effective physician-patient communication within the context of the vulnerability of patients with pain, with in-depth discussion of the benefits of a shared decision-making model. The second part will involve a review of basic techniques to improve communication with complex pain patients using case presentations to stimulate audience participation.

PEF-07 Risk Assessment: What It Is and How to Use It

Ted W. Jones, PhD, CPE

Thursday/9.10 1:35p - 2:30p

Level 4/Nolita 1

Risk assessment has become a standard of care, if not mandated, when opioids are prescribed for chronic pain. There are now multiple validated risk assessment tools from which the practitioner can choose, several being published since the last major review of the literature was done by Chou in 2009. The available tools will be reviewed and the pros and cons of each discussed. We will then address how risk assessment results can be used in planning a patient's treatment, particularly impacting patient monitoring and medication choices. New data will be presented on medication aberrant behavior by existing patients and how this might impact risk assessment of patients later in their treatment career—addressing the neglected topic of the risk assessment of patients who have been in treatment for a while.

PEF-08 Adult Learning: Not for the Faint of Heart

Kashelle Lockman, PharmD; Mary Lynn McPherson, PharmD, BCPS, CPE, FASPE

Thursday/9.10 2:35p - 3:30p

Level 4/Nolita 1

As pain educators, we have a responsibility to teach other health professionals, health profession students, and our patients how to manage pain. But how do we do that successfully? How many adults do you know who love to go sit in a lecture? In this session, participants will explore the assumptions and principles of adult learning. We will focus on practical applications of adult learning theory to design pain related education for different audiences, including nonspecialist health professionals, health profession students, and patients. After the facilitators introduce Malcolm Knowles' theory of adult learning, philosophies of learning, and informal learning, the audience will work through and discuss an educational case study focusing on health professionals and another case study focusing on patients. During this discussion, we will review technologies and resources that are useful for teaching adults. Using the knowledge and skills developed in this session, participants can then develop a personal plan for continued self-learning.

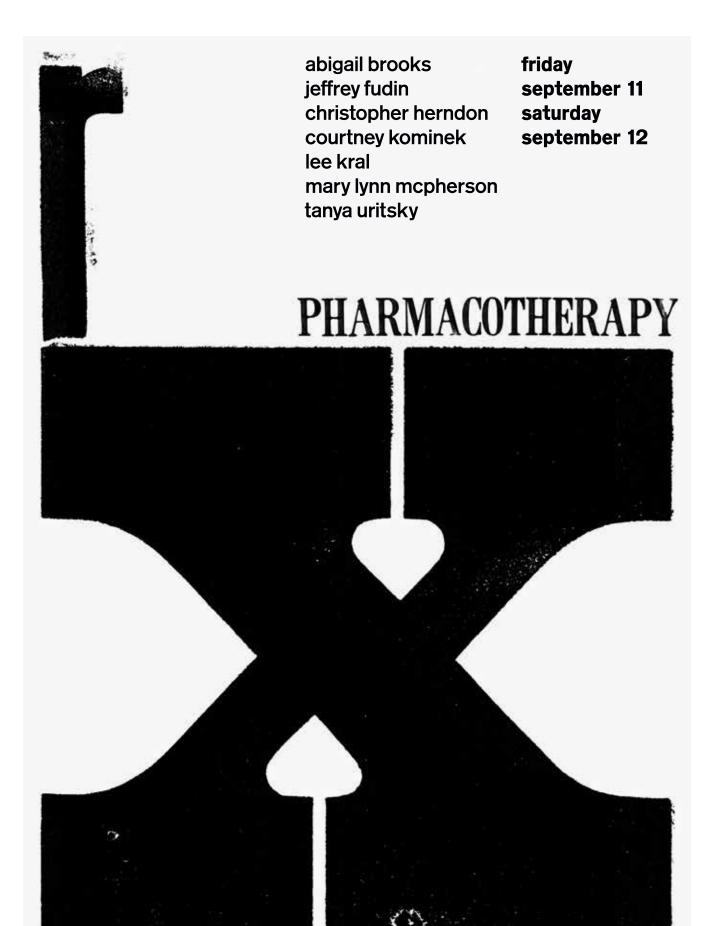
PEF-09 Creating a Treatment Plan for Higher Risk Patients: A Case Based Approach

Ted W. Jones, PhD, CPE

Thursday/9.10 4:35p - 5:25p

Level 4/Nolita 1

Creating a treatment plan for a higher risk patient, or one who presents with complicating issues, can be a clinical challenge to the frontline practitioner. This workshop uses a case based approach



to teaching this skill. After a brief review of the essential information needed for an initial pain evaluation, participants will be given a practice case to work up. Participants will then discuss their treatment plan, choice of medications, and referrals made for each case.

PHM-01 Update on Methadone Safety and Efficacy Guidelines

Mary Lynn McPherson, PharmD, BCPS, CPE, FASPE

Friday/9.11 10:20a - 11:10a

Level 3/Gracia 1

Methadone has unique pharmacokinetic and pharmacodynamic properties that make it an appealing analgesic in treating pain in patients with advanced illnesses; however, these same properties render dosing and monitoring more demanding than other opioids. Consensus guidelines were published recently by the American Pain Society and College on Problems of Drug Dependence, in collaboration with the Heart Rhythm Society. A consensus-building meeting was also held recently to determine the relevance of these published quidelines for patients receiving hospice care or palliative care services. Specifically, the group considered the intensity of recommended preemptive and continued monitoring (eg, ECG and other monitoring) for patients admitted to hospice care and patients receiving palliative care services either concurrently with disease-modifying therapy, or without disease-modifying therapy. Consensus was gained on characteristics of methadone-appropriate patients (both opioid-naïve and opioidtolerant) and clinical situations that would indicate using methadone in more of an adjunctive role as opposed to completely switching to methodone. Recommendations were made regarding which risk factors should be considered prior to instituting methadone therapy, when it is appropriate to obtain an ECG, and frequency of monitoring if appropriate. Dosing strategies for both opioidnaïve and opioid-tolerant patients were recommended, as well as strategies when interacting drugs are present.

PHM-O2 When What Goes Up, Must Come Down: Practical Considerations for Opioid Tapering

Lee Kral, PharmD, BCPS, RPh, CPE; Tanya Uritsky, PharmD, BCPS

Friday/9.11 11:15a - 12:10p

Level 3/Gracia 1

There are many reasons that opioid therapy may be considered for discontinuation. With the ongoing nationwide focus on the opioid overdose problem, providers and patients are looking for ways to minimize or discontinue opioid therapy. There are very few resources available to assist practitioners with this process, and it engenders a lot of anxiety for both providers and patients. A review of current guidelines was recently published by these presenters, highlighting a patient based approach to opioid tapering in a nonaddiction setting. This program will present several patient case scenarios and walk learners through the process of tapers for multiple different opioids, highlighting clinical nuances along the way based on presenters' experience.

PHM-03 Opioid Conversion Calculations

Mary Lynn McPherson, PharmD, BCPS, CPE, FASPE

Friday/9.11 1:35p - 2:30p

Level 3/Gracia 1

Many patients receiving opioids will need to switch 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 skills in opioid conversion calculation.

PHM-O4 Naloxone Kudos vs Kinetics: A Debate on Emergency Response and Comparative Routes of Administration (IN, IM, Auto-IM)

Abigail T. Brooks, PharmD; Jeffrey Fudin, PharmD, FCCP; Courtney M. Kominek, PharmD

Friday/9.11 4:35p - 5:25p

Level 3/Gracia 1

While politicians and lawmakers are busy patting themselves on their backs for expanding naloxone access, perhaps they have lost sight of science. Irrespective of the most desirable route and mode of administration, the US Centers for Disease Control has estimated at least a 10-fold increase in the medical use of opioids in the last 20 years to address the widespread problem that is chronic pain

with a coinciding increase in opioid related overdoses and deaths. Risks for opioid overdose exist outside of substance abuse and include dose, age, gender, concomitant medications, and comorbid medical conditions. In order to effectively use a naloxone product for opioid overdose, one must first recognize the signs and symptoms of opioid induced respiratory depression. With pain clinicians at the helm to encourage various public health initiatives relative to opioid reversal, it is incumbent upon all healthcare providers to educate patients and accessible caregivers to recognize an opioid overdose emergency and act swiftly to prevent opioid induced respiratory depression and possible death. Appropriate education should be completed at point of prescribing and/or dispensing the opioid when naloxone is considered. Discussions for the patient and caregiver(s) should include overall risks and benefits of long-term opioid use and the potential benefit of having naloxone on hand. Evolving regulation and Good Samaritan laws regarding naloxone availability, variable and inconsistent interstate prescriptive authority, and distribution all necessitate the importance to stay current with the jurisprudence surrounding this potentially life-saving antidote.

PHM-05 Pharmacokinetic and Pharmacodynamic Drug Interactions

Christopher M. Herndon, PharmD, BCPS, CPE

Saturday/9.12 7:00a - 7:55a

Level 3/Gracia 1

Medications are frequently incorporated into the treatment plan for patients in pain. A strong understanding of the pharmacokinetic and pharmacodynamic (PK/PD) characteristics of these agents is paramount for the prescriber/pain educator. This session will review general PK principles (absorption, distribution, metabolism, elimination, and toxicity) of commonly prescribed medication classes in the care of patients in pain. Clinically relevant drug-drug, drug-disease, and drug-food interactions will be discussed in a case based format.

PHM-06 Nonopioid Analgesics: Antidepressants, Adjuvant Therapies, and Muscle Relaxants

Christopher M. Herndon, PharmD, BCPS, CPE

Saturday/9.12 8:00a - 8:55a

Level 3/Gracia 1

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 Could Levorphanol Levitate Above Methadone Misadventure?

Abigail T. Brooks, PharmD; Jeffrey Fudin, PharmD, FCCP; Courtney M. Kominek, PharmD

Saturday/9.12 **3:35p - 4:30p**

Level 3/Gracia 5

Although methadone has a role in the treatment of opioid dependence, its unique mechanism of action, oral bioavailability, absence of active metabolites, and delayed withdrawal syndrome makes it a viable option for chronic pain management. With these benefits come multiple pitfalls, including variable pharmacokinetics and pharmacogenetic considerations, potential for multiple drug interactions, QTc prolongation, and an extended titration period. Thus, the risks of methadone therapy may outweigh the benefits in some patients. Levorphanol, less commonly used or prescribed compared to methadone, shares all the benefits but avoids almost all of the risks associated with methadone resulting in an overall more favorable risk-to-benefit profile for the treatment of chronic and neuropathic pain.

POD-01 Diagnosis and Treatment of Superimposed Chronic Lower Extremity Nerve Entrapment in Patients With Metabolic Disease

Stephen L. Barrett, DPM, MBA

Thursday/9.10 9:00a - 9:55a

Level 4/Nolita 3

Lower extremity peripheral nerve entrapment is poorly understood, whereas upper extremity patients with metabolic diseases routinely get proper referral for superimposed nerve entrapment such as carpal tunnel syndrome (CTS). Interestingly, in the general US population there is a 2% incidence of CTS, but in the diabetic population the incidence ranges from 14% to 28%. This clearly indicates that metabolic disease plays a very important role in the development of peripheral nerve

entrapment. Significant reduction of pain and restoration of sensation can be restored by peripheral nerve decompression surgery in properly selected patients, with minimal risk. The incidence of ulceration can be reduced to .3% compared to the expected 15% in patients with diabetic peripheral neuropathy via this type of treatment. Improvement of balance has also been demonstrated in peer reviewed studies, which can obviate falls in the geriatric patient, which will also be discussed.

POD-02 Morton's Neuritis

Andrew Rader, DPM

Thursday/9.10 11:15a - 12:10p

Level 4/Nolita 3

A common cause of forefoot pain is Morton's neuritis. This neuritis is a result of compression injury to the common plantar digital nerve branch to the third and fourth toes. The area of compression is a fibro-osseous tunnel in the third intermetatarsal space. Traditional treatment includes accommodation, injections, and surgical resection of the compressed nerve. A new and evidence-based treatment algorithm will be discussed that preserves the plantar sensation while alleviating the pain syndrome.

POD-03 "Underneath the Radar" Lower Extremity Pain Generators— Diagnosis and Treatment

Stephen L. Barrett, DPM, MBA

Thursday/9.10 2:35p - 3:30p

Level 4/Nolita 3

Development of chronic pain in the lower extremity is common after frequent injuries such as ankle sprain, fracture, and failed lower extremity surgery. The current clinical paradigm is constructed to attach primacy to the fracture or soft tissue injury, as the primary pain generator. In many cases of pain that continues after the expected required time for normal healing of bone and ligament, there is peripheral nerve injury. This presentation will discuss common, but mostly overlooked, peripheral nerve injury that is truly responsible for the development of chronic pain syndromes.

POS-01 Scientific Poster Session and Reception*

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

Thursday/9.10 7:00p - 9:00p

Level 3/The Chelsea

POS-02 Poster/Podium Presentations*

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

Friday/9.11 7:00a - 7:55a

Level 3/Gracia 5

This session presents posters selected for oral presentations.

REG-01 It's NOT Vulvodynia: It's Lichen Sclerosus! Have You Missed this Diagnosis?

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

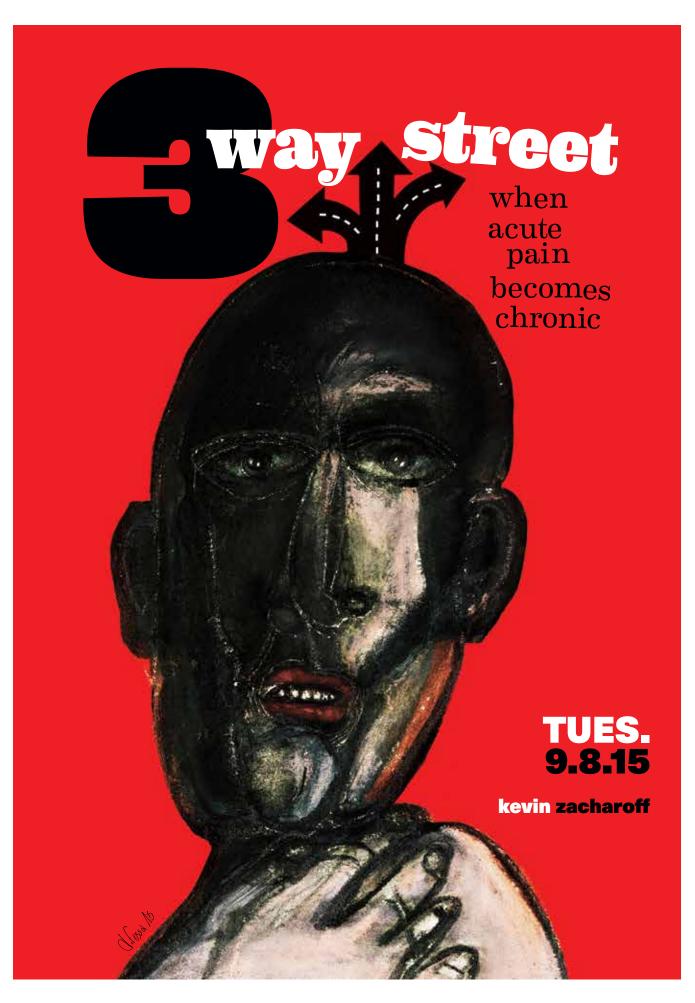
Tuesday/9.8 3:35p - 4:30p

Level 4/Nolita 2

Lichen sclerosus (LS) is an often unrecognized and unknown life altering condition affecting the anal and genital areas of women of all ages, as well as some uncircumcised men. Few healthcare providers are aware of its existence and even fewer women have ever heard of it. In addition, once diagnosed, women are often too embarrassed to openly discuss it. Women with LS are often misdiagnosed for years with chronic yeast and urinary tract infections and experience severe pain and purities, as their female architecture disappears and their quality of life and ability to participate changes drastically. HCPs knowledgeable about LS often have a narrow/limited focus of care that addresses women's sexual functioning without considering the element of pain and its impact on participation and overall quality of life. This presentation looks at LS and its impact on women. Its focus is to increase accurate and early diagnosis and treatment and improve the quality of lives of women with LS. Findings from a phenomenological qualitative research study with women affected by LS also will be shared. Understanding the lived experiences of women with LS will shed light on the actual impact of such a devastating condition on women's lives.

^{*}This presentation is not certified for credit.

^{*}This presentation is not certified for credit.



REG-02 Regional Pain Syndromes: When Sex Hurts

Georgine Lamvu, MD, MPH, FACOG

Thursday/9.10 11:15a - 12:10p

Level 3/Gracia 5

Approximately 14 million US women report painful intercourse at some point in their lives. In spite of this prevalence, most women with this type of pain remain undiagnosed and untreated. Painful intercourse, or dyspareunia, can result from a variety of physiologic processes that are heavily modulated by psychological, environmental, and cultural factors. The burden of this type of pain can be devastating to women, their partners, and their families leading to poor quality of life and isolation. Treatment of sexual pain is often hampered by social myths and miscommunication between patients and providers. This lecture will focus on our current understanding of the female sexual cycle and the pathophysiology of chronic painful intercourse. The lecture will provide attendees with a broad and structured approach to the screening and evaluation of women who present with painful intercourse, and will also differentiate treatment options based on age differences as women transition from reproductive age to menopause. Specific recommendations will be made for cancer survivors who experience pain after treatment.

REG-03 Regional Pain Syndromes: Simplifying the Gender Specific Complexities of Female Chronic Pelvic Pain

Georgine Lamvu, MD, MPH, FACOG

Thursday/9.10 4:35p - 5:25p

Level 3/Gracia 5

Nearly 25 million women suffer from chronic pelvic pain (CPP) syndromes that often result from various interactions between the pelvic organs, the central nervous system, and environmental factors. In spite of the high prevalence of CPP, research shows that most women suffer, sometimes for years, without receiving treatment. Given the complexity of CPP, it is not surprising that providers find it difficult to evaluate and treat women with this symptom. This lecture will begin with an overview of the pathophysiology of CPP and subsequently progress to specific interactions between female neuroanatomy and gender specific factors such as hormonal variations, sexual function, and pain behavior. The goal of this presentation is to provide a structured template for integrating our current understanding of pain biology into the evaluation and multidisciplinary treatment of women with CPP.

REG-04 Regional Pain Syndromes: Neck and Back

Srinivas Nalamachu, MD

Friday/9.11 10:20a - 11:10a

Level 4/Nolita 3

Every year, thousands of patients go see their primary care practitioner for the treatment of regional pain syndromes. This lecture focuses on regional pain syndromes including acute low back pain, chronic low back pain, cervicobrachial syndrome, cervical dystonia, lumbosacral/cervical radiculopathy, spinal stenosis, and disk herniation. We will discuss symptoms, the physical exam, diagnostic testing, and pharmacologic/nonpharmacologic treatment options.

REG-05 Regional Pain Syndromes: Knee and Hip

Srinivas Nalamachu, MD

Saturday/9.12 **7:00a - 7:55a**

Level 3/Gracia 5

Every year, thousands of patients go see their primary care practitioner for the treatment of regional pain syndromes. This lecture focuses on regional pain syndromes including meralgia paresthetica, trochanteric bursitis, Baker's cyst, meniscal injuries, cruciate ligament injuries, osteoarthritis of hip and knee, sacroiliac dysfunction, and piriformis syndrome. We will discuss symptoms, the physical exam, diagnostic testing, and pharmacologic/nonpharmacologic treatment options.

SIS-01 3-Way Street: When Acute Pain Becomes Chronic

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

Tuesday/9.8 7:00a - 7:55a

Level 4/Mont-Royal Ballroom

Many factors have been proposed to increase the likelihood of acute pain becoming chronic including, but not limited to, undertreatment. The number of contributing factors along with the lack of

consistent algorithms can often make the prediction and prevention of this transition to chronic pain challenging. This session will describe this phenomenon and some theories behind its development, along with case based situations that outline strategies to help decrease the likelihood that patients with acute pain will develop chronic pain and experience its associated consequences.

SIS-02 State Dosage Thresholds and Their Potential Impacts on Pain and Overdose Prevention

Jeffrey Fudin, PharmD, FCCP; Stephen J. Ziegler, PhD, JD

Tuesday/9.8 8:00a - 8:55a

Level 4/Mont-Royal Ballroom

State governments continue to explore ways to reduce prescription drug abuse and unintentional overdose. One novel approach has been the adoption of dosage thresholds in state prescribing guidelines. The state of Washington was the first to adopt such a model, which requires a pain consultation once a chronic pain patient reaches a total daily dose of 120 mg (morphine equivalency). Although these models continue to be adopted across the United States in various forms and methods, there are growing concerns that these models may not only increase pain, but also increase unintentional overdose and potential underdose associated withdrawal symptoms. The panel will discuss the variation among the states and the concerns associated with the dosage threshold model.

sis-03 Is That Medicine Real or Counterfeit?

Jay Joshi, MD

Tuesday/9.8 9:00a - 9:55a

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 was \$4 billion in the US; >8% of the medical devices in circulation are counterfeit; aerospace and 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. 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. However, this verification is currently not being done.

SIS-04 Let No Man Write My Epitaph: Managing Chronic Pain in the Patient With Addiction

Melissa Durham, PharmD; Steven Richeimer, MD; Harriet Rossetto, LCSW

Tuesday/9.8 9:00a - 12:00p

Level 4/Mont-Royal Ballroom

Prescription pain medication is a great blessing for the vast majority of those who endure pain and discomfort. Yet for those who suffer with pain and addiction and/or are in recovery, such medication may produce terrible and destructive results. Pain medication often fuels an individual's addiction, which may further lead to drug-seeking fraudulence. Certainly, the prescribing physician and pharmacist are thrust into a conflict when working with a patient who is an addict. This presentation addresses the broad-ranging questions regarding the relationship between addiction and pain medication. Through decades of experience in the field of addiction rehabilitation, as well as personal accounts, we will explore: helping the patient who is an addict; how to best help recognize an addict who does not identify as one; the growing awareness of drug-seeking scams; and how to balance vigilance in prescribing medications with compassion for the suffering patient in our midst.

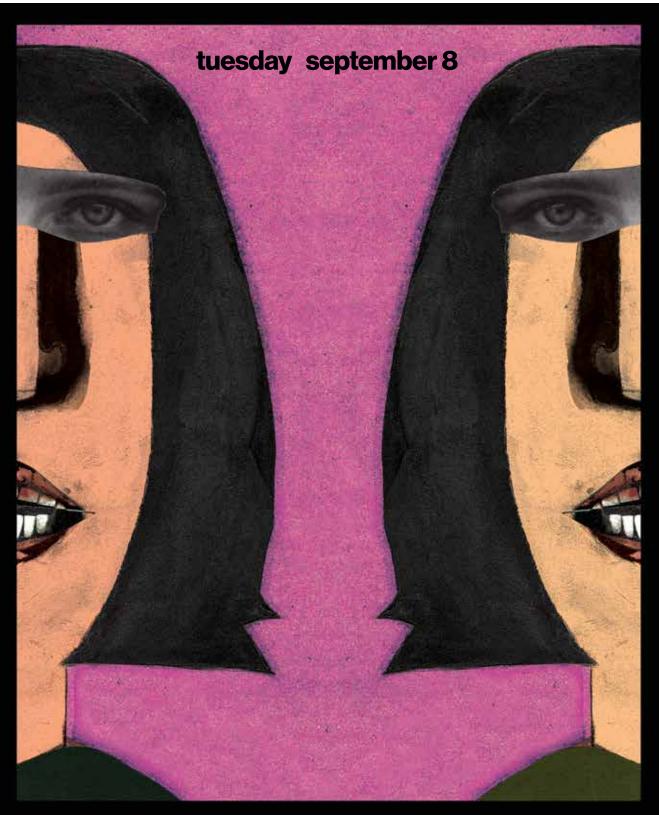
SIS-05 Connecting the Anatomical Dots for Common Pain Syndromes: An Overview of Injection Techniques for Frontline Practitioners

Michael K. Perry, CRNA

Tuesday/9.8 7:00a - 8:55a

Level 4/Yaletown 1

This session is an overview (not comprehensive) and is intended for all healthcare providers who



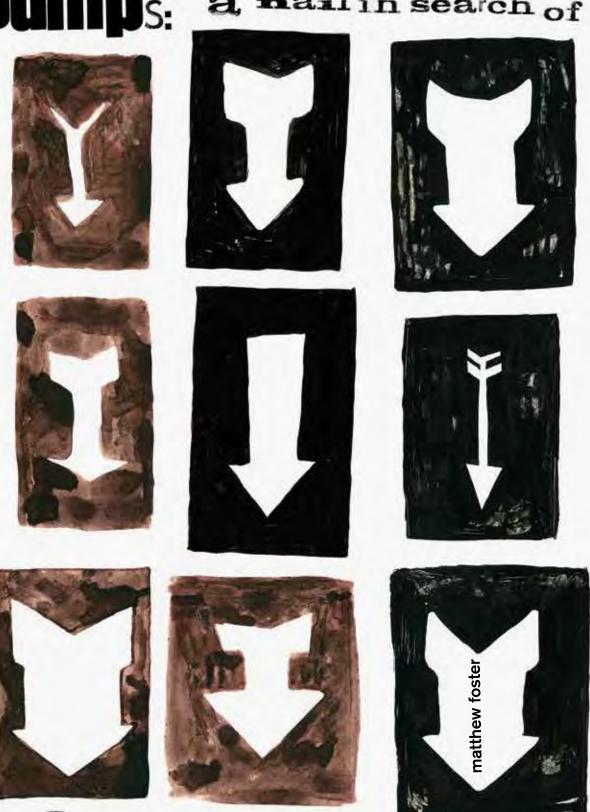
let no man write my epitaph.

managing chronic pain in the patient with addiction

melissa durham steven richeimer harriet rossetto

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a hammer

wednesday 9.9

see patients on a daily basis suffering from migraine headaches to numerous conditions such as shingles, neuropathies, peripheral, and torso pain syndromes. Injection techniques will be described for each and every condition presented and can be done in an office setting by licensed providers whose scope of practice or licensure allows them to perform injections to treat their patients. The primary focus is for family practitioners as well as nurse practitioners and physicians assistants if their state allows them to treat with injections. The information provided is to be used at the discretion of the learner to use to the best of their abilities. The techniques provided during this session are meant to increase awareness of additional pain management interventions that may allow patients, over time, to decrease medications and address the physical problem of pain.

Please note that this course is limited to 50 participants; preregistration is required.

sis-o6 Virtual Reality: Does It Have a Role in Pain Management?

Theresa Mallick-Searle, MS, RN-BC, ANP-BC

Tuesday/9.8 3:35p - 4:30p

Level 4/Mont-Royal Ballroom

Pain is a sensory and emotional experience that is substantially modulated by psychological, social, and contextual factors. Research now indicates that the influence of these factors is even more powerful than expected and involves the therapeutic response to analgesic drugs as well as the pain experience itself, which in some circumstances can even be a form of reward. The use of virtual reality (VR) is relatively new in its inception and still too costly to use mainstream; however, an understanding of the basic principles and utility as a powerful treatment in both acute and chronic pain conditions will add to the toolbox of pain practitioners. This presentation will define the concept of VR, evaluate the utility of VR in pain management, and explore the application of VR in combination with other cognitive behavioral therapies.

SIS-07 PDMPs: A Nail in Search of a Hammer

Matthew P. Foster, PharmD

Wednesday/9.9 7:00a - 7:55a

Level 4/Yaletown 1

Prescription drug monitoring programs (PDMPs) are now available in nearly the entire US. However, there is variability in the accessibility of the data, as well as mandates regarding use of the data. This didactic course provides a review of the different types of PDMP services offered by the states, the current success in getting prescribers to use the PDMPs, and what are the next steps needed in these programs to make them more successful in curbing controlled substance misuse and abuse.

SIS-08 Complex Regional Pain Syndrome: Prevention, Assessment, and Treatment

Russell L. Bell, MD; Martin D. Cheatle, PhD; Peter G. Pryzbylkowski, MD; Peter Yi, MD

Wednesday/9.9 9:00a - 10:55a

Level 3/Gracia 7

Complex regional pain syndrome (CRPS) is a chronic neuropathic disorder that oftentimes occurs after even minor injuries. The patient's reported severity of pain typically exceeds the typical clinical course of an initial trauma. CRPS is a common disorder with an estimated population based rate of 5.5 cases/100,000 person years in the United States. CRPS cases tend to frustrate clinicians due to the severity of the reported disability, the chronicity of this disorder, and the oftentimes poor response to a multitude of interventions. CRPS patients, like patients with other pain disorders, tend to have noteworthy concomitant mood disorders and can develop secondary medical problems due to inactivity and deconditioning. This multidisciplinary panel will review the history of CRPS, preventative measures following trauma, assessment, and differential diagnosis, and pharmacologic, novel nonpharmacologic, and interventional treatment strategies.

sis-og The Groundhog Day Phenomenon

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

Wednesday/9.9 1:35p - 2:30p

Level 4/Mont-Royal Ballroom

Over the course of the past 20 years there has been much discussion, debate, and research about the appropriate assessment, treatment, and follow-up of patients with chronic pain. In many cases, the discussion involves the role of opioid analgesics as part of the treatment plan. This presentation will review these subjects from both a historical and current perspective, presenting a number of examples

how both this discussion and clinical settings seem to have fallen into a circular, nonproductive pattern, where despite "advances," people don't know appropriate courses of action to take—or policies and procedures don't exist. Older topics, controversies, and issues will be explored along with newer controversies, with the intention of providing attendees with a reproducible and implementable set of approaches that can break the cycle and move care to the next level without every clinical setting thinking the wheel needs to be reinvented in every single instance.

SIS-10 Pain Clinical Trials

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

Wednesday/9.9 9:00a - 10:55a

Level 4/Mont-Royal Ballroom

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 various elements related to the clinical study of analgesics. To be discussed: 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 shall have a comprehensive understanding of analgesic trial design and reporting.

SIS-11 Pain Management in Workers' Compensation: Overview of Spend, Utilization, and Treatment Guidelines

Matthew P. Foster, PharmD

Wednesday/9.9 2:35p - 3:30p

Level 3/Gracia 5

The vast majority of workers' compensation claims are focused on pain management in order to care for the injured worker and pharmaceuticals account for a large portion of that therapy. This didactic course will provide an overview of the trends impacting the top medications utilized in the treatment of injured workers, including chronic pain management, compounded medications, and comorbid conditions. It will also review the treatment guidelines used at the state and national level to ensure appropriate use of opioid analgesics in this select population. Understanding these trends and guidelines can help ensure that the injured worker receives the right medication at the right time, helping them return to function sooner.

SIS-12 The Tyranny of "Shoulds"

Steven D. Passik, PhD

Wednesday/9.9 1:35p - 2:30p

Level 3/Gracia 5

In this presentation, Dr. Passik will examine the pressures on pain practitioners in today's medical, legal, political, and media climate. He will explore the dangers of burnout and its impact on pain care. The talk will also include potential solutions and attempt to inspire the building of a pain care community to help mitigate stressors on providers.

SIS-13 Who's On First? Pain Specialists Discuss Their Approaches to Pain Management

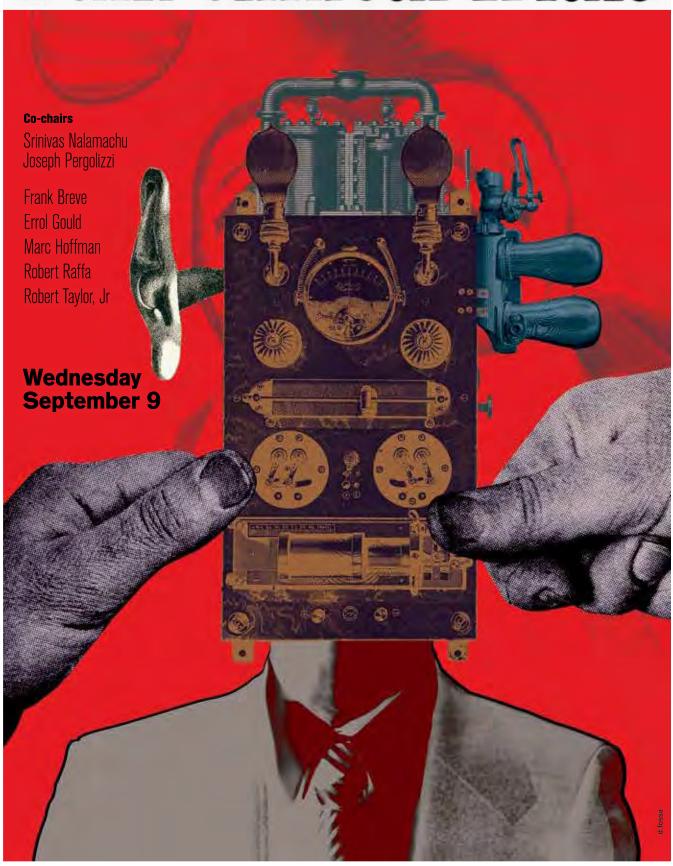
Charles E. Argoff, MD, CPE; Michael R. Clark, MD, MPH, MBA; Gary E. Kaplan, DO, ABFP, DABPM, FAAMA; Srinivas Nalamachu, MD; Sanford M. Silverman, MD

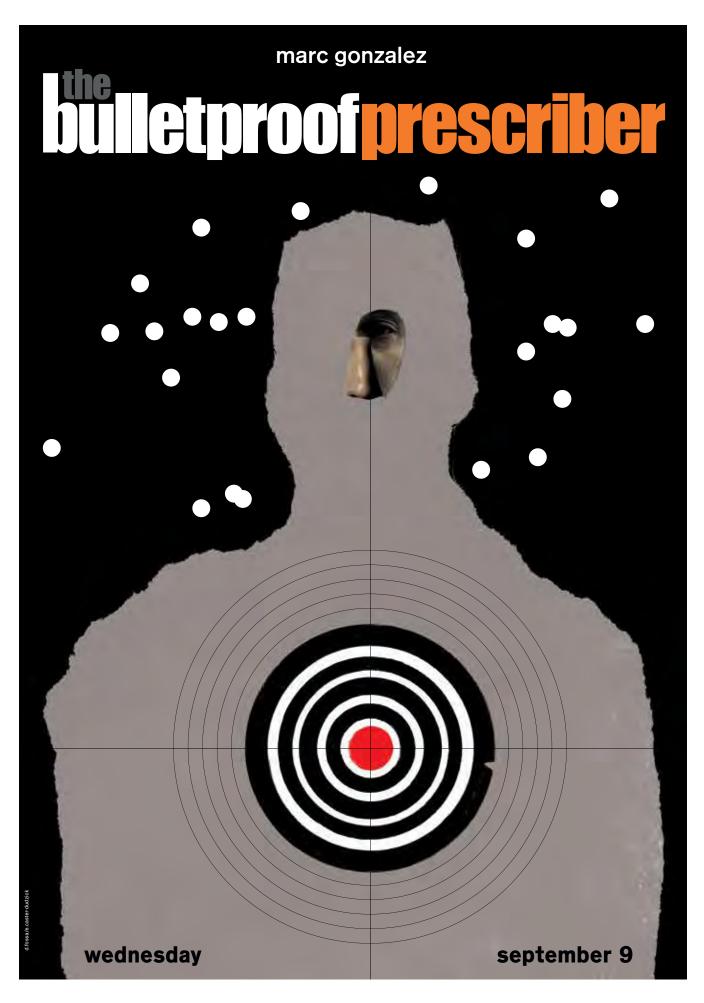
Wednesday/9.9 2:35p - 3:30p

Level 4/Mont-Royal Ballroom

Frontline practitioners are often faced with needing to refer chronic pain patients to pain specialists. Do certain pain conditions necessitate a particular type of pain specialist? How do you choose among anesthesiologists, neurologists, osteopaths, physiatrists, and psychiatrists. Do orthopedists and rheumatologists really manage pain? These questions and many others will be addressed in a case based panel discussion with experts representing the majority of pain specialties.

Pain Clinical Trials





SIS-14 The Bulletproof Prescriber

Marc S. Gonzalez, PharmD; Steve Louie, JD

Wednesday/9.9 4:35p - 5:25p

Level 4/Nolita 3

This presentation will place the attendees in the shoes of a pharmaceutical diversion investigator, from receiving a complaint of a pill mill, gathering intelligence information, developing probable cause, preparing and serving a search warrant, and presenting the case for prosecution. Multiple actual fact patterns will be reviewed as information would be gathered in an investigation. The attendees will see what acts or failure to act can be problematic for the subject of an investigation and how law enforcement works "behind the scenes" in the furtherance of successful adjudication.

SIS-15 Current Evidence-Based Guidelines for the Use of Ultrasound in Pain

Michael M. Bottros, MD

Thursday/9.10 7:00a - 7:55a

Level 3/Gracia 7

With the recent advances in ultrasound technology, an increasing number of practitioners are using ultrasound for anatomical visualization during procedures related to pain management, either alone or concomitant with fluoroscopy or other modalities. In order to better understand its potential, we will review the basics of ultrasound and its application to a breadth of standard pain management procedures to achieve optimal results. In doing so, we will grade its evidence in relationship to "gold standard" techniques.

SIS-16 Understanding DEA Requirements for Electronic Prescribing of Controlled Substances

Sean P. Kelly, MD

Thursday/9.10 7:00a - 7:55a

Level 3/Gracia 1

In 2010, the DEA finalized a rule allowing electronic prescribing of controlled substances (EPCS), which promises to address the provider efficiency and patient safety challenges associated with paper-based prescriptions for controlled substances. EPCS improves clinical workflow efficiency, decreases patient wait times at pharmacies, minimizes the risk of potential medication errors and inaccuracies, and helps curb "doctor shopping," drug diversion, and fraud. However, the DEA regulations mandate that specific requirements are met before providers and healthcare organizations can enable EPCS. For example, providers must undergo proper identity proofing, they must use 2-factor authentication at the time of prescribing, and there must be a comprehensive auditing and reporting mechanism for the entire process.

SIS-17 Controversies in Pain Medicine X = The Unknown: Widespread Pain

Charles E. Argoff, MD, CPE; Gary E. Kaplan, DO, ABFP, DABPM, FAAMA

Thursday/9.10 10:20a - 11:10a

Level 3/Gracia 1

Chronic widespread pain is a pervasive condition that presents with a range of troubling symptoms, both psychological and physical. Is it always fibromyalgia? How do you perform a differential diagnosis? Should skin biopsies be considered to demystify the presentation? These questions and others will be addressed in this activity.

SIS-18 Facet Joint Pain: Advances in Diagnosis and Treatment

Michael M. Bottros, MD

Thursday/9.10 11:15a - 12:10p

Level 3/Gracia 1

Low back pain is among the most prevalent and debilitating conditions among adults in the United States. The health economic impact is an outstanding \$293 billion. While the differential diagnosis can be long and varied, facet joint pain can be a source in 15% to 45% of patients with chronic low back pain. We will review facet joint anatomy as well as the history and physical exam findings associated with facet arthropathy. We will also explore treatment options and the changes that these treatments can produce, not just peripherally, but in the central nervous system as well.

SIS-19 The Imperfect Solution

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

Thursday/9.10 9:00a - 9:55a

Level 3/Gracia 1

The management of chronic pain has many attributes that distinguish it from almost all other medical conditions. An important characteristic of pain is that, unlike hypertension, diabetes, and other chronic medical conditions, the patient contributes to the process of defining a successful treatment outcome. Another question that often arises is the paradigm of "cure" in terms of chronic pain treatment. Unfortunately, there may often be a number of misalignments between patients and their healthcare providers, including incongruity of goals and expectations about treatment and the likelihood and/or prospect of a curative outcome. This presentation will explore issues that often arise in clinical practice from these types of situations, and frequent clinical dilemmas encountered resulting from them. Recommendations for avoiding common pitfalls in clinical practice will be offered in a way intended to be constructive, provocative, and meaningfully beneficial to healthcare providers and their patients with chronic pain.

SIS-20 Hurts So Good: Examining the Crossroads of Pain and Pleasure

Michael R. Clark, MD, MPH, MBA

Thursday/9.10 1:35p - 2:30p

Level 4/Nolita 3

There is evidence that suggests that pain and pleasure are part of a continuum, as there are biological connections between the neurochemical pathways involved in the perception of both. There exists a body of research that indicates that dopamine, the brain's pleasure chemical, is involved in response to pain, and which explores the relationship between dopamine and endogenous opioids. This presentation will address the inherent conflict of these 2 primary motivators and discuss situations where they seem to comfortably coexist, such as in sexuality and addiction.

SIS-21 Suspicion: What Should I Do if I Think My Patient Is Diverting, Abusing, or Both?

Kevin Barnard; Jennifer Bolen, JD; Stephen J. Ziegler, PhD, JD

Thursday/9.10 2:35p - 3:30p

Level 4/Mont-Royal Ballroom

Prescribers are often at a loss on what to do when confronted with the possibility that their patients may be diverting or abusing the drugs they have been prescribed. These dilemmas raise a myriad of issues involving trust, deception, liability, patient privacy, ethics, patient termination, abandonment, referral, and treatment. Accordingly, this roundtable of medico-legal experts will explore these issues and offer specific suggestions when facing such matters.

SIS-22 Visceral Pain

Paul J. Christo, MD, MBA

Friday/9.11 7:00a - 7:55a

Level 3/Gracia 3

Visceral pain can be disabling and significantly affect a person's quality of life. Often hard to localize, the pain also refers to other parts of the body. Sensitization can occur both centrally and peripherally. We will examine the pathophysiology of visceral pain, specific upper and lower abdominal pain syndromes, pelvic and genital pain, etiologies, and treatment strategies for these conditions.

SIS-23 Chronic Pain Patients Who Fail Standard Treatments: Identification and Strategies

Forest Tennant, MD, DrPH, FACPM, MPH

Friday/9.11 **7:00a - 7:55a**

Level 4/Mont-Royal Ballroom

This presentation is to bring awareness to the growing problem of chronic pain patients who are failing standard treatments. They fail to respond to a standard treatment regimen of nonpharmacologic and pharmacologic agents including a daily opioid dosage of about 80 to 100 mg equivalence of morphine. Often these patients are labeled as "drug seekers," unmotivated, noncompliant, or difficult. Since 1975, our clinic facility has primarily accepted chronic pain



the imperfect Solution

kevin zacharoff

thursday september 10

patients who have failed standard treatments including opioid administration. Only in recent years have there been adequate technologic and diagnostic tools to scientifically study possible reasons for treatment failure. Included in these study tools are opioid serum levels, genetic testing, hormone profiles, neuroinflammatory biomarkers, viral titers, and malabsorption determination. Our studies show that essentially all treatment failure patients have centralized pain, and treatment strategies must specifically address this disorder. Some failure patients appear to have genetic metabolic defects, opioid malabsorption, or severe hormonal deficiencies as their apparent cause of treatment failure. Our experience indicates that an effective treatment regimen can be developed for almost every failure patient with the basic goals of normal mental and physical functions, the ability to carry out activities of daily living, and the achievement of some quality of life.

SIS-24 Exit From the Dark Side of Pain: The Inherited Patient on Polypharmacy, Including Opioids

Douglas L. Gourlay, MD, MSc, FRCPC, FASAM; Howard A. Heit, MD, FACP, FASAM

Friday/9.11 10:20a - 12:10p

Level 4/Yaletown 1

The use of controlled substances, particularly opioids, have at times been seen as the problem or the solution in pain management. The common myth that it is simple to stop medications, particularly opioids, that are no longer needed is simple has left many patients relegated to continued use of often difficult to manage medications. This makes the issue of exit strategies even more important when using controlled substances. In this case based workshop, we will explore several of the more common controlled substance related issues facing primary care. While the focus will be on opioids, the sedative class of drugs will also be considered.

Please note that this course is limited to 50 participants; preregistration is required.

SIS-25 Clinical Conundrum: The Pertinent Negative

Gary W. Jay, MD, FAAPM

Friday/9.11 2:35p - 3:30p

Level 3/Gracia 5

What do you do with a pain patient with a totally negative neurologic, musculoskeletal, general, and psych examination, and who doesn't have a central sensitization syndrome? In this presentation we will discuss 3 patients with the above (maybe not at the start, but certainly later) and discuss: true mystery illnesses; significant changes in a patient who refuses to get better (and really doesn't want to); a patient who doesn't want to get better but does; and a patient who wants to get better and then—unintended consequences. Also to be discussed, an intermittent pain problem that has its own time schedule! A negative examination may mean a number of things!! Oh yes—and some things you just have to think about!!!

sis-26 Hormones and Pain Care

Forest Tennant, MD, DrPH, FACPM, MPH

Friday/9.11 4:35p - 5:25p

Level 3/Gracia 7

This presentation will cover the fundamentals of hormone testing and treatment in pain care. Hormone testing may serve as a biomarker for uncontrolled pain, and pain care may suggest a need for hormone replacement and may identify complications which are characteristic of hormone abnormalities. Replacement of some hormones may be needed to facilitate well-being and analgesic effectiveness. Neurohormones innately produced in the central nervous system, including oxytocin, human chorionic gonadotropin, and progestins, are now being investigated. Early reports suggest merit. Technological advances have made hormone profile testing available to pain care and interpretation of profiles will be a part of the presentation.

SIS-27 Opioid Induced Hyperalgesia

Sanford M. Silverman, MD

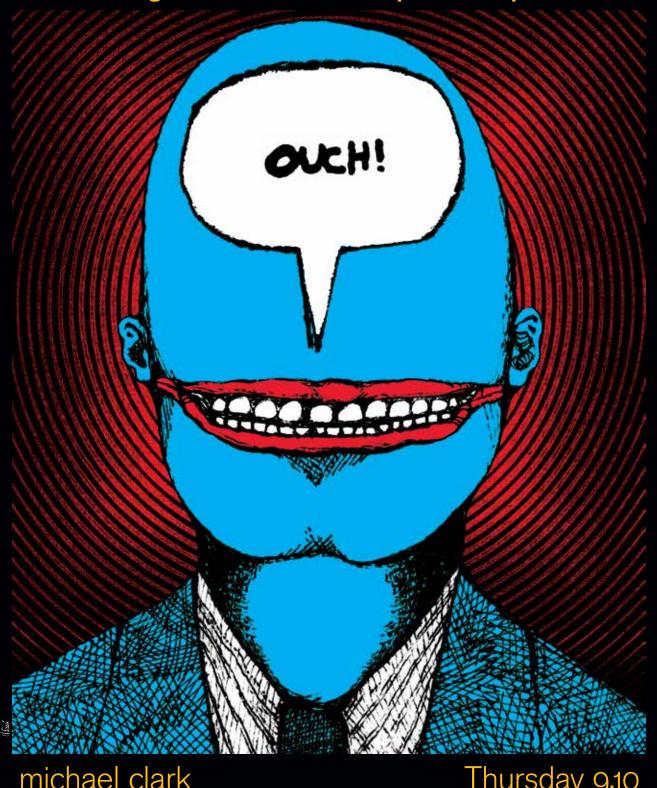
Saturday/9.12 10:20a - 11:10a

Level 4/Mont-Royal Ballroom

Opioid induced hyperalgesia (OIH) is side effect usually seen with patients receiving chronic high dose opioid therapy. It has been described both in laboratory and clinical settings. The

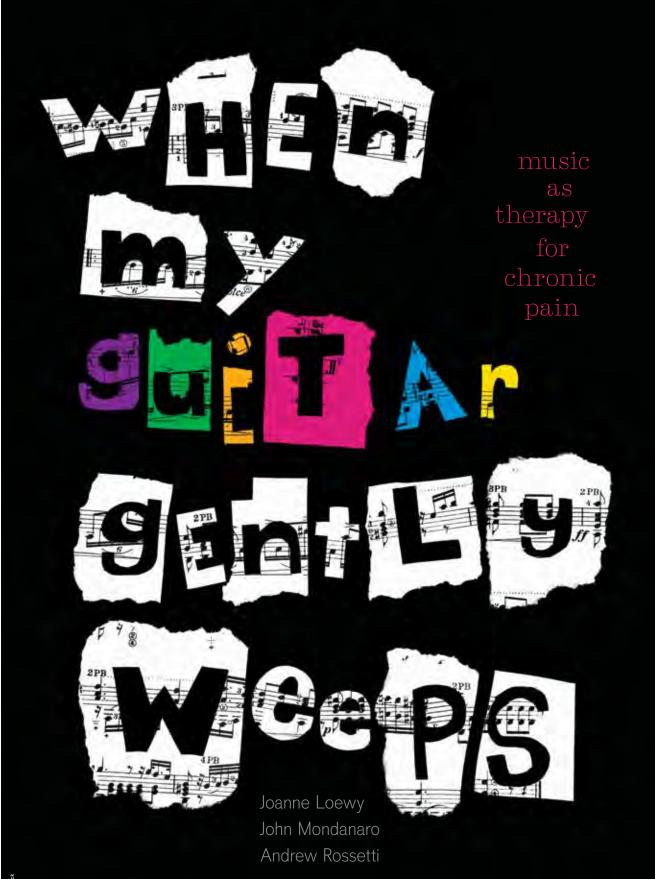
hurts so good

examining the crossroads of pain and pleasure



michael clark

Thursday 9.10



Saturday 9.12

mechanisms and diagnosis of OIH will be discussed, and the attendee will learn how to evaluate a patient with OIH as well as selecting treatment options. Its underlying neurophysiology with various mechanisms will also be discussed.

SIS-28 Medical Cannabinoids: An Update on What You Need to Know for Your Practice

Michael E. Schatman, PhD, CPE, DASPE

Friday/9.11 9:00a - 9:55a

Level 4/Mont-Royal Ballroom

Medical cannabinoids continue to become more prominent in the treatment of a variety of chronic pain conditions, with this prominence likely fueled by growing opiophobia in the United States. For many years, federal government regulations limited high-quality research on the safety and efficacy of medical cannabinoids in the treatment of pain. As a result of these regulatory challenges, most of the so-called "evidence" in support of these drugs was anecdotal in nature, or based upon methodologically-suspect empirical investigation. Fortunately, regulations on conducting much needed cannabinoid research are beginning to become more relaxed. Nevertheless, procannabinoid investigators are demonstrating considerable bias, leaving physicians confused regarding cannabinoids' efficacy and safety, thereby perpetuating medical cannabis "neuromysticism." This lecture will examine and evaluate the recent research and provide physicians with up-to-date and accurate information on what we know and don't know about cannabinoid medicine, with the goad of informing evidence-based pain practice.

SIS-29 Stem Cell Therapy: The Future of Pain Management

Orlando G. Florete, Jr, MD

Saturday/9.12 10:20a - 11:10a

Level 4/Nolita 1

Stem cell therapy is one of the newest innovations in the management of chronic pain and degenerative diseases. It has also the most promising outlook in terms of success and prognosis. Stem cells are undifferentiated cells found in multiple sources including amniotic fluid, placenta, embryonic tissue, bone marrow, periosteum, synovial membrane, and adipose tissue. These pluripotent cells can give rise to endoderm, ectoderm, and mesodermal cells. They are capable of robust autologous engraftment and show diverse therapeutic applications including regeneration of multiple degenerated joints and relief of chronic pain; recovery from ischemic strokes, myocardial infarction, brain and spinal cord injury; rescuing liver failure; and treatment of various neurologic conditions including ALS and MS. Stromal vascular fraction is a major source of stem cells in adult tissue, especially adipose tissue, and is well suited for therapeutic use because it is easily harvested, isolated, and cultured. The technique of stem cell extraction is easy and can be done on site. Patient recovery time is minimal, relief of pain is almost immediate, complications are relatively low, and initial data showed very promising response to treatment.

sis-30 When My Guitar Gently Weeps: Music as Therapy for Chronic Pain

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

Saturday/9.12 10:20a - 12:10p

Level 3/Gracia 3

Although opioid prescriptions are effectively used to treat chronic pain, certain conditions—such as fibromyalgia, migraine headaches, and back pain—are associated with high levels of anxiety where pharmacologic regimens may have limited potency. Similarly, symptoms of pain, when linked to trauma—an aversive event, combat, or an injury—may further impact the patient experience exacerbating the condition with negative neural affiliates, which may result in medicinal failure. Pharmacological treatment alone in such instances may not be absorbed readily into the patient's bloodstream as a result of a conscious or habitual resistance. As such, the capacity to trust and readily accept mechanisms of management in pain control is limited. Music intervention affects the brain's response to stimuli that can gait an acceptance and thus cue the body toward more effective integration of treatment. As music can entrain to the body-mind implicit relationship, it can dramatically influence treatment outcomes.

The first half of this course will provide research and clinical findings that reflect the clinical conditions that have resulted in poor pain management strategies. Treatment regimens will be addressed in simple format and will be complemented by medical music plans for use within the physician appointment time. Relaxation programs and a method for creating "playlists" will be shared as a tool for easy implementation. Our team will distribute a sample healing CD to utilize as part of clinical practice, in treating patients holistically as part of a music based pain

management protocol (MBPMP). The second half of this session will share strategies where music can most effectively be utilized in office treatment procedures such as venipuncture, biopsies, heel sticks, and spine pain injections. These strategies will include the use of breathing, toning, and meditation synthesis enhanced by entrainment.

sis-31 Big Data or Ball of Confusion? Technology in Pain Management

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

Saturday/9.12 11:15a - 12:10p

Level 4/Mont-Royal Ballroom

Technology is playing an ever-increasing role in the provision of healthcare today. In many cases, technology is solving logistical problems in the clinic setting, and in other cases, new problems are developing as a result. Regardless of whether or not technology in pain medicine is improving the quality of care, questions still exist with respect to treatment outcomes despite the large amount of data that technology is producing. This presentation will explore common clinical logistics in pain medicine, examine deficits in outcome data, and explore possible applications of technology to help improve quality of care and outcome assessment.

SIS-32 Fudin vs Gudin: The Gloves Come Off!

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

Thursday/9.10 7:00a - 7:55a

Level 3/Gracia 5

The issues: 1) High dose opioids—Are they still a therapeutic option? 2) Constipation—What do you mean you need a drug to treat it? 3) Abuse deterrent opioid formulations—Do we really need them? Pain management is certainly not a specialty without controversy. Opioid prescribing appears to have plateaued, and various states and agencies have recommended somewhat arbitrary dosing limits. High dose opioids may be appropriate for select patients, but just how astute is the average clinician at recognizing just who is appropriate? Constipation is the most bothersome adverse effect related to opioids, and it has been managed conservatively with over the counter laxative preparations and home remedies for decades. Is there really a need for prescription therapies? With greater than 100,000 deaths related to opioids in the last decade, clinicians, patients, parents, regulators, and pharmaceutical companies are seeking ways to improve the safe use of controlled substances for pain. With the most common form of misuse being by oral overconsumption, will abuse deterrent formulations be the answer to abuse and overdose related deaths? And will naloxone change outcomes?

Along with statewide prescription drug monitoring programs, urine drug toxicology screening has become standard of care for clinicians who routinely prescribe opioids for chronic noncancer pain. Although relatively sensitive and specific rapid screens are available for office use, most labs are advocating expensive quantitative gas or liquid chromatography/mass spectrometry testing. But do all 80-year-olds really need PCP, ecstasy, K2, and spice testing every month?

Come prepared for controversy and also to share your opinions!

sis-33 Rhapsody on a Windy Night: When Pain and Sleep Share the Same Bed

Gary W. Jay, MD, FAAPM

Saturday/9.12 **2:35p - 3:30p**

Level 3/Gracia 5

The physiology of sleep and aspects of its pathophysiology will be discussed. Various pain related changes in sleep physiology will be discussed, as well as the relationships between headache, pain, and sleep. The effects of sleep disturbances secondary to pain will be explored, and we will look at the effects of opioids on sleep and respiratory disorders.

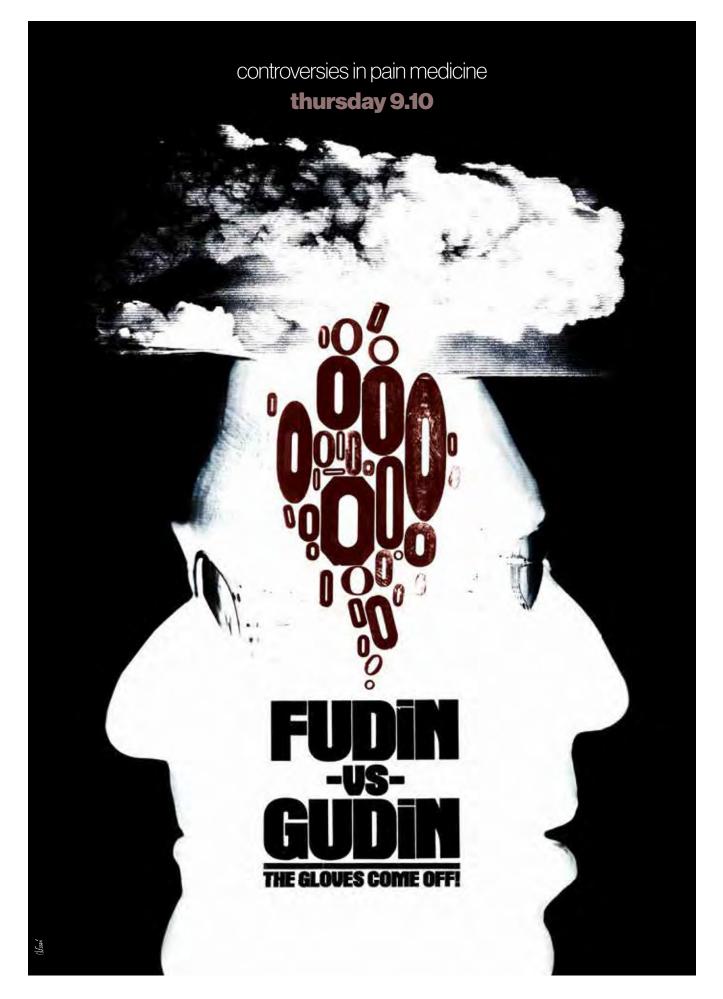
SIS-34 Improving Pain Management HCAHPS Scores

Jeffrey A. Gudin, MD; Cynthia F. Knorr-Mulder, MSN, BCNP, NP-C

Tuesday/9.8 8:00a - 8:55a

Level 4/Nolita 2

Patient satisfaction, as a direct and public measure of quality of care, is changing the way hospitals address quality improvement. Across the United States, hospitals are asking patients to report on their experience during their hospital stay. This information is collected using a



standardized survey tool called the Hospital Consumer Assessment of Healthcare Providers and Systems, or HCAHPS. With all hospitals using the same standard survey, meaningful comparisons are being made regarding the patients experience and perception of pain management. Scores are publically reported 4 times a year, which places all hospitals in the spotlight. Patients' overall perception of the type of care that they receive is based on whether or not their pain is well-managed and kept under control. Hospital executives look for the assistance of pain specialists to improve HCAHPS scores as a way to improve quality care and outcomes. Additionally, Medicare values the perceptions of patients' care and takes that into consideration while reimbursing hospitals. Managing patients' pain and improving HCAHPS scores will be financially profitable for hospitals, since it is part of Medicare's determinant for reimbursement.

Do you know how your most recent HCAHPS scores for pain management have been trending? During this session we will share with you strategies, tools, techniques, and protocols we have implemented to improve HCAHPS scores even when treating the most difficult pain management patients. It takes administrative support; an outstanding pain management team; caring, skilled, and attentive staff; engaged providers; excellent communication; consistency and compliance to improve scores. Learn how strategies such as education, scripting, therapeutic communication, motivational interviewing, huddles, rounding, managing up, communication boards, and more have helped hospital HCAHPS scores trend upward and create a culture of excellence.

sis-35 Motivating Your Patients in Pain Towards Physical Therapy

Kathryn Schopmeyer, PT, DPT, CPE

Tuesday/9.8 7:00a - 7:55a

Level 4/Nolita 2

The evidence for exercise benefits in the chronic pain population is robust and well understood. But many patients are reluctant to return to physical activities or frequently decline referral to physical therapy because of past experiences. Primary care providers and specialists often struggle to motivate their pain patients to participate actively in their recovery, and the reasons are multifactorial. Understanding the causes for movement challenges and movement related pain cycles will improve communication with patients. This talk will present several explanations for why movement is challenging and what contributes to negative experiences with physical rehabilitation. It will also provide strategies to use in the clinic to facilitate greater adherence to a multimodal treatment plan.

SIS-36 Combating One Public Health Crisis With Another: Patients' Response to DEA Rescheduling of Opioids

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

Tuesday/9.8 8:00a - 8:55a

Level 4/Nolita 3

According to the Institute of Medicine (2011), chronic pain is a national public health issue affecting tens of millions. Experts agree the "opioid crisis" is also a public health issue. The CDC (2013) reports opioids cause nearly 3 of 4 prescription drug overdoses—more deaths than cocaine and heroine combined. A recent NIH report (2015) asserts a lack of evidence to prove long-term opioid use works, while chronic pain patients report positive outcomes from opioids. Despite an unknown root cause, the DEA responded to the opioid crisis by changing the classification of hydrocodone—the most prescribed opioid—from Schedule III to Schedule II. This restricts access to abusers, as well as chronic pain patients who rely on prescribed drugs to decrease pain and improve quality of life. Before the regulatory change, previous studies showed drug access issues. Using secondary data from a hydrocodone survey of access since the regulatory change, currently underway by the National Fibromyalgia and Chronic Pain Association, this course looks at the results of a theoretical problem: What happens when we address one public health issue through regulation without first exploring the consequences to patients of another?

SIS-37 Perception vs Reality: An Overview of Epidural Steroids

Jay Joshi, MD

Tuesday/9.8 1:35p - 2:30p

Level 4/Nolita 2

There are general assumptions—interventional pain management and epidural steroid injections are synonymous; there is essentially one type of epidural steroid injection; epidural steroid injections are dangerous or extreme; they don't work; and they are used for back pain. Over the

last 15 years, the utilization of epidural steroid injections has increased and the type of providers that claim they perform epidural steroid injections has increased as well. This presentation will help educate the audience about interventional pain management, epidural steroid injections, when they should be utilized, who should perform them, how they should be performed, and myths/facts.

SYM-O1 Comprehensive Pain Management: Uncovering and Addressing Opioid-Induced Constipation

Charles E. Argoff, MD, CPE; Jeffrey A. Gudin, MD; Anthony J. Lembo, MD

Tuesday/9.8 12:00p - 1:30p

Level 3/Brera Ballroom

Although as many as half of patients on long-term opioid therapy experience symptoms of constipation, this common side effect is often not addressed by clinicians, leaving many individuals to suffer in silence. Do you know which of your patients is experiencing opioid-induced constipation? What strategies do you employ to help ease the symptoms of constipation in your opioid-treated patients? Join us for a practical and engaging discussion among experts in pain management and gastroenterology. During this Interactive ExchangeTM program, 3D animations and interactive case study discussions shaped by audience feedback will allow faculty presenters to share recommendations on efficiently assessing bowel patterns and prescribing both prophylactic and more intensive bowel regimens. The goal is to help pain-treating clinicians gain a deeper understanding of the effects of opioids on the gastrointestinal tract and strategies to alleviate constipation symptoms in patients on chronic opioid therapy.

SYM-02 Multimodal Approaches to the Treatment of Mixed Pain: What Is New?

Oscar de Leon-Casola, MD

Wednesday/9.9 7:00a - 7:55a

Level 3/Gracia 5

The pathophysiology of many chronic pain syndromes involves both a neuropathic and a nociceptive component. Such chronic pain conditions, the so-called mixed pain syndromes, require both a careful assessment and a multimodal therapeutic approach. Mixed pain syndromes are very common and include a large proportion of low back pain, cancer pain, chronic postoperative pain, as well as most forms of osteoarthritis. A multimodal treatment approach may involve synchronous use of 2 or more agents with different mechanisms of action or the use of a single agent that works on multiple pain mechanisms. Since drug combinations create the possibility of drug-drug interactions, consideration should be given to drugs that are not metabolized through the P450 enzyme system. Any analgesic regimen that involves the use of an opioid should include principles of safe prescribing, including stratification of risk for opioid misuse.

SYM-03 Essential Tools for Treating the Patient in PainTM Anatomy of Ouch: The Pathophysiology of Pain

Charles E. Argoff, MD, CPE

Wednesday/9.9 10:20a - 11:10a

Level 3/Gracia 1

This session will provide an in-depth look at the pathophysiology of pain to include TRPV channels, thermosensation, prostaglandin pathways, cytokines, and classification of fibers in peripheral nerves. Systemic and neuropathic pain and the role of glia in chronic pain will also be discussed. The session will also address visceral pain, complex regional pain syndrome, psychological factors associated with neuropathic pain, and much more.

SYM-O4 Essential Tools for Treating the Patient in PainTM The Science Behind Marijuana as an Analgesic

Armando Villarreal, MD

Wednesday/9.9 11:15a - 12:10p

Level 3/Gracia 1

Addressing the compounding issues related to evidence of the analgesic properties of marijuana and its medical use in the US, this session provides a balanced, up-to-date review of the evidence and the inherent challenges related to the appropriate medical use of marijuana in the treatment of chronic pain.

SYM-O5 Essential Tools for Treating the Patient in Pain™ Strategies for Success With Chronic Opioid Therapy

Farshad Ahadian, MD

Wednesday/9.9 1:35p - 2:30p

Level 3/Gracia 1

Committed to improving the outcomes and safety of all pain patients, this presentation improves the utilization of evidence-based protocols and practices designed to mitigate risks and improve patient outcomes for persons being treated with extended release opioid analysesics as part of a comprehensive pain treatment plan.

SYM-06 Essential Tools for Treating the Patient in Pain™ Understanding and Treating Neuropathic Pain

Charles E. Argoff, MD, CPE

Wednesday/9.9 4:35p - 5:25p

Level 3/Gracia 1

Highlighting the neuroanatomy of neuropathic pain pathways, this session addresses the complexities and impact of neuropathic pain, identifies characteristics and mechanisms of neuropathic pain, and provides a comprehensive overview of pharmacologic agents, both antineuropathic and OTC agents that can be used as one approach to delivering a comprehensive neuropathic pain treatment plan.

SYM-07 Chronic Pain: Discussions and Debates Around Responsible Opioid Prescribing

Charles E. Argoff, MD, CPE; Michael J. Brennan, MD; Jeffrey A. Gudin, MD

Saturday/9.12 12:00p - 1:30p

Level 3/Brera Ballroom

This Clinical Issues™ program addresses current recommendations for responsible opioid prescribing. A faculty panel of expert pain specialists will discuss and debate how to best individualize chronic opioid therapy for the diverse population of patients with functionally impairing chronic pain. Potential problematic issues related to patient selection, opioid trials, the roles of abuse-deterrent formulations, and strategies to address aberrant drug-taking behaviors will be central to the presentations. The symposium's debate-to-consensus format is designed to engage attendees and promote critical thinking, with the faculty panel exploring areas in which the real-world implications of emerging clinical data are just beginning to manifest. Attendee participation will be encouraged throughout the program, by such means as polling questions on case studies and voting on the outcomes of faculty debates. The overall activity goal is to help clinicians evaluate current data sources, analyze potential interpretations of the latest evidence, and overcome common clinical challenges, such that expert insights can be integrated into practical solutions that protect patients, prescribers, and the public. We look forward to seeing you at the lunch symposium.







XenoPort 401

	PainEDU	Purdue Medical Information	Millennium
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Autogenor Inc. 415

419 423 425 429 433		CompuGroup Medical	Waters Corp 423	NeuroMetrix 425	Orchard Software	Sciex
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AstraZeneca

301

Purdue Pharma L.P. 309

317

422		426	428		432
kaléo	Linden Care	mSPEC	Aegis Scie	ences Corp.	TechNeal
Lab Corp-Medtox		Confirmatrix		Dominion Diagnostics	Infinite Therapeutics
323		327		331	333

BELMONT EXHIBIT HALL

Depomed

Takeda Pharmaceuticals

217

Egalet 225

231

HealthOS

Teva

101

211 INSYS Therapeutics

Ethos Laboratories 111

Salix

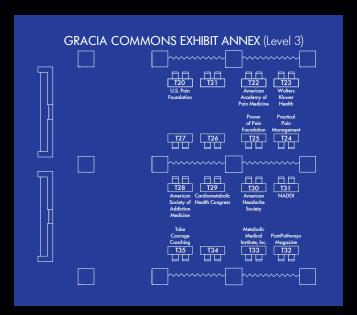
222	224	226		230	232
myoscience	Ameritox	Free Pharma	dom ceuticals	Drug Testing Program Management	eLab Solutions
Gensco Laboratories	Parkway Clinical Laboratories (PCL)		Purdue OADP		MEDISCA
123	125		129		133

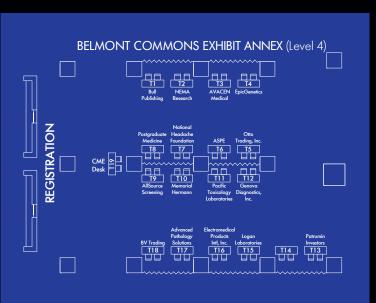
124 118 120 Quest Diagnostics

130 American Screening Corp 128 Continuum Laboratory Solutions 132 Gulfstream Diagnostics

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106 HRMD





SCHEDULE

Hamilton Robotics 439 InSource Diagnostics 445 Expo Enterprise RxProLogic 449 451

436	438	440	442	444	446	448	450
ApolloLIMS	Ace taminophen Aware ness Coalition	C-MED Solutions	Genotox Laboratories	Radeas Labs LLC	Mylan Inc.	Proove Biosciences	Hawaiian Moon
Iroko	En	ido	MTL Solutions	GenTech Scientific	PainBrain	Mercedes Medical	Chemware
337	339		343	345	347	349	351

BELMONT EXHIBIT HALL

336	338	340	342	344	346	348	350
Thermo Scientific	Thermo Fisher Scientific	MedComp Sciences	Noble	RADARS	AllMeds Specialty Practice Services	Adva- Net	Letco Medical
Aspen Medical	Alternative Biomedical Solutions	Pharmaco Technologies	Quantum Analytics	PharmBlue	Alere Toxicology	GLOBO- SA	Xpress Laboratories
237	239	241	243	245	247	249	251

236	238	240	242	244			250
PCCA	Medorizon	Acadian Diagnostic Laboratories	SurgiLogix	Benzer Pharmacy	Pain Medicine News	Healthcare Chaplaincy Network	RxAssurance Corp
SI-BONE	Feel Good, Inc.	Innovative Healthcare Solutions	Schuyler House	ProCare Counseling	Integrity Health	AML Diagnostics	Calloway Labs
137	139	141	143	145	147	149	151

Wednesday/99

6:30p - 9:00p Welcome Reception

THURSDAY/9.10

10:00**a** – 12:30**p** 2:30**p** – 5:00**p**

FRIDAY/9.11

10:00**a** - 12:30**p** 2:30**p** - 5:00**p**

4:00**p** - 5:00**p**

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
240	ACADIAN DIAGNOSTIC LABORATORIES www.acadianlab.com	Acadian Diagnostic is a high complexity laboratory used by the physician to validate specific drugs when medically necessary.
438	ACETAMINOPHEN AWARENESS COALITION www.knowyourdose.org	The Acetaminophen Awareness Coalition (AAC) works to educate patients and consumers 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 and encourages consumers to follow four safe use steps: 1) always read and follow the medicine label; 2) know if their medicines contain acetaminophen; 3) take only one medicine at a time that contains acetaminophen; and 4) ask their healthcare provider or pharmacist if they have any questions.
348	ADVA-NET www.adva-net.com	Adva-Net is the nation's largest Comprehensive Pain Management, Post-Acute Care, and Addiction Management Network. Adva-Net is currently enrolling new providers to join our specialty network. Inquire about the Adva-Net Advantage and its benefits.
т 17	ADVANCED PATHOLOGY SOLUTIONS www.apslabgroup.com	Please visit our booth for more information.
428	AEGIS SCIENCES CORP. www.aegislabs.com	For 25 years, Aegis® has remained one of the most trusted drug testing laboratories for pain management, forensics and sports organizations throughout the U.S. With Aegis® you have access to: testing in oral fluid, urine and/or blood; consultation with 14 PhD, 5 PharmD and 1 MD experts; and the highest quality client service in the industry.
124	AEON CLINICAL LABORATORIES www.aeonclinical.com	Our mission at Aeon Clinical is better patient care through state of the art toxicology testing and personalized pharmacogenomics. We are confident that partnering with us will provide you with the most accurate analysis and timely results to optimize your treatment plan. Use Aeon Clinical for your testing needs so you can prescribe with confidence.
247	ALERE TOXICOLOGY www.aleretoxicology.com	As a world leader in toxicology, Alere offers healthcare providers a broad range of services to help them optimize outcomes and improve patient care. Our innovative medication monitoring solutions enable healthcare providers to improve clinical decision-making and provide more personalized, cost-effective patient care.
346	ALLMEDS SPECIALTY PRACTICE SERVICES www.allmeds.com	AllMeds provides pain management's most successful specialty EHR and practice services, including specialty-focused revenue cycle management services. AllMeds' specialty nature better ensures pain practices of rapid implementation periods, higher adoption rates, real returns on investment, and greater rates of success. Leverage AllMeds' 16 years of successful service to specialty medicine today.
Т9	ALLSOURCE SCREENING SOLUTIONS www.allsourcescreening.com	All Urine Screens are CLIA WAIVED, OTC COMPLIANT, and FDA 510-k CLEARED. GUARANTEED 7% Discount. Take 7% off of what you are paying now and that is your price with AllSource. We also match your shipping to get a true 7% discount. Urine Screens - Dip Cards - Saliva Screen. AllSource will MANUFACTURE your screens specifically to your needs.

BOOTH	ORGANIZATION	DESCRIPTION
239	ALTERNATIVE BIOMEDICAL SOLUTIONS www.absbiomedical.com	ABS offers solutions for in-office urine drug testing ranging from immunoassay screening to LCMS confirmation. For immunoassay screening we offer a complete line of instrumentation ranging from our smaller BS-200 bench top analyzer to our larger and faster Olympus Chemistry analyzers. We offer a large menu of assays including oxycodone, fentanyl, suboxone, tramadol and others. For larger clinics, we offer in-office LCMS equipment for confirmation testing. We offer flexible acquisition options including our popular cost per sample (CPS) program. Our CPS is the easiest, quickest and most economical way to implement urine drug testing.
T22	AMERICAN ACADEMY OF PAIN MEDICINE www.painmed.org	For over 30 years, the American Academy of Pain Medicine (AAPM) has been the premier non-profit, professional medical association serving more than 2,400 pain physicians and members of their treatment teams. AAPM is the recognized authority for appropriate and effective pain care through its knowledge, scholarship and commitment. Our mission is to optimize the health of patients in pain and eliminate the major public health problem of pain by advancing the practice and specialty of pain medicine. We are committed to the highest standard of patient care; scholarship, science, and research; upholding ethical standards and professional integrity and advancing public health.
Т30	AMERICAN HEADACHE SOCIETY www.americanheadachesociety.org	The American Headache Society® (AHS) is the professional organization for the study and management of headache and face pain. AHS activities include an annual scientific meeting, a comprehensive headache symposium, regional symposia for neurologists and family practice physicians, and publication of the journal Headache. AHS established the American Migraine Foundation and the 36 Million Migraine Campaign—a national awareness effort to increase research funding for migraine.
130	AMERICAN SCREENING CORP www.americanscreeningcorp.com	American Screening, LLC is an ISO 13485 leading point of care manufacturer/distributor specializing in FDA, OTC/CLIA Waived Rapid Drug Test cups and dips, selling worldwide to 27 countries. We also sell, Saliva Drug Test, Alcohol, HCG, LH, H.Pylori, Strep A, Flu A/B, FOB, Chlamydia, HIV, HBV, HCV, and many more.
т 28	AMERICAN SOCIETY OF ADDICTION MEDICINE www.asam.org	ASAM is a professional society representing over 3,400 physicians and associated professionals dedicated to increasing access and improving the quality of addiction treatment; educating physicians, other medical professionals and the public; supporting research and prevention; and promoting the appropriate role of physicians in the care of patients with addiction.
т6	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.

ВООТН	ORGANIZATION	DESCRIPTION
224	AMERITOX www.ameritox.com	Ameritox helped pioneer the prescription drug monitoring necessary to address the national epidemic of prescription drug misuse, abuse, and diversion. As a trusted leader in Pain Medication Monitoring Solutions SM , Ameritox provides medical and business professionals with health care solutions that can help improve patient care and prevent tragedy. Ameritox, headquartered in Baltimore, Maryland, has 800 employees nationwide and laboratory facilities in Greensboro, North Carolina.
149	AML DIAGNOSTICS www.amldx.com	AML Diagnostics is a metabolic concierge lab that offers toxicology testing. AML toxicology testing assists healthcare practitioners in the diagnosis, intervention, treatment and monitoring for the recovery of patients. AML Diagnostic testing not only provides quick, precise, reliable results but also tools for the optimal long-term recovery and wellness of patients. Why choose AML? Quick turn around time; unparalleled customer service; dedicated account manager; online physician portal for test orders and results access; LC/MS provides reliable sensitivity and specificity; easy to read & patient friendly reports; comprehensive menu of testing; custom panels available; and in-hours physician available for consultations.
436	APOLLOLIMS www.apollolims.com	ApolloLIMS is an enterprise Laboratory Information Management System built to offer superior laboratory automation. The core architecture of ApolloLIMS was designed to offer maximum efficiency with better workflows. We provide integration of physician orders (CPOE) through EMR interfaces, manage bi-directional laboratory instrument communication and offer secure patient reports via an online web portal. ApolloLIMS is the right answer for all the challenges faced by the modern laboratory.
		ApolloLIMS is the flagship product of Common Cents Systems, Inc. With over 20 years of experience in the laboratory industry we have the knowledge and experience to make your laboratory project a success.
237	ASPEN MEDICAL PRODUCTS www.aspenmp.com	Aspen Medical Products is a leader in the development of innovative spinal bracing for post-trauma stabilization, pre- and postsurgical stabilization, pain management and long-term patient care. Aspen Medical Products offers multiple orthotic options that provide unsurpassed motion restriction, superior comfort and an economic advantage, encouraging better patient compliance.
301	ASTRAZENECA www.astrazeneca.com	AstraZeneca is a global, innovation-driven biopharmaceutical business that focuses on the discovery, development and commercialization of prescription medicines, primarily for the treatment of cardiovascular, metabolic, respiratory, inflammation, autoimmune, oncology, infection and neuroscience diseases. AstraZeneca operates in over 100 countries and its innovative medicines are used by millions of patients worldwide.
415	AUTOGENOMICS, INC. www.autogenomics.com	AutoGenomics Inc., a privately held company based in Vista, California, has developed the first automated, microarray based multiplexing diagnostic platform that can be used to assess disease signatures with novel genomic and proteomic markers in the area of pharmacogenomics, genetic disorders, infectious disease and cancer. With the discovery of genes and their link to various disease states, the platform has the versatility to revolutionize the way patients are diagnosed, monitored and managed, leading to the era of precision medicine.
тз	AVACEN MEDICAL www.avacen.com	Please visit our booth for more information.

ВООТН	ORGANIZATION	DESCRIPTION
244	BENZER PHARMACY www.benzerpharmacy.com	Benzer Pharmacy is a chain of independent retail pharmacies specializing in compounding and specialty medication. It is no stranger to covering new ground, whether it is up and coming hot specialty topics such as RA, HIV or physical ground by expanding into new states. Benzer Pharmacy currently has locations throughout Florida, Michigan, Virginia, North Carolina, Tennessee, Texas, Georgia, and Louisiana. Benzer Pharmacy is projected to grow rapidly in order to make maximum reach to customers through walk-in personalized services. Our goal is to provide amazing service and advice for all customers.
TI	BULL PUBLISHING COMPANY www.bullpub.com	The Bull Publishing Company is a health publisher, and we are featuring our newest title: Living a Healthy Life with Chronic Pain, the first specialized book of the best selling Living a Healthy Life with Chronic Conditions series by Kate Lorig of Stanford University et al. Come and meet co-author Lisa Webster, RN, in our booth. We also feature the groundbreaking book, Less Pain, Fewer Pills, by Beth Darnall.
т 18	BV TRADING www.bvtrading.us	Please visit our booth for more information.
151	CALLOWAY LABS www.callowaylabs.com	Calloway Laboratories Inc. is a national independent clinical urine and oral fluid toxicology laboratory located in Massachusetts focused on providing services to clinicians to enable more effective management of patients resulting in better clinical outcomes. Calloway's mission is to work together with physicians and treating clinicians to align our initiatives on behalf of the patient, specifically those that promote medically necessary services that provide better clinical outcomes.
Т29	CARDIOMETABOLIC HEALTH CONGRESS www.cardiometabolichealth.org	The Cardiometabolic Health Congress (CMHC) is more than an annual conference or regional meeting. Cardiometabolichealth.org provides a single point of access for busy practitioners to stay abreast of evolving science, clinical practice advances and continuing education in cardiometabolic disease prevention and management. CMHC provides a complete platform of education spanning live and digital communications that extends the energy and experience of our national and regional conferences throughout the year and to a wider audience of frontline clinicians with an interest in cardiometabolic health.
		With more than one-third of the population having at least one cardiometabolic risk factor—dyslipidemia, CHD, hypertension, diabetes and/or obesity—the CMHC provides a one-of-a-kind opportunity for busy clinicians to catch up on the latest developments in these overlapping areas of cardiometabolic health. The program is at the cutting-edge of science, translating the latest research to practical approaches for the entire multidisciplinary health care team.
351	CHEMWARE www.chemware.com	ChemWare has been in the laboratory automation business since 1987, and is now one of the largest LIMS companies in the U.S. specializing in off-the-shelf pain management, drugs of abuse and forensic toxicology LIMS applications. ChemWare differentiates its offering by providing significantly more off-the-shelf functionality than is available through any other LIMS targeted for the pain, DOA and toxicology sectors. This is because no other LIMS vendor has comparable experience in the pain and DOA laboratory automation markets, subject matter expertise, and regulatory and reporting know-how specific to the industry. Unlike other vendors, ChemWare does not engage in development projects in which the product is custom-built by an offshore development team. ChemWare's business model ensures that the customer is not locked into a proprietary solution or one that requires vendor customization, specialized services or support.

ВООТН	ORGANIZATION	DESCRIPTION
440	C-MED SOLUTIONS www.c-medsolutions.com	C-MED Solutions is a medical consulting firm based in Atlanta, Georgia. Our professionals are dedicated to helping medical practices maximize growth opportunities for their business. What is our approach? We provide personalized healthcare solutions and products that effectively enhance patient care, meet regulatory standards, and generate new streams of revenue.
		Visit our booth to learn more about how our services, partnerships, and products can assist in growing your practice.
118	COLLEGIUM www.collegiumpharma.com	Collegium Pharmaceutical, Inc. is a specialty pharmaceutical company developing and planning to commercialize next generation, abuse-deterrent products for the treatment of patients suffering from chronic pain and other diseases. We are committed to developing and commercializing a portfolio of products that address the growing problems associated with non-medical use, abuse and misuse of prescription products by leveraging the Company's proprietary DETERx® technology platform. Collegium's lead product candidate, Xtampza ER TM , is an abuse-deterrent, extended-release, oral formulation of oxycodone. Xtampza ER has received Fast Track designation from the U.S. Food and Drug Administration (FDA).
419	COMPUGROUP MEDICAL www.cgm.com/us	Please visit our booth for more information.
327	CONFIRMATRIX www.confirmatrixlabs.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. To learn more about Confirmatrix Laboratory and our services, contact us today. We look forward to becoming your partner in care.
128	CONTINUUM LABORATORY SOLUTIONS www.continuumlabservices.com	Continuum is one of the leaders of comprehensive clinical lab testing equipment and supplies in the United States. Our proprietary methodologies allow us to provide some of the fastest, most reliable, and customized urine and oral fluid (saliva) test and equipment in the nation. Our turnkey lease programs are a total solution for your operation.
217	DEPOMED www.depomed.com	Depomed, Inc., is a specialty pharmaceutical company focused on developing and commercializing products to treat pain and other central nervous system conditions. The company was founded in 1995 and has established itself by developing and incorporating promising technology into differentiated therapeutic products, taking those products through clinical approval, and building a strong market presence.
331	DOMINION DIAGNOSTICS www.dominiondiagnostics.com	Dominion Diagnostics is a leading national laboratory that offers drug detection and prescription drug monitoring, clinical blood testing services, and a full suite of provider support solutions. Since 1997, Dominion Diagnostics has provided services to clients representing a diversity of medical specialties across the United States, including addiction medicine, behavioral health, pain medicine, primary care, psychiatry, and hospital systems. Dominion Diagnostics is supported by a world-class team that shares a commitment to clinical excellence, compliance, and integrity.

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230	DRUG TESTING PROGRAM MANAGEMENT www.dtpm.com	Drug Testing Program Management (DTPM) is the leader in installing Physician Office Laboratories providing the highest quality analyzers, software and turnkey setup in the industry. DTPM opened its doors in 1993 and has a long history of placing specialty laboratories in all types of settings and has customers in over 40 states. DTPM places specialty laboratories in drug courts, treatment centers and physician offices and can provide you a laboratory with no up front cost.
225	EGALET www.egalet.com	Egalet is a fully integrated specialty pharmaceutical company focused on developing effective medicines for patients with acute and chronic pain while helping to protect physicians, families, and communities from the burden of abuse.
232	ELAB SOLUTIONS www.elabsolutions.com	eLab is a full service toxicology laboratory. We specialize in implementing high complexity physicians office laboratories. This includes the accreditation process as well as the supplying of reagents, analyzers, lab directors and everything associated with the lab. eLab also provides EMR integration and next day turn around on confirmation results.
т16	ELECTROMEDICAL PRODUCTS INTL, INC. www.alpha-stim.com	Alpha-Stim's unique patented technology manages even the most severe pain while simultaneously treating anxiety, depression, and insomnia. It's supported by more research than any device in its class. See studies at alpha-stim.com where you can also give the devices a virtual test drive online. Or call 1-800-FOR-PAIN. Free 60-day loan for practitioners.
339	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.
Т4	EPICGENETICS www.fmtest.com	EpicGenetics is dedicated to developing practical diagnostic medical tests where either none exist or they fail to provide acceptable reliability. We have sponsored active research programs regarding diagnostic testing at the Harvard School of Public Health and the University of Illinois College of Medicine at Chicago. Our research findings are published in peer-reviewed, prestigious medical and scientific journals. We recently introduced the first ever diagnostic test for fibromyalgia. This test has uncovered an immunologic pathway which proves that fibromyalgia is an actual medical disease whose etiology stems from a white blood cell set of abnormalities.
111	ETHOS LABORATORIES www.ethos-labs.com	Ethos is an analytics and assessment organization dedicated to the field of pain management. Ethos' unique offerings include functional biomarkers of pain, electronic risk assessment, steady-state blood testing, compliance testing, and hormone testing.
449	EXPO ENTERPRISE INC. www.ngno-ions.com	Please visit our booth for more information.
139	FEEL GOOD, INC. www.healthmateforever.com	Please visit our booth for more information.
226	FREEDOM PHARMACEUTICALS www.freedomrxinc.com	Freedom Pharmaceuticals ("Freedom") specializes in the supply and custom repackaging of fine compounding chemicals – active pharmaceutical ingredients (APIs), pre-made bases and excipients – to independent compounding pharmacies throughout the United States. At Freedom, our goals are simple: supply your compounding pharmacy with the highest quality fine chemicals available; consult with your pharmacy on proper third-party billing techniques; and give your staff the personalized customer service necessary to operate successfully in this rapidly changing industry.

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442	GENOTOX LABORATORIES www.genotoxlabs.com	Genotox Laboratories combines innovative technologies and extraordinary service to help physicians treating people with pain provide superior care. Founded by a fellowship trained physician specializing in pain management, Genotox has developed a patented validity measurement (ToxID) designed to improve the physician's ability to treat patients receiving chronic opioid therapy. The Genotox ToxID method combined with urine drug testing and pharmacogenomic testing enables the pain specialist to optimize COT and reduce the risks of patient abuse, misuse or diversion of the prescribed treatments. Unique service offerings, quick turnaround time and excellent customer care combine to make Genotox your best choice for laboratory services.
123	GENSCO LABORATORIES, LLC www.genscolabs.com	Gensco Laboratories is a specialty pharmaceutical company focusing on research, development and marketing of transdermal prescription products. As an innovator of pharmaceutical products and the development of patented drug delivery systems, we are dedicated to the continual pursuit of novel and effective therapies that improve health. Gensco transdermal prescription products include: LiDORx®, SpeedGel Rx®, TranzGel® and the newly launched first transdermal medication for gout, ColciGel®.
T12	GENOVA DIAGNOSTICS, INC. www.gdx.net	Please visit our booth for more information.
345	GENTECH SCIENTIFIC www.gentechscientific.com	For 20 years, GenTech Scientific has proven to be a reputable provider of refurbished laboratory equipment. With a \$5 million inventory and 10 chemists on hand, we are able to provide expert services with fast turnaround. With 20 years of analytical instrument service, GenTech Scientific is able to offer quality refurbished mass spectrometer (MS), gas chromatograph (GC), high performance liquid chromatograph (HPLC), and inductively coupled plasma (ICP) systems from all major manufacturers such as Agilent, Waters, AB Sciex, Thermo/Finnigan, Varian, Shimadzu, Hitachi, Edwards and more. Please stop by our booth and find out how we can help you!
249	GLOBO-SA www.iqmassage.com	Please visit our booth for more information.
132	GULFSTREAM DIAGNOSTICS www.gulfdiagnostics.com	Gulfstream Diagnostics offers full laboratory services for urine drug testing (UDT) and pharmacogenomics testing (PGT). We can provide same-day results and 72-hour confirmations, and our staff devotes itself equally to patient wellbeing and client needs alike. No matter your location, we're available to help.
439	HAMILTON ROBOTICS www.hamiltoncompany.com	Hamilton Robotics designs and manufactures liquid handling robotics, process analytics, and automated storage solutions. Chronic pain is a major heath issue and Hamilton Robotics provides diverse automation tools for low-high throughput testing and help guide the treatment and personalized patient care. Our workstations serve as a high precision base upon which to conduct research in neurology, pharmacotherapy, pain management and biological sample processing for clinical diagnostics. To this end we employ teams of highly skilled and experienced application and hardware specialists around the world to provide our customers with unique solutions to automate their assays successfully and within budget.
450	HAWAIIAN MOON www.aloecream.biz	Say goodbye to dry skin with Hawaiian Moon Organic Aloe Cream! This cream penetrates the skin up to seven layers deep and being free of parabens, sulfates, dyes, fragrance, mineral oil, and any other harsh chemicals, it will leave your skin soft and moisturized.

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248	HEALTHCARE CHAPLAINCY NETWORK www.healthcarechaplaincy.org	HealthCare Chaplaincy Network is a global nonprofit organization whose mission is to increase patient satisfaction and help people facing illness, grief, pain, spiritual distress, and death find comfort and meaning – whoever they are, whatever they believe, wherever they are. HCCN is dedicated to advancing the integration of spiritual care in health care through clinical practice, research and education. Learn about our: new technology-driven programs that cost-effectively deliver spiritual care inside and outside hospital settings; international "Caring for the Human Spirit Conference" (April 11-13, 2016) and ongoing webinars for multiple disciplines; and other services to promote person-centered care and overall wellness.
231	HEALTHOS www.paincareos.com	HealthOS announces the launch of PainCareOS TM – a HIPAA compliant, cloud based pain management workflow optimization tool. PainCareOS provides clinical decision support tools, providing a simple solution to organize, track and automate case management. Highlights include: enhances your risk management protocols; opioid risk profiling plus urine toxicology and illicit substances tracking; laboratory solutions tools at point-of-care; optimizes revenue cycle management; helps mine meaningful knowledge from intake questionnaires; improves patient & staff engagement; and includes insurance validation for real-time eligibility, benefits & co-payment information.
106	HRMD www.txpainphysicians.com	Please visit our booth for more information.
333	INFINITE THERAPEUTICS www.infinitymassagechairs.com	The Infinity Riage is the most advanced therapeutic massage chair available. Covering 35% more of your body with the first glute massage, the Riage delivers stress relief like no other. State of the art roller foot reflexology, sensors for customized massage, lumbar heat and Bluetooth music streaming offers endless luxury, and the ULTIMATE MASSAGE!
141	INNOVATIVE HEALTHCARE SOLUTIONS www.i-h-s.com	Please visit our booth for more information.
445	INSOURCE DIAGNOSTICS www.insourcedx.com	InSource Diagnostics was founded with a very simple vision: utilize the best quality science to support medication monitoring and drugs of abuse testing. We are passionate about customer service and training, and can help you set up a new testing program or optimize the one you have. Our new SPHERE research study is designed to help identify patients that may be predisposed for adverse drug events (AEs). Stop by our booth to learn how your clinic might participate in this cutting edge research!
211	INSYS THERAPEUTICS www.insysrx.com	INSYS Therapeutics is a specialty pharmaceutical company developing and commercializing supportive care products. We focus our research efforts on product candidates that utilize innovative formulations to address the clinical shortcomings of existing pharmaceutical products. Our currently marketed product is a treatment option for the management of breakthrough cancer pain.
147	INTEGRITY HEALTH www.integrityhealthplus.com	Integrity Health Plus (IHP) is a medical management organization that offers comprehensive laboratory services, world-class ambulatory surgical centers and life-changing wellness programs. Our innovative solutions enable physicians, partners and medical networks to optimize patient care by allowing them to focus on their core business. At the same time, we maximize their profitability by generating and managing new revenue streams.
337	IROKO PHARMACEUTICALS, LLC www.iroko.com	Iroko is a global specialty pharmaceutical company, based in Philadelphia, dedicated to advancing the science of analgesia. Iroko is at the forefront of the development of SoluMatrix® NSAIDs—new low dose drug products based on existing NSAIDs—using iCeutica Inc.'s proprietary SoluMatrix Fine Particle Technology™ exclusively licensed to Iroko for NSAIDs.

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422	KALÉO www.kaleopharma.com	kaléo is a pharmaceutical company dedicated to putting a new generation of life-saving personal medical products into your patient's hands. Each kaléo product combines an established drug with an innovative delivery platform with the goal of achieving superiority, cost effectiveness and patient preference.
323	LAB CORP-MEDTOX www.labcorp.com	LabCorp MedWatch® is one of the nation's premier medical drug monitoring programs and is offered through LabCorp and its specialty testing laboratory, MedTox Laboratories. The LabCorp MedWatch® program offers a full menu of medical drug monitoring tests that provides unparalleled choice, flexibility, and clinical value for your specific monitoring needs.
350	LETCO MEDICAL www.letcomedical.com	Since 1993, Letco Medical has been a compounding supplier committed to providing pharmacies with complete customer satisfaction by offering the highest quality compounding products, customer service and technical support along with the fastest delivery times in the industry. Letco® Medical is your partner in compounding. We offer an extensive line of compounding chemicals, supplies, equipment, capsules, pre-made topical bases and oral delivery vehicles to support the art and science of compounding. We pride ourselves in knowing that the satisfaction of a job well done is only obtained through a combination of hard work, perseverance, and a thoughtful approach to do our best for our customers and our company. We communicate honestly and openly to continue to build long lasting and trustworthy relationships with our customers and employees. We thank you for trusting us as a partner in your compounding pharmacy. We look forward to working and growing with you.
424	LINDEN CARE www.lindencare.com	LindenCare is specialty pharmacy servicing all 50 states and the District of Columbia. In addition to being a full service pharmacy, our niche business is the dispensing of narcotic and controlled medications.
т15	LOGAN LABORATORIES www.loganlabs.net	Logan Laboratories is a premier full-service toxicology laboratory for the testing of prescription and illicit drugs. Our proven drug confirmation process utilizes modern day technology to provide accurate results. Logan Laboratories specializes in pain management assurance testing and has developed a confirmation process that is dependable, timely, and accurate.
340	MEDCOMP SCIENCES www.medcompsciences.com	MedComp Sciences is a premiere laboratory providing exceptional service, specializing in therapeutic medication and illicit drug monitoring: urine, oral fluid and blood analysis; pharmacogenetics: profiling of individual genetic variations to achieve optimum treatment and efficiency; compounding pharmacy: providing patient-specific medications; health and wellness programming: education for healthcare providers in the use of preventive coding, counseling and screening that is provided by insurance carriers for utilization to help improve meaningful use (measurement of wellness) for patients

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133	MEDISCA www.medisca.com	MEDISCA is an industry leader in the repackaging and distribution of pharmaceutical compounding supplies. For over 20 years, MEDISCA has been dedicated to providing the pharmaceutical compounding community with the highest quality fine chemicals, compounding supplies, solutions, and comprehensive training. Founded in 1989, MEDISCA now has several offices throughout Canada, the United States and Australia. MEDISCA NETWORK is a multi-dimensional company dedicated to offering the compounding community the cornerstone elements for the growth and establishment of a successful compounding practice. MEDISCA NETWORK offers a comprehensive portfolio of compounding training activities through the use of ACPE-accredited providers and provides technical support services geared toward the practice of pharmacy compounding. Our broad range of training activities are held in multiple venues across North America for pharmacists, pharmacy technicians and allied health professionals.
238	MEDORIZON www.medorizon.com	Medorizon has grown to a 60-employee organization, with unique experience in pain management and urine toxicology claims submission. Our staff manages the billing and collection process for over 400 providers throughout the United States. Our team has a diverse background including practice management experience, coding expertise, operations management, information systems, insurance claim processing, and compliance including HIPAA. Our organizational structure is based on a team-approach. Each client is assigned a Project Leader for the installation/implementation and an Account Manager to manage the day-to-day activity. In fact, at Medorizon, we are so dedicated to customer service, many of our staff members are bi-lingual in order to assist in patient inquiries. We have over 20 years experience with all aspects of pain management and billing needs.
T10	MEMORIAL HERMANN www.parc.memorialhermann.org	The goal of the Memorial Hermann Prevention and Recovery Center (PaRC) Pain Recovery Program is to help individuals achieve relief from pain and continue to build long-term pain and addiction recovery. PaRC offers medically supervised inpatient detox, residential treatment, outpatient treatment, aftercare program and family education and support. Located in Houston, Texas, PaRC is a nationally recognized TJC Accredited, DSHS licensed program for alcohol and substance abuse treatment providing the highest level of quality of care in a confidential setting. The PaRC is contracted with most insurance and managed care companies excluding Medicare of Medicaid. Please call 877-464-7272 for more information.
349	MERCEDES MEDICAL www.mercedesmedical.com	Mercedes Medical is a national medical supply company specializing in clinical laboratory, pathology and toxicology products. Mercedes Medical provides a full range of consumable supplies and equipment to over 10,000 customers nationwide, and prides itself on being a low cost leader in the market since 1990.
т33	METABOLIC MEDICAL INSTITUTE, INC. 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, researchers and the public. MMI provides educational courses through conferences, workshops, online modules, and fellowship and certification programs. MMI educational courses are affiliated with leading universities and taught by Nobel-prize winning scientists, expert clinicians and researchers drawn from a variety of medical, basic science, technology and business disciplines. MMI programs are held to the highest standards of academic rigor and train practitioners in the methods of metabolic, preventive and integrative medicine, an approach that uncovers the deeper causes of disease and reveals the uniqueness of each patient.

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409	MILLENNIUM HEALTH www.millenniumhealth.com	Millennium Health is a leading health solutions company that delivers accurate, timely, 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.
426	MSPEC www.mspecgroup.com	mSPEC group provides the highest level of excellence in customized LCMS & HPLC maintenance service programs and technical support. Our philosophy is focused on customer satisfaction. We strive in supplying unparalleled responsive, professional support for mass spectrometer products and peripherals. We offer dedicated expertise and a proven cost effective approach to meet your laboratory requirements.
343	MTL SOLUTIONS www.mtl-solutions.com	MTL Solutions is a full-service laboratory management partner. We offer physician offices and independent clinical laboratories unparalleled support and resources for establishing, refining and operating a compliant and sustainable clinical laboratory. Our team has decades of experience in the medical, legal, financial and technical aspects of laboratory operations, allowing us to offer unrivaled expertise in laboratory planning & set up; billing/coding/reimbursement management; compliance & communications; laboratory restructure & monthly management; and expert witness services.
446	MYLAN INC. www.mylan.com	Mylan is one of the world's leading global pharmaceutical companies. Our growing portfolio of around 1,400 medicines include generic and brand name products in a variety of dosage forms. The company has innovative research and development capabilities and is one of the world's largest active pharmaceutical ingredient manufacturers.
222	MYOSCIENCE www.ioverahealth.com	FDA-cleared to block pain, the iovera system uses precision targeting and the body's natural response to cold for immediate relief without the use of drugs.
тзі	NADDI www.naddi.org	The National Association of Drug Diversion Investigators, or NADDI, is a non-profit membership organization that works to develop and implement solutions to the problem of prescription drug diversion. NADDI advocates for the responsible use of prescription drugs by people who need them, and at the same time, aggressively works with law enforcement and regulators to pursue those involved in related criminal activity. Our primary focus is training and education for our members, which include law enforcement personnel, regulatory agents, health professionals, health care fraud investigators and pharmaceutical companies.
т7	NATIONAL HEADACHE FOUNDATION www.headaches.org	The National Headache Foundation's mission is "To cure headache, and end its pain and suffering." Its vision is "A World Without Headache." It is the premier educational and informational resource for those with headache, health care providers, and the public. It publishes the quarterly magazine, HeadWise®, and the monthly e-newsletter, NHF News to Know. For information or a list of physicians in a geographical area who treat headache, visit our website or call 1-888-NHF-5552.
T2	NEMA RESEARCH www.nemaresearch.com	Please visit our booth for more information.

ВООТН	ORGANIZATION	DESCRIPTION
425	NEUROMETRIX www.neurometrix.com	Quell TM is sleek lightweight pain relief utilizing NeuroMetrix's patented, wearable intensive nerve stimulation (WINS) technology to provide 100% drug free relief from chronic pain. Designed for people with painful diabetic neuropathy, fibromyalgia, sciatica and osteoarthritis among others, the device provides relief in as little as fifteen minutes and is FDA cleared for use during the day while active and at night while sleeping. NeuroMetrix, the maker of Quell, is a publicly traded (Nasdaq:NURO) medical technology company founded in the labs of MIT and Harvard, that develops wearable technology and neurodiagnostic devices.
342	NOBLE www.noblemedical.com	Noble Medical is a worldwide provider of on-site rapid UA drug testing products. These products include the most comprehensive CLIA WAIVED point of care urinalysis test cup offerings available on the market today. Our staff specializes in assisting the pain management and behavioral heath care agencies nationwide with implementing their medication monitoring drug testing programs. Noble Medical, where our products provide you with "Results You Can Trust."
429	ORCHARD SOFTWARE 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.
т5	OTTO TRADING, INC. www.unimedmassager.com	Please visit our booth for more information.
T11	PACIFIC TOXICOLOGY LABORATORIES www.pactox.com	Pacific Toxicology Labs has recently validated a method to definitively measure Cannabidiol "CBD" in urine and offer it as a part of Medication Monitoring Testing.
347	PAINBRAIN www.mypainbrain.com	A solution to the opiate epidemic. PainBrain is a real-time cognitive assessment & treatment tool enabling doctors to use non-opiate modalities in analyzing and treating patients. Developed by a team of medical doctors with MIT neuroscientists, PainBrain represents a paradigm shift in the assessment and treatment of patients with chronic pain, depression, substance abuse, and anxiety. PainBrain empowers patients to improve & enables your practice to be multi-dimensional, help reduce opiate use, and help your practice. The power of the mind!
405	PAINEDU www.painedu.org	PainEDU is an educational website for healthcare providers looking to learn more about treating chronic pain patients. Visit us and learn more about the PainCAS: Clinical Assessment System, our web-based clinical tool for assessing pain and opioid risk in chronic pain patients. PainCAS includes electronic versions of the SOAPP and COMM, validated tools that assess the likelihood of aberrant drug related behaviors, and helps healthcare professionals better manage their patients' chronic pain through standardized pain and opioid risk assessments, and automatically generated clinician and patient reports. You can learn more about PainCAS and request a product demo on our website.

BOOTH	ORGANIZATION	DESCRIPTION
246	PAIN MEDICINE NEWS www.painmedicinenews.com	Pain Medicine News (PMN), the best-read publication in the United States according to Kantar Media, is mailed 10 times annually to 45,655 pain-treating physicians. The newspaper offers extensive coverage of pain-related presentations at major clinical meetings and feature articles on topics relevant to practicing clinicians. PMN also presents in-depth clinical and educational reviews written by thought leaders, as well as cutting-edge practice management articles.
Т32	PAINPATHWAYS MAGAZINE www.painpathways.org	PainPathways Magazine, available for home and office, provides information and inspiration for people with pain, healthcare providers and caregivers. News on industry leaders, innovative treatments, current research, helpful products, clinical trials, pain survivors, national advocacy and integrative wellness. Free shipping of waiting room copies for medical offices/hospitals. Sold in Barnes & Noble. 8 years serving the pain community. Quarterly print and digital editions. Searchable. Sharable. Continuous, new content on our website.
125	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, anti-depressants, 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.
т13	PATRUMIN INVESTORS www.patrumin.com	Patrumin Investors is a registered investment advisor that specializes in the construction of concentrated U.S. equity portfolios. Key products we manage include: Patrumin U.S. Smallcap Equity Strategy, Patrumin U.S. Multicap Strategy and Patrumin U.S. Dividends Plus+ Strategy. We do not invest in other managers or outside investors. Instead, we research companies and construct our own portfolios that we manage for clients and our employees.
236	PCCA www.pccarx.com	At PCCA, we help practitioners and pharmacists use compounding to create personalized medicine that makes a real difference in patients' lives. Our products give pharmacists innovative tools while our education and support provide pharmacists and practitioners alike with invaluable resources. PCCA works with our member pharmacies to help them deliver compounding therapies for a wide range of conditions encountered in areas such as: pediatrics, women's and men's health, otolaryngology, pain management, dermatology (wound and scar), and palliative care.
102	PERNIX THERAPEUTICS www.pernixtx.com	Pernix Therapeutics is a specialty pharmaceutical business with a focus on acquiring, developing and commercializing prescription drugs primarily for the U.S. market. The Company targets under-served therapeutic areas such as CNS, including neurology and pain management, and has an interest in expanding into additional specialty segments. The Company promotes its branded products to physicians through its two Pernix sales forces and markets its generic portfolio through its wholly owned subsidiaries, Macoven Pharmaceuticals, LLC, and Cypress Pharmaceutical, Inc.

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245	PHARMBLUE www.pharmblue.com	PharmBlue is a national specialty pharmacy that offers a unique integrated approach to accommodate the diverse needs of pain organizations and their patients. PharmBlue offers a range of services that have progressive levels of integration, that is customized to the clinics needs, while improving adherence and overall compliance and outcomes. A few unique services offered though PharmBlue are in-clinic pharmacy, in-clinic medication concierge services, and discrete home delivery services.
241	PHARMACO TECHNOLOGIES www.pharmacotech.com	Please visit our booth for more information.
т8	POSTGRADUATE MEDICINE, TAYLOR & FRANCIS www.informahealthcare.com/pgm www.tandfonline.com/ipgm	Postgraduate Medicine, the rapid peer-reviewed medical journal established in 1916 by Charles Mayo and published for physicians, will be publishing a specific issue on pain management in January 2016. The upcoming pain management issue will cover the latest interventions and therapeutic options for managing both acute and chronic pain, new concepts and breakthroughs, adverse event and drug safety, and issues with abuse of pain medication, with an emphasis on providing clarity for primary care physicians. Postgraduate Medicine will be accepting manuscript submissions for this issue up until the end of October.
Т25	POWER OF PAIN FOUNDATION www.powerofpain.org	The Power of Pain Foundation provides support services to pain patients and caregivers. These Educational, Awareness, Social and Access to Care program address the immediate need of chronic pain patients with nerve conditions such as RSD, CRPS, lyme, lupus, post cancer pain, diabetic neuropathy and 150+ nerve pain diseases, effecting patients around the world.
Т24	PRACTICAL PAIN MANAGEMENT www.practicalpainmanagement.com	Practical Pain Management and PracticalPainManagement.com strive to provipain specialists—clinicians on the front lines of pain—with practical clinical information written by pain experts on a variety of pain topics. We provide real-world clinical insights to help you navigate the latest research in order to bring these benefits to your patients.
145	PROCARE COUNSELING www.procarecounseling.com	Please visit our booth for more information.
448	PROOVE BIOSCIENCES www.proove.com	Proove Bio is The Personalized Pain Medicine Company. Our mission is to change the future of medicine. Based in Southern California, Proove provides physicians with information to improve the selection, dosing, and evaluation o medications.
407	PURDUE MEDICAL INFORMATION www.purduehcp.com	Please visit our booth for more information.
129	PURDUE OADP www.TeamAgainstOpioidAbuse.com	Learn about evolving technologies that are being investigated or used to add abuse-deterrent properties to formulations of opioid medications at the Opioids with Abuse-Deterrent Properties (OADP) booth. Information presente will include 1) a review of the rationale for developing opioid analgesic drug products that deter particular methods of abuse, 2) highlights of the federal strategy to reduce both the prevalence and consequences of opioid analgesic abuse, and 3) information to help locate FDA-approved abuse-deterrence claims within a drug product's label.
309	PURDUE PHARMA L.P. www.purduehcp.com	Purdue Pharma L.P. is well known for its pioneering work on chronic pain, a principal cause of human suffering. The company's leadership and employees are dedicated to providing healthcare professionals, patients and caregivers with effective therapies, and innovative educational resources and tools that support their proper use.

BOOTH	ORGANIZATION	DESCRIPTION
243	QUANTUM ANALYTICS www.LQA.com	Quantum Analytics is a multi-vendor analytical instrumentation vendor, which specializes in cross-platform system integration, training, support, and rent/lease/finance options to offer a turn-key laboratory startup solution for pain management analysis applications.
120	QUEST DIAGNOSTICS www.questdiagnostics.com	Quest Diagnostics, the world's leading provider of diagnostic testing, information and services, offers a comprehensive test menu including toxicology, immunology, endocrinology, oncology, rheumatology and genetics. Beyond our comprehensive menu of laboratory testing services, we offer a variety of resources to help you manage your patients, run your office and stay current with the latest medical advances.
344	RADARS www.radars.org	The RADARS® System is a non-profit public health prescription drug abuse, misuse, and diversion surveillance system that collects timely product and geographically specific data. The RADARS® System has grown since its inception in 2001 and is made up of several surveillance programs each designed to provide different but complementary perspectives on prescription drug abuse in the United States and internationally.
444	RADEAS LABS LLC www.radeas.com	Radeas laboratories is a clinical laboratory and consultation service. What makes us unique is that we provide a comprehensive solution of laboratory services to healthcare providers. By delivering toxicology and hormone testing, wellness panels as well as consulting services, we aim to produce a full scope of medical laboratory services both accurately and efficiently.
250	RXASSURANCE CORP www.rxassurance.com	RxAssurance is a digital prescription optimization company. We use web and smartphone technology to empower patients to share their health information. We collect ePRO data including prescription adherence, effectiveness, side effects and quality of life between visits and transform it into actionable information for better decision-making by providers. Our pain medication management platform, OpiSafe TM , helps doctors and patients better manage the complexity of prescribing opioid medications safely. We perform baseline assessments and risk stratification, generate provider-
		patient agreements, follow patients daily, and track random UAs. We check the PDMP for doctors and create a one-page patient summary screen including all documentation.
451	RXPROLOGIC www.rxprologic.com	A cloud-based decision tool for risk stratification and pain management protocol recommendations.
117	SALIX www.salix.com	For over 20 years, Salix Pharmaceuticals has been committed to providing effective solutions for the management of many chronic and debilitating conditions. Salix currently markets products to U.S. healthcare providers in the areas of gastroenterology, hepatology, colorectal surgery, endocrinology, internal medicine, primary care, infectious disease, allergy/immunology and pediatric urology.
143	SCHUYLER HOUSE www.schuylerhouse.com	SchuyLab is a market leader in the development and implementation of LIS products and services for private and public hospital laboratories, reference laboratories, physicians office laboratories and other laboratory institutions in the United States and other parts of the world, supplying products and services that meet the global market requirements. Working together with our customers, SchuyLab delivers total laboratory information system solutions that not only are innovative and intelligent, but are also focused at local level on a global basis.

BOOTH	ORGANIZATION	DESCRIPTION
433	SCIEX www.sciex.com	SCIEX helps to improve the world by enabling scientists and laboratory analysts to find answers to the 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 technology to clinical testing laboratories. SCIEX Diagnostics offers an expanding portfolio of mass spectrometry based solutions and assays for in vitro diagnostic use, enabling customers to deliver high-quality results to clinicians who make decisions affecting patient care.
137	SI-BONE www.si-bone.com	SI-BONE, Inc. is the leading sacroiliac (SI) joint medical device company dedicated to the development of tools for diagnosing and treating patients with low back issues related to SI joint disorders. The company is manufacturing and marketing a minimally invasive surgical (MIS) technique for the treatment of SI joint pathology.
242	SURGILOGIX www.surgilogix.com	SurgiLogix is a leading provider of regenerative amniotic human allograft tissue. Through our commitment to bringing innovation and regenerative medicine together we support surgeons and physicians in their efforts to accelerate healing, reduce inflammation and pain, and improve outcomes for their patients. Focusing on delivering only chorion-free products that are processed in AATB accredited facilities, and providing hands-on support and dependable product delivery ensures Surgilogix remains the premier provider of human allograft products. Surgilogix's range of products are applicable for a variety of specialties including sports medicine, orthopedics, spine and musculoskeletal medicine, urology and wound care.
т35	TAKE COURAGE COACHING www.takecouragecoaching.com	Take Courage Coaching TM is a telephonic pain coaching service dedicated to helping those in chronic pain. Living alone with chronic pain can be disheartening; some guidance and support make all the difference between languishing and thriving. Patients may be referred by healthcare professionals and case workers.
317	TAKEDA PHARMACEUTICALS www.takeda.us	Based in Deerfield, Illinois, Takeda Pharmaceuticals U.S.A, Inc., and Takeda Global Research & Development Center, Inc., market oral diabetes, insomnia, rheumatology and gastroenterology treatments and seek to bring innovative products to patients through a pipeline that includes compounds in development for diabetes, cardiovascular disease, gastroenterology and neurology.
432	TECHNEAL www.techneal.com	TechNeal is a laboratory management, consulting, and distribution company with key interests in toxicology and genomics. We have pioneered a turnkey solution for many start up laboratories and an a la carte version for many established laboratories. Just to name a few of the services our programs provide are: staffing, regulatory affairs, administration, workflow, financial analysis, application submission, and product selection. We have helped laboratories across the globe create an extensive menu with minimal costs and a great increase in revenue.
101	TEVA www.tevapharm.com	Teva Pharmaceuticals is a leading global pharmaceutical company with a focus in pain care. With a diverse portfolio and pipeline of products to help advance treatments in pain management, Teva is committed to supporting responsible pain care that meets the needs of people living with pain as well as healthcare professionals.
338	THERMO FISHER SCIENTIFIC www.thermofisher.com	Capitol Vial manufactures and sells drugs of abuse collection kits for urine, hair, saliva and blood. Our transport vials feature a unique patented twin valve design that provides a robust, leak resistant seal. We also offer a state of the art automatic aliquoting instrument for high volume labs. Please stop by our booth to see our solutions to your collection needs.

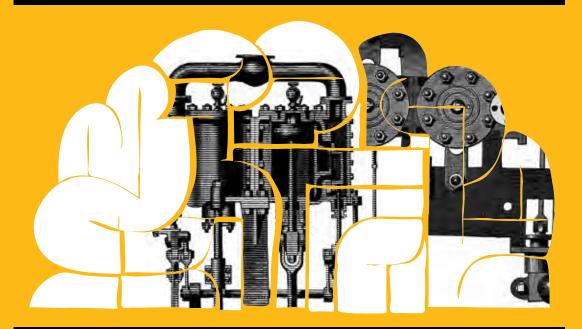
BOOTH	ORGANIZATION	DESCRIPTION
336	THERMO SCIENTIFIC www.thermoscientific.com	Look to Thermo Scientific for continuous innovation in clinical research solutions, including mass spectrometry, chromatography, automated online sample preparation, multiplexing, software and consumables. Whether your lab is large or small. Whether your need is to analyze small molecules or proteins. We have the expertise, products and flexibility to supply the right answer.
T20	U.S. PAIN FOUNDATION www.uspainfoundation.org	Please visit our booth for more information.
423	WATERS CORP www.waters.com	Waters Corporation creates business advantages for laboratory-dependent organizations by delivering scientific innovation to enable customers to make significant advancements. Waters helps clinical customers perform routine, high capacity testing, optimize laboratory operations and ensure regulatory compliance with a connected portfolio of separations and analytical science, laboratory informatics and mass spectrometry.
Т23	WOLTERS KLUWER HEALTH www.lww.com	Please visit our booth for more information.
401	XENOPORT www.xenoport.com	XenoPort, Inc., is a biopharmaceutical company focused on developing and commercializing a portfolio of internally discovered product candidates for the potential treatment of neurological disorders. XenoPort is currently commercializing HORIZANT® (gabapentin enacarbil) Extended-Release Tablets in the United States and developing its novel fumaric acid ester product candidate, XP23829, as a potential treatment for patients with moderate-to-severe chronic plaque-type psoriasis and/or relapsing forms of Multiple Sclerosis. REGNITE® (gabapentin enacarbil) Extended-Release Tablets is being marketed in Japan by Astellas Pharma Inc. XenoPort recently granted exclusive world-wide rights for the development and commercialization of its clinical-stage oral product candidate, arbaclofen placarbil, to Reckitt Benckiser Pharmaceuticals, Inc., for all indications. XenoPort's pipeline of product candidates also includes a potential treatment for patients with Parkinson's disease.
251	XPRESS LABORATORIES www.xpresslaboratories.com	Xpress Laboratories, located in the heart of Dallas, Texas, is a forward-thinking clinical laboratory. We empower physicians by delivering accurate, personalized, and revolutionary results in areas of pharmacogenomics, toxicology, women's health, and preventative cancer. Now, physicians are provided with an unmatched insight into the individual. Such insight is driving continued development in and customization of patient care, leading to improved patient outcome. Xpress Laboratories responds to the ever-changing needs of the medical community by remaining at the forefront of technological and scientific advancements.

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WHERE DOES IT HURT?

GRALISE® (gabapentin) tablets

BRIEF SUMMARY: For full prescribing information, see package insert.

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.

DOSAGE AND ADMINISTRATION

- Postherpetic neuralgia
 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 split, crush, or chew the tablets.
- If GRALISE dose is reduced, discontinued, or substituted with an alternative medication, this should be done gradually over a minimum of one 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 or in patients on hemodialysis.
- In adults with postherpetic neuralgia, GRALISE therapy should be initiated and titrated as follows:

Table 1 GRALISE Recommended Titration Schedule

	Day 1	Day 2	Days 3-6	Days 7-10	Days 11-14	Day 15	
Daily dose	300 mg	600 mg	900 mg	1200 mg	1500 mg	1800 mg	
CONTRAINDICATIONS							

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

Table 2 GRALISE Dosage Based on Renal Function

1	Once-da	aily	dosing

Creatinine clearance (mL/min) GRALISE dose (once daily with evening meal)

1800 mg 30-60

600 mg to 1800 mg GRALISE should not be administered Patients receiving hemodialysis GRALISE should not be administered

WARNINGS AND PRECAUTIONS

WARKINGS 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.

Table 3 Risk by Indication for Antiepileptic Drugs (including gabapentin, the active ingredient in Gralise) in the Pooled Analysis

Indication	Epilepsy	Psychiatric	Other	Total	
Placebo patients with events per 1000 patients	1.0	5.7	1.0	2.4	
Drug patients with events per 1000 patients	3.4	8.5	1.8	4.3	
Relative risk: incidence of events in drug patients/incidence in placebo patients	3.5	1.5	1.9	1.8	
Risk difference: additional drug patients with events per 1000 patients	2.4	2.9	0.9	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. 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 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 rhoughts 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 a week or longer (at the discretion of the prescriber). Tumorigenic Potential In standard precial 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 preexisting 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)/ 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. A total of 359 patients with neuropathic pain associated with postherpetic neuralgia have received GRALISE at doses up to 1800 mg daily during placebo-controlled clinical studies. 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. Of GRALISE-treated patients who experienced adverse reactions in clinical studies, the majority of those adverse reactions were either "mild" or "moderate". Table 4 lists all adverse reactions, regardless of causality, occurring in at least 1% of patients with neuropathic pain associated with postherpetic neuralgia in the GRALISE group for which the incidence was greater than

Table 4 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
Dealchain	17	4.4

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
In addition to the adverse reactions rep GRALISE were reported during the cli		

th an uncertain relationship to ılgia. 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 hypertrophy, erythema multiforme, elevated liver function tests, 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

Coadministration of gabapentin immediate release (125 mg and 500 mg) and hydrocodone (10 mg) reduced hydrocodone (20 mg) 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 this interaction at other doses not known. When a single dose (60 mg) of controlled-release morphine capsule was administered 2 hours prior to a single dose (600 mg) of gabapentin immediate release in 12 volunteers, mean gabapentin AUC values increased by 44% compared to gabapentin immediate release administered without morphine. The pharmacokinetics of morphine were not affected by administration of gabapentin immediate release 2 hours after morphine. The magnitude of this interaction at other doses is not known. An organization containing aluminum hydroxide and magnesium hydroxide reduced the bioavailability of gabapentin immediate release by about approximately 20%, but by only 5% when gabapentin was taken 2 hours after antacids. It is recommended that GRALISE be taken at least 2 hours following antacid administration. There are no pharmacokinetic interactions between gabapentin and the following antiepileptic drugs: phenytoin, carbamazepine, valproic acid, phenobarbital, and naproxen. Cimetidine 300 mg decreased the apparent oral clearance of gabapentin by 14% and creatinine clearance by 10%. The effect of gabapentin immediate release on cimetidine was not evaluated. This decrease is not expected to be clinically significant. Gabapentin immediate release (400 mg three times daily) had no effect on the pharmacokinetics of norethindrone (2.5 mg) or ethinyl estradiol (50 mcg) administered as a single tablet, except that the C on rorethindrone was increased by 13%. This interaction is not considered to be clinically significant. Gabapentin immediate release pharmacokinetic parameters were comparable with and without probenecid, indicating that gabapentin does not undergo renal tubular secretion by the pathway that is blocked by probenecid.

USE IN SPECIFIC POPULATIONS

Pregnancy Pregnancy Category C: Gabapentin has been shown to be fetotoxic in rodents, causing delayed ossification of several bones in the skull, vertebrae, forelimbs, and hindlimbs. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. To provide information regarding the effects of *in utero* exposure to GRALISE, physicians are advised to recommend that pregnant patients taking GRALISE enroll in the North American Antiepileptic Drug (NAAED) Pregnancy Registry. This can be done by calling the toll free number 1-888-233-2334, and must be done by calling the toll free number 1-888-233-2334. and must be done by calling the solution on the registry can also be found at the website http://www.aedpregnancyregistry.org/. **Nursing Mothers** Gabapentin is secreted into human milk following oral administration. A nursed infant could be exposed to a maximum dose of approximately 1 mg/kg/day of gabapentin. Because the effect on the nursing infant is unknown, GRALISE should be used in women who are nursing only if the benefits clearly outweigh the risks. **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 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. GRALISE is known to be substantially excreted by the kidney. Reductions in GRALISE does should be made in patients with age-related compromised renal function. [see Dosage and Administration]. Hepatic Impairment Because gabapentin is not metabolized, studies have not been conducted in patients with hepatic impairment. 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 administrated in patients with CrCL between 15 and 30 or in patients undergoing hemodialysis [see Dosage and Administration].

DRUG ABUSE AND DEPENDENCE

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

OVERDOSAGE

A lethal dose of gabapentin was not identified in mice and rats receiving single oral doses as high as 8000 mg/kg. Signs of acute toxicity in animals included ataxia, labored breathing, ptosis, sedation, hypoactivity, or excitations. Acute oral overdoses of gabapentin immediate release in humans up to 49 grams have been repet. In these sass, double vision, sturred 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.

CLINICAL PHARMACOLOGY

Pharmacokinetics <u>Absorption and Bioavallability</u> Gabapentin is absorbed from the proximal small bowel by a saturable L-amino transport system. Gabapentin bioavailability is not dose proportional; as the dose is increased, bioavailability decreases. When GRALISE (1800 mg once daily) and gabapentin immediate release (600 mg three times a day) were administered with high fat meals (50% of calories from fat), GRALISE has a higher C_{ms} and lower AUC at steady state compared to gabapentin immediate release. Time to reach maximum plasma concentration (T_{ms}) for GRALISE is 8 hours, which is about 4-6 hours longer compared to gabapentin immediate release.

NONCLINICAL TOXICOLOGY

Carcinogenesis, Mutagenesis, Impairment of Fertility Gabapentin was given in the diet to mice at 200, 600, and 2000 mg/kg/day and to rats at 250, 1000, and 2000 mg/kg/day for 2 years. A statistically significant increase in the incidence of pancreatic acinar cell adenoma and carcinomas was found in male rats receiving the high dose; the no-effect dose for the occurrence of carcinomas was 1000 mg/kg/day. Peak plasma concentrations of galapentin rats receiving the high dose of 2000 mg/kg/day were more than 10 times higher than plasma concentrations of galapentin rats receiving 1800 mg/kg/day well plasma concentrations in humans receiving 1800 mg/kg/day belasma concentrations were more than 6.5 times higher than in humans receiving 1800 mg/kg/day belasma concentrations were more than 6.5 times higher than in humans receiving 1800 mg/day. The pancreatic acinar cell carcinomas did not affect survival, did not metastasize and were not locally invasive. The relevance of this finding to carcinogenic risk in humans is unclear. Studies designed to investigate the mechanism of gabapentin-induced pancreatic carcinogenesis in rats indicate that gabapentin stimulates DNA synthesis in rat pancreatic acinar cells in vitro and, thus, may be acting as a tumor promoter by enhancing mitogenic activity. It is not known whether gabapentin has the ability to increase cell proliferation in other cell types or in other species, including humans. Gabapentin did not demonstrate mutagenic or genotoxic potential in 3 in vitro and 4 in vivo assays. No adverse effects on fertility or reproduction were observed in rats at doses up to 2000 mg/kg (approximately 11 times the maximum recommended human dose on an mg/m² basis).





GRALISE is indicated for the management of postherpetic neuralgia (PHN).

When your PHN patients face challenges by Night and Day

GRALISE THE NIGHT











- At night, when pain is at its worst¹
- GRALISE is taken with the evening meal
- Side effects that are transient¹
- Dizziness (10.9%) and somnolence (4.5%) were the most common side effects, and declined during the 2-week titration period to reach sustained low levels thereafter

TAKE WITH

EVENING

• In clinical trials, 9.7% of GRALISE patients discontinued prematurely due to adverse reactions versus 6.9% for placebo4



Elderly patients experienced consistent results by Night and Day - even those over 753

• Dosage adjustment of GRALISE is necessary in patients with impaired renal function. GRALISE should not be administered in patients with creatinine clearance <30 mL/min or in patients undergoing hemodialysis. Reductions in GRALISE dose should be made in patients with age-related compromised renal function.

Indication 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 Antiepileptic drugs, including gabapentin, the active ingredient of GRALISE, increase the risk of suicidal thoughts or behavior. Increased seizure frequency may occur in patients with seizure disorders if GRALISE is rapidly discontinued. Withdraw GRALISE gradually over a minimum of 1 week. The most common adverse reaction to GRALISE (≥5% and twice placebo) is dizziness.

Please see adjacent page for Brief Summary of Prescribing Information. Full Prescribing Information and Medication Guide are available at GRALISE.com.

References: 1. 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. 2. Data on file, 2013. Depomed Inc. 3. Gupta A, Li S. Safety and efficacy of once-daily gastroretentive gabapentin in patients with postherpetic neuralgia aged 75 years and over. Drugs Aging. 2013;30:999-1008. 4. GRALISE [prescribing information]. Newark, CA: Depomed Inc.; December 2012.



