CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016

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CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016

• Introduction
• Guideline Development Process
• Recommendations
• Discussion
• Conclusion
Introduction

• The number of people experiencing chronic pain is substantial
• US prevalence estimated at 11.2% of the adult population
• Patients should receive appropriate pain treatment based on a careful consideration of the benefits and risks of treatment options
• Opioids are commonly prescribed for pain, with approximately 3% to 4% of the adult US population prescribed long-term opioid therapy

Fig. 1. Total number of prescriptions dispensed in the U.S. by various specialties for IR and ER/LA opioids in 2009.
Evidence for short term efficacy

• Evidence supports short-term efficacy of opioids in randomized clinical trials lasting < 12 weeks
  • Patients receiving opioid therapy for chronic pain report some pain relief when surveyed

• Few studies have been conducted to assess the long-term benefits of opioids for chronic pain (pain lasting >3 months) with outcomes examined at least 1 year later

Patients with Chronic Non-Cancer Pain

INITIAL STEPS
- Comprehensive assessment
- Assessment of risk of misuse
- Screening tests (optional)
- Inquiry of prescription monitoring programs
- Baseline urine drug testing

DIAGNOSIS
- X-rays, MRI, CT, neurophysiologic studies
- Psychological evaluation (basic)
- Precision diagnostic interventions (optional)
- Consultation(s) as needed

MEDICAL NECESSITY
- Physical diagnosis
- Non-controlled substance therapy
- Physical modalities
- Behavioral interventions (optional)
- Interventional pain management (optional)
- Other alternatives
- Consultation(s) as needed

TREATMENT GOALS
- Decrease pain by 30% and/or increase function by 30%
- Minimal adverse effects

Assess effectiveness of opioid therapy

INFORMED DECISION-MAKING
- Controlled substance agreement
- Random evaluations including pill counts and urine drug testing

INITIAL TREATMENT (8-12 WEEKS)
- Stratification of risk
- Understanding opioids
- Initiation with low dose short-acting opioid therapy
- Titrage

ADHERENCE MONITORING
- Prescription drug monitoring programs
- Urine drug testing (follow urine drug testing algorithm)
- Pill counts
- Behavioral assessment during each visit

SIDE EFFECTS
- Driving
- Sedation
- Constipation
- Breathing

DISCONTINUE
- Persistent or new pain
- Abuse, misuse
- Lack of analgesia
- Lack of activity
- Adverse effects
- Abnormal behavior
- Taper and discontinue
- Repeat comprehensive evaluation
- Consider consultation

CONTINUE
- Analgesia of 30% and/or activity increase by 30%
- No misuse, abuse, adverse effects (manageable)
- Continue monitoring
- Wean, discharge, or maintain

Fig. 2. Guidance to opioid therapy.

Risks Associated with Opioid

- Opioid pain medication use presents serious risks
- From 1999 to 2014, more than 165,000 persons died of overdose related to opioid pain medication in the United States
- In 2013, an estimated 1.9 million persons abused or were dependent on prescription opioid pain

Fig. 4. Percentage of patients and prescription drug overdoses, by risk group – United States.

The evidence review focused on 5 key questions:

- Determining when to initiate or continue opioids for chronic pain,
- Opioid selection, dosage, duration, follow-up, and discontinuation,
- Assessing risk and addressing harms of opioid use

Resulted in 12 recommendations in 3 areas:

Key Question 1. Effectiveness and Comparative Effectiveness

- In patients with chronic pain, what is the effectiveness of long-term (≥1 year) opioid therapy vs. placebo or no opioid therapy for long-term (≥1 year) outcomes related to pain, function, and quality of life.
- How does effectiveness vary depending on: (1) the specific type or cause of pain (e.g., neuropathic, muscularkeletal including low back pain), fibromyalgia, sickle cell disease, inflammatory pain, and headache disorders); (2) patient demographics (e.g., age, race, ethnicity, gender); and (3) patient comorbidities including past or current alcohol or substance use disorders, mental health disorders, medical comorbidities, and high risk for addiction.
- In patients with chronic pain, what is the comparative effectiveness of opioids vs. nonopioid therapies (pharmacologic or nonpharmacologic) on outcomes related to pain, function, quality of life, and doses of opioids used.

Key Question 2. Harms and Adverse Events

- In patients with chronic pain, what are the risks of opioids vs. placebo or no opioid on (1) opioid, abuse, addiction, and related outcomes; (2) overdose and (3) other harms, including gastrointestinal-related harms, falls, fractures, motor vehicle crashes, endocrine/obesity, infections, cardiovascular events, cognitive harms, and psychological harms (e.g., depression).
- How do harms vary depending on: (1) the specific type or cause of pain (e.g., neuropathic, muscularkeletal including low back pain), fibromyalgia, sickle cell disease, inflammatory pain, and headache disorders); (2) patient demographics; (3) patient comorbidities (including past or current substance use disorder or high risk for addiction); and (4) the dose of opioids used.

Key Question 3. Dosing Strategies

- In patients with chronic pain, what is the comparative effectiveness of different methods for starting and titrating opioids on outcomes related to pain, function, and quality of life, risk of overdose, addiction, abuse, misuse, and doses of opioids used.
- In patients with chronic pain, what is the comparative effectiveness of immediate-release vs. extended-release long-acting (ER/LA) opioids on outcomes related to pain, function, and quality of life, risk of overdose, addiction, abuse, misuse, and doses of opioids used.
- In patients with chronic pain, what is the comparative effectiveness of different ER/LA opioids on outcomes related to pain, function, and quality of life and risk of overdose, addiction, abuse, or misuse.
- In patients with chronic pain, what is the comparative effectiveness of immediate-release or ER/LA opioids alone on outcomes related to pain, function, and quality of life risk of overdose, addiction, abuse, or misuse, and doses of opioids used.

Key Question 4. Risk Assessment and Risk Mitigation Strategies

- In patients with chronic pain being considered for long-term opioid therapy, what is the accuracy of instruments for predicting risk of opioid overdose, addiction, abuse, or misuse.
- In patients with chronic pain, what is the effectiveness of use of risk-prediction instruments on outcomes related to overdose, addiction, abuse, or misuse.
- In patients with chronic pain prescribed long-term opioid therapy, what is the effectiveness of risk mitigation strategies, including (1) opioid management plans, (2) patient education, (3) urine drug screening, (4) use of prescription drug monitoring program data, (5) use of monitoring instruments, (6) more frequent monitoring intervals, (7) pill counts, and (8) usual abuse deterrent formulations on outcomes related to overdose, addiction, abuse, or misuse.
- What is the comparative effectiveness of treatment strategies for managing patients with addiction to prescription opioids on outcomes related to overdose, abuse, misuse, pain, function, and quality of life.

Key Question 5. Effect of Opioid Therapy for Acute Pain on Long-term Use

- In patients with acute pain, what are the effects of prescribing opioid therapy vs. not prescribing opioid therapy for acute pain on long-term opioid use.

Box 2: Key Questions for the Clinical Evidence Review

CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016

• Intended for primary care clinicians treating patients with chronic pain
  • pain conditions that typically last >3 months or past the time of normal tissue healing in outpatient settings

• May be applied to patients > 18 years with chronic pain (outside of active cancer treatment, palliative care, and end-of-life care)

• Intended to:
  • Improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain
  • Improve the safety and effectiveness of pain treatment
  • Reduce the risks associated with long-term opioid therapy

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• CDC used the CDC Advisory Committee on Immunization Practices (ACIP) translation of the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) method for guideline development

• Within the ACIP GRADE framework, the quality of a body of evidence was graded, and the recommendations were developed and placed into categories (A or B) based on the quality of evidence, balance of benefits and harms, values and preferences, and resource allocation.
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• **Recommendations**
• Discussion
• Conclusion
The guideline includes 12 recommendations:

<table>
<thead>
<tr>
<th>Box 5. Centers for Disease Control and Prevention Recommendations for Prescribing Opioids for Chronic Pain Outside of Active Cancer, Palliative, and End-of-Life Care</th>
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<tbody>
<tr>
<td><strong>Determining When to Initiate or Continue Opioids for Chronic Pain</strong></td>
</tr>
<tr>
<td>1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.</td>
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<td>2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.</td>
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<td>3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.</td>
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<tr>
<td><strong>Opioid Selection, Dosage, Duration, Follow-up, and Discontinuation</strong></td>
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<td>4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.</td>
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<td>5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to 50 morphine milligram equivalents (MME) or more per day, and should avoid increasing dosage to 90 MME or more per day or carefully justify a decision to titrate dosage to 90 MME or more per day.</td>
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<td>6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than 7 days will rarely be needed.</td>
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<td>7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.</td>
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<td><strong>Assessing Risk and Addressing Harms of Opioid Use</strong></td>
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<td>8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/d), or concurrent benzodiazepine use are present.</td>
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<td>9. Clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.</td>
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<td>10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.</td>
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<td>11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.</td>
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<td>12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.</td>
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All recommendations are category A (apply to all patients outside of active cancer treatment, palliative care, and end-of-life care) except recommendation 10 (designated category B, with individual decision making required); detailed ratings of the evidence supporting the recommendations are provided in the full guideline publication.7

“1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate. (Recommendation category: A; evidence type: 3)”

- Exercise therapy and CBT should be used to reduce pain and improve function in patients with chronic pain
- Can be used when there is limited access to specialty care.
- Proven short-term benefits and low risk
- If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate, to provide greater benefits to patients

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety. (Recommendation category: A; evidence type: 4)

- Determine how effectiveness will be evaluated
- Establish treatment goals
  - Should include improvement in both pain relief and function (dependent on clinical circumstances)
  - Function can include emotional and social as well as physical dimensions
  - Clinicians may use validated instruments such as the 3-item “Pain average, interference with Enjoyment of life, and interference with General activity” (PEG) Assessment Scale to track patient outcomes
    - Clinically meaningful improvement defined as a 30% improvement in scores for both pain

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy. (Recommendation category: A; evidence type: 3)

- Clinicians should ensure that patients are aware of potential benefits of, harms of, and alternatives to opioids before starting or continuing opioid therapy
- Important considerations include the following:
  - Be explicit and realistic about expected benefits of opioids
  - Emphasize improvement in function as a primary goal and that function can improve even when pain is still present
  - Advise patients about serious adverse effects of opioids
  - Advise patients about common effects of opioids
  - Discuss effects that opioids may have on ability to safely operate a vehicle
  - Discuss increased risks for opioid use disorder, respiratory depression, and death at higher dosages, along with the importance of taking only the amount of opioids prescribed

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy. (Recommendation category: A; evidence type: 3)

- Review increased risks for respiratory depression when opioids are taken with benzodiazepines, other sedatives, alcohol, illicit drugs such as heroin, or other opioids.
- Discuss risks to household members and other individuals
- Discuss the importance of periodic reassessment to ensure opioids are helping to meet patient goals and to allow opportunities for opioid discontinuation
- Discuss planned use of precautions to reduce risks, including use of PDMP information and urine drug testing. Consider including discussion of naloxone use for overdose reversal.
- Consider whether cognitive limitations might interfere with management of opioid therapy (for older adults in particular)
4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids. (Recommendation category: A; evidence type: 4)

- When an ER/LA opioid is prescribed, using a product with predictable pharmacokinetics and pharmacodynamics is preferred to minimize unintentional overdose risk
- Methadone - should not be the first choice for an ER/LA opioid
  - Only clinicians who are familiar with methadone’s unique risk profile and who are prepared to educate and closely monitor their should consider prescribing methadone for pain.
- Transdermal fentanyl- only clinicians who are familiar with the dosing and absorption properties should consider prescribing it

5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to 50 morphine milligram equivalents (MME) or more per day, and should avoid increasing dosage to 90 MME or more per day or carefully justify a decision to titrate dosage to 90 MME or more per day. (Recommendation category: A; evidence type: 3)

- Start opioids at lowest effective dosage
- Use caution when increasing opioid dosages
- Increase dosage by the smallest practical amount
  - If dosage reaches or exceeds 50 MME per day, should implement increased frequency of follow-up and considering offering naloxone.
- Avoid increasing opioid dosages to 90 MME or more per day

Opioid-related overdose risk is dose-dependent

- Dosages of 50 to <100 MME per day were found to increase risk for opioid overdose by factors of 1.9 to 4.6
- Dosages of ≥ 100 MME per day were found to increase risk for opioid overdose by factors of 2.0 to 8.9

Box 4. Cautions About Calculating Morphine Milligram Equivalent Doses:

Equianalgesic dose conversions are only estimates and cannot account for individual variability in genetics and pharmacokinetics.

Do not use the calculated dose in morphine milligram equivalents (MME) to determine the doses to use when converting one opioid to another; when converting opioids, the new opioid is typically dosed at substantially lower than the calculated MME dose to avoid accidental overdose due to incomplete cross-tolerance and individual variability in opioid pharmacokinetics.

Use particular caution with methadone dose conversions because the conversion factor increases at higher doses.

Use particular caution with fentanyl because it is dosed in µg/h instead of mg/d, and its absorption is affected by heat and other factors.

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Table 4. Morphine Milligram Equivalent Doses for Commonly Prescribed Opioids

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Conversion Factor</th>
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<tbody>
<tr>
<td>Codeine</td>
<td>0.15</td>
</tr>
<tr>
<td>Fentanyl transdermal, µg/h</td>
<td>2.4</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>1</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>4</td>
</tr>
<tr>
<td>Methadone, mg/d</td>
<td></td>
</tr>
<tr>
<td>1-20</td>
<td>4</td>
</tr>
<tr>
<td>21-40</td>
<td>8</td>
</tr>
<tr>
<td>41-60</td>
<td>10</td>
</tr>
<tr>
<td>≥61-80</td>
<td>12</td>
</tr>
<tr>
<td>Morphine</td>
<td>1</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>1.5</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>3</td>
</tr>
<tr>
<td>Tapentadol</td>
<td>0.4</td>
</tr>
</tbody>
</table>


b All doses are in mg/d except for fentanyl, which is µg/h. Multiply the daily dosage for each opioid by the conversion factor to determine the dose in morphine milligram equivalents (MME). For example, tablets containing hydrocodone, 5 mg, and acetaminophen, 300 mg, taken 4 times a day would contain a total of 20 mg of hydrocodone daily, equivalent to 20 MME daily; extended-release tablets containing oxycodone, 10 mg, and taken twice a day would contain a total of 20 mg of oxycodone daily, equivalent to 30 MME daily.

c Tapentadol is a µ-receptor agonist and norepinephrine reuptake inhibitor. Morphine milligram equivalents are based on degree of µ-receptor agonist activity, but it is unknown if this drug is associated with overdose in the same dose-dependent manner as observed with medications that are solely µ-receptor agonists.

6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than 7 days will rarely be needed. (Recommendation category: A; evidence type: 4)

- Acute pain can often be managed without opioids
- Prescribe no greater quantity than needed for the expected duration of pain
  - Often 3 days or less
  - More than 7 days will rarely be needed
- Should not prescribe additional opioids to patients “just in case” pain continues longer than expected
- Should not prescribe ER/LA opioids for the treatment of acute pain

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids. (Recommendation category: A; evidence type: 4)

- Consider lower follow-up intervals when ER/LA opioids are started or increased (when total daily opioid dosage is ≥ 50 MME per day)
- Regularly reassess all patients receiving long-term opioid therapy, at least every 3 months
  - Reevaluate patients exposed to greater risk of opioid use disorder or overdose more frequently
- Clinicians should work with patients to reduce opioid dosage or to discontinue opioids when possible if clinically meaningful improvements in pain and function are not sustained
  - When opioids are reduced or discontinued, a taper slow enough to minimize symptoms and signs of opioid withdrawal should be used
  - A decrease of 10% of the original dose per week is a reasonable starting point
  - Slower tapers (ex. 10% per month) might be appropriate and better tolerated, particularly when patients have been taking opioids for years.
8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/d), or concurrent benzodiazepine use, are present. (Recommendation category: A; evidence type: 4)

- Careful consideration of risks and benefits should be taken in the following patients:
  - Patients with moderate or severe sleep-disordered breathing
  - Pregnant patients
    - Arrange for delivery at a facility prepared to evaluate and treat neonatal opioid withdrawal syndrome
  - Patients with renal or hepatic insufficiency
  - Patients ≥ 65 years
  - Patients with anxiety or depression

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/d), or concurrent benzodiazepine use, are present. (Recommendation category: A; evidence type: 4) Continued...

- Consider offering naloxone when prescribing opioids to patients:
  - At increased risk of overdose, including patients with a history of overdose
  - With a history of substance use disorder
  - Taking benzodiazepines with opioids
  - At risk of returning to a high dose to which they are no longer tolerant (eg, patients recently released from prison)
  - Taking higher dosages of opioids (≥50 MME/d)

9. Clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months. (Recommendation category: A; evidence type: 4)

- Ideally, PDMP data should be reviewed before every opioid prescription
- If patients are found to have high opioid dosages, dangerous combinations of medications, or multiple controlled substance prescriptions written by different clinicians, several actions can be taken to augment clinicians’ abilities to improve patient safety:
  - Clinicians should discuss information from the PDMP with their patient and confirm that the patient is aware of the additional prescriptions.
  - Clinicians should discuss safety concerns, including increased risk for respiratory depression and overdose, with patients found to be receiving opioids from more than 1 prescriber or receiving medications that increase risk when combined with opioids (eg, benzodiazepines).
  - Clinicians should avoid prescribing opioids and benzodiazepines concurrently whenever possible. Clinicians should communicate with others managing the patient to discuss the patient’s needs, prioritize patient goals, weigh risks of concurrent benzodiazepine and opioid exposure, and coordinate care.
  - Clinicians should calculate the total MME/d for concurrent opioid prescriptions. If patients are found to be receiving high total daily dosages of opioids, clinicians should discuss their safety concerns with the patient, consider tapering to a safer dosage, and consider offering naloxone.
  - Clinicians should discuss safety concerns with other clinicians who are prescribing controlled substances for their patient.
  - Clinicians should consider the possibility of a substance use disorder and discuss concerns with their patient.
  - If clinicians suspect their patient might be sharing or selling opioids and not taking them, clinicians should consider urine drug testing to assist in determining whether opioids can be discontinued without causing withdrawal. A negative drug test for prescribed opioids might indicate the patient is not taking prescribed opioids, although clinicians should consider other possible reasons for this test result.
  - Clinicians should not dismiss patients from their practice on the basis of PDMP information. Doing so could result in missed opportunities to provide potentially lifesaving information and interventions.

10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs. (Recommendation category: B; evidence type: 4)

• In most situations, initial urine drug testing can be performed with a relatively inexpensive immunoassay panel for commonly prescribed opioids and illicit drugs.
  • Patients prescribed less commonly used opioids might require specific testing for those agents.
  • Clinicians should be familiar with the drugs included in urine drug testing understand how to interpret results
  • Before ordering urine drug testing, clinicians should explain to patients that testing is intended to improve their safety
  • Clinicians should discuss unexpected results with the local laboratory or toxicologist and with the patient.
  • Clinicians should not dismiss patients from care based on a urine drug test result.

11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible. (Recommendation category: A; evidence type: 3)

• Should avoid prescribing opioids and benzodiazepines concurrently whenever possible.
  • Certain circumstances when it might be appropriate to prescribe opioids to a patient receiving benzodiazepines
    • severe acute pain in a patient taking long-term, stable low-dose benzodiazepine therapy

• Check the PDMP for concurrent controlled medications prescribed by other clinicians

• Consider involving pharmacists and pain specialists as part of the management team when opioids are co-prescribed with other CNS depressants

• When tapering of benzodiazepines or opioids to reduce risk of fatal respiratory depression, might be safer/more practical to taper opioids first
  • Taper benzodiazepines gradually because abrupt withdrawal can be associated with rebound anxiety, hallucinations, seizures, delirium tremens, and, in rare cases, death

12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder. (Recommendation category: A; evidence type: 2)

- If clinicians suspect opioid use disorder, they should discuss their concerns with their patient and provide an opportunity for the patient to disclose related concerns or problems
- Clinicians should assess for opioid use disorder using DSM-5 criteria
- Clinicians should offer or arrange for patients with opioid use disorder to receive evidence-based treatment
  - Oral or long-acting injectable naltrexone can also be used in nonpregnant adults
  - For pregnant women with opioid use disorder, medication-assisted therapy with buprenorphine or methadone has been associated with improved maternal outcomes
- Clinicians unable to provide treatment themselves should arrange for patients with opioid use disorder to receive care from a substance use disorder treatment specialist

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Discussion / Take Home Points

• Nonopioid therapy is preferred for treatment of chronic pain
• Opioids should be used only when benefits for pain and function are expected to outweigh risks
• Before starting opioids, clinicians should establish treatment goals with patients
• When opioids are used, clinicians should prescribe the lowest effective dosage
  • Carefully reassess benefits and risks when considering increasing dosage to 50 MME or more per day
  • Avoid concurrent opioids and benzodiazepines whenever possible
  • Evaluate benefits and harms of continued opioid therapy with patients every 3 months
  • For patients with opioid use disorder, offer /arrange evidence-based treatment, such as medication-assisted treatment with buprenorphine or methadone.
Clinical Tools


http://www.cdc.gov/drugoverdose/prescribing/resources.html
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Conclusion

• The guideline is intended to:
  • improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain,
  • improve the safety and effectiveness of pain treatment,
  • reduce the risks associated with long-term opioid therapy
    • opioid use disorder, overdose, death
References


