PRESCRIBING OPIOIDS FOR CHRONIC PAIN

ADAPTED FROM CDC GUIDELINE

Opioids can provide short-term benefits for moderate to severe pain. Scientific evidence is lacking for the benefits to treat chronic pain.

IN GENERAL, DO NOT PRESCRIBE OPIOIDS AS THE FIRST-LINE TREATMENT FOR CHRONIC PAIN (for adults 18+ with chronic pain > 3 months excluding active cancer, palliative, or end-of-life care).

BEFORE PRESCRIBING

1. ASSESS PAIN & FUNCTION
   Use a validated pain scale. Example: PEG scale where the score = average 3 individual question scores (30% improvement from baseline is clinically meaningful).
   Q1: What number from 0 – 10 best describes your PAIN in the past week? (0 = "no pain", 10 = "worst you can imagine")
   Q2: What number from 0 – 10 describes how, during the past week, pain has interfered with your ENJOYMENT OF LIFE? (0 = “not at all”, 10 = “complete interference”)
   Q3: What number from 0 – 10 describes how, during the past week, pain has interfered with your GENERAL ACTIVITY? (0 = “not at all”, 10 = “complete interference”)

2. CONSIDER IF NON-OPIOID THERAPIES ARE APPROPRIATE
   Such as: NSAIDs, TCAs, SNRIs, anti-convulsants, exercise or physical therapy, cognitive behavioral therapy.

3. TALK TO PATIENTS ABOUT TREATMENT PLAN
   • Set realistic goals for pain and function based on diagnosis.
   • Discuss benefits, side effects, and risks (e.g., addiction, overdose).
   • Set criteria for stopping or continuing opioid. Set criteria for regular progress assessment.
   • Check patient understanding about treatment plan.

4. EVALUATE RISK OF HARM OR MISUSE. CHECK:
   • Known risk factors: illegal drug use; prescription drug use for nonmedical reasons; history of substance use disorder or overdose; mental health conditions; sleep-disordered breathing.
   • Prescription drug monitoring program data (if available) for opioids or benzodiazepines from other sources.
   • Urine drug screen to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.
   • Medication interactions. AVOID CONCURRENT OPIOID AND BENZODIAZEPINE USE WHENEVER POSSIBLE.

WHEN YOU PRESCRIBE

START LOW AND GO SLOW. IN GENERAL:
• Start with immediate-release (IR) opioids at the lowest dose for the shortest therapeutic duration. IR opioids are recommended over ER/LA products when starting opioids.
• Avoid ≥ 90 MME/day; consider specialist to support management of higher doses.
• If prescribing ≥ 50 MME/day, increase follow-up frequency; consider offering naloxone for overdose risk.
• For acute pain: prescribe < 3 day supply; more than 7 days will rarely be required.
• Counsel patients about safe storage and disposal of unused opioids.
The Office of the Surgeon General

See below for MME comparisons. For MME conversion factors and calculator, go to TurnTheTideRx.org/treatment.

**50 MORPHINE MILLIGRAM EQUIVALENTS (MME)/DAY:**
- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15mg)

**90 MORPHINE MILLIGRAM EQUIVALENTS (MME)/DAY:**
- 90 mg of hydrocodone (18 tablets of hydrocodone/acetaminophen 5/300)
- 60 mg of oxycodone (4 tablets of oxycodone sustained-release 15mg)

### AFTER INITIATION OF OPIOID THERAPY

**ASSESS, TAILOR & TAPER**
- Reassess benefits/risks within 1-4 weeks after initial assessment.
- Assess pain and function and compare results to baseline. Schedule reassessment at regular intervals (≤ 3 months).
- Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- If over-sedation or overdose risk, then taper. Example taper plan: 10% decrease in original dose per week or month. Consider psychosocial support.
- Tailor taper rates individually to patients and monitor for withdrawal symptoms.

### TREATING OVERDOSE & ADDICTION

- Screen for opioid use disorder (e.g., difficulty controlling use; see DSM-5 criteria). If yes, treat with medication-assisted treatment (MAT). MAT combines behavioral therapy with medications like methadone, buprenorphine, and naltrexone. Refer to findtreatment.samhsa.gov. Additional resources at TurnTheTideRx.org/treatment and www.hhs.gov/opioids.

- Learn about medication-assisted treatment (MAT) and apply to be a MAT provider at www.samhsa.gov/medication-assisted-treatment.
- Consider offering naloxone if high risk for overdose: history of overdose or substance use disorder, higher opioid dosage (≥ 50 MME/day), concurrent benzodiazepine use.

### ADDITIONAL RESOURCES

**CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN:**
www.cdc.gov/drugoverdose/prescribing/guideline.html

**SAMHSA POCKET GUIDE FOR MEDICATION-ASSISTED TREATMENT (MAT):**
store.samhsa.gov/MATguide

**NIDAMED:**
www.drugabuse.gov/nidamed-medical-health-professionals

**ENROLL IN MEDICARE:**
go.cms.gov/pecos
Most prescribers will be required to enroll or validly opt out of Medicare for their prescriptions for Medicare patients to be covered. Delay may prevent patient access to medications.

**JOIN THE MOVEMENT**

of health care practitioners committed to ending the opioid crisis at TurnTheTideRx.org.