



## OPIOID PRESCRIBING GUIDELINES

Opioid prescriptions are increasing in the United States. In 2012, more than 259 million prescriptions for opioids were written. In addition, opioid prescriptions per capita increased from 7.3% from 2007 to 2012. Rates of prescriptions increased more for family practice, general practice, and internal medicine practitioners compared to other specialists. The rates of opioid prescribing varies greatly across states and cannot be explained by the health conditions of the patients. Pain may be undertreated in certain patients, especially in racial and ethnic minority groups, women, the elderly, persons with cognitive impairment, and those with cancer and at the end of life. This issue of *CLIPs* provides a review of the Centers for Disease Control's current recommendations for prescribing opioids for chronic pain. If you need further information, please contact the Center for Healthcare Innovation and Patient Outcomes Research (CHIPOR) at [CHIPOR@samford.edu](mailto:CHIPOR@samford.edu).

**Frieden TR, Jaffe HW, Cono J, Richards CL, Iademaro MF. CDC Guideline for prescribing opioids for chronic pain-United States, 2016. *MMWR Recomm Rep.* 2016;65 (No. 1):1-49.**

### Chronic Pain

- Chronic pain is defined as pain that lasts > 3 months or past the time of normal tissue healing.
- The number of patients experiencing chronic pain is increasing.
- According to a recent survey, approximately 43% of adults in the US experienced musculoskeletal pain (e.g., arthritis, rheumatism, chronic back or neck problems, and frequent severe headaches).

### Opioid use

- From 1999 to 2014, more than 165,000 persons died from overdose related to opioid pain medication in the United States.
- Opioid use and sales of opioid medications have increased at a paralleled rate.

### Guideline focus

- The purpose of this guideline is to provide recommendations for prescribing opioid pain medications by primary care clinicians for chronic pain in outpatient settings (not including active cancer treatment, palliative care, and end-of-life care).
- Recommendations are based on systematic review of the best evidence.

**Table 1: CDC Recommendations for Prescribing Opioids**

#### **Determining When to Initiate or Continue Opioids for Chronic Pain**

1. Consider nonpharmacologic or non-opioid therapy for chronic pain. Consider opioids only if benefits outweigh risks.
2. Establish treatment goals prior to the initiation of therapy. Continue therapy in instances of improvement in pain and function.
3. Discuss known risks and benefits of opioid therapy with patients prior to prescribing therapy.

**Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation**

4. Prescribe immediate-release opioids instead of extended-release / long-acting (e.g., ER, LA) opioids for initial use.
5. Prescribe the lowest effective dosage of opioids. Carefully assess individual benefits and risks of increasing dose to  $\geq 50$  morphine mg equivalents (MME)/day and should avoid increasing dosage to  $\geq 90$  MME/day.
6. Use lowest effective doses for acute pain. Prescribe no greater quantity than needed for the expected duration. Typically, 3 days or less is sufficient. Greater than 7 days of therapy is rarely required.
7. Evaluate benefits/harms within 1-4 weeks of starting opioid therapy. Monitoring should be completed every 3 months or more frequently. If benefits do not outweigh risks, prescribers can change (taper) therapy and/or discontinue opioids.

**Assessing risks and addressing harms of opioid use**

8. Prior to initiating opioid therapy, risk factors for opioid-related harm should be evaluated. Clinicians should consider offering naloxone in patients with an increased risk for opioid over doses (e.g., history of overdose, history of substance use disorder, higher opioid dosages [ $\geq 50$  MME/day], or concurrent benzodiazepine use).
9. A review of the patient's controlled substance use history should be evaluated to determine if the patient is receiving other opioid medications or may be receiving a dangerous combination of medications that may increase the risk of an overdose. Monitoring should occur at each prescription to every 3 months.
10. Prescribers should use urine drug testing before starting opioid therapy and consider repeat screenings annually to assess for prescribed medications and illicit drugs.
11. Avoid prescribing opioid pain medications and benzodiazepines concurrently, when possible.
12. Prescribers should offer treatment with buprenorphine or methadone, in combination with behavioral therapies, for patients with opioid use disorder.

Conclusions

- Several strategies will be used to disseminate the guidelines to prescribers.
- Clinical decision support systems in electronic health records will be developed to assist in improving prescribing of opioids and patient care within health systems.
- Additional availability of prescription drug monitoring program (PDMP) data will be available within and across states to comply with the current guidelines.

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