

Summary of Recommendations for Prescribing Opioids

Opioid Treatment for Acute Pain

1. Opioid medications should only be used for treatment of acute pain when the severity of the pain warrants that choice and, after determining that other non-opioid pain medications or therapies are contraindicated or will not provide adequate pain relief.
2. Check the Controlled Substance Database (CSD) before prescribing opioids to learn more about the patient's controlled substance prescription history at the inception of a patient-prescriber relationship and when prescribing opioids in an emergency treatment setting.
3. Proactively consider initial and ongoing risks associated with opioid exposure based on age of the patient, history of substance use disorder, or psychiatric, physical or medical comorbidities.
4. Prescribe immediate-release and short-acting (IR/SA) opioids. Extended-release/long-acting (ER/LA) opioids, including methadone, should rarely, if ever, be prescribed for acute pain, including postoperative pain. Severe acute pain that persists longer than the anticipated healing time warrants re-examination.
5. Prescribe the lowest effective dose and no more than the number needed for the usual duration of pain associated with that condition, usually 3-5 days and rarely more than 7-10 days.
6. Avoid prescribing, and advise against, concurrent use of opioids and CNS depressants such as benzodiazepines, alcohol, muscle relaxant medications, sedative hypnotics including prescription and over-the-counter sleep aids, etc.
7. Advise the patient to securely store the medications, not share with others, and dispose of opioids properly when the pain has resolved to prevent nonmedical use of the medications.

Opioid Treatment for Chronic Pain

Before Prescribing Opioid Treatment for Chronic Pain

Chronic Pain Assessment

1. Opioid medications should only be used for treatment of chronic pain when the severity of the pain warrants that choice and after determining that other non-opioid pain medications or therapies are contraindicated or will not provide adequate pain relief.
2. Proactively consider initial and ongoing risks associated with opioid exposure based on age of the patient, history of substance use disorder, or psychiatric, physical, or medical comorbidities.

Comprehensive Evaluation

1. Perform a comprehensive evaluation, consisting of the patient's social/work history, medical history, mental health/substance use history, and physical examination, before initiating opioid treatment for chronic pain.
2. Refer to disease-specific guidelines for recommendations of treatment for specific diseases or conditions of chronic pain.

Risk of Substance Use Disorder Screening

1. Use a validated screening tool to assess the patient's risk of opioid use disorder before prescribing an opioid medication long-term for chronic pain.
2. Urine drug screening is strongly recommended before initiating opioid treatment for chronic pain.
3. Check the Controlled Substance Database (CSD) before prescribing opioids for chronic pain.



Establish Treatment Goals and a Written Treatment Plan

Treatment Plan

1. Establish a patient-provider collaborative written opioid treatment plan before opioid therapy; review and update the plan on a regular basis.
2. Treatment goals should include measurable goals for function, quality of life, and improved pain control and should be developed jointly by patient and prescriber.
3. Obtain and document accurate information about the patient's treatment and history.
4. The treatment plan and goals should explicitly include a plan to modify or discontinue opioid therapy when benefits do not outweigh the risks or when the patient fails to adhere to the agreement.

Informed Consent

1. Discuss with patients the known risks and realistic benefits of opioid therapy and patient and prescriber responsibilities for managing therapy, including any conditions for continuation of opioid treatment. This discussion should be documented using a written and signed informed consent form, which is often combined with the treatment agreement.
2. Educational material about the patient's opioid treatment plan should be in written form and discussed in-person with the patient and, when applicable, the family or caregivers.

Initiating and Adjusting Opioid Treatment

Opioid Treatment Trial

1. Combine opioid therapies with non-opioid analgesics, adjuvant analgesics and non-pharmacologic therapies, as appropriate for the patient.
2. Initiate opioid medication as a short-term trial to assess the effects of opioid treatment or pain intensity, function and quality of life.
3. Begin the trial with Immediate Release/Short-Acting (IR/SA) opioid medication.
4. Methadone should not be used for pain unless the prescriber has extensive training or experience with its use and when the benefits outweigh the known risks.
5. Prescribe the lowest effective dose. Use caution, carefully reassess evidence of individual benefits and risks when increasing dosage to > 50 morphine milligram equivalents (MME)/day, and avoid or carefully justify a decision to increase dosage to > 90 MME/day.
6. The prescription should be written on tamper-resistant prescription paper or e-prescribed to prevent fraud.
7. Regular face-to-face visits with evaluation of progress against goals should be scheduled during the period when the opioid dosage is being adjusted. The opioid trial or long-term treatment should be continually evaluated for functional benefit and achievement of treatment goals, using appropriate tracking tools.
8. Parenteral (intravenous, intramuscular, subcutaneous) administration of opioids for chronic pain is strongly discouraged, unless prescribing within an inpatient or palliative care setting.

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Risk Mitigation

1. Avoid prescribing, and counsel against, concurrent use of opioids and CNS depressants such as benzodiazepines, alcohol, muscle relaxant drugs, sedative hypnotics including prescription and over-the-counter sleep aids, etc.
2. Assess the patient's risk for sleep apnea and strongly consider formal screening.
3. Perform drug screening on randomly selected visits and any time aberrant behavior is suspected.
4. Check the Controlled Substance Database (CSD) at least quarterly during treatment of chronic pain with opioids.
5. Co-prescribe an approved naloxone delivery kit for patients receiving opioids for treatment of chronic pain.
6. Provide the patient and caregivers information on the signs and symptoms of opioid overdose, how to obtain naloxone, and the timely and proper administration of naloxone.
7. Counsel the patient to securely store the medications, not share with others, and dispose of opioids properly if no longer needed to prevent nonmedical use of the medications.

Maintenance - Periodic Monitoring and Dose Adjustments

1. Monitor opioid therapy through face-to-face visits by discussing treatment goals, effect and mood, analgesia, activity and level of function, adverse effects and aberrant behaviors.
2. Continuation or modification of therapy should depend on the prescriber's evaluation of progress toward stated treatment goals.
3. Medication adjustments, if necessary, should be made and prescriptions provided during a clinic visit.

Multi-Disciplinary Approach

1. Obtain a consultation for a patient with complex pain conditions or serious comorbidities.
2. Refer patients at risk for Substance Use Disorder (SUD) or those exhibiting behaviors of abuse diversion or addiction to a SUD specialist for treatment.
3. Offer or arrange evidence-based treatment for a patient with opioid use disorder, which usually includes medication-assisted treatment with buprenorphine, naltrexone or methadone, and behavioral therapies.
4. Patients with co-existing psychiatric disorders should receive ongoing mental health support and treatment while being treated for chronic pain.

Discontinuing Opioid Treatment

1. Discontinue opioid treatment when pain problems have been resolved, treatment goals are not being met, adverse effects outweigh benefits, or dangerous or illegal behaviors are demonstrated.
2. Offer assistance to safely taper medications or obtain appropriate treatment when a patient chooses to stop treatment or has been discharged for agreement violations.