Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

- ☐ Check that return visit is scheduled ≤3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
  - If ≥50 MME/day total (≥50 mg hydrocodone; ≥33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥90 MME/day total (≥90 mg hydrocodone; ≥60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG 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"

CDC

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

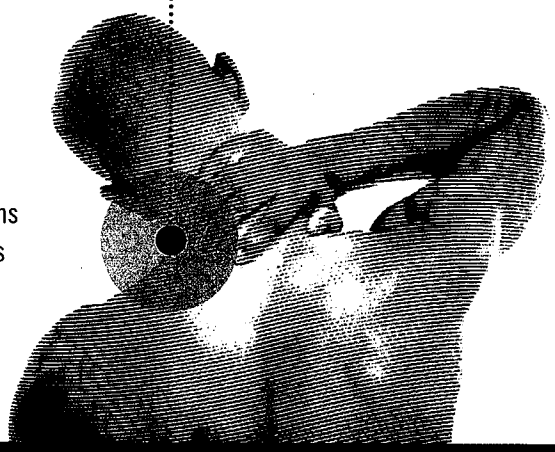
1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

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 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.

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.

CLINICAL REMINDERS

- **Opioids are not first-line or routine therapy for chronic pain**
- **Establish and measure goals for pain and function**
- **Discuss benefits and risks and availability of nonopioid therapies with patient**



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- **Use immediate-release opioids when starting**
- **Start low and go slow**
- **When opioids are needed for acute pain, prescribe no more than needed**
- **Do not prescribe ER/LA opioids for acute pain**
- **Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed**

4 When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

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)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

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 seven days will rarely be needed.

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.

ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

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/day), or concurrent benzodiazepine use, are present.

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.

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.

11 Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

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.

CLINICAL REMINDERS

- **Evaluate risk factors for opioid-related harms**
- **Check PDMP for high dosages and prescriptions from other providers**
- **Use urine drug testing to identify prescribed substances and undisclosed use**
- **Avoid concurrent benzodiazepine and opioid prescribing**
- **Arrange treatment for opioid use disorder if needed**

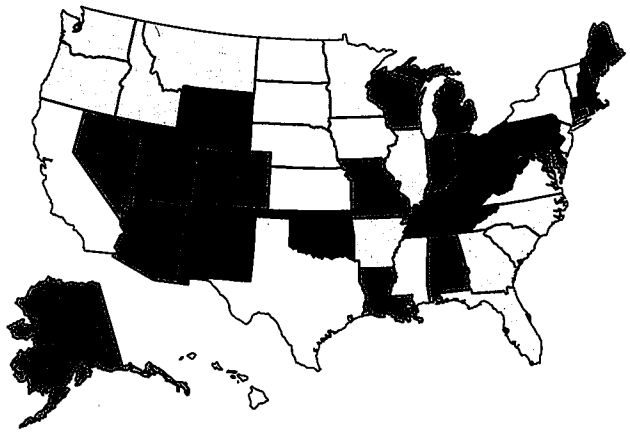
LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

The Opioid Epidemic: By the Numbers

Our nation is in the midst of an unprecedented opioid epidemic. More people died from drug overdoses in 2014 than in any year on record, and the majority of drug overdose deaths (more than six out of ten) involved an opioid.[1] Since 1999, the rate of overdose deaths involving opioids—including prescription opioid pain relievers and heroin—nearly quadrupled, and over 165,000 people have died from prescription opioid overdoses.[2] Prescription pain medication deaths remain far too high, and in 2014, the most recent year on record, there was a sharp increase in heroin-involved deaths and an increase in deaths involving synthetic opioids such as fentanyl.

Prevention, treatment, research, and effective responses to rapidly reverse opioid overdoses are critical to fighting the epidemic—a top priority for the U.S. Department of Health and Human Services (HHS). In March 2015, HHS Secretary Sylvia M. Burwell announced an initiative targeting three priority areas to tackle the opioid epidemic and help save lives. These include: improving prescribing practices, expanding access to and the use of medication-assisted treatment, and expanding the use of naloxone.

Drug overdose death rates, United States, 2014*



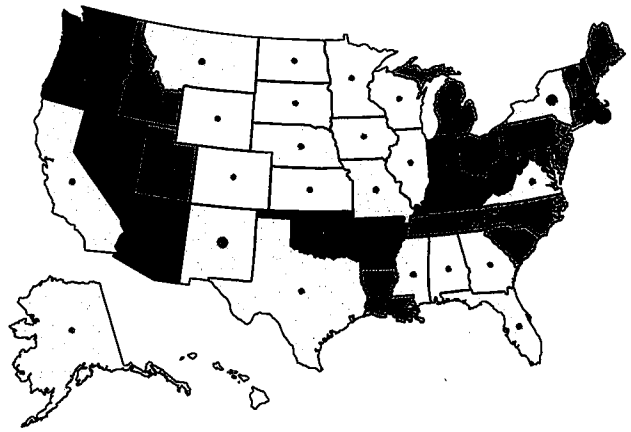
Drug overdose deaths per 100,000 population

- 6.3 - 11.7
- 11.9 - 14.4
- 15.1 - 18.4
- 19 - 35.5

*Age-adjusted death rate per 100,000 population

Source: CDC National Vital Statistics System

Rate of Past Year Opioid Abuse or Dependence* and Rate of Medication-Assisted Treatment Capacity with Methadone or Buprenorphine



Rate per 1,000 persons aged 12 years and older

Rate of dependence

- 3.4 - 6.4
- 6.5 - 9.2
- 9.4 - 10.3
- 10.8 - 12.9

Treatment capacity

- 0.7 - 3.0
- 3.2 - 4.3
- 4.4 - 7.2
- 7.3 - 16.5

*Opioid abuse or dependence includes prescription opioids and/or heroin

Source: AJPH 2015;105(8):e55-63.

Economic Impact of the Opioid Epidemic:

- **$55 billion** in health and social costs related to prescription opioid abuse each year[1]
- **$20 billion** in emergency department and inpatient care for opioid poisonings[2]

Source: Pain Med. 2011;12(4):657-67.[1] 2013;14(10):1534-47.[2]

On an average day in the U.S.:

- More than **650,000 opioid prescriptions** dispensed[1]
- **3,900 people** initiate nonmedical use of prescription opioids[2]
- **580 people** initiate heroin use[2]
- **78 people** die from an opioid-related overdose*[3]

*Opioid-related overdoses include those involving prescription opioids and illicit opioids such as heroin

Source: IMS Health National Prescription Audit[1] / SAMHSA National Survey on Drug Use and Health[2] / CDC National Vital Statistics System[3]

1. CDC, MMWR, 2015; 64;1-5.
2. CDC Vital Signs, 60(43);1487-1492

HHS Opioid Initiative: One Year Later

The HHS Opioid Initiative targets three key areas that build on efforts to address the opioid epidemic and seek to expand evidence-informed strategies that have the greatest potential for impact. As demonstrated below, much progress has been made in the last year; however, our ability to do more to turn the tide of the opioid epidemic is significantly limited without adequate funding to support expanding access for individuals with opioid use disorder to seek and complete treatment, and sustain recovery.

To help achieve the goals of the Opioid Initiative, the President's budget requests $1.1 billion in new mandatory and discretionary investments over FY 2017 and FY 2018 to expand access to treatment, and prevent opioid misuse and abuse.

The Administration looks forward to working with the Congress to secure the funding needed to provide families and communities with the support they need for opioid abuse prevention and to ensure that treatment is available for those who seek it.

Progress to Date

Opioid Prescribing Practices

In 2014, more than 240 million prescriptions were written for prescription opioids, which is more than enough to give every American adult their own bottle of pills. Raising further alarm, four in five new heroin users started out by misusing prescription opioids.

- The Centers for Disease Control and Prevention (CDC) in March 2016 released its Guideline for Prescribing Opioids for Chronic Pain to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings.
- As of March 2016, CDC has awarded over $30 million to 29 states to improve safe prescribing practices, such as enhancing Prescription Drug Monitoring Programs (PDMPs), through its Prescription Drug Overdose (PDO) grants. CDC has recently released a funding announcement, which could expand to 50 states by the end of FY 2016.
- In January 2016, the Centers for Medicare and Medicaid Services (CMS) released an Informational Bulletin on Medicaid best practices for addressing prescription drug overdoses, misuse and addiction.
- In October 2015, the Administration announced that over 40 provider groups committed to training prescribers in safe prescribing. Since then, more than 60 medical schools and 191 nursing schools have committed to requiring their students to take some form of prescriber education in line with the CDC Guideline. In addition, the President issued a memorandum requiring all federal health care professionals who prescribe opioids to be appropriately trained.

Medication-Assisted Treatment (MAT)

MAT is a proven, effective treatment for individuals with an opioid use disorder. MAT has been shown to increase treatment retention, and to reduce opioid use, risk behaviors that transmit HIV and hepatitis C virus, recidivism, and mortality.

- In 2015 the Substance Abuse and Mental Health Administration (SAMHSA) made awards totaling $10.7 million to 11 high-burden states through their Medication-Assisted Treatment for Prescription Drug and Opioid Addiction program. Applications for the next round were due in May 2016, and awards will be made to an additional 11 states.
- The Health Resources and Services Administration (HRSA) awarded $94 million to 271 health centers in March 2016 to improve and expand substance use disorder treatment in underserved areas.
- In December 2015, the Agency for Healthcare Research and Quality announced up to $12 million will be available over several years to fund research projects to support implementation of MAT in rural primary care practices.
- SAMHSA published a notice of proposed rule-making in March 2016 seeking to expand access to treatment through an increase in the number of patients a qualified physician may treat with buprenorphine.
- The U.S. Food and Drug Administration (FDA) in May 2016 approved Probuphine, the first buprenorphine implant for the maintenance treatment of opioid dependence.

Naloxone

Quickly responding to an opioid overdose with the lifesaving reversal drug naloxone is critical. Expanding access to naloxone for first responders and individuals likely to witness an overdose and training health care providers to prescribe naloxone to at-risk patients are essential actions to reverse the epidemic.

- HHS agencies continue to expand access to naloxone through grants to high-need, rural, and tribal communities. For example, in September 2015 HRSA awarded $1.8 million in grant funding to support expanding access to naloxone in 18 rural communities.
- FDA approved a "user-friendly" intranasal formulation of naloxone in November 2015. This followed FDA's approval of an auto-injector formulation of naloxone in April 2014.
- In April 2014, SAMHSA sent a letter to State agencies that administer the Substance Abuse Block Grants (SABG) to clarify that at a State's discretion, SABG funds could be used to purchase naloxone and cover costs associated with dissemination of overdose kits.

Next Steps

Opioid Prescribing Practices

While actions to address prescription opioid abuse must target both prescribers and high-risk patients, prescribers are the gatekeepers for preventing inappropriate access and providing appropriate pain treatment. The Administration continues to support mandatory prescriber education on the use of opioids for pain management. In addition, the FY 2017 President's Budget request includes:

- $80 million, an increase of $13 million, to support improved uptake of CDC's new Guideline among providers and ongoing support to all 50 states and D.C. through CDC's prescription drug overdose activities.
- $5 million in funding for the Office of the National Coordinator for Health IT (ONC) to harmonize technical standards in support of integration of PDMPs with health IT systems, improve clinical decision-making, and further the adoption of electronic prescribing of controlled substances.

Medication-Assisted Treatment (MAT)

While quality MAT is proven to be an effective treatment, the majority of people with an opioid use disorder do not receive it. The FY 2017 President's Budget request includes:

- $920 million over two years for SAMHSA's State Targeted Response Cooperative Agreements to support expanding access to MAT for opioid use disorders.
- $15.9 million for SAMHSA's Pregnant and Postpartum Women (PPW) program, which takes a family-centered approach and provides comprehensive residential substance use disorder treatment, prevention, and recovery support services for pregnant and postpartum women and their families.
- $50 million over two years in National Health Service Corps funding to support nearly 900 health professionals to provide substance use disorder treatment services, including MAT, in areas across the country most in need of behavioral health providers.
- $30 million over two years for SAMSHA to evaluate the effectiveness of treatment programs employing MAT under real-world conditions and help identify opportunities to improve treatment for patients with opioid use disorders.
- $10 million for a Buprenorphine Prescribing Authority Demonstration to expand access to buprenorphine by allowing nurse practitioners and physician assistants to make prescriptions if allowed by State law, in partnership with the U.S. Department of Justice.

Naloxone

Overdose deaths involving synthetic opioids, including fentanyl, increased by 80% from 2013 to 2014. Adding to the urgency to increase access to overdose reversal drugs, multiple doses of naloxone may be needed to reverse a fentanyl overdose, given its higher potency compared with other opioids. The FY 2017 President's Budget request includes:

- $12 million for SAMHSA's Grants to Prevent Prescription Opioid and Heroin Overdose-Related Deaths, which will help equip first responders with naloxone and provide education on its use.
- $10 million for HRSA's Rural Opioid Overdose Reversal Grant Program to enable 30 rural communities to purchase naloxone to rapidly reverse the effects of opioid overdoses, and to train licensed health care professionals and emergency responders on its use.