



# 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  $\geq 90$  MME/day; consider specialist to support management of higher doses.
- If prescribing  $\geq 50$  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.

See below for MME comparisons. For MME conversion factors and calculator, go to [TurnTheTideRx.org/treatment](http://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 ( $\leq 3$  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](http://findtreatment.samhsa.gov). Additional resources at [TurnTheTideRx.org/treatment](http://TurnTheTideRx.org/treatment) and [www.hhs.gov/opioids](http://www.hhs.gov/opioids).
- Learn about medication-assisted treatment (MAT) and apply to be a MAT provider at [www.samhsa.gov/medication-assisted-treatment](http://www.samhsa.gov/medication-assisted-treatment).
- Consider offering naloxone if high risk for overdose: history of overdose or substance use disorder, higher opioid dosage ( $\geq 50$  MME/day), concurrent benzodiazepine use.

## ADDITIONAL RESOURCES

CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN:  
[www.cdc.gov/drugoverdose/prescribing/guideline.html](http://www.cdc.gov/drugoverdose/prescribing/guideline.html)

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

NIDAMED: [www.drugabuse.gov/nidamed-medical-health-professionals](http://www.drugabuse.gov/nidamed-medical-health-professionals)

ENROLL IN MEDICARE: [go.cms.gov/pecos](http://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](http://TurnTheTideRx.org).



The Office of the  
Surgeon General

