CDC Guideline for Prescribing Opioids for Chronic Pain

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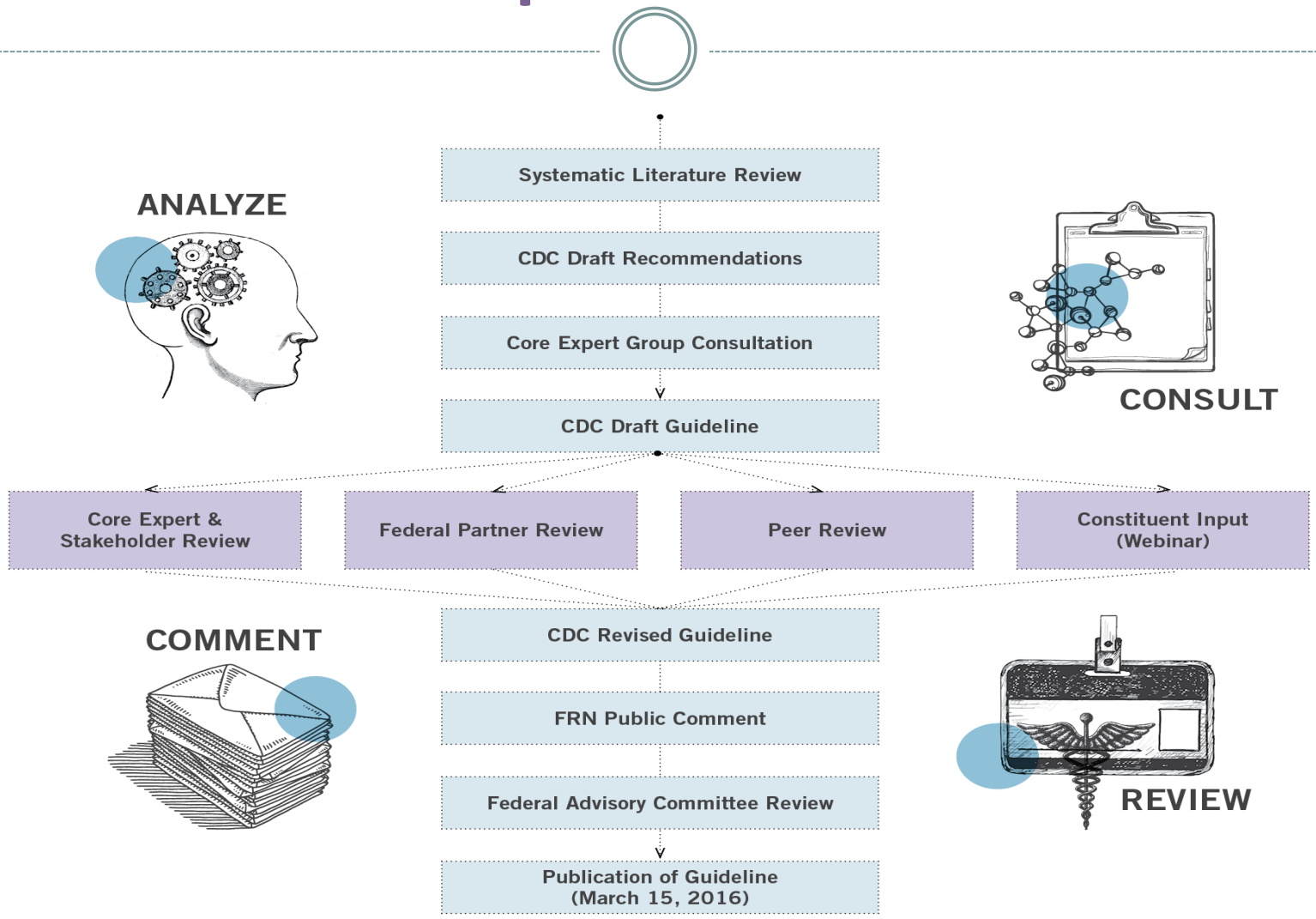
Note: Slides adapted from a presentation developed by the CDC National Center for Injury Prevention and Control

Background for CDC guideline

- Need to address prescription opioid prescribing as a public health problem given marked increases in overdoses and OUD
- Guidelines developed by several states and agencies but have inconsistencies in methods and recommendations
- National guidelines don't incorporate the most recent evidence
- Clinicians report uncertainty about how to prescribe opioids and want clear, consistent guidance
- Primary audience: Primary care providers
- Target population: Adults with chronic pain
  - Exclude: Patients undergoing active treatment for cancer, palliative care, end-of-life care'

Guideline Development Process



Clinical Evidence Review

- 2014 AHRQ sponsored review for NIH Pathways To Prevention Workshop
- Benefits and harms of long-term opioid therapy for chronic pain
- CDC commissioned review update in 2015
- Key questions addressed:
  - Effectiveness and comparative effectiveness
  - Harms/adverse events
  - Dosing strategies
  - Risk mitigation strategies
  - Effects of opioid use for acute pain on long-term use

Systematic Review Findings

- No long-term (≥1 year) outcomes in pain/function
  - Most placebo-controlled trials ≤6 week; effects small-moderate for pain, limited for function
- Opioid dependence in primary care: 3% to 26%
- Dose-dependent association with risk of overdose/harms
  - No evidence that dose escalations associated with improved pain/function
- No clear differences between round-the-clock and/or long-acting vs. PRN and/or immediate-release
  - Initiation with long-acting opioid associated with increased risk of overdose
- Methadone and concomitant use of benzodiazepines associated with higher mortality/overdose risk
- Accuracy of risk prediction instruments is inconsistent and suboptimal
- Increased likelihood of long-term use when opioids used for acute pain

Organization of recommendations

- **12 recommendations grouped into three conceptual areas:**
  - When to initiate or continue opioids for chronic pain (1-3)
  - Opioid selection, dosage, duration, follow-up, and discontinuation (4-7)
  - Assessing and mitigating harms of opioid use (8-12)
- **Recommendations graded as category A (strong) or B (conditional)**
- **Supporting evidence type classified as 1 (well-conducted RCT's) through 4 (observational studies with limitations)**

Recommendation #1

- Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain.
- Consider opioid therapy only if expected benefits are anticipated to outweigh risks to the patient.
- If opioids are used, combine with appropriate nonpharmacologic therapy and nonopioid pharmacologic therapy.

(Recommendation category A: Evidence type: 3)

Opioids are not first-line or routine therapy for chronic pain

- A number of nonopioid therapies are effective for chronic pain
  - Benefits similar or slightly less than opioids with substantially lower risk of serious harms
  - Use nonpharmacologic therapy such as exercise or cognitive behavioral therapy (CBT)
  - Use nonopioid pharmacologic therapy (nonsteroidal anti-inflammatory drugs, acetaminophen, anticonvulsants, certain antidepressants) with nonpharmacologic therapy
- When opioids used, combine with nonopioid therapies to provide greater benefits.
  - Biopsychosocial approach to chronic pain
  - Address psychological comorbidities

Recommendation #2

- Before starting opioid therapy for chronic pain, establish treatment goals with all patients, including realistic goals for pain and function, and have a plan wot discontinuation of therapy 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.

(Recommendation category A: Evidence type: 4)

Establish and measure progress towards goals

- Before initiating opioid therapy for chronic pain
  - Be explicit about expected benefits.
  - Determine how effectiveness will be evaluated.
  - Establish realistic treatment goals with patients.
    - Focus on function as well as improvement in pain
- 3-item PEG Assessment Scale*
  - Pain average (0-10)
  - Interference with Enjoyment of life (0-10)
  - Interference with General activity (0-10)

*30% = clinically meaningful improvement

Recommendation #3

- Before starting and periodically during opioid therapy, discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

(Recommendation category A: Evidence type: 3)

Ensure patients are aware of harms associated with opioids

- Discuss:
  - serious and common adverse effects
  - increased risks of overdose
    - at higher dosages
    - when opioids are taken with other drugs or alcohol
  - periodic reassessment, PDMP and urine checks; and
  - risks to family members and individuals in the community.

Recommendation #4

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

(Recommendation category A: Evidence type: 4)

Dosing strategies and selection of opioids

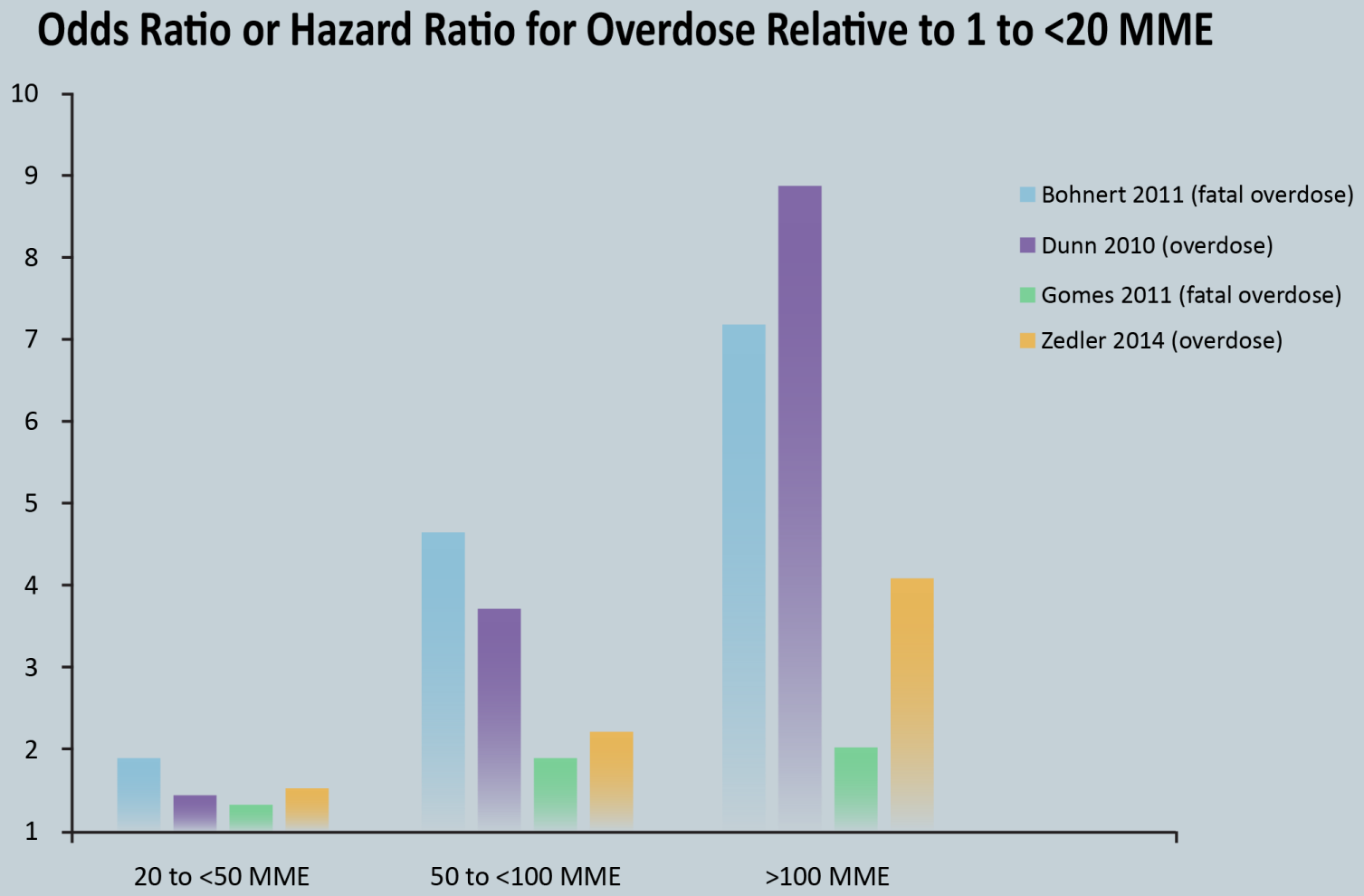
- In general, avoid the use of immediate-release opioids combined with ER/LA opioids.
- Methadone should not be the first choice for an ER/LA opioid.
  - Only providers familiar with methadone's unique risk and who are prepared to educate and closely monitor their patients should consider prescribing it for pain.
- Only consider prescribing transdermal fentanyl if familiar with the dosing and absorption properties and prepared to educate patients about its use.

Recommendation #5

- When opioids are started, prescribe the lowest effective dosage.
- Use caution when prescribing opioids at any dosage
  - Reassess benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day
  - Avoid increasing dosage to ≥90 MME/day or titrate dosage to ≥90 MME/day only in patients who experience incremental benefits relative to harms.

(Recommendation category A: Evidence type: 3)

Prescribed opioid dose (MME) and risk of overdose



Dose considerations

- Start with lowest effective dosage and increase gradually by the smallest practical amount.
- If total opioid dosage ≥50 MME/day
  - reassess pain, function, and treatment
  - increase frequency of follow-up; and
  - consider offering naloxone.
- Avoid increasing opioid dosages to ≥90 MME/day.
- If escalating dosage requirements
  - discuss other pain therapies with the patient
  - consider working with the patient to taper opioids down or off
  - consider consulting a pain specialist.

If patient is already receiving a high dosage

- Offer established patients already taking ≥90 MME/day who otherwise do not meet criteria for tapering, offer the opportunity to re-evaluate their continued use of high opioid dosages in light of recent evidence regarding the association of opioid dosage and overdose risk.
- For patients who agree to taper opioids to lower dosages, collaborate with the patient on a tapering plan.

Recommendation #6

- When opioids are used for acute pain, prescribe the lowest effective dose of immediate-release opioids and prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.
  - 3 days or less will often be sufficient; more than 7 days rarely needed.

(Recommendation category A: Evidence type: 4)

When opioids are needed for acute pain

- Prescribe the lowest effective dose.
- Prescribe amount to match the expected duration of pain severe enough to require opioids.
- Often $\leq$ 3 days and rarely more than 7 days needed.
- Do not prescribe additional opioids "just in case".
- Re-evaluate patients with severe acute pain that continues longer than the expected duration to confirm or revise the initial diagnosis and to adjust management accordingly.
- Do not prescribe ER/LA opioids for acute pain treatment.

Recommendation #7

- Evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation.
- Evaluate benefits and harms of continued therapy 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.

(Recommendation category A: Evidence type: 4)

Follow-up

- Re-evaluate patients
  - within 1-4 weeks of starting long-term therapy or of dosage increase
  - at least every 3 months or more frequently.
- At follow up, determine whether
  - opioids continue to meet treatment goals
  - there are common or serious adverse events or early warning signs
  - benefits of opioids continue to outweigh risks
  - opioid dosage can be reduced or opioids can be discontinued.

Tapering Opioids

- Work with patients to taper opioids down or off when
  - no sustained clinically meaningful improvement in pain and function
  - opioid dosages $\geq$50 MME/day without evidence of benefit
  - concurrent benzodiazepines that can't be tapered off
  - patients request dosage reduction or discontinuation
  - patients experience overdose, other serious adverse events, warning signs.
- Taper slowly enough to minimize opioid withdrawal
  - A decrease of 10% per week is a reasonable starting point; some patients may do better with slower taper
- Optimize nonopioid pain management and psychosocial support

Recommendation #8

- Before starting and periodically during continuation of opioid therapy, evaluate risk factors for opioid-related harms.
- Incorporate into the management plan strategies to mitigate risk
  - Consider naloxone when factors that increase risk for opioid overdose are present; e.g. history of overdose, history of substance use disorder, higher opioid dosages ($\geq$50 MME/day), or concurrent benzodiazepine use

(Recommendation category A: Evidence type: 4)

Recommendation #9

- Review the patient's history of controlled substance prescriptions using state PDMP data, to help determine whether the patient is receiving opioid dosages or dangerous combinations that put him/her at high risk for overdose.
- 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.

(Recommendation category A: Evidence type: 4)

If prescriptions from multiple sources, high dosages, or dangerous combinations

- Discuss safety concerns with patient (and any other prescribers they may have), including increased risk for overdose.
- For patients receiving high total opioid dosages, consider tapering to a safer dosage, consider offering naloxone.
- Consider opioid use disorder and discuss concerns with your patient.
- Do not dismiss patients from care—use the opportunity to provide potentially lifesaving information and interventions.

Recommendation #10

- Obtain 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.

(Recommendation category B: Evidence type: 4)

Use UDT to assess for prescribed opioids and other drugs that increase risk

- Be familiar with urine drug testing panels and how to interpret results.
- Don't test for substances that wouldn't affect patient management.
- Before ordering urine drug testing
  - explain to patients that testing is intended to improve their safety
  - explain expected results; and
  - ask patients whether there might be unexpected results.
- Discuss unexpected results with local lab and patients.
- Verify unexpected, unexplained results using specific test.
- Do not dismiss patients from care based on a urine drug test result.

Recommendation #11

- Avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

(Recommendation category A: Evidence type: 3)

Avoid concurrent opioids and benzodiazepines whenever possible

- Concomitant benzodiazepine use observed in a high proportion of opioid-related overdose deaths.
  - other medications with respiratory depressant effects may also be associated with similar risks
- Taper benzodiazepines gradually.
- Offer evidence-based psychotherapies for anxiety.
  - cognitive behavioral therapy
  - specific anti-depressants approved for anxiety
  - other non-benzodiazepine medications approved for anxiety
- Coordinate care with mental health professionals.

Recommendation #12

- 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.

(Recommendation category A: Evidence type: 2)

If you suspect opioid use disorder (OUD)

- Discuss with your patient and provide an opportunity to disclose concerns.
- Assess for OUD using DSM-5 criteria. If present, offer or arrange MAT.
  - Buprenorphine through an office-based buprenorphine treatment provider or an opioid treatment program specialist
  - Methadone maintenance therapy from an opioid treatment program specialist
  - Oral or long-acting injectable formulations of naltrexone (for highly motivated non-pregnant adults)
- Consider obtaining a waiver to prescribe buprenorphine for OUD (see http://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management)