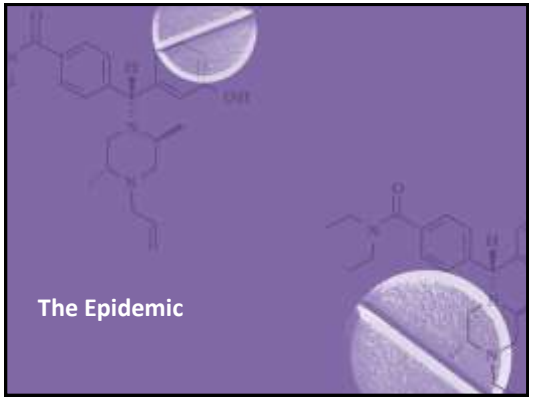
CDC Guideline for Prescribing Opioids for Chronic Pain
The 12 Step Program?

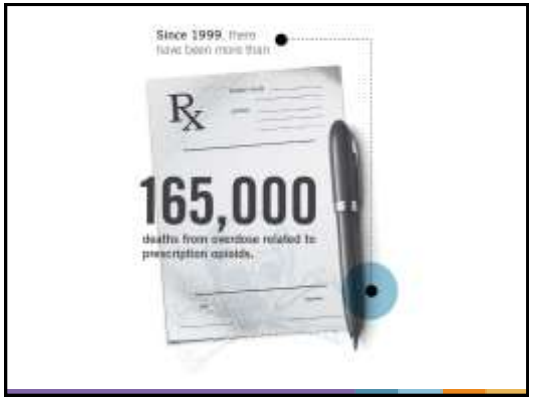


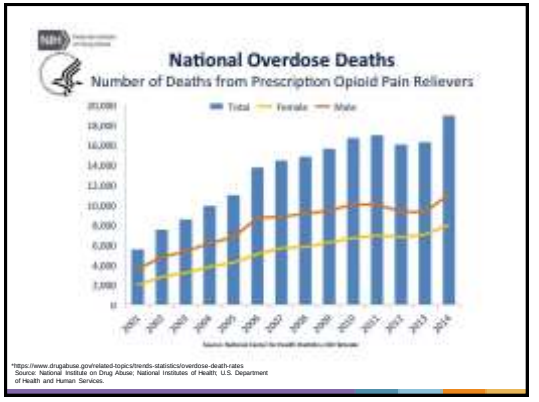
Chronic Pain and Prescription Opioids

- 11% of Americans experience daily (chronic) pain
- Opioids frequently prescribed for chronic pain
- Primary care providers commonly treat chronic, non-cancer pain
  - account for ~50% of opioid pain medications dispensed
  - report concern about opioids and insufficient training

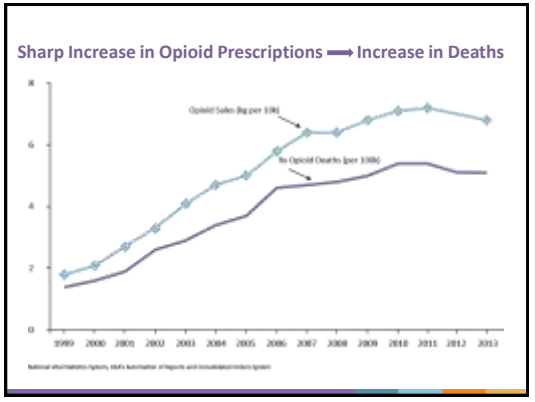
CDC looks at four categories of opioids:

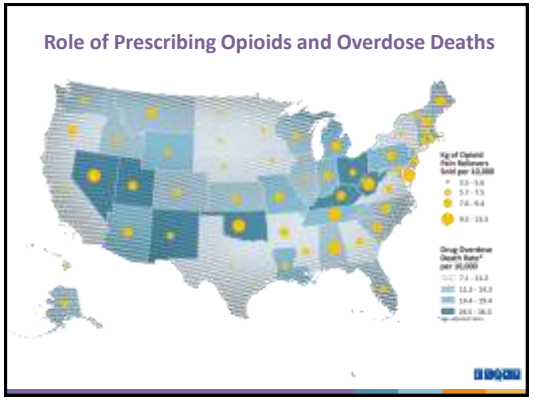
- **Natural opioid analgesics,** including morphine and codeine, and **semi-synthetic opioid analgesics,** including drugs such as oxycodone, hydrocodone, hydromorphone, and oxymorphone;
- **Methadone,** a synthetic opioid;
- **Synthetic opioid analgesics** other than methadone, including drugs such as tramadol and fentanyl; and
- **Heroin,** an illicit (illegally-made) opioid synthesized from morphine that can be a white or brown powder, or a black sticky substance.





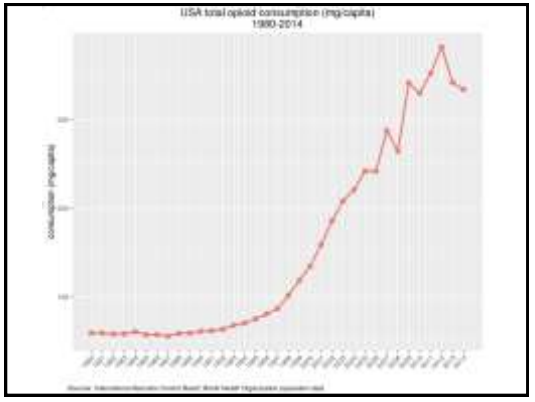
4 of 5 new heroin users describe starting with prescription opioids



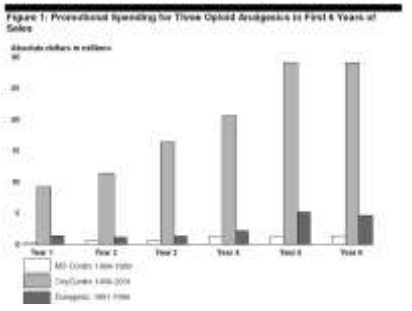


Opioid Prescribing by Morphine Mg Equivalents by County 2015

Source: MMWR / July 7, 2017 / Vol. 66 / No. 26 US Department of Health and Human Services/Centers for Disease Control and Prevention



Dollars Spent Marketing OxyContin (1996-2001)



Source: United States General Accounting Office: Dec. 2003, "OxyContin Abuse and Diversion and Efforts to Address the Problem."

"The risk of addiction is much less than 1%"

Porter J, Jick H. *Addiction rare in patients treated with narcotics*. N Engl J Med. 1980 Jan 10;302(2):123

Cited 824 times (Google Scholar)

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N Engl J Med. 1980 Jan 10;302(2):123.

ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,[1] Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

JANE PORTER
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Waltham, MA 02154 Boston University Medical Center

1. Jick H, Miettinen OS, Shapiro S, Lewis GP, Siskind V, Slone D. Comprehensive drug surveillance. JAMA. 1970; 213:1455-60.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. J Clin Pharmacol. 1978; 18:180-8.

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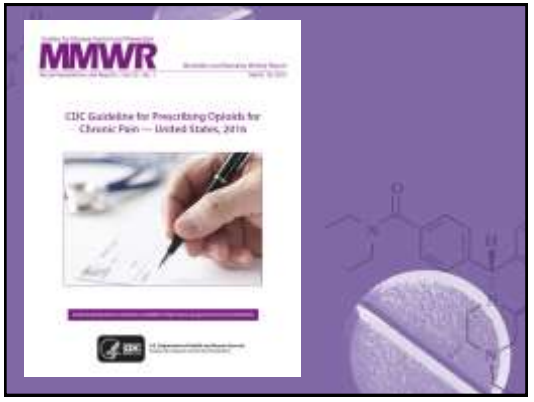
REVIEW

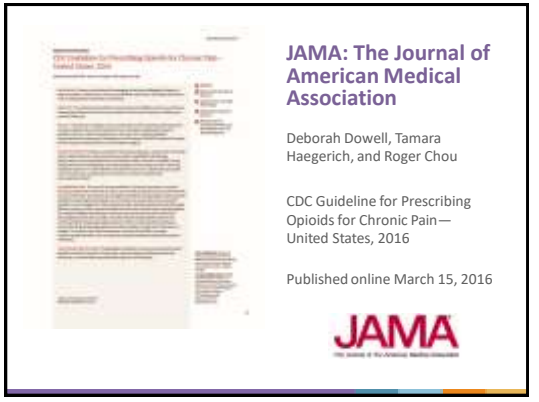
Annals of Internal Medicine

The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a National Institutes of Health Pathways to Prevention Workshop

Need for Opioid Prescribing Guidelines

- Previous opioid prescribing guidelines have been developed by several states and agencies but were **inconsistent**
- Most recent national guidelines are **several years old** and don't incorporate the most recent evidence
- Need for **clear, consistent** recommendations





JAMA: The Journal of American Medical Association

Deborah Dowell, Tamara Haegerich, and Roger Chou

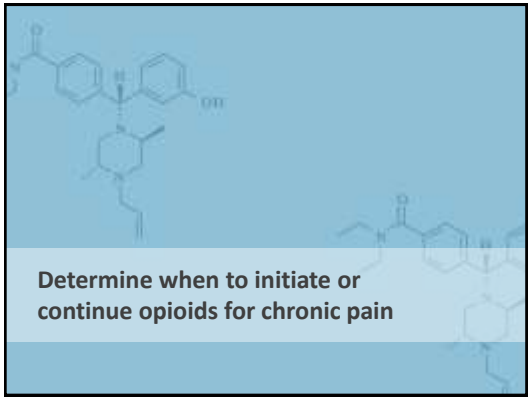
CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016

Published online March 15, 2016

JAMA

Organization of Recommendations

- **The 12 recommendations are grouped into three conceptual areas:**
  - Determining when to initiate or continue opioids for chronic pain
  - Opioid selection, dosage, duration, follow-up, and discontinuation
  - Assessing risk and addressing harms of opioid use



Determine when to initiate or continue opioids for chronic pain

Recommendation #1

1

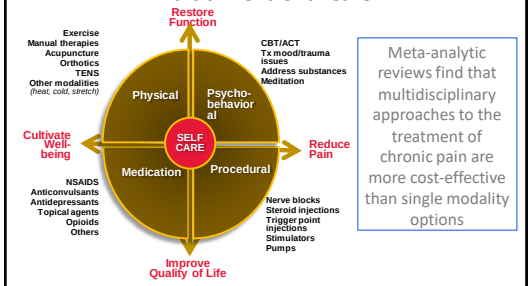
- Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain.
- Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient.
- If opioids are used, they should be combined with nonpharmacologic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

(Recommendation category A: Evidence type: 3)

Opioids not first-line or routine therapy for chronic pain

- Use nonpharmacologic therapy such as exercise or cognitive behavioral therapy (CBT) to reduce pain and improve function.
- Use nonopioid pharmacologic therapy (nonsteroidal anti-inflammatory drugs, acetaminophen, anticonvulsants, certain antidepressants) when benefits outweigh risks, combined with nonpharmacologic therapy.
- When opioids used, combine with nonpharmacologic therapy and nonopioid pharmacologic therapy to provide greater benefits.

Multidimensional Care



Meta-analytic reviews find that multidisciplinary approaches to the treatment of chronic pain are more cost-effective than single modality options

*Flor H, Fydrich T, Turk DC. Efficacy of multidisciplinary pain treatment centers: a meta-analytic review. Pain. 1992;49:221-230.
*Gatchel RJ, Okifuji A. Evidence-based scientific data documenting the treatment and cost-effectiveness of comprehensive pain programs for chronic nonmalignant pain. J Pain. 2006;7:779-793.
*Kamper SJ, Apeldoorn AT, Chiarotto A, Smeets RJ, Ostelo RW, Guzman J, et al. Multidisciplinary biopsychosocial rehabilitation for chronic low back pain. Cochrane Database Syst Rev. 2014:CD000963.

Recommendation #2

2

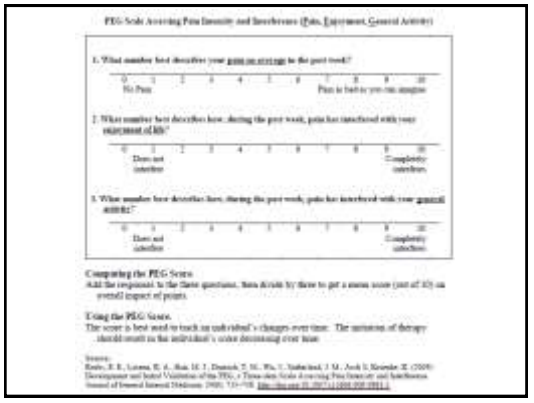
- Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks.
- Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

(Recommendation category A: Evidence type: 4)

Establish and measure progress toward goals

- Before initiating opioid therapy for chronic pain
  - Determine how effectiveness will be evaluated.
  - Establish treatment goals with patients.
    - Pain relief
    - Function
- Assess progress using 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



PEG Scale Assessing Pain Intensity and Interference (Pain, Enjoyment, General Activity)

1. What number best describes your pain on average in the past week?

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Computing the PEG Score

Add the responses to the three questions, then divide by three to get a mean score (out of 10) on overall impact of pain.

Using the PEG Score

The score is best used to track an individual's changes over time. The variations of therapy should result in the individual's score decreasing over time.

Source:

Krebs, E. E., Lorenz, K. A., Bair, M. J., Damush, T. M., Wu, J., Sutherland, J. M., Asch, S., Kroenke, K. (2009) Development and Initial Validation of the PEG, a Three-item Scale Assessing Pain Intensity and Interference. Journal of General Internal Medicine, 24(6), 733–738. http://doi.org/10.1007/s11606-009-0981-1

Recommendation #3

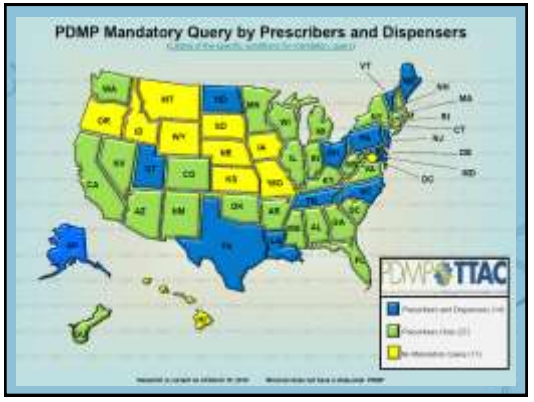
3

- 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.

(Recommendation category A: Evidence type: 3)

Ensure patients are aware of potential benefits, harms, and alternatives to opioids

- Be explicit and realistic about expected benefits.
- Emphasize goal of improvement in pain and function.
- 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.



Opioid selection, dosage, duration, follow-up, and discontinuation

Recommendation #4

4

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

(Recommendation category A: Evidence type: 4)

Choose predictable pharmacokinetics and pharmacodynamics to minimize overdose risk

- 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.

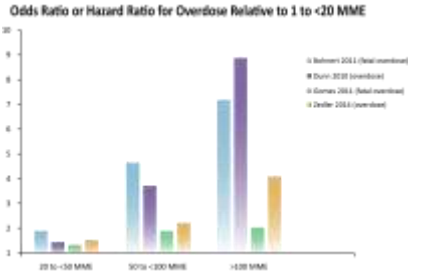
Recommendation #5

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 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.

(Recommendation category A: Evidence type: 3)

Relationship of prescribed opioid dose (MME) and overdose



Start low and go slow

- Start with lowest effective dosage and increase 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.

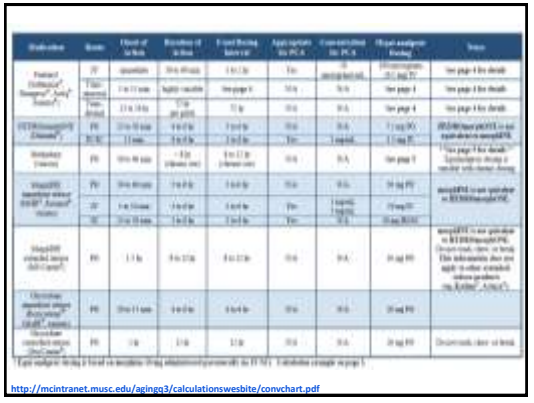
If patient is already receiving a high dosage

- Offer established patients already taking ≥90 MME/day 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.

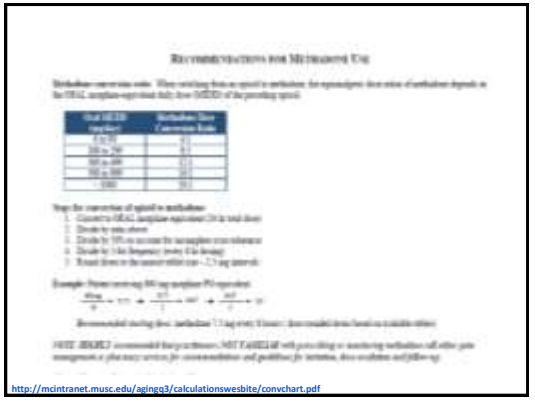
Equianalgesic Table

ORAL (mg)	Drug	Parenteral (mg)
30	Morphine	10
7.5-8	Hydromorphone	1.5
15-20	Oxycodone	-
200	Codeine	120
300	Demerol	75

Numerous equianalgesic tables published. The best recommendation is to pick one and use it.



http://mcintranet.musc.edu/agingg3/calculationswesbite/convchart.pdf



http://mcintranet.musc.edu/agingg3/calculationswesbite/convchart.pdf

Fentanyl Patch Guidelines

Current Analgesic	Daily Dosage (mg/day)			
Oral morphine	60-134	135-224	225-314	315-404
Intramuscular or Intravenous morphine	10-22	23-37	38-52	53-67
Oral oxycodone	30-67	67.5-112	112.5-157	157.5-202
Oral codeine	150-447			
Oral hydromorphone	8-17	17.1-26	26.1-39	39.1-51
Intravenous hydromorphone	1.5-3.4	3.5-5.6	5.7-7.9	8-10
Intramuscular meperidine	75-165	166-278	279-390	391-503
Oral methadone	20-44	45-74	75-104	105-134
	⇓	⇓	⇓	⇓
Recommended DURAGESIC Dose	25 mcg/ hour	50 mcg/ hour	75 mcg/ hour	100 mcg/ hour

Fentanyl Patch Guidelines

TABLE 2[1]: RECOMMENDED INITIAL DURAGESIC DOSE BASED UPON DAILY ORAL MORPHINE DOSE

Oral 24-hour Morphine (mg/day)	DURAGESIC Dose (mcg/hour)
60-134	25
135-224	50
225-314	75
315-404	100
405-494	125
495-584	150
585-674	175
675-764	200
765-854	225
855-944	250
945-1034	275
1035-1124	300

Recommendation #6

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.
- 3 days or less will often be sufficient; more than 7 days will rarely be 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

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.

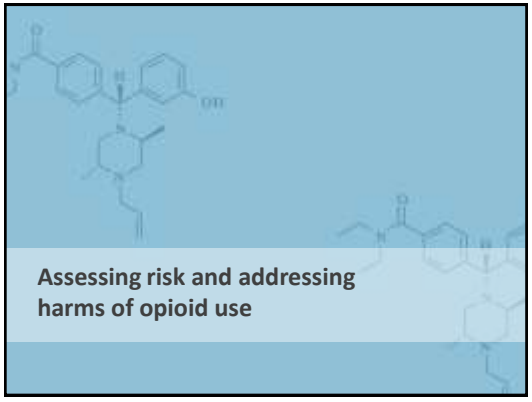
(Recommendation category A: Evidence type: 4)

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 ≥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
- Access appropriate expertise for tapering during pregnancy
- Optimize nonopioid pain management and psychosocial support



Assessing risk and addressing harms of opioid use

Recommendation #8

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.

(Recommendation category A: Evidence type: 4)

Certain factors increase risks for opioid-associated harms

- Avoid prescribing opioids to patients with moderate or severe sleep-disordered breathing when possible.
- During pregnancy, carefully weigh risks and benefits with patients.
- Use additional caution with renal or hepatic insufficiency, aged ≥65 years.
- Ensure treatment for depression is optimized.
- Consider offering naloxone when patients
  - have a history of overdose
  - have a history of substance use disorder
  - are taking central nervous system depressants with opioids
  - are on higher dosages of opioids (≥ 50 MME/day).

Narcan® (naloxone)

- Naloxone is a drug used to reverse the effects of opioids.
- Naloxone is safe and effective.
- Naloxone has no effect on non-opioid overdoses.
- In the United States[6], there are:
  - ✓ Over 180 naloxone programs
  - ✓ Over 50,000 people trained
  - ✓ Over 10,000 overdose reversals (lives saved)

Recommendation #9

9

- Clinicians should review the patient's history of controlled substance prescriptions using state PDMP data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him/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.

(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.
- If you suspect your patient might be sharing or selling opioids and not taking them, consider urine drug testing to assist in determining whether opioids can be discontinued without causing withdrawal.
- Do not dismiss patients from care—use the opportunity to provide potentially lifesaving information and interventions.

Recommendation #10

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.

(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

11

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

(Recommendation category A: Evidence type: 3)

Avoid concurrent opioids and benzodiazepines whenever possible

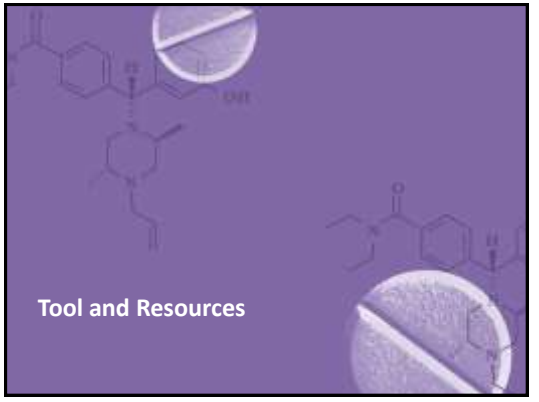
- Taper benzodiazepines gradually.
- Offer evidence-based psychotherapies for anxiety.
  - cognitive behavioral therapy
  - specific anti-depressants approved for anxiety
  - other non-benzodiazepine medications approved for anxiety
- Coordinate care with mental health professionals.

Recommendation #12

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.

(Recommendation category A: Evidence type: 2)

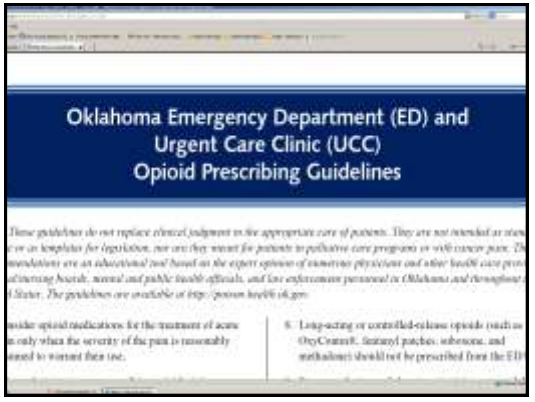


Tools and Materials

- Provider and patient materials
  - Checklist for prescribing opioids for chronic pain
  - Fact sheets
  - Posters
  - Web banners and badges
  - Social media web buttons and infographics
- CDC Opioid Overdose Website
  www.cdc.gov/drugoverdose/index.html

Training and Resources

- COCA Call Webinar Series
- Fact sheets
  - New Opioid Prescribing Guideline
  - Assessing Benefits and Harms of Opioid Therapy
  - Prescription Drug Monitoring Programs
  - Calculating Total Daily Dose of Opioids for Safer Prescribing
  - Pregnancy and Opioid Pain Medications



Opioid Prescribing Guidelines for Oklahoma Health Care Providers in the Office-Based Setting

Note: These guidelines do not replace clinical judgment in the appropriate care of patients. They are not intended as standards of care or as templates for legislation, nor are they meant for patients in palliative care programs or with cancer pain. The recommendations are an educational tool based on the expert opinion of numerous physicians and other health care providers, medical licensing boards, mental and public health officials, and law enforcement personnel in Oklahoma and throughout the United States. The guidelines are available at http://www.health.ok.gov.

Opioid Treatment for Acute Pain

Opioid Treatment for Chronic Pain

An Act

- 1 hour education in pain management or opioid use/addiction
- 7 day treatment for acute pain
- Under 18 or pregnant must enter into a patient-provider agreement
- May refill for another 7 days with proper documentation
- Third fill must enter into a pain-management agreement