CDC Clinical Practice Guidelines for Prescribing Opioids for Pain

Updated November 3, 2022

On November 3, 2022, an update to the Centers for Disease Control and Prevention's (CDC) Opioid Guidelines was released from the previous 2016 guidelines. These guidelines provide 12 voluntary recommendations for managing acute, subacute, and chronic pain. They are not applicable to pain management related to sickle cell disease, cancer-related pain treatment, palliative care, or end-of-life care.

Recommendation 1: Determine whether to initiate opioids for acute pain (duration <1 month).

- Non-opioid therapies are at least as effective as opioids for many common types of acute pain.
- Clinicians should maximize the use of non-pharmacologic and non-opioid pharmacologic therapies as appropriate for the specific condition and patient and only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient.
- Before prescribing opioid therapy for acute pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy.

Recommendation 2: Determine whether to initiate opioids for subacute pain (1- to 3-month duration) or chronic pain (duration >3 months).

- Non-opioid therapies are preferred for subacute and chronic pain.
- Clinicians should maximize the use of non-pharmacologic and non-opioid pharmacologic therapies as appropriate for the specific condition and patient and only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient.
- Before starting opioid therapy for subacute or chronic pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy, work with patients to establish treatment goals for pain and function, and consider how opioid therapy will be discontinued if benefits do not outweigh risks.

Recommendation 3: Clinicians should prescribe immediate-release opioids.

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

Recommendation 4: Clinicians should prescribe the lowest effective dosage.

- When opioids are initiated for opioid-naïve patients with acute, subacute, or chronic pain, clinicians should prescribe the lowest effective dosage.
- If opioids are continued for subacute or chronic pain, clinicians should use caution when prescribing opioids at any dosage, should carefully evaluate individual benefits and risks when considering increasing dosage and should avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients.

Recommendation 5: Clinicians should carefully weigh the benefits and risks and exercise care when changing the opioid dosage.

- For patients already receiving opioid therapy, clinicians should carefully weigh the benefits and risks and exercise care when changing the opioid dosage.
- If the benefits outweigh the risks of continued opioid therapy, clinicians should work closely with patients to optimize non-opioid therapies while continuing opioid therapy.
- If the benefits do not outweigh the risks of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper to lower dosages or, if warranted based on the individual clinical circumstances of the patient, to appropriately taper and discontinue opioids.
- Unless there are indications of a life-threatening issue, such as warning signs of impending overdose, (e.g., confusion, sedation, or slurred speech), **opioid therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages from higher dosages.**

Recommendation 6: Clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.

- When opioids are needed for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.
- Patients should be evaluated at least every two weeks if they continue to receive opioids for acute pain.
- If opioids are continued for ≥1 month, clinicians should ensure that potentially reversible causes of chronic pain are addressed and that opioid prescribing for acute pain does not unintentionally become long-term opioid therapy simply because medications are continued without reassessment.

Recommendation 7: Clinicians should regularly reevaluate the benefits and risks of continued opioid therapy with patients.

- Clinicians should evaluate benefits and risks with patients within 1-4 weeks of starting opioid therapy for subacute or chronic pain or of dosage escalation.
- Clinicians should follow up with and evaluate patients with subacute pain who started opioid therapy for acute pain and have been treated with opioid therapy for 30 days
- Clinicians should regularly reassess all patients receiving long-term opioid therapy, including patients who are new to the clinician but on long-term opioid therapy, with a suggested interval of every 3 months or more frequently for most patients.

Recommendation 8: Clinicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone.

- Before starting and periodically during the continuation of opioid therapy, clinicians should evaluate the risk for opioid-related harms and discuss it with patients.
- Clinicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone.

Recommendation 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 combinations that put the patient at high risk for overdose.

- Ideally, PDMP data should be reviewed before every opioid prescription for acute, subacute, or chronic pain. This practice is recommended in all jurisdictions where PDMP availability and access policies, as well as clinical practice settings, make it practicable (e.g., clinician and delegate access permitted).
- To review the requirements of Pennsylvania PDMP use for prescribers under Act 191 of 2014 you can visit health.pa.gov.

Recommendation 10: Clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances.

- When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medications as well as non-prescribed controlled substances.
- Before starting opioids and periodically (at least annually) during opioid therapy, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed opioids and other prescription and nonprescription controlled substances that increase the risk for overdose when combined with opioids, including nonprescribed and illicit opioids and benzodiazepines.

Recommendation 11: Clinicians should use particular caution when prescribing opioid pain medication and benzodiazepines concurrently and consider whether the benefits outweigh the risks of concurrent prescribing of opioids and other central nervous system depressants.

- In patients receiving opioids and benzodiazepines long term, clinicians should carefully weigh the benefits and risks of continuing therapy with opioids and benzodiazepines and discuss with patients and other members of the patient's care team.

Recommendation 12: Clinicians should offer or arrange treatment with evidence-based medications to treat patients with opioid use disorder.

- Detoxification on its own, without medications for opioid use disorder, is not recommended for opioid use disorder because of increased risks of resuming drug use, overdose, and overdose death.

Learn more about the updated CDC's Clinical Practice Guideline for Prescribing Opioids for Pain by viewing this webinar recording that was held on November 17, 2022.

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