SAFE OPIOID PRESCRIBING GUIDELINES

For Health Care Providers

June 2021

Treating pain effectively and safely has become a challenge for many health care providers. There has been an influx of misuse, addiction, overdose, diversion, and death related to the use of opioids. While opioids are one tool for managing pain, they carry a significant risk when misused, and often lack evidence-based value for improving pain and function for those with musculoskeletal pain, such as low back pain.

The guidelines outlined in this document are intended to improve communication about the benefits and risks of opioids for musculoskeletal pain, improve safety and effectiveness of pain treatment, and reduce risks associated with long-term opioid therapy. Its focus is to help guide the treatment of musculoskeletal pain.

Highlights

These guidelines prompt health care providers to:

- Use non-opioid and non-pharmacologic therapies for initial pain management, particularly for chronic pain unrelated to cancer, and in particular when treating child-bearing or pregnant patients.
- Assess risk of harm and misuse by a patient.
- Give realistic “recovery” education and reassurance throughout the course of treatment.
- Assess, reassess, and monitor a patient’s progress on a consistent basis using validated assessment tools.
- Leverage safe prescribing measures, such as limited quantities (e.g., three to seven days), and follow treatment-agreement interventions (e.g., checking the pharmacy board, urine drug screens, or pill counts).
- Leverage multidisciplinary partners for consultation and/or referral in the treatment or management of pain (e.g., mechanical therapy, pain specialist, and behavioral and use opioids as a last resort.

The guidelines cover the following clinical scenarios:

- Opioid prescribed for pain
- Opioid prescription renewal
- Patient on a higher dose of an opioid or for an extended period of time
- Tapering or weaning a patient off of opioids

These guidelines are not intended for patients who are in active cancer treatment or acute care (hospitalized), have sickle cell disease, or need palliative or end-of-life care.

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Clinical scenario: Opioid prescribed for pain	
Provide brochure	If available.
Check use of non-opioid therapies	Check that non-opioid therapies have been tried and optimized: • Medications (e.g., non-steroidal anti-inflammatory drugs [NSAIDs], tricyclic antidepressants [TCAs], serotonin and norepinephrine reuptake inhibitors [SNRIs], and anticonvulsants) • Physical and mechanical therapies: Physical therapy (PT), occupational therapy (OT), chiropractic care, and acupuncture • Home exercise program • Procedures, such as injections
Evaluate risk of harm or misuse	Assess for: • Aberrant behaviors (e.g., Illegal use, misuse, and abuse) using tools and interventions – ○ Urine drug testing: Screen for the presence of prescribed substances, undisclosed prescription drugs, and illicit substance use. ○ Prescription drug monitoring program (PDMP): Screen for opioids, benzodiazepines, sedatives, and stimulants (such as ADHD medications) from other providers. Check initially and periodically (e.g., every prescription, or every one to three months). ○ Calls to patient for pill counts or in-office checks. • Screen for behavioral health concerns or risk factors using validated assessments, such as the Patient Health Questionnaire (PHQ)-4, PHQ-9, Generalized Anxiety Disorder-7 (GAD-7), CAGE-AID, or Opioid Risk Tool (ORT). Refer to behavioral services if needs or risks are identified. • History of substance use disorder, overdose, or behavioral health diagnosis. • Sleep-disordered breathing. • Concurrent benzodiazepine and sedatives use. (Avoid concurrent use.)
Educate and reassure	• Discuss the realistic recovery time, self-care activities, appropriate medications, and tests based on the acute versus chronic phases. • Set realistic goals for pain and function based on the diagnosis (e.g., walk around the block). • Discuss the benefits and risks, such as addiction and overdose. • Set criteria for stopping or continuing opioids; discuss openly. • Provide information about additional support services, such as support groups and resources.
Assess and monitor	Assess baseline pain and function. • Follow up timely and regularly to monitor for improvement in pain and function. • Always optimize other therapies, such as PT, chiropractic care, and cognitive behavioral therapy, if applicable. Work with a patient to taper or reduce dosage of an opioid, and discontinue, if needed. • Schedule an initial reassessment within one to four weeks.

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Safe prescribing measures	If a prescription is for more than 15 days, or if long-term exposure is anticipated, utilize a treatment agreement (e.g., one pharmacy, one provider, no early refills, and assessing risk through tools such as a PDMP and urine drug screenings). Consider establishing an agreement with a patient who is taking benzodiazepines, if warranted. *There may be exceptions. For example, opioid exposure of one to two weeks might not require an agreement, but opioid use beyond two weeks may warrant it.* • Prescribe short-acting opioids using the lowest dosage on the product label; match the duration to the scheduled reassessment. • Start low and go slow. Prescribe the lowest effective dose. Use immediate-release or short-acting opioids instead of extended release (ER) or long-acting opioids. • Prescribe the minimal quantity for the expected duration of pain (e.g., three to seven days, or less), and educate the patient about the allotted time and subsequent plan; set clear expectations. • Combine an opioid prescription with non-pharmacologic or non-opioid pharmacologic therapy, as appropriate, to provide greater benefits. • Avoid prescribing opioid pain medications and a benzodiazepines concurrently, whenever possible. • Offer or arrange evidence-based treatment (usually Medication-assisted Treatment with buprenorphine or methadone, in combination with behavioral therapies) for a patient who has an opioid use disorder.
Care coordination and referrals	Make a: • Timely consultation and/or referral to mechanical therapy, such as PT, OT, chiropractic care, or acupuncture. • Referral to a PT or OT specialist, or a chiropractor, during the acute or chronic phase, if appropriate, with a required reevaluation following a therapeutic trial of care (e.g., two to four weeks). ***Note:*** *The primary care provider (PCP) or specialist should monitor patient outcomes during the therapeutic trial, and refer to the provider with best results. If the patient fails to demonstrate significant functional gains, a referral for an alternative form of treatment should be considered.* Timely consultation and/or referral to a pain management specialist for any one of the following scenarios: • Requires opioids beyond one month. • Requires morphine milligram equivalent (MME) 30 mg, such as PERCOCET® 7.5 three times a day, or hydrocodone10 mg three times a day, or more, daily. • Has musculoskeletal or radicular pain, and the response has been inadequate after four to six physical therapy visits, OR after 30 days of treatment. **When in doubt, consult and refer.** **Recommendation:** Make a consultation and/or referral within 60 days of the onset of symptoms. Timely consultation with and/or referral to behavioral health services. Request expedited evaluation, if needed, based on the risk: • Higher opioid doses or longer-term opioid use requiring behavioral intervention • Polypharmacy with narcotics, such as opioids with benzodiazepines or other sedatives • Active addiction, history of addiction, or substance use disorder requiring intervention • Positive behavioral health assessment screening for depression, anxiety, or other behavioral health diagnosis • Limited improvement, continued pain, fear avoidance affecting recovery, and no behavioral health treatment • Disability or pending disability **Be clear on treatment plan, expected outcomes and time length of prescription.**

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Clinical scenario: Opioid prescription renewal **Stop and reassess** if there is no improvement, aberrant behavior, or adverse side effects.	
Check use of non-opioid therapies	Check that non-opioid therapies have been tried and optimized. Determine if referrals, or additional therapies and/or referrals, should be considered first.
Evaluate risk of harm or misuse	Follow the recommendations outlined in the "Clinical scenario: Opioid prescribed for pain" section of this document, AND: • Observe for signs of over-sedation or overdose risk. If yes, taper the dose. • Check for an opioid use disorder, if indicated (e.g., difficulty controlling use). If yes: Refer for treatment. **Determine whether to continue, adjust, taper, or stop opioids.**
Educate and reassure	Follow the recommendations outlined in the "Clinical scenario: Opioid prescribed for pain" section of this document.
Assess and monitor	Follow the recommendations outlined in the "Clinical scenario: Opioid prescribed for pain" section of this document, AND: • Assess if the patient has had a reevaluation within one to four weeks of an opioid prescription renewal; compare to baseline. • Calculate the current opioid dosage MME.
Safe prescribing measures	Follow the recommendations outlined in the "Clinical scenario: Opioid prescribed for pain" section of this document.
Care coordination and referrals	Follow the recommendations outlined in the "Clinical scenario: Opioid prescribed for pain" section of this document.

Clinical scenario: Patient on a higher dose of an opioid for an extended period of time

Follow the recommendations outlined in the "Clinical scenario: Opioid prescribed for pain" section of this document, AND:
• Do not dismiss a patient from care. Instead, offer supportive services (e.g., cognitive behavioral therapy, counseling, referral and collaboration with a behavioral provider, or other alternative treatment options).
• If a patient is receiving a high opioid dosage, consider:
  ○ Collaborating with the patient to taper to a safer dosage.
  ○ Offering naloxone if the patient is at a higher risk for respiratory depression.
• If patient is taking a benzodiazepine with an opioid:
  ○ Communicate with other current providers managing the patient.
  ○ Weigh the patient's goals, needs, and risks.
• If considering an opioid use disorder, discuss safety concerns and treatment options.

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Clinical scenario: Tapering or weaning a patient off of opioids	
When to taper Provider directed	Consider tapering or weaning off of opioids when a patient: • Fails to show significant analgesia and/or functional improvement, despite dose and/or incremental increase in dose. • Is taking a high-risk opioid dose and/or mixing with polypharmacy. Has comorbidities (e.g., sleep apnea, prolonged QT, pulmonary disease). • Is experiencing side effects of medication that interfere with the quality of life and ability to function safely. • Exhibits aberrant behaviors, significant behavioral or physical risks, increased impairment, or violates the treatment agreement. • Requests it.
How to taper	Tapering plans should be individualized, and minimize symptoms of opioid withdrawal, while maximizing pain treatment with non-pharmacologic therapies and non-opioid medications. • Before starting the taper, set a date to begin, provide information to the patient, and set up behavioral supports. • Explain the reason for the taper: "I am concerned…" • Determine the rate of taper based on the degree of risk. • If multiple drugs are involved, taper one at a time (e.g., start with benzodiazepines followed by opioids). • Recommend decreasing opioid use by 10 to 15 percent per week, or if a more rapid taper is needed, decreasing opioid use by 25 percent per week. • Engage behavioral health services if needed and not already engaged. • **Go slow:** A decrease of 10 to 15 percent of the original dose per week is a reasonable starting point. Some patients who have taken opioids for a long time might find even slower tapers easier (e.g., 10 percent per month). Discuss the increased risk for overdose if the patient quickly returns to a previously prescribed higher dose. • **Consult:** Coordinate with specialists and treatment experts as needed, especially for a patient who is at high risk of harm, such as pregnant women or those with an opioid use disorder. *Use extra caution during pregnancy due to the possible risks to the patient and fetus if the patient goes into withdrawal.* • **Support:** Make sure the patient receives appropriate psychosocial support. If needed, work with behavioral health providers, arrange for treatment of an opioid use disorder, and offer naloxone for overdose prevention. Watch for signs of anxiety, depression, and opioid use disorder during the taper, and offer support or a referral, as needed. • **Encourage:** Let the patient know that most people have improved function without worse pain after tapering off of opioids. Some patients even have less pain after a taper, although it might briefly get worse at first. Tell the patient, "I know you can do this," or "I'll stick by you through this process."

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General considerations when tapering	Some short-term increase in pain is to be expected initially. This is usually transient, and many times opioids may be completely discontinued with no increase in pain and with improved function and quality of life. • The slower the taper, the less the short-term discomfort. It's often helpful to educate the patient about the risks of their current regimen, and what to expect as they taper off of the medications. • Some highly motivated patients prefer a rapid taper (weeks versus months). A patient's preference needs to be considered when designing a taper schedule. • Psychosocial support is an essential component of a successful medication taper or withdrawal for a patient who has been on long-term opioid therapy, or is struggling with the treatment plan change. Reassurance is critical, as many times the patient is experiencing fear and anxiety related to the potential recurrence of pain and development of withdrawal symptoms. • Provide adjuvant medications to address any withdrawal symptoms, and support the patient throughout the weaning phases. Consider the following, if clinical appropriate: ○ Antidepressants to manage mood, sleep disturbances, and irritability (e.g., trazadone) ○ Hydroxyzine for insomnia and anxiety ○ Anti-epileptics for neuropathic pain (e.g., gabapentin or Neurontin®) ○ Clonidine for autonomic withdrawal symptoms (e.g., rhinorrhea, diarrhea, sweating, or tachycardia) ○ NSAIDs for myalgia ○ Antidiarrheal for diarrhea