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Observations of the Opioid Workgroup of the Board of Scientific Counselors of the National Center for Injury Prevention and Control on the Updated CDC Guideline for Prescribing Opioids

Recommendation #1: Nonopioid therapies are preferred for many common types of acute pain. Clinicians should only consider opioid therapy for acute pain only if benefits are anticipated to outweigh risks to the patient. (Recommendation Category: A; Evidence Type: 3)

Recommendation #2: Nonopioid therapies are preferred for subacute and chronic pain. Clinicians should 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 known risks and realistic benefits of opioid therapy, should establish treatment goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. If opioids are used, they should be combined with other therapies as appropriate. (Recommendation Category: A, Evidence Type: 3)

Recommendation #3: When starting opioid therapy for acute, subacute, or chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids. (Recommendation Category: A and Evidence Type: 3)

Recommendation #4: When opioids are started 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 reassess evidence of individual benefits and risks when considering 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 and Evidence Type: 3)

Recommendation #5: For patients already receiving higher opioid dosages (e.g., >90 MME/day), clinicians should carefully weigh benefits and risks and exercise care when reducing or continuing opioid dosage. 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 and Evidence Type: 4)

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Recommendation #6: When opioids are used for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. One to three days or less will often be sufficient; more than seven days will rarely be needed. (Recommendation Category: A and Evidence Type: 4)

Recommendation #7: Clinicians should continue opioid therapy for subacute or chronic pain only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for subacute or chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. (Recommendation Category: A, Evidence Type: 4)

Recommendation Statement #8: Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss with patients. Clinicians should incorporate into the management plan strategies to mitigate risk, including 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)

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 dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for acute or chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months. (Recommendation Category: A, Evidence Type: 4)

Recommendation #10: When prescribing opioids for chronic pain, clinicians should use drug testing before starting opioid therapy and consider 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)

Recommendation #11: Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants. (Recommendation Category: A, Evidence Type: 3)

Recommendation #12: Clinicians should offer or arrange treatment with medication for patients with opioid use disorder. (Recommendation Category: A, Evidence Type: 2)

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What do the "Category" designation of the recommendations mean?

Category A recommendations apply to all patients

Category B recommendations require individual decision making where different choices will be appropriate for different patients so that clinicians must help patients arrive at a decision consistent with patient values and preferences and specific clinical situations.

What do the "Principle" designation of the recommendations mean?

PRINCIPLE 1: MINIMIZE BIAS

PRINCIPLE 2: SCIENTIFIC INTEGRITY

PRINCIPLE 3: ENHANCE INCLUSIVITY

PRINCIPLE 4: PATIENT AND CLINICIAN CENTERED

PRINCIPLE 5: HISTORICAL CONTEXT

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