1. **GUIDELINES:**
   These guidelines are intended to provide a general approach to prescribing opioids in the ambulatory practice setting and is consistent with the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain. Where applicable, respective state laws for the prescribing and dispensing of controlled substances should be incorporated.

2. **PURPOSE:**
   To promote the latest evidence and best practices for the safe and effective treatment of acute and chronic pain. The substantial increase in opioid-related morbidity and mortality coupled with the lack of evidence of benefit for opioids in chronic pain has created an unparalleled challenge to our healthcare system. While adequate and appropriate treatment of pain remains imperative, emerging data requires that we adopt a new paradigm when treating pain and prescribing opioids. Providers should be empowered to use opioids where it is determined opioids are the best option of treatment after exhausting other options that are likely safe and effective. At the same time, the provider should be empowered to limit opioids where the risk of harm outweighs potential benefit.

3. **SCOPE:**
   These guidelines apply to the ambulatory practice clinic settings. Hospital based physician offices or clinics are also expected to adhere to site specific accrediting body standards. These guidelines do not apply to patients with terminal illness, nursing home patients or patients enrolled in hospice or palliative care.

4. **PROCEDURE:**
   **A. ACUTE PAIN TREATMENT GUIDELINES**
   1. Nonpharmacologic therapy and nonopioid pharmacologic therapy should be optimized as a first line therapy to treat pain.
   2. If opioids are indicated and required to treat acute pain
Patients should be informed of the risks and benefits of the treatment including nausea, constipation, respiratory depression and risk of addiction in susceptible patients.

Prescribe the lowest effective dose of immediate-release opioids. Three days or less will usually be sufficient; more than 5-7 days will rarely be needed. Clinicians should not prescribe extended release/long acting opioids for the treatment of acute pain.

Patients should be informed that the use of illicit drugs or alcohol is prohibited while using a controlled substance.

Patients should be informed of the need for safe storage and safe disposal of opioid medications.

Providers reserve the right to check the state Prescription Drug Monitoring Program (PDMP) query (where access is available), perform a mental health screening, a substance abuse risk evaluation or perform a drug screen if clinically indicated.

If the patient continues to have pain requiring additional opioids after 7 days, they should be re-evaluated. This evaluation is ideally a face-to-face visit, but could be a phone evaluation depending on circumstances.

Providers should use additional discretion when considering opioids in patients <24 years old, patients with underlying mental health issues and patients with a history of substance use as these patients are at higher risk of misusing opioids or developing an addiction.

B. CHRONIC PAIN TREATMENT GUIDELINES (applies to patients with a chronic pain condition or patients who have taken daily opioids for more than 6 weeks)

1. Perform a detailed history/physical exam and obtain appropriate tests as indicated. Obtain and review records from previous caregivers to supplement your understanding of the patient’s chronic pain problem, including past treatments. After completing your initial evaluation, attempt to establish a working diagnosis and tailor a treatment plan to your patient’s desired functional goals.

Assessing Risk

2. Assess mental health status in each patient with a diagnosis of chronic pain. Mental health metrics such as PHQ-2 or PHQ-9© (for depression) and GAD-7© (for anxiety) are useful screening tools. Treatment of any underlying mental health conditions will improve response to pain treatment.

3. Assess risk for substance abuse. Patients with a current or past history of substance use disorder are at a greater risk of harm from opioids. Ask patients about past or current substance use/abuse (alcohol, prescription medications, illicit drugs or tobacco/e-nicotine) prior to initiating opioids for chronic pain. Providers may elect to use a validated tool to screen for a substance use disorder.

4. Order a urine drug monitoring test. This serves to screen for illicit substances and depending on medication and dose, may also confirm adherence to use of prescription medications.
5. Review the state PDMP before initiating opioid therapy. Using PDMP data, determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at risk for overdose.

**Initiation**

**CAUTION:** Clinicians should initiate opioid therapy only if expected benefits for pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacological therapy and non-opioid pharmacologic adjunctive therapy, as appropriate, to minimize opioid risk.

6. Together, review and sign a Controlled Substance Treatment Agreement. An agreed upon treatment plan should include a plan to mitigate the level and functional impact of chronic pain, initially having opioids serve as a temporary bridge of pain control as a better solution is sought. Discuss the potential risks and benefits of opioid treatment for chronic pain, as well as expectations related to prescription requests and proper medication use. Provide a simple and clear explanation to help patients understand the key elements of their treatment plan. Patients should understand the expected duration of opioid treatment and the reasons why opioid therapy would need to be weaned or discontinued, such as non-compliance with the treatment agreement.

7. Set functional goals with your patients that include achievable targets for pain management. Have a conversation with your patient about their treatment plan and set realistic goals for improvement in pain control. Aim for a reduction in pain with patient-specific functional improvements as key outcomes. Achieving complete resolution of chronic pain with prescribed medications alone is an unrealistic expectation for the vast majority of patients. A multifaceted treatment plan, utilizing medications together with a combination of other treatment modalities, will usually provide the optimal balance of risk and benefit for most patients.

**Continued Prescribing, Evaluation and Monitoring**

8. The risks of harm from prescription opioids increase on a continuum with increases in daily dose. Patients taking >50mg Morphine Equivalent Dose (MED) per day have an increased risk of harm, including overdose and death. Providers should continually evaluate the risk/benefit ratio and have frank discussions with the patient to ensure that both the provider and the patient agree that continuation of the opioid treatment is desired.

9. Providers should avoid prescribing opioid doses exceeding 90mg MED per day (exceptions include pain specialists, palliative care providers, patients being treated for a painful hemoglobinopathy crisis, for severe burns or active cancer). Patients currently on doses exceeding 90mg MED should be slowly and compassionately weaned down to 90mg MED. Weaning opioids should be coupled with an individualized plan to optimize nonpharmacologic modalities and non-opioid pharmacologic therapy to treat patient’s pain. The patient and provider may choose to transfer care to a pain specialist. If patient does not tolerate a slow wean, provider may consider referral to a specialist or evaluation for Medication Assisted Treatment (MAT) with Buprenorphine or Methadone.
10. Evaluate the benefits and harm with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or dose escalation.

11. For stable patients taking chronic daily opioids, they need to be seen for a face to face visit to address pain at least every 3 months or more frequently when adjusting doses or when clinically indicated. Remember the 5 A’s when managing chronic pain patients with opioids:
   a) Assess Affect
   b) Ask about activities of daily living (ADL’s)
   c) Assess analgesia (is the patient meeting their functional goals)
   d) Assess adverse effects of treatment
   e) Monitor for aberrant drug use behaviors

12. Providers must continually document a favorable benefit to risk ratio to justify continuing an opioid medication.

13. Although PDMP data is reviewed when starting opioid therapy for chronic pain, it should be reviewed periodically during opioid therapy ranging from every prescription to a minimum of every three months.

14. Urine drug testing (UDT) should be performed periodically; annually is the suggested minimum. This is another tool that compliments other risk assessments. It will help identify patients using illicit substances and depending on the medication and the dose may assist in monitoring patients’ adherence to their prescribed medications. Contact the lab toxicologist to fully understand the specifications and limitations of the available drug tests.

**Discontinuation**

**CAUTION:** Intermittent dialogue about weaning or discontinuing use should occur.

15. Wean or discontinue controlled substances, while continuing to provide non-opioid care for patients, if suspected or diagnosed addiction, no objective data suggesting favorable benefit, and/or violation of treatment agreement or evidence of illicit substances. Refer suspected or diagnosed addiction to chemical dependency evaluation and treatment. Identification of substance use disorder represents an opportunity for a clinician to initiate potentially life-saving interventions. Unless there is a concern for your safety, do not abandon patients with substance abuse, drug or alcohol addiction.

16. Terminate care if the patient exhibits violent or abusive behavior toward staff, there is evidence of falsified prescriptions or stolen prescriptions and/or there is evidence from the PDMP of a persistent pattern of patient getting prescriptions from outside providers. It is important that the patient understands they cannot get additional prescriptions but they can be cared for in other ways (non-opioid treatment modalities, support for substance use disorder, etc.).

**Additional Safety Precautions**

17. Chronic opioid use is inappropriate in the treatment of Fibromyalgia because of the interaction of unique pathophysiologic characteristics of the patients and effects associated with chronic opioid use (J Clin Rheumatol 2013;19: 72-77)

18. Use of benzodiazepines to treat anxiety is strongly discouraged.
19. Co-prescribing benzodiazepines and opioids should be avoided when possible. This combination significantly increases risks of overdose/respiratory depression.

20. Due to higher risk of respiratory arrest, use opioids with caution, if at all, in patients with underlying medical conditions such as sleep apnea, COPD, CHF and any other diseases that compromise respiratory function.

21. Patients with active alcohol or substance abuse disorders should not be prescribed chronic opioids or benzodiazepines from primary care providers.

22. Replacing lost, stolen or misplaced controlled substances is strongly discouraged.

23. All controlled substances written for PRN dosing must specify the maximum number of pills per day or per month (i.e. Vicodin 1 pill q 6hours PRN pain, maximum 2/day or 60/month)

24. Initiating controlled substances in patients that are determined to be high risk is strongly discouraged. High risk patients must be closely monitored for misuse, addiction and diversion. Providers must have a plan in place if addiction or diversion is suspected.

25. Naloxone should be recommended for all patients who are at high risk of overdose. This includes but is not limited to patients with a history of sedation or overdose, patients with underlying respiratory conditions, patients on higher opioid doses, patients being co-prescribed other sedating medications or patients with prior addiction issues.