Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

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CDC Guidelines for Opioid Prescribing

CDC Clinical Practice Guidelin...
States, 2022

Objectives

1

Understand the genesis of the 2016 CDC Guidelines

2

Understand the recommendations of the 2016 Guidelines

3

Understand the new guidelines

Intention of the 2016 Guidelines

Provide	Provide recommendations to healthcare providers on the appropriate prescribing of opioids
Improve	Improve patient outcomes
Reduce	Reduce the risks associated with opioid use

2016 Guideline Caveats

Intended for primary care providers and were not intended to apply to the treatment of pain related to:

- Cancer
- End-of-life care

Not intended to be rigid rules but rather to provide guidance to clinicians in their decision-making process regarding opioid prescribing

2016 CDC Guidelines

Centers for Disease Control and Prevention

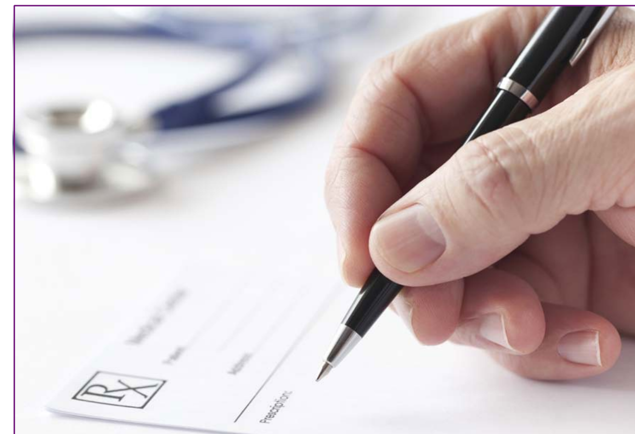
MMWR

Morbidity and Mortality Weekly Report

Early Release / Vol. 65

March 15, 2016

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



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

2016 CDC Guidelines

1. OPIOIDS ARE NOT FIRST-LINE THERAPY

Non-pharmacologic therapy and **non-opioid 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 non-pharmacologic therapy and non-opioid pharmacologic therapy, as appropriate.

Alternatives to Opioids

- Physical therapy
- Osteopathic Manipulative Treatment (OMT)
- Acetaminophen
- Ibuprofen

2016 CDC Guidelines

2. ESTABLISH GOALS FOR PAIN AND FUNCTION

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 opioid 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.

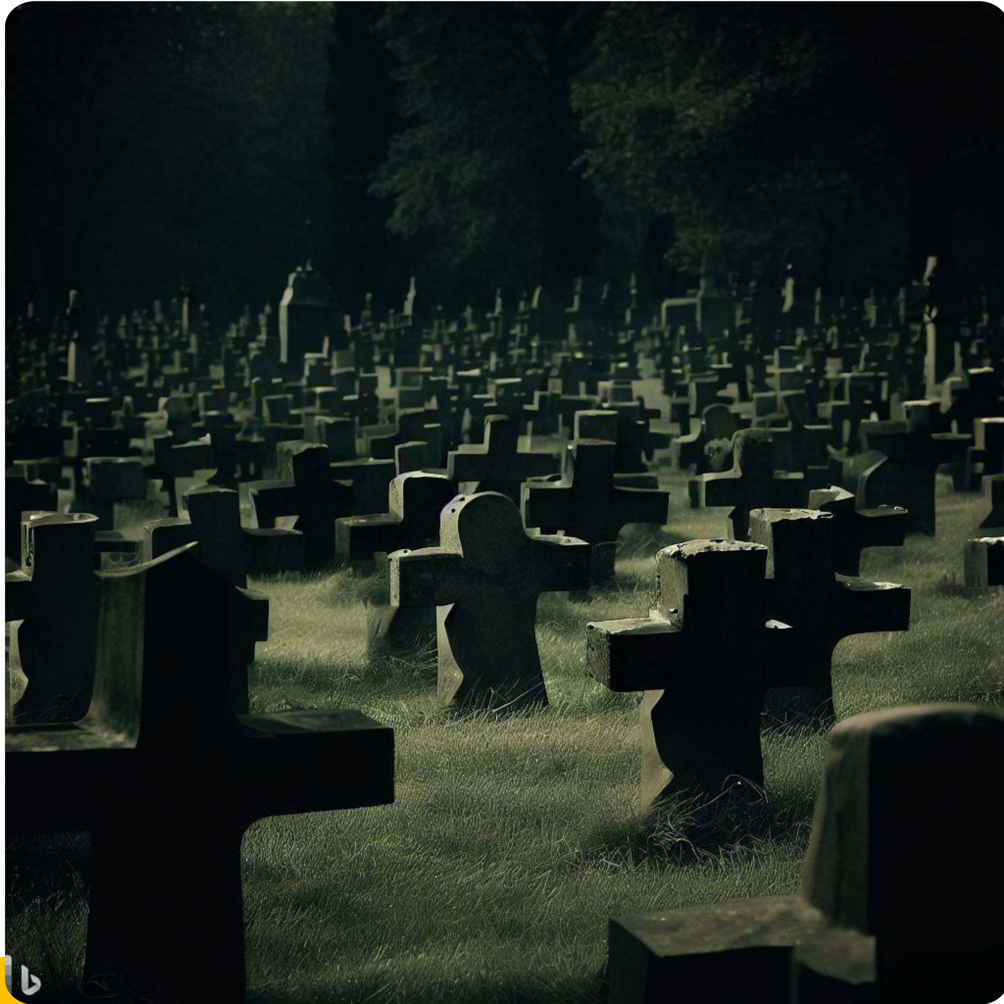
What is your goal of using opioids?

- To have the patient pain free?
  - Is that likely?
- What is the patient able to do because of the medication?
- What evidence do you have that the benefits are worth the risk?

CDC Guidelines

3. DISCUSS RISKS AND BENEFITS

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.



Risks

- Death
- Hospitalization
- Increased Pain
- Addiction

Benefits of Opioids for Chronic Pain

- Highly Controversial

Benefits of Opioids for Chronic Pain

Randomized trials have demonstrated that opioid therapy for up to 12–16 weeks is superior to placebo, but have not addressed longer-term use.

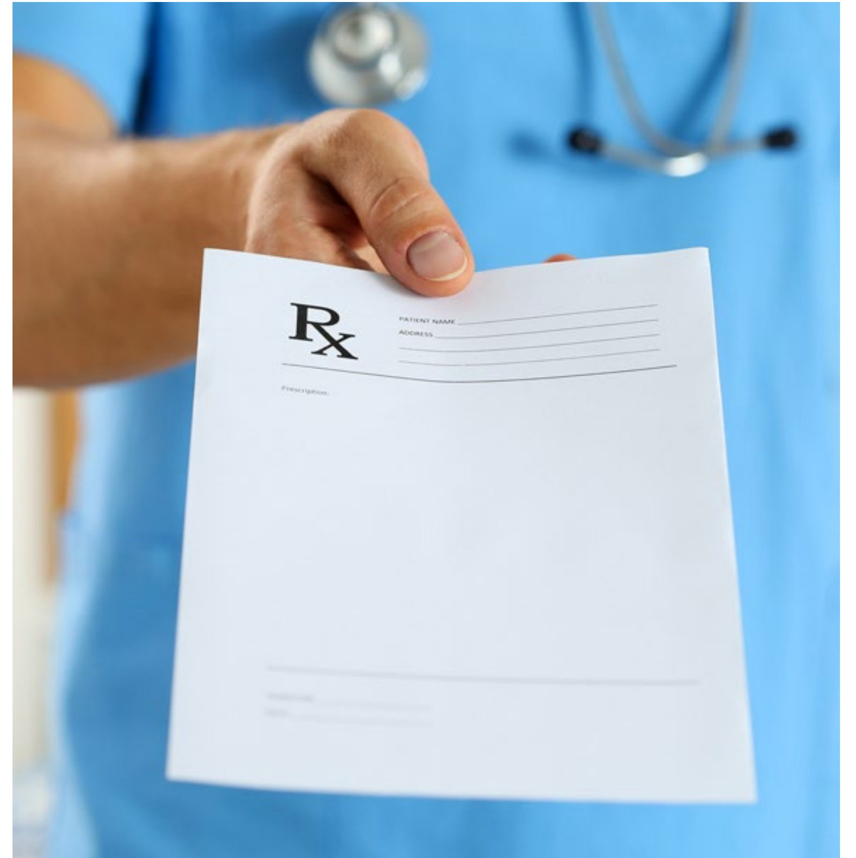
The US has conducted an experiment of population-wide treatment of chronic pain with long-term opioid therapy. The benefits have been hard to demonstrate, but the harms are now well demonstrated.

Sullivan MD, Howe CQ. Opioid therapy for chronic pain in the United States: promises and perils. Pain. 2013 Dec;154 Suppl 1(0 1):S94-S100. doi: 10.1016/j.pain.2013.09.009. Epub 2013 Sep 11. PMID: 24036286; PMCID: PMC4204477.

2016 CDC Guidelines

4. USE IMMEDIATE-RELEASE OPIOIDS WHEN STARTING

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



2016 CDC Guidelines

5. USE THE LOWEST EFFECTIVE DOSE

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 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.

MME

- Convert all opioids to morphine

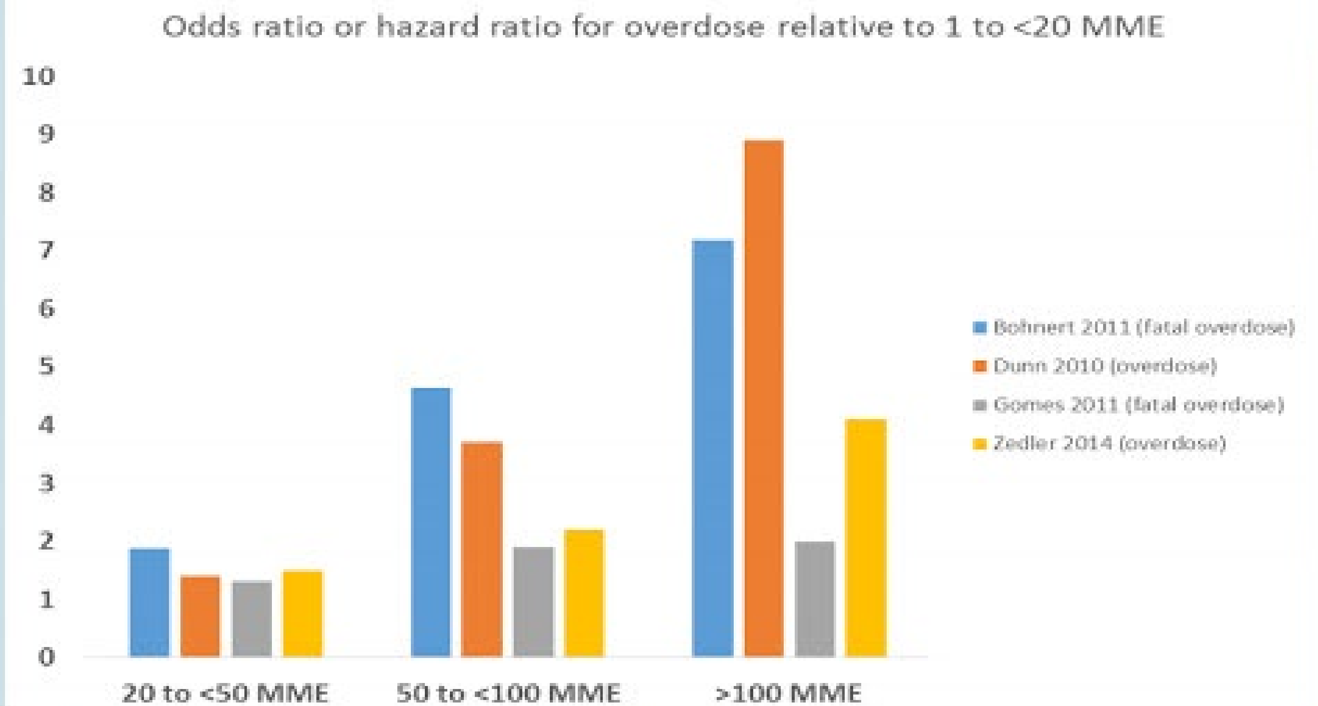
- Calculate the 24 hour dose

MME Conversion Chart

Calculating morphine milligram equivalents (MME)

OPIOID (doses in mg/day except where noted)	**CONVERSION FACTOR**
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

Risk of Overdose by MME



MME in Oklahoma

- There is no legal limit on MME in the State of Oklahoma
- Pharmacies and Insurance companies can limit
- Liability significantly increases if there is a bad outcome
- If the prescriber chooses to prescribe greater than 100 MME, document the rationale should be documented thoroughly. 63 O.S § 2-309I(J)(3)

2016 CDC Guidelines

6. PRESCRIBE SHORT DURATIONS FOR ACUTE PAIN

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. Three days or less will often be sufficient; more than seven days will rarely be needed.

CDC MMWR March 2017

Choice of first prescription	Number (%) of patients	One-year probability of continued use, %	Three-year probability of continued use, %
Long Acting Opioids	6,588 (0.5)	27.3	20.5
Tramadol	120,781 (9.33)	13.7	6.8
Hydrocodone Short Acting	742,112 (57.3)	5.1	2.4
Oxcodone Short Acting	219,224 (16.9)	4.7	2.3
Schedule II Short Acting	14,877 (1.2)	8.9	5.3
Schedule III-IV and Nalbuphine	190,665 (14.7)	5.0	2.2

2016 CDC Guidelines

7. EVALUATE BENEFITS AND HARMS FREQUENTLY

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.

Check Ins With the Patient

- Discuss symptomatology
- Discuss the function and benefit of opioids
- Discuss cravings and addiction
- Pill count/UDS

2016 CDC Guidelines

8. USE STRATEGIES TO MITIGATE RISK

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.

Who Needs Narcan?

- Everyone
- Physicians
- Previous overdose
- Concurrent Benzodiazepines

2016 CDC Guidelines

9. REVIEW PDMP DATA

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 chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

Oklahoma PMP

- Must be checked at the initial prescription and every 6 months
- Should be checked at every prescription
- When you don't check it, you are acknowledging that information was readily available that would have changed your decision that you decided not to ask
- Failure to check per statute can result in action:
  - Criminal
  - Civil
  - Administrative

2016 CDC Guidelines

10. USE URINE DRUG TESTING

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.

Urine Drug Screens

- Should be done at first visit
- Should be done frequently in the beginning of treatment
- Should be done routinely after
- All patients tested the same

2016 CDC Guidelines

11. AVOID CONCURRENT OPIOID AND BENZODIAZEPINE

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

Are Benzodiazepines Addictive?

- Yes!
- Schedule IV
- True abuse liability is unknown but thought to be very high

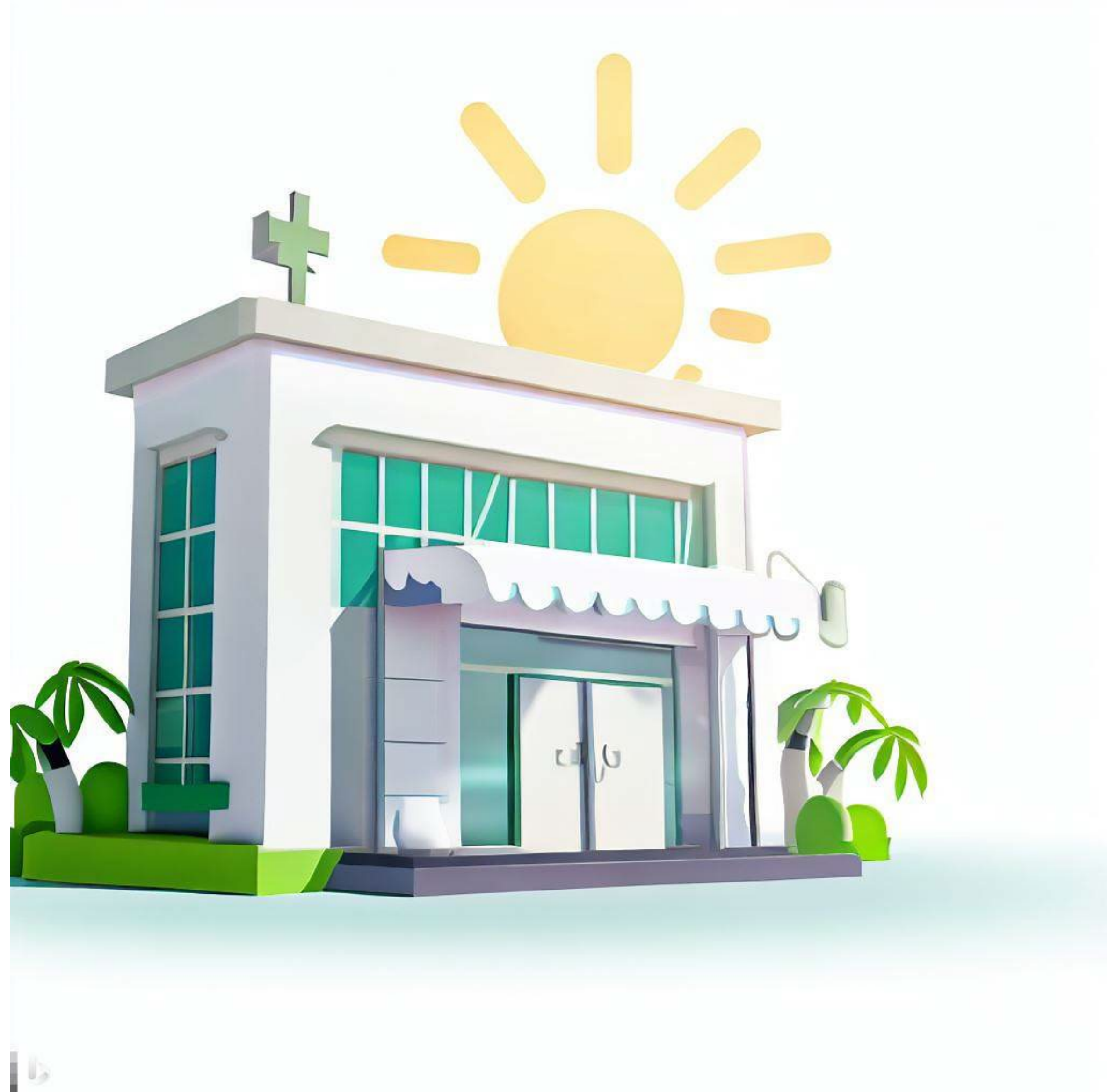
Benzodiazepine Statistics

- Between 1996-2013:
  - Prescriptions increased by over 67% (Yale)
  - Overdoses increased by 500%
- Xanax is the #1 prescribed psychiatric medication in the country
  - 50 million prescriptions annually
- Improper use of Xanax results in over 125,000 emergency room visits per year
- Among teenagers, addiction rates to Benzos are higher than opioids

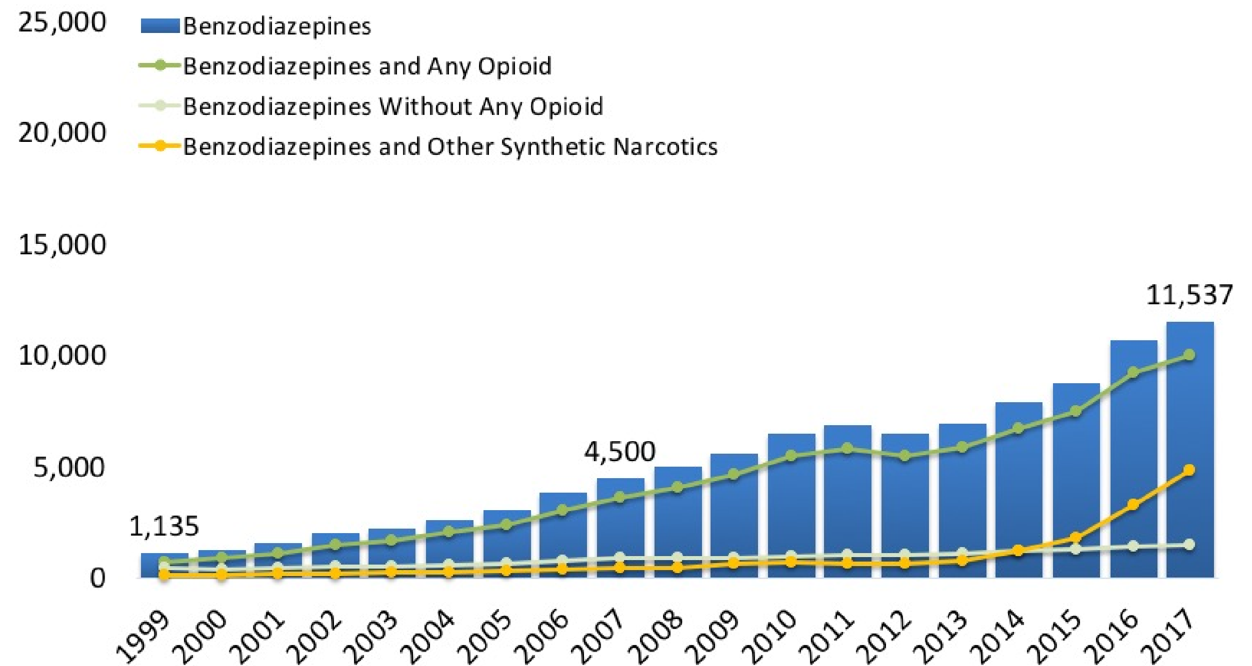
https://drugabuse.com/benzo-epidemic-a-killer-hiding-in-the-shadow-of-opioids/

Trends in Benzodiazepines Prescriptions

- Benzodiazepines prescriptions have increased by 51%
- Visits for benzodiazepines increased from 3.4 to 7.8% of all primary care visits
- Prescription rates did not change among psychiatrists, but instead by primary care



Opioid Overdose Deaths & Benzodiazepines



Beaman's Rules for Benzos

- Don't Use Them
- Not first-line therapy for anxiety (SSRIs)
- Doesn't treat anxiety, masks it
- Highly addictive

2016 CDC Guidelines

12. OFFER TREATMENT FOR OPIOID USE DISORDER

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.

What happens if a patient is addicted to opioids?

Don’t fire them

Help them obtain treatment for their disease like you would any other illness

Prompt termination could increase liability

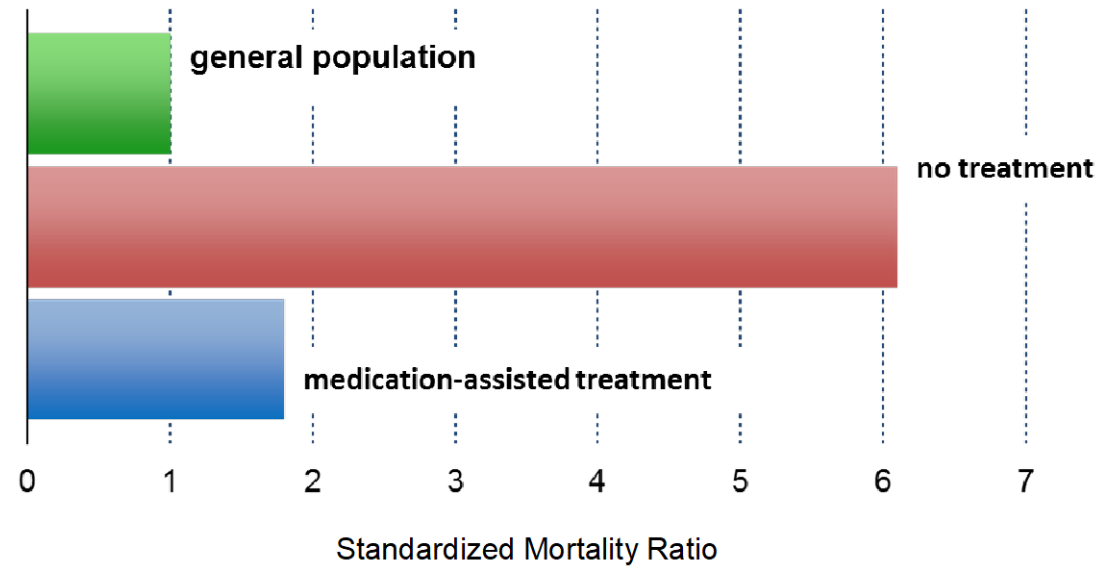
Discontinuation of Opioids

- Discontinuing opioids after extended periods of continuous opioid use can be challenging for clinicians and patients

- Tapering or discontinuing opioids in patients who have taken them long term can be associated with clinically significant risks, particular if opioids are tapered rapidly or patients do not receive effective support. 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 fromhigher dosages.

Benefits of MAT: Decreased Mortality

Death rates:



Dupouy et al., 2017
Evans et al., 2015
Sordo et al., 2017

The Goal is to Keep People Alive

2022 CDC Guidelines

Since the release of the 2016 CDC Opioid Prescribing Guideline, new evidence has emerged on:

Benefits and risks of prescription opioids for:

Acute

Chronic pain

Comparisons with nonopioid pain treatments

Dosing strategies

Opioid dose-dependent effects

Risk mitigation strategies

Opioid tapering and discontinuation

2022 CDC Guidelines Evidence since the 2016 Guidelines

- Misapplication of the 2016 CDC Opioid Prescribing Guideline
- Benefits and risks of different tapering strategies
- Rapid tapering associated with patient harm
- Challenges in patient access to opioids
- Patient abandonment and abrupt discontinuation of opioids
- A seminal randomized clinical trial comparing prescription opioids to nonopioid medications on long-term pain outcomes
- The association of characteristics of initial opioid prescriptions with subsequent likelihood for long-term opioid use and the small proportion of opioids used by patients compared with the amount prescribed to them for postoperative pain

2022 Guidelines

1. Nonopioid therapies are at least as effective as opioids for many common types of acute pain. Clinicians should maximize use of nonpharmacologic and nonopioid 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 category: B; evidence type: 3).

2. Nonopioid therapies are preferred for subacute and chronic pain. Clinicians should maximize use of nonpharmacologic and nonopioid 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, should work with patients to establish treatment goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks (recommendation category: A; evidence type: 2).

2022 Guidelines

3. 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 category: A; evidence type: 4).
4. 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 category: A; evidence type: 3).
5. For patients already receiving opioid therapy, clinicians should carefully weigh benefits and risks and exercise care when changing opioid dosage. If benefits outweigh risks of continued opioid therapy, clinicians should work closely with patients to optimize nonopioid therapies while continuing opioid therapy. If benefits do not outweigh 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 circumstances of the patient, 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 category: B; evidence type: 4).

2022 Guidelines

6. 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 (recommendation category: A; evidence type: 4).

7. 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 regularly reevaluate benefits and risks of continued opioid therapy with patients (recommendation category: A; evidence type: 4).

2022 Guidelines

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss risk with patients. Clinicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone (recommendation category: A; evidence type: 4).

9. When prescribing initial opioid therapy for acute, subacute, or chronic pain, and periodically during opioid therapy for chronic pain, 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 (recommendation category: B; evidence type: 4).

10. 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 other prescribed and nonprescribed controlled substances (recommendation category: B; evidence type: 4).

11. Clinicians should use particular caution when prescribing opioid pain medication and benzodiazepines concurrently and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants (recommendation category: B; evidence type: 3).

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 for resuming drug use, overdose, and overdose death (recommendation category: A; evidence type: 1).

Major Differences with 2022 CDC Guidelines

- Removed MME limit
- Removed 7 day limit

Oklahoma Rules

- Prescription Monitoring Program – PMP must be checked at the initial prescription and then at least every 180 days. 63 O.S. § 2-309D(G)

Oklahoma Rules
Acute Pain Prescription Limits

- Prescriber shall not issue an initial prescription for an opioid drug in a quantity exceeding seven (7) day supply. Prescription shall be for the lowest effective dose of immediate-release opioid drug and must state "acute pain" on the face of the prescription. 63 O.S. § 2-309I(A) & (G).

- Following the initial seven (7) days, after consultation (in person or by telephone), a subsequent 7-day prescription may be issued if prescriber determines the prescription is necessary and appropriate, documents the rationale for prescribing, and determines and documents the prescription does not present undue risk of abuse, addiction or diversion. A second 7-day prescription of an immediate-release opioid drug in a quantity not to exceed seven (7) days may be issued on the same day as the initial prescription if:
  - (i) The subsequent prescription is due to a major surgical procedure and/or "confined to home" status as defined in 42 U.S.C. 1395n(a);
  - (ii) The practitioner provides the subsequent prescription on the same day as the initial prescription;
  - (iii) The practitioner provides written instruction on the subsequent prescription indicating the earliest date on which the prescription may be filled (i.e. "do not fill until" date);
  - (iv) The subsequent prescription is dispensed no more than five (5) days after the "do not fill until" date indicated on the prescription. 63 O.S. § 2-309(I)(B)(5)

Oklahoma Rules

- If a medication needs to be changed due to allergy, ineffective dose or other medical condition, document thoroughly in the record the need and rationale for change.

Oklahoma Rules
Chronic Pain

- If continuing treatment for three months or more, practitioner shall:

(1) review every three (3) months the course of treatment, any new information regarding etiology of pain and progress toward treatment objectives;

(2) assess patient prior to every renewal to determine if patient is experiencing dependency, Opioid Use Disorder, or addiction and document assessment;

    (1) if a Substance use disorder (SUD) is present a referral to a specialist should be considered

(3) Periodically make reasonable efforts, unless clinically contraindicated to stop, decrease dosage, or try other treatment modalities;

(4) Review PMP;

(5) Monitor compliance with patient provider agreement, and state “chronic pain” on the face of the prescription. After one year of compliance with the patient provider agreement, physician may review treatment plan and assess patient at six-month intervals. 63 O.S. § 2-309I(F)

Oklahoma Rules

Prior to an Initial Prescription for any Opioid: practitioner shall:

(1) take and document a thorough medical history;

(2) Conduct and document a physical exam;

(3) develop a treatment plan;

(4) access the PMP;

(5) limit supply to no more than seven (7) days for acute pain;

(6) if the patient is under 18, enter into a patient -Provider Agreement with the parent or legal guardian;

(7) if the patient is a pregnant woman enter into a patient –provider agreement. 63 O.S. § 2-309I(A) & (B)

Oklahoma Rules
Informed Consent & Risk Discussions

Prior to initial prescription and again prior to third prescription, practitioner must discuss risks including:

(1) risks of addiction and overdose, dangers of taking opioids with alcohol, benzodiazepines and other CNS central nervous system depressants;

(2) reason the prescription is necessary;

(3) alternative treatment available;

(4) risks can include fatal respiratory depression. practitioner shall document the discussion in the medical record. 63 O.S. § 2-309I(D)

Oklahoma Rules
Patient-Provider Agreement

- Practitioner shall enter into a Patient-Provider Agreement with a Patient:

(1) at the time of the third prescription for opioid drug;

(2) If Patient requires more than three months of pain management;

(3) if Patient is prescribed benzodiazepines and opioids together;

(4) if Patient requires more than 100 mg morphine milligram equivalents (MME);

(5) If Patient is pregnant;

(6) with the parent or legal guardian if the Patient is a minor. 63 O.S. § 2-309I(J); 63 O.S. § 2-309I(B)(6),(7); 63 O.S. § 2-101(45)

Oklahoma Rules
Exclusions

- The requirements of SB 1446 and SB 848 do not apply to a Patient who has sickle cell disease, is in treatment of cancer or receiving aftercare cancer treatment, hospice, palliative care, residents of a long-term care facility, or medications for treatment of substance abuse or opioid dependence. 63 O.S. § 2-309I(H)

Oklahoma Rules
Written Policy

Any provider authorized to prescribe opioids shall adopt and maintain a written policy including exclusion of written contract patient-provider agreement between practitioner and qualifying opioid therapy patient. 63 O.S. § 2-309I (I) (J)

Oklahoma Rules
Standard of Care

This law shall not be construed to require a practitioner to limit or forcibly taper a patient on opioid therapy.

The standard of care requires effective and individualized treatment for each patient as deemed appropriate by the prescribing practitioner

Conclusion

- The CDC Guidelines have been very helpful in understanding the appropriate use of opioids
- Physicians should be aware of the risks when using opioids
- The 2022 Guidelines have loosened the safety a little but still urges caution

Questions?

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