AMDG
agency medical directors' group

A collaboration of state agencies, working together to improve health care quality for Washington State citizens

	2015 AMDG	2016 CDC
Acute phase	▪ Prescribe the lowest necessary dose for the shortest duration **(<14 days)**. ▪ Opioid use beyond the acute phase is rarely indicated. ▪ Use non-opioid therapies such as behavioral intervention, physical activity and non-opioid analgesics. ▪ Check the PMP prior to prescribing opioids. ▪ **Don't prescribe opioids for non-specific back pain, headaches or fibromyalgia**.	▪ Prescribe the lowest effective dose of immediate-release opioids and no greater quantity than needed for expected duration **(≤3 days is usually sufficient; ≥7 days is rarely needed)**. (6)
Perioperative	▪ Evaluate thoroughly preoperatively: **check the PMP and assess risk for over-sedation and difficult-to-control pain.** ▪ Avoid adding or continuing benzodiazepines, carisoprodol, sedative-hypnotics or CNS depressants with opioids. ▪ **Do not discharge with more than a 2-week supply of opioids, many surgeries may require less. Continued opioid therapy require re-evaluation by the surgeon:** ✓ **Discharge with acetaminophen, NSAIDs or very limited supply (2-3 days) of short-acting opioids for some minor surgeries.** ▪ For patients on chronic opioids, taper to preoperative doses or lower within 6 weeks following major surgery.	▪ No recommendation

Subacute phase/transition phase	▪ Don't continue opioids without clinically meaningful improvement in function (CMIF) and pain. ▪ Have a plan for how and when to discontinue opioids if CMIF wasn't achieved or the patient has had a serve adverse outcome. ▪ **Avoid opioids if the patient has significant respiratory depression, current substance use disorder, history of prior opioid overdose or a pattern of aberrant behaviors.** ▪ **Don't prescribe opioids with benzodiazepines, carisoprodol or sedative-hypnotics.** ▪ Screen for comorbid mental health conditions and risk for opioid misuse using validated tools. ▪ Recheck the PMP and administer a baseline urine drug test (UDT) if you plan to prescribe opioids beyond 6 weeks.	▪ Initiate opioids only if expected benefits for pain and function outweigh risks. (1) ▪ Establish treatment goals and consider how to discontinue if benefits do not outweigh risks. (2) ▪ Incorporate risk mitigating strategies into treatment plan including **offering naloxone for patients with history of overdose, substance use disorder, high opioid dose (≥ 50 MME/day), or concurrent benzodiazepines.** (8) ▪ Review PDMP when starting opioids. (9) ▪ Use urine drug testing before starting opioids for chronic pain. (10)

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Chronic phase	▪ **Continue to prescribe opioids only if there is sustained CMIF and no serious adverse events, risk factors or contraindications.** ▪ Discuss potential benefits and risks with opioids including addiction and overdose. Have a signed treatment agreement. ▪ Use best practices to ensure effective treatment and minimize potential adverse outcomes: ✓ **Repeat PMP check and UDT at frequency determined by the patient's risk category**. ✓ **Assess and document function and pain using a validated tool at each visit where opioids are prescribed**. ✓ Monitor for opioid-related adverse outcomes. ✓ Consult with a pain management specialist before exceeding 120 mg/day MED. ▪ **Consider prescribing naloxone for doses > 120 mg/day MED.** ▪ Don't prescribe opioids with benzodiazepines, carisoprodol or sedative-hypnotics. ▪ Prescribe the lowest possible effective dose. ▪ **Prescribe in multiples of 7-day supply to reduce incidence of supply ending on a weekend.**	▪ Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain. If opioids are used, they should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy. (1) ▪ Continue opioids only if there is clinically meaningful improvement in pain and function that outweighs risks. (2) ▪ Discuss known opioid risks and realistic benefits and responsibilities for managing therapy periodically. (3) ▪ **Prescribe immediate release opioids when initiating opioid therapy.** (4) ▪ **Evaluate benefits and harms within 1-4 weeks of starting opioids or of dose escalation and every 3 months**. (7) ▪ **Re-review PDMP periodically with each prescription or every 3 months**. (9) ▪ **Use urine drug testing at least annually**. (10) ▪ Avoid prescribing opioid and benzodiazepines concurrently. (11)

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Dose	▪ **Avoid opioids if there is any FDA or clinical contraindications:** ✓ **Significant respiratory depression, acute or severe asthma in an unmonitored setting, known or suspected paralytic ileus or hypersensitivity** ✓ **Current substance use disorder (SUD) or past opioid use disorder** ✓ **History of prior opioid overdose** ✓ **Pattern of aberrant behaviors** ▪ Use great caution at any dose and prescribe naloxone if patient has a mental health disorder, family or personal history of SUD, medical condition that increase sensitivity to opioid side effects or concurrent benzodiazepine use. ▪ **Do not escalate to >120 mg/day MED without first obtaining a pain consult.**	▪ **Use caution at any dose and reassess benefits and risks when considering increasing to ≥50 MME/day.** (5) ▪ **Avoid increasing to ≥90 MME/day or justify the decision to increase.** (5)

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Considerations for taper	▪ **When to discontinue:** ✓ **At the patient's request** ✓ **No CMIF** ✓ **Risks outweigh benefits** ✓ **Severe adverse outcome or overdose event** ✓ **Substance use disorder (except tobacco) identified** ✓ **Aberrant behaviors exhibited** ✓ **To maintain compliance with DOH rules or consistency with AMDG guideline** ▪ Consider an outpatient taper if the patient isn't on high dose opioids or doesn't have comorbid substance use disorder or other active mental health disorder. ▪ Seek consultation if the patient failed previous taper or is at greater risk for failure due to high dose opioids, concurrent benzodiazepine use, comorbid substance use disorder or other active mental health disorder.	▪ If benefits don't outweigh harms of continued opioid therapy, optimize other therapies and work to taper opioids to lower dose or discontinue. (7)
How to discontinue	▪ Taper opioids first for patients who are also on benzodiazepines. ▪ Unless safety considerations require a more rapid taper, start with 10% per week and adjust according to the patient's response. ▪ Don't reverse the taper; it can be slowed or paused while managing withdrawal symptoms. ▪ Watch for signs of unmasked mental health disorders, especially in patients on prolonged or high-dose opioids.	▪ No recommendation
Recognizing and treating opioid use disorder	▪ Assess for opioid use disorder and/or refer for a consultation if the patient exhibits aberrant behaviors. ▪ Help patients get medication-assisted treatment along with behavioral therapies. ▪ **Prescribe naloxone (especially if you suspect heroin use) and educate patient's contacts on how to use it.**	▪ Offer or arrange evidence-based treatment for patients with opioid use disorder. (12)

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Special populations	▪ Counsel women before and during pregnancy about maternal, fetal, and neonatal risks. ▪ **For children and adolescents,** avoid prescribing opioids for most chronic pain problems. ▪ In older adults, initiate opioids at 25–50% lower dose than for younger adults. ▪ **For cancer survivors,** rule out recurrence or secondary malignancy for any new or worsening pain symptom. ▪ **See Dose section for FDA or clinical contraindications**	▪ Discuss family planning and how long-term opioids may affect future pregnancy for reproductive-age women. ▪ Use caution and increase monitoring for patients ≥65 years. ▪ Avoid prescribing opioids to patients with moderate or **severe sleep-disordered breathing** whenever possible. ▪ Ensure treatment for **depression and other mental health conditions** is optimized. Consider using tricyclic or SNRI antidepressants for analgesic as well as antidepressant effects. ▪ Use caution and increase monitoring for patients with **renal and hepatic insufficiency**. ▪ In persons with **active or recent past history of substance abuse**, consider consulting SUD specialists and pain specialists regarding pain management. ▪ For patients with **prior nonfatal opioid overdose**, work to reduce opioid dose and discontinue opioids when possible.