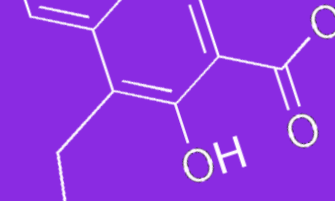
Opioid Prescribing



Opioids can provide short-term relief of moderate to severe acute pain, but there is little evidence supporting their effectiveness for chronic pain, and they have substantial risks. Long-term opioid use should be reserved for patients with cancer-related pain, or patients receiving palliative or end-of-life care. If you prescribe opioids for other conditions, use safety principles as embodied by Limiting Use and Avoiding Adverse Consequences.

Limiting Use

1. **Do not prescribe opioids as first-line or routine therapy for chronic pain**; use nonpharmacologic and nonopioid pharmacologic therapies first (see Chronic Pain Treatment Principles).
2. **Discuss benefits, risks, and side effects of opioid therapy (e.g., addiction, overdose)**; continue to reassess the risks and benefits of opioids throughout treatment.
3. **Set realistic and measurable goals for pain and function**; plan for how opioid therapy will be stopped if benefits do not outweigh risks.
4. **Use short-acting opioids when starting opioid therapy for chronic pain**.
5. **Prescribe the lowest effective dosage when starting opioid therapy**, and reassess risks and benefits when increasing dosages to 50 morphine milligram equivalents (MME) per day or more, and avoid increasing dosages to 90 MME per day or more.

Prescribing Calculations
50 morphine milligram equivalents (MME) =
50 mg hydrocodone/day, or 33 mg oxycodone/day

6. **Long-term opioid use often starts with treatment of acute pain**. When using opioids for acute pain, prescribe short-acting forms and no more than necessary; three days or less is often sufficient.

Avoiding Adverse Consequences

7. **Follow-up regularly to re-evaluate risk of harm and reduce dose or taper if needed**; follow-up should occur within one to four weeks of starting opioid therapy or increasing dosage and continue quarterly.
8. **Prescribe naloxone to individuals who are undergoing long-term opioid therapy**, due to the higher risk of an overdose while taking these drugs.
9. **Check the Prescription Drug Monitoring Program (PDMP)** for prescriptions from other providers when starting opioid therapy and each time before writing a prescription.
10. **Use urine drug screening to identify prescribed substances and undisclosed use of other drugs** before starting opioid therapy and periodically thereafter.
11. **Avoid concurrent benzodiazepine and opioid prescribing**.
12. **Arrange treatment for opioid use disorder if needed, including medication-assisted treatment (buprenorphine or methadone)**. Philadelphia's Department of Behavioral Health and Intellectual disAbility Services can help you identify treatment options through its website. (http://bit.ly/DBHResources)
13. **Incorporate buprenorphine treatment into your own practice**. Find out how through the SAMHSA website. (https://bit.ly/BupeWaiver)

Chronic Pain Treatment Principles

Use non-opioid therapies whenever possible. The principles below provide guidance on therapy for chronic pain, based on the type of condition.

1. **Use first-line medications as the preferred option**:
    a. Acetaminophen
    b. NSAIDs
    c. Gabapentin/pregabalin for neuropathic pain or fibromyalgia
    d. Tricyclic antidepressants and SNRIs for neuropathic pain or fibromyalgia; TCAs for headaches
    e. Topical agents such as lidocaine or capsaicin
2. **Focus on functional goals and improvement**, engaging patients actively in their pain management.
3. **Use disease-specific treatments when available** (e.g., triptans for migraines, gabapentin/ pregabalin/duloxetine for neuropathic pain).
4. **Identify and address co-existing mental health conditions** (e.g., depression, anxiety, PTSD).
5. **Consider interventional therapies** (e.g., corticosteroid injections) in patients who fail standard non-invasive therapies.
6. **Use treatments with multiple modes**, including interdisciplinary rehabilitation for patients who have failed standard treatments, have severe functional deficits, or psychosocial risk factors.

Benzodiazepine Prescribing

1. **Do not initiate benzodiazepines for first-line treatment of anxiety disorders**; other pharmacologic and nonpharmacologic treatments can be safe and effective.
2. **Do not prescribe benzodiazepines to treat insomnia without appropriate evaluation, and do not prescribe them chronically**; when they are used, do not prescribe them other than for short-term, situational insomnia, or for more than ten days.
3. **Do not prescribe benzodiazepines to patients with substance use disorders**; use treatment history, information from other providers (including from the Prescription Drug Monitoring Program, or PDMP) and urine drug screenings as potential indicators of abuse.
4. **Do not prescribe benzodiazepines to patients enrolled in medication-assisted treatment for opioid use disorders or who are prescribed opioid medications**.