Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

□ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
□ Check that non-opioid therapies tried and optimized.
□ Discuss benefits and risks (eg, addiction, overdose) with patient.
□ Evaluate risk of harm or misuse.
  ▪ Discuss risk factors with patient.
  ▪ Check prescription drug monitoring program (PDMP) data.
  ▪ Check urine drug screen.
□ Set criteria for stopping or continuing opioids.
□ Assess baseline pain and function (eg, PEG scale).
□ Schedule initial reassessment within 1–4 weeks.
□ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

□ Check that return visit is scheduled ≤ 3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

□ Assess pain and function (eg, PEG); compare results to baseline.
□ Evaluate risk of harm or misuse:
  ▪ Observe patient for signs of over-sedation or overdose risk.
    – If yes: Taper dose.
  ▪ Check PDMP.
  ▪ Check for opioid use disorder if indicated (eg, difficulty controlling use).
    – If yes: Refer for treatment.
□ Check that non-opioid therapies optimized.
□ Determine whether to continue, adjust, taper, or stop opioids.
□ Calculate opioid dosage morphine milligram equivalent (MME).
  ▪ If ≥50 MME/day total (≥50 mg hydrocodone; ≥33 mg oxycodone), increase frequency of follow-up; consider offering naltrexone.
  ▪ Avoid ≥90 MME/day total (≥90 mg hydrocodone; ≥60 mg oxycodone), or carefully justify; consider specialist referral.
□ Schedule reassessment at regular intervals (≤3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

▪ Benefits of long-term opioid therapy for chronic pain not well supported by evidence.
▪ Short-term benefits small to moderate for pain; inconsistent for function.
▪ Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:
▪ Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
▪ Physical treatments (eg, exercise therapy, weight loss).
▪ Behavioral treatment (eg, CBT).
▪ Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:
▪ Illegal drug use; prescription drug use for nonmedical reasons.
▪ History of substance use disorder or overdose.
▪ Mental health conditions (eg, depression, anxiety).
▪ Sleep-disordered breathing.
▪ Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores
(30% improvement from baseline is clinically meaningful)

Q1: What number from 0–10 best describes your pain in the past week?
  0 = “no pain”, 10 = “worst you can imagine”

Q2: What number from 0–10 describes how, during the past week, pain has interfered with your enjoyment of life?
  0 = “not at all”, 10 = “complete interference”

Q3: What number from 0–10 describes how, during the past week, pain has interfered with your general activity?
  0 = “not at all”, 10 = “complete interference”

TO LEARN MORE

www.cdc.gov/drugoverdose/prescribing/guideline.html

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