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 naloxone.
  • 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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