Appropriate Opioid Use

(modified December 2024)

This toolbox provides resources to help clinicians managing chronic pain with opioids, one of the most challenging areas of clinical practice. **Also check with your licensing body for information on state or provincial regulations pertaining to dosing limits, screening, monitoring, etc**. Note that CDC guidance regarding opioid prescribing does not apply to patients with cancer, sickle cell disease, or at the end of life.[1]

Goal	Suggested Strategies or Resources
Limit opioid use for acute pain.	• Adequate treatment of acute pain (sudden onset; duration <1 month) or subacute pain (unresolved acute pain lasting one to three months) is important to prevent transition to chronic pain (pain lasting >3 months), but care should be taken to ensure that patients do not accidentally transition from using opioids for acute pain to prolonged use.[1,2] • Do not use opioids first-line for most kinds of acute pain. Nonopioids are at least as effective as opioids for low back pain, neck pain, musculoskeletal injuries (e.g., strains, sprains, tendonitis, bursitis), headaches, dental pain, minor surgery, and kidney stones.[1] See our chart, *Analgesics for Acute Pain in Adults*, for preferred treatments. • Prescribe the lowest effective dose.[1] Prescribe only enough for the anticipated duration of severe pain, then re-evaluate.[1] • Advise patients that short-term use can lead to unnecessary long-term use, so the opioid will be discontinued as soon as appropriate.[1] • Do not prescribe extended-release opioids for acute pain.[3]
Identify appropriate/ inappropriate uses for subacute or chronic opioids.	• Nonopioids are preferred for subacute and chronic pain.[1] • Opioids are most appropriate for patients with moderate to severe pain that affects function or quality of life with unsatisfactory response to non-opioids (e.g., acetaminophen or NSAIDs for osteoarthritis, tricyclics, duloxetine, or anticonvulsants for neuropathic pain).[2,4] • Generally avoid opioids in pelvic pain, fibromyalgia, headaches, migraine, back pain, temporomandibular disease, irritable bowel syndrome, ill-defined pain syndromes.[1,5]

Identify patients at risk for opioid misuse before prescribing.
 	
Continued…
	• Screen for opioid abuse risk factors (e.g., age <45 years, widespread pain without objective findings, current or past misuse of alcohol or other substances, major psychosocial issues, refusal to accept a multimodal approach).[4]
	  ○ The Patient Health Questionnaire, a screening tool for depression, is available at https://cde.drugabuse.gov/sites/nida_cde/files/PatientHealthQuestionnaire-2_v1.0_2014Jul2.pdf.
	  ○ The Primary Care PTSD Screen is available at http://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp.
	• Be wary of patients insisting on specific products or claiming allergies to specific analgesics; this can be a red flag for drug-seeking behavior.[6] Use our chart, *Opioid Allergy*, for help finding the best options for potentially allergic patients.
	• Risk assessment tools include:
	  ○ the one-minute **ORT** (Opioid Risk Tool: https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf).

Goal	Suggested Strategies or Resources
Identify patients at risk for opioid misuse, continued	○ **SOAPP-R** (Screener and Opioid Assessment for Patients with Pain, revised: https://d1li5256ypm7oi.cloudfront.net/colospine/2016/08/SOAPP-R-Screener-and-Opioid-Assessment-for-Patients-with-Pain-Revised-160816-57b258fc9a277.pdf). ○ **DIRE** (Diagnosis, Intractability, Risk, Efficacy: http://www.agencymeddirectors.wa.gov/Files/AssessmentTools/11-DIRE_score.pdf). ○ **PMQ** (Pain Medication Questionnaire). A systematic review recommended the PMQ, but not the ORT, and deemed SOAPP-R potentially useful.[7] • In the **US**, check your state's prescription drug monitoring program to identify patients who may be improperly using or diverting opioids and other controlled substances, or getting a benzodiazepine prescription from another prescriber. In **Canada**, use your provincial drug information system or prescription monitoring program, if available. ○ The CDC recommends checking before the initial prescription, before each prescription, or at minimum, every 3 months.[1]
Reduce risk of overdose.	• Screen for, and address, mental health problems (e.g., depression, substance use disorder).[2] • Avoid opioids in patients with active mental illness or a history of substance use disorder, including alcohol.[9] Optimize non-opioids instead.[9] • Consider limiting quantities in at-risk patients.[9,14] • Keep in mind that women are at higher risk of overdose than men.[2] • If possible, avoid other respiratory/central nervous system depressants (e.g., benzodiazepines, barbiturates, diphenhydramine, muscle relaxants, promethazine).[2,8] Our toolbox, *Appropriate Use of Oral Benzodiazepines*, has tips for deprescribing. • Reserve long-acting opioids for severe, continuous subacute or chronic pain, in opioid-tolerant patients who have been benefiting from certain dosages (consult product labeling) of short-acting agents for at least one week.[1] ○ There's no proof long-acting opioids are safer or more effective.[1] In fact, the risk of unintentional overdose is two-fold higher, especially during the first two weeks.[10] Long-acting opioids are also associated with higher all-cause mortality compared to anticonvulsants or antidepressants in chronic noncancer pain.[4] ○ Try to avoid combining short- and long-acting opioids.[1] For example, for breakthrough pain that occurs near the end of the dosing interval, the fentanyl patch can be dosed every 48 hours, and *MS Contin* or *OxyContin* every eight hours.[11,12] • Consider the partial opioid agonist buprenorphine for patients who need an opioid for chronic pain, but for whom an opioid with a wider margin of safety than a full agonist is desirable. • A trial of a different opioid (opioid rotation) can be considered for uncontrolled pain, to improve pain and function.[9] ○ Use caution when switching between opioids.[9] See our chart, *Equianalgesic Dosing of Opioids for Pain Management.* • Advise patients/caregivers to hold the dose and contact the prescriber in the event of somnolence, or if an opioid reversal agent is used (**see opioid reversal agents section, below**). • Ensure that patients and caregivers understand not to break, split, or crush sustained-release formulations.

Goal	Suggested Strategies or Resources
Dose opioids safely.	• Start with a low dose of a short-acting opioid (e.g., oxycodone 5 mg every 4 to 6 hours as needed).[4,9,13] • Consider limiting the initial opioid trial to oral morphine 50 mg/day, or its equivalent.[9] • The CDC guidelines recommend careful reassessment of benefits and risks before increasing the daily dose, especially to ≥50 mg morphine or its equivalent (e.g., hydrocodone 50 mg [US], hydromorphone 10 mg, oxycodone 30 mg).[1] Most patients do not achieve additional benefit from higher doses, but do incur increased risk.[1] Doses ≥50 MME/day double the risk of death from an opioid overdose compared to <20 MME/day.[1] o Some healthcare systems, payers, and state medical boards have protocols related to dosage thresholds, although the CDC guidance is not intended to set standards related to dosages or durations.[1] o Also see "Follow-up and Evaluation" section, below. • Few trials have evaluated ≥90 mg morphine or its equivalent.[1] o Be aware that overdose risk increases 2 to 8.9-fold oral morphine ≥100 mg/day, or its equivalent, compared to the risk with doses <20 mg/day.[1,a] • **Reserve methadone for patients who have failed other opioids, and only prescribed by clinicians experienced in its use**.[4] Methadone safety guidelines can be found at http://www.jpain.org/article/S1526-5900(14)00522-7/pdf. • When opioids other than morphine are used: o See the CDC site to calculate MME/day: https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf. o Download the CDC app for MME calculations: https://www.cdc.gov/opioids/healthcare-professionals/prescribing/app.html.
Provide an opioid reversal agent.	• Offer naloxone or nalmefene (US), especially for patients with sleep apnea, history of overdose or substance use, concomitant benzodiazepine use, or use of relatively high opioid doses (e.g., or ≥50 MME/day). • Use our *Opioid Reversal Agents Quick Start Guide* as a stepwise approach to identify candidates for take-home naloxone or nalmefene (US). • For more detailed information our FAQ, *Meds for Opioid Overdose*, addresses common questions that arise in practice regarding naloxone for opioid overdose.
Manage patient expectations.	• Set goals with the patient for functional improvement, and document them for future monitoring purposes; this is how efficacy will be determined.[9] Think SMART: the goals should be Specific, Measurable, Action-oriented, Realistic, Time-dependent.[13] • Explain that improving pain and function by about 30% is a success.[1] • Explain that evidence of long-term benefit is lacking and delineate risks.[1] • View the opioid prescription as a time-limited trial; you are testing benefit to the patient, not committing to long-term opioid use.[9] Discuss how the opioid will be discontinued if benefits do not outweigh risks.[1]

Goal	Suggested Strategies or Resources
Educate patients about opioid safety.	• An educational poster from the CDC promoting non-opioid alternatives is available at http://www.cdc.gov/drugoverdose/pdf/guidelines_patients_poster-a.pdf. • A patient fact sheet from the CDC discussing opioid risks, opioid alternatives, and measures to improve opioid safety is available at http://www.cdc.gov/drugoverdose/pdf/guidelines_factsheet-patients-a.pdf. • ISMP Canada provides information to consumers on safe medication use, including opioids: https://www.safemedicationuse.ca/tools_resources/tips.html. • Patient counseling should include advice to avoid driving during dose increases or if they are sedated. Patients should be told to avoid using alcohol or sedating drugs. If they do use these substances, they should not drive.[9] • Patients should be counseled on how to safely store and dispose of opioids.[1] Treatment agreements often include an expectation of secure storage. • Apprise patients of the risks of opioid use (e.g., hypogonadism, sleep apnea, tolerance, hyperalgesia [i.e., pain sensitization caused by chronic opioid use], withdrawal, and opioid use disorder) at baseline and periodically.[1,9]

Prevent and identify misuse at follow-up.	• Consider a treatment agreement, at minimum, for patients at high risk of misuse, or patients not well known to the prescriber.[14] Some experts feel that a treatment agreement is needed for all patients receiving opioids for chronic noncancer pain.[4] Treatment agreements have not been proved to prevent opioid misuse.[4,9]
	• Require in-person follow-up in order for patients to obtain a refill or new prescription.[4]
	• Consider pill counts.[14]
	• **COMM** (Current Opioid Misuse Measure) can be used to screen for abuse in **current** opioid users.[7]
	• Consider **urine drug testing**.
	  o Consider baseline and periodic (at least annually) urine drug testing, although this is not evidence-based.[1,9]
	  o Consider testing three or four times per year in patients at high risk per the ORT or taking >120 mg of morphine daily.[10]
	  o Approximately 30% of urine drug screening will show unexpected results, mostly due to not detecting the prescribed opioid or presence of tetrahydrocannabinol.[9] If urine testing is planned, either at baseline or follow-up, know how to interpret the results and plan how you will apply them.[4]
	• Consider abuse-deterrent formulations. Keep in mind these products have not been proven to prevent opioid misuse.[9]

Ensure appropriate follow-up and evaluation of opioid therapy. *Continued…*	• Schedule follow-up at least every one to four weeks while determining the optimal dose, then at least every three months.[1] Treatment agreements generally require in-person follow-up in order for patients to obtain a refill or new prescription.[4] o A trial of three to six months is reasonable, but efficacy wanes after three months.[9] Patient perception of benefit past three months may be related to relief of interdose withdrawal as opposed to pain relief.[9] • Chronic pain is often accompanied by impaired function, multiple medical conditions, and psychological disorders.[1,4] Address these areas in addition to evaluation of efficacy (i.e., improved function and pain control), adverse effects, and evidence of misuse.[1]

Goal	Suggested Strategies or Resources
Appropriate follow-up and evaluation, continued	○ An assessment tool for function, the SF36 Health Survey, is available at http://www.rand.org/health/surveys_tools/mos.html. ○ A checklist for adverse effects, function, and opioid dependence is available from the Utah Department of Health at http://health.utah.gov/prescription/pdf/guidelines/checklist%20for%20adverse%20effects.pdf. ○ An assessment tool for pain, the Brief Pain Inventory (Short Form), is available at http://www.health.utah.gov/prescription/pdf/guidelines/BriefPainInvNPEC.pdf. ○ The two-item version of the Graded Chronic Pain Scale is available at http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf (See Figure B). It measures pain intensity and related disability. • Canadian opioid management tools and guidelines are available at: http://nationalpaincentre.mcmaster.ca/guidelines.html. • **Re-evaluate therapy** before increasing the daily dose to 50 mg of oral morphine or its equivalent.[1,a] (Canada: before escalating the daily dose to ≥90 mg, consider referral for a second opinion.[9]) ○ Assess diagnosis, pain control, function, and adverse effects.[1] ○ Maximize non-opioids and offer an opioid taper, explaining risks and benefits.[1] ○ Increase monitoring frequency.[1] ○ Consider offering an opioid reversal agent.[1] • If misuse occurs, evaluate whether continuation of chronic opioid therapy is appropriate. Restructuring of therapy (e.g., more intensive monitoring, opioid tapering with optimization of non-opioid modalities, education/counseling) or referral may be indicated.[4,10,17]
Use appropriate non-opioid and adjunctive therapies.	• Maximize non-opioid pain medications before opioids are used.[1,9] • Integrate interdisciplinary therapy.[2] This usually involves exercise and psychological therapy.[2] ○ Therapies that require patient participation (e.g., exercise, cognitive behavioral therapy) may have better long-term benefit than passive therapies (e.g., massage) on pain and function.[1] ○ Supervised therapy for stretching, strengthening, and aerobic exercise may be appropiate.[10] • Sleep hygiene is recommended.[10] • To **prevent** constipation, fluids, dietary fiber, and exercise can be recommended. Consider "prophylactic treatment" with daily use of an osmotic laxative (polyethylene glycol [PEG] 3350). Avoid bulk-forming laxatives.[16] • Ensure associated comorbidities are treated (e.g., depression, obesity).[1]

Goal	Suggested Strategies or Resources
Taper dose or discontinue opioids when appropriate.	• Discontinue the opioid as pain resolves, with tapering if the opioid has been used around the clock for more than a few days.[1] The taper can be brief if the opioid was prescribed short-term, for acute pain.[1] For hospitalized patients, coordinate tapering: o A taper may not be appropriate if the opioid is discontinued due to a life-threatening issue.[1] • For opioids started in the hospital, discuss the tapering plan with the patient and outpatient provider.[1] • Consider dose reduction or tapering and discontinuation in the event of inefficacy despite a three-month trial, suspected side effects that outweigh benefits, comorbidities or drug interactions that increase risks (e.g., fall risk, kidney impairment), evidence of misuse or diversion, or signs of intoxication, overdose, or suspected hyperalgesia.[1,4,10] Alternatively, rotation to another opioid could be attempted in case of inefficacy or side effects, or to facilitate dose reduction.[9] • For practical tapering tips and protocols, see our FAQ, *Opioid Tapering: Tips for Success*.
Advise safe opioid disposal.	• **US**: Learn where and how to dispose of unused meds at https://www.fda.gov/consumers/consumer-updates/where-and-how-dispose-unused-medicines. • **Canada**: Learn about getting rid of old meds at the Health Products Stewardship Association site https://healthsteward.ca/ or call 844-535-8889.
Offer treatment for opioid use disorder.	• Medication-assisted treatment of opioid use disorder has the most evidence and helps prevent withdrawal symptoms and decreases illicit opioid use, overdose death, and criminal activity.[18] • Find a physician in your area authorized to prescribe buprenorphine for opioid dependence at http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator. • In Canada, consult federal-, provincial-, and territorial-funded programs.
Manage opioids appropriately in the inpatient setting, including at discharge. *Continued…*	• In the emergency department (ED), urgent care, or at discharge: o watch for red flags for abuse (e.g., frequent ED visits, non-opioid allergies, requesting specific opioids).[20] o prescribe only enough opioid doses to cover the number of days that the pain is expected to be severe enough to require opioids.[21] For example days' supply for different types of surgery, see https://michigan-open.org/prescribing-recommendations/. o do not prescribe long-acting opioids (except in hospice patients, with hospice consultation).[19] o check your state/provincial prescription drug monitoring program before writing an opioid.[19] o communicate tapering plans at transitions of care so that opioids started in the hospital do not end up being continued chronically.[22] • See The Joint Commission's pain assessment and management standards for hospitals: https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_report_issue_11_2_11_19_rev.pdf.

Goal	Suggested Strategies or Resources
Opioids in the inpatient setting, continued	• Generally, continue long-term, pre-op opioids in surgical patients.[10] Coordinate post-op pain care with the outpatient prescriber.[10] • In the ED, Alternatives to Opioids ("ALTO") include acetaminophen, NSAIDs, lidocaine (e.g., renal colic pain), and ketamine. See our chart, *Analgesics for Acute Pain in Adults*, for details. • Use multimodal, opioid-sparing analgesia (e.g., acetaminophen, an NSAID, gabapentin or pregabalin, lidocaine, local or regional anesthesia, ketamine) perioperatively.[15] ○ Post-op, consider around-the-clock oral acetaminophen as the "backbone" of analgesia.[15] • If an opioid is needed, the oral route is preferrable when possible.[15] • Instruct patients on disposing any leftover doses.[23]
Where permitted by law, ensure appropriate use of cannabinoids for pain.	• A clinical practice guideline for medical cannabis or cannabinoids for chronic pain is available at https://www.bmj.com/content/bmj/374/bmj.n2040.full.pdf. • See the College of Family Physicians of Canada's cannabis resources for family physicians at https://www.cfpc.ca/en/education-professional-development/practice-tools-guidelines/cannabis-resources-for-family-physicians.

a. See our chart, *Equianalgesic Dosing of Opioids for Pain Management*.

Abbreviations: ED = emergency department; MME = morphine milligram equivalents; NSAID = nonsteroidal anti-inflammatory drug; ORT = Opioid Risk Tool; PTSD = post-traumatic stress disorder

Users of this resource are cautioned to use their own professional judgment and consult any other necessary or appropriate sources prior to making clinical judgments based on the content of this document. Our editors have researched the information with input from experts, government agencies, and national organizations. Information and internet links in this article were current as of the date of publication.

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