UTAH DEPARTMENT OF HEALTH
Violence & Injury Prevention Program

GUIDELINES FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

Provider Action	Utah 2009	CDC 2016
PRE-TREATMENT		
Pain history	Assess prior treatment of pain	Assess history and characteristics of pain and potentially contributing factors
Past medical history	Assess medical and mental health conditions, medications, substance addiction or dependence	Evaluate risk factors for opioid-related harms
Family History/Social History	Assess social history	Clinicians should re-evaluate patients who are exposed to greater risk of opioid use disorder or overdose (e.g., patients with depression or other mental health conditions, a history of substance use disorder, a history of overdose, taking ≥50 MME/day, or taking other central nervous system depressants with opioids) more frequently than every 3 months.
Pregnancy	Not addressed	Clinicians and patients together should carefully weigh risks and benefits when making decisions about whether to initiate opioid therapy for chronic pain during pregnancy. Before initiating opioid therapy for chronic pain for reproductive-age women, clinicians should discuss family planning and how long-term opioid use might affect any future pregnancy
Prescription Drug Monitoring Program -Initial assessment of past use	Check PDMP	Review PDMP when starting opioid therapy for chronic pain
Physical Exam	Assess pain severity, functional status, quality of life	Assess pain severity, functional status, quality of life
Laboratory - Urine Drug Screening initial assessment	Perform before initiating long term opioids	Use urine drug testing to identify prescribed substances and undisclosed use
Opioid Indication	Consider all options, including nonpharmaceutical treatment; opioids considered only when other therapies not beneficial	Consider all options, including non-pharmaceutical treatment; opioids considered only when other therapies not beneficial
INITIAL OPIOID TREATMENT		
Drug choice	Short term trial; start with short acting opioids	Short term trial; start with short acting opioids
Methadone	Prescribed by clinicians familiar with its risks and use	Prescribed by clinicians familiar with its risks and use
Starting dosage	Start at low dose and titrate slowly	Start at a low dose and titrate slowly
Duration of initial treatment	Short term trial	Short term trial
Co-prescribing	Close attention to benzodiazepines/other sedatives	Avoid concurrent benzodiazepine and opioid prescribing
Documentation	Written treatment plan; Informed consent; written education material to patient, family, caregiver	Clinicians and patients who set a treatment plan in advance will clarify expectations regarding how opioids will be prescribed and monitored, as well as situations in which opioids will be discontinued or doses tapered (e.g. if treatment goals are not met, opioids are no longer needed, or adverse events put the patient at risk) to improve patient safety

FOLLOW-UP VISITS		
Treatment progress	Regular visits with evaluation of progress; assess analgesia, activity, adverse effects, and aberrant behavior	Monitoring progress toward patient-centered functional goals (e.g., walking around the block, returning to part-time work, attending recreational activities) can also contribute to the assessment of functional improvement. Clinicians should evaluate patients to assess benefits and harms of opioids within 1 to 4 weeks of starting long-term opioid therapy or of dose escalation. Clinicians should consider follow-up intervals within the lower end of this range when ER/LA opioids are started or increased or when total daily opioid dosage is ≥50 MME/day.
High-dose opioids	>120-200 MME/day; increase clinical vigilance	Avoid increasing dosage to >90 MME/day or carefully justify a decision to titrate dosage to >90 MME/day
Co-prescribing	Not addressed	Naloxone co-prescribing can be facilitated by clinics or practices with resources to provide naloxone training and by collaborative practice models with pharmacists
Past controlled prescription drug use	Check PDMP regularly	Review PDMP periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months
Laboratory - Urine Drug Screening Monitoring	Randomly selected visits and when aberrant behavior is suspected	Consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs
OPIOID DISCONTINUATION		
Rationale documentation	Document nonadherence to the treatment plan; discontinue if goals are not met, if adverse effects outweigh benefits or if dangerous or illegal behaviors are demonstrated	Document nonadherence to the treatment plan; discontinue if goals are not met, if adverse effects outweigh benefits or if dangerous or illegal behaviors are demonstrated
Tapering plan	10% reduction/week over 6 to 8 weeks	Decrease of 10% of the original dose each week is a reasonable starting point
Referral for Medication Assisted Treatment or other substance abuse treatment services as appropriate	Consider consultation for complex cases or referral to a pain management, mental health or substance use specialist	Arrange for evidence-based treatment (Medication Assisted Treatment with buprenorphine or methadone in combination with behavioral therapies) for opioid use disorder if needed
GUIDELINE DEVELOPMENT METHODS		
Evidence review, grading, and decision making	Review of previous guidelines; consensus approval	Review of previous guidelines; consensus approval
Conflicts of Interest	Disclosed	Disclosed