CDC 2016 Opioid Guidelines
& PDMP Rules

92EKES

Recommendation 1

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate (recommendation category: A, evidence type: 3)

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Recommendation 2

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety (recommendation category: A, evidence type: 4).

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Recommendation 3

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy (recommendation category: A, evidence type: 3).

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Recommendation 4

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids (recommendation category: A, evidence type: 4).

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Recommendation 5

5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day (recommendation category: A, evidence type: 3).

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Recommendation 6

6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed (recommendation category: A, evidence type: 4).

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Recommendation 7

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids (recommendation category: A, evidence type: 4).

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Recommendation 8

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present (recommendation category: A, evidence type: 4).

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Recommendation 9

9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months (recommendation category: A, evidence type: 4).

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Recommendation 10

10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs (recommendation category: B, evidence type: 4).

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Recommendation 11

11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible (recommendation category: A, evidence type: 3).

92EKES

Recommendation 12

12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder (recommendation category: A, evidence type: 2).

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Opiate conversion

- Oxycodone is 50 % stronger than morphine
- 40 mg of oxycodone is equal to 60 mg of oral morphine

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CDC conversion factors

- OPIOID (doses in mg/day except where noted)
- CONVERSION FACTOR Codeine 0.15
- Fentanyl transdermal (in mcg/hr) 2.4
- Hydrocodone 1
- Hydromorphone 4
- Oxycodone 1.5
- Oxymorphone 3

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PDMP

- We must check each time we write for an opioid or benzodiazepine
- The Pennsylvania PDMP now requires birth date with 3 letters of first and last name.
- Multiple connects to other states are in place but must have full name.
- Pennsylvania state is creating a report card of how often prescribers are checking PDMP

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REFERENCES

- CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016
- Recommendations and Reports / March 18, 2016 / 65(1);1–49
- CALCULATING TOTAL DAILY DOSE OF OPIOIDS FOR SAFER DOSAGE
- https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose
- Pennsylvania PDMP

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