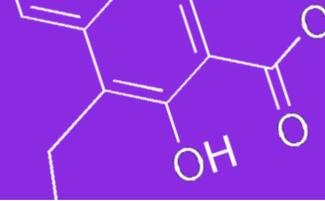


# Opioid Prescribing



Opioids can provide short-term relief of moderate to severe acute pain, but there is little evidence supporting their effectiveness for chronic pain, and they have substantial risks. Long-term opioid use should be reserved for patients with cancer-related pain, or patients receiving palliative or end-of-life care. If you prescribe opioids for other conditions, use safety principles as embodied by Limiting Use and Avoiding Adverse Consequences.

## Limiting Use

- 1 **Do not prescribe opioids as first-line or routine therapy for chronic pain;** use nonpharmacologic and nonopioid pharmacologic therapies first (see Chronic Pain Treatment Principles).
- 2 **Discuss benefits, risks, and side effects of opioid therapy (e.g., addiction, overdose);** continue to discuss the risks and benefits of opioids throughout treatment.
- 3 **Set realistic and measurable goals for pain and function;** plan for how opioid therapy will be stopped if benefits do not outweigh risks.
- 4 **Use short-term opioids when starting opioid therapy for chronic pain.**  
**Prescribe the lowest effective dosage when starting opioid therapy,** and reassess risks and benefits when increasing dosages by 50 morphine milligram equivalents (MME) per day or more, and avoid increasing dosages by 90 MME per day or more.
- 6 **Long-term opioid use often starts with treatment of acute pain.** When using opioids for acute pain, prescribe short-acting forms and no more than necessary; three days or less is often sufficient.

### Prescribing Calculations

50 morphine milligram equivalents (MME) =  
50 mg hydrocodone/day, or 33 mg oxycodone/day

## Avoiding Adverse Consequences

- 7 **Follow-up regularly to re-evaluate risk of harm and reduce dose or taper if needed;** follow-up should occur within one to four weeks of starting opioid therapy or increasing dosage and continue quarterly.
- 8 **Prescribe naloxone to individuals who are undergoing long-term opioid therapy,** due to the higher risk of an overdose while taking these drugs.
- 9 **Check the Prescription Drug Monitoring Program (PDMP)** for prescriptions from other providers when starting opioid therapy and each time before writing a prescription.
- 10 **Use urine drug screening to identify prescribed substances and undisclosed use of other drugs** before starting opioid therapy and periodically thereafter.
- 11 **Avoid concurrent benzodiazepine and opioid prescribing.**
- 12 **Arrange treatment for opioid use disorder if needed, including medication-assisted treatment (buprenorphine or methadone).** Philadelphia's Department of Behavioral Health and Intellectual disAbility Services can help you identify [treatment options through its website](http://bit.ly/DBHResources). (<http://bit.ly/DBHResources>)
- 13 **Consider incorporating buprenorphine treatment into your own practice.** Find out how through the [SAMHSA website](http://bit.ly/SAMHSA). (<http://bit.ly/SAMHSA>)

# Chronic Pain Treatment Principles

Use non-opioid therapies whenever possible. The principles below provide guidance on therapy for chronic pain, based on the type of condition.

- 1. Use first-line medications as the preferred option:**
  - a. Acetaminophen
  - b. NSAIDs
  - c. Gabapentin/pregabalin for neuropathic pain or fibromyalgia
  - d. Tricyclic antidepressants and SNRIs for neuropathic pain or fibromyalgia; TCAs for headaches
  - e. Topical agents such as lidocaine or capsaicin
- 2. Focus on functional goals and improvement**, engaging patients actively in their pain management.
- 3. Use disease-specific treatments when available** (e.g., triptans for migraines, gabapentin/pregabalin/duloxetine for neuropathic pain).
- 4. Identify and address co-existing mental health conditions** (e.g., depression, anxiety, PTSD).
- 5. Consider interventional therapies** (e.g., corticosteroid injections) in patients who fail standard non-invasive therapies.
- 6. Use treatments with multiple modes**, including interdisciplinary rehabilitation for patients who have failed standard treatments, have severe functional deficits, or psychosocial risk factors.

## Benzodiazepine Prescribing

- 1. Do not initiate benzodiazepines for first-line treatment of anxiety disorders;** other pharmacologic and nonpharmacologic treatments can be safe and effective.
- 2. Do not prescribe benzodiazepines to treat insomnia without appropriate evaluation, and do not prescribe them chronically;** when they are used, do not prescribe them other than for short-term, situational insomnia, or for more than seven days.
- 3. Do not prescribe benzodiazepines to patients with substance use disorders;** use treatment history, information from other providers (including from the Prescription Drug Monitoring Program, or PDMP) and urine drug screenings as potential indicators of abuse.
- 4. Do not prescribe benzodiazepines to patients enrolled in medication-assisted treatment for opioid use disorders or who are prescribed opioid medications.**

