CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022

Elements are essential for communication and discussion w/ pts before starting opioid tx for *subacute or chronic* pain

- Review available low-cost options for pain mgmt for all pts, and particularly for pts who have low incomes, do not have health insurance, or have inadequate insurance. Review considerations related to access to care because of the clinical oversight needed to initiate and continue opioid tx and other treatments for pain.

- Be explicit and realistic about expected benefits of opioids, explaining that there is not robust evidence that opioids improve pain or function w/ long-term use and that complete elimination of pain is unlikely.

- Emphasize improvement in function as a primary goal and that function can improve even when pain is not eliminated.

- Advise pts about serious adverse effects of opioids, including potentially fatal resp depression and development of a potentially serious OUD that can cause distress and inability to fulfill major obligations at work, school, or home.

- Advise pts about common effects of opioids, such as constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids.

    - To prevent constipation associated w/ opioid use, advise pts to increase hydration and fiber intake and to maintain or increase physical activity. Prophylactic pharmacologic tx (e.g., a stimulant laxative such as senna, w/ or w/ o a stool softener) is usually needed to ensure regular bowel movements if opioids are taken regularly. Stool softeners or fiber laxatives w/o another laxative should be avoided.

- If opioid/acetaminophen combos are prescribed, advise pts of the risks for taking additional OTC products containing acetaminophen.

- Discuss effects that opioids might have on ability to safely operate a vehicle or other machinery, particularly when opioids are initiated, when dosages are increased, or when other CNS depressants, such as BZDs or alcohol, are used concurrently.

- Discuss the potential for workplace toxicology testing programs to detect therapeutic opioid use.

- Discuss increased risks for OUD, resp depression, and death at higher dosages, along w/ the importance of taking only the amt of opioids prescribed (i.e., not taking more opioids than prescribed or taking them more often).

- Review increased risks for resp depression when opioids are taken w/ BZDs, other sedatives, alcohol, nonprescribed drugs such as heroin, or other opioids.

- Discuss risks for household members and other persons if opioids are intentionally or unintentionally shared w/ others for whom they are not prescribed, including the possibility that others might experience OD at the same or at lower dosage than prescribed for the pt and that young children are susceptible to unintentional ingestion. Discuss storage of

opioids in a secure, preferably locked location and options for safe disposal of unused opioids.

- Discuss the importance of periodic reassessment to ensure that opioids are helping to meet pt goals and, if opioids are not effective or are harmful, to allow opportunities for consideration of opioid tapering and dosage reduction or D/C and of additional nonpharmacologic or nonopioid pharmacologic treatment options.

- Discuss expectations for clinician and pt responsibilities to mitigate risks of opioid tx and planned use of precautions to reduce risks, including naloxone for OD reversal and clinician use of PDMP info and toxicology screening.

- Consider whether cognitive status might interfere w/ mgmt of opioid tx and, if so, determine whether a caregiver can responsibly comanage med tx. Discuss the importance of reassessing med use over time w/ both the pt and caregiver, as appropriate.