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

Recommendation 3

When starting opioid tx for acute, subacute, or chronic pain, clinicians should prescribe IR opioids instead of extended-release and long-acting (ER/LA) opioids (recommendation category: A; evidence type: 4).

Implementation Considerations

- Don't treat acute pain w/ ER/LA opioids or initiate opioid tx for subacute or chronic pain w/ ER/LA opioids; don't prescribe ER/LA opioids for intermittent or prn use.

- ER/LA opioids should be reserved for severe, continuous pain. FDA has noted that some ER/LA opioids should be considered only for pts who have received certain dosages of opioids of IR opioids daily for ≥1 week.

- When changing to an ER/LA opioid for a pt previously receiving a different IR opioid, consult product labeling and reduce total daily dosage to account for incomplete opioid cross-tolerance.

- Use additional caution w/ ER/LA opioids and consider a longer dosing interval when prescribing to pts w/ renal or hepatic dysfunction because decreased clearance of meds among these pts can lead to accumulation of drugs to toxic levels and persistence in the body for longer durations.

- Methadone should *not* be the first choice for an ER/LA opioid. Only clinicians who are familiar w/ methadone's unique risk profile and who are prepared to educate and closely monitor their pts, including assessing risk for QT prolongation and considering ECG monitoring, should consider prescribing methadone for pain.

- Only clinicians who are familiar w/ the dosing and absorption properties of the ER/LA opioid transdermal fentanyl and are prepared to educate their pts about its use should consider prescribing it.