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

Recommendation 11

Clinicians should use particular caution when prescribing opioid pain medication and BZDs concurrently and consider whether benefits outweigh risks of concurrent prescribing of opioids and other CNS depressants (recommendation category: B; evidence type: 3).

Implementation Considerations

- Although in some circumstances it might be appropriate to prescribe opioids to a pt who is also prescribed BZDs (e.g., severe acute pain in a pt taking long-term, stable low-dose BZD tx), clinicians should use particular caution when prescribing opioid pain medication and BZDs concurrently. In addition, clinicians should consider whether benefits outweigh risks for concurrent use of opioids w/ other CNS depressants (e.g., muscle relaxants, nonBZD sedative hypnotics, and potentially sedating anticonvulsant meds such as gabapentin and pregabalin).

- Buprenorphine or methadone for OUD should not be withheld from pts taking BZDs or other meds that depress the CNS.

- Check the PDMP for concurrent controlled meds prescribed by other clinicians; consider involving pharmacists as part of the mgmt team when opioids are coprescribed w/other CNS depressants.

- In pts receiving opioids and BZDs long term, clinicians should carefully weigh the benefits and risks of continuing tx w/ opioids and BZDs and discuss w/ pts and other members of pt's care team.

- Risks of concurrent opioid and BZD use are likely to be greater w/ unpredictable use of either med, w/use of higher-dosage opioids and higher-dosage BZDs in combo, or w/ use w/ other substances including alcohol (compared w/ long-term, stable use of lower-dosage opioids and lower-dosage BZDs w/o other substances).

- In specific situations, BZDs can be beneficial, and stopping BZDs can be destabilizing.

- Taper BZDs gradually before D/C because abrupt withdrawal can be assoc w/ rebound anxiety, hallucinations, seizures, delirium tremens, and, rarely, death. Rate of tapering should be individualized.

- If BZDs prescribed for anxiety are tapered or discontinued, or if pts receiving opioids require treatment for anxiety, evidence-based psychotherapies (e.g., CBT), specific antidepressants or other nonBZD meds approved for anxiety, or both, should be offered.

- Clinicians should communicate w/other clinicians managing the pt to discuss the pt's needs, prioritize pt goals, weigh risks of concurrent BZD and opioid exposure, and coordinate care.