



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

Recommendation 4

When opioids are initiated for opioid-naïve pts w/ acute, subacute, or chronic pain, clinicians should prescribe the lowest effective dosage. If opioids are continued for subacute or chronic pain, clinicians should use caution when prescribing opioids at any dosage, should carefully evaluate individual benefits and risks when considering increasing dosage, and should avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to pts (rec category: A; evidence type: 3).

Implementation Considerations

- The recs related to opioid dosages aren't intended to be used as an inflexible, rigid standard of care; rather, they are intended to be guideposts to help inform clinician-pt decision-making. Risks of opioid use, including risk for OD and OD death, increase continuously w/ dosage, and there is no single dosage threshold below which risks are eliminated. Therefore, the rec language emphasizes that clinicians should avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to pts rather than emphasizing a single specific numeric threshold. Further, these recs apply specifically to starting opioids or to increasing opioid dosages, and a different set of benefits and risks applies to reducing opioid dosages.
- When initiating opioids for opioid-naïve pts w/ acute, subacute, or chronic pain, prescribe the lowest effective dosage.

- For pts not already taking opioids, the lowest effective dose can be determined using product labeling as a starting point w/ calibration as needed based on the severity of pain and other clinical factors such as renal or hepatic insufficiency.
- The lowest starting dose for opioid-naïve pts is often equivalent to a single dose of approx.. 5–10 MME or a daily dosage of 20–30 MME/day. A listing of common opioid medications and their doses in MME equivalents is provided in the table below.
- If opioids are continued for subacute or chronic pain, use caution when prescribing opioids at any dosage; generally avoid dosage increases when possible.
- Many pts don't experience benefit in pain or function from increasing opioid dosages to ≥ 50 MME/day but are exposed to progressive increases in risk as dosage increases. Therefore, before increasing total opioid dosage to ≥ 50 MME/day, pause and carefully reassess evidence of individual benefits and risks. If the decision is made to increase dosage, use caution and increase dosage by the smallest practical amount. The recs related to opioid dosages aren't intended to be used as an inflexible, rigid standard of care; rather, they are intended to be guideposts to help inform clinician-pt decision-making.
- Additional dosage increases beyond 50 MME/day are progressively more likely to yield diminishing returns in benefits for pain and function relative to risks to pts as dosage increases further. Carefully evaluate a decision to further increase dosage on the basis of individualized assessment of benefits and risks and weighing factors such as dx, incremental benefits for pain and function relative to risks w/ previous dosage increases, other treatments and effectiveness, and pt values and preferences. The recs related to opioid dosages aren't intended to

be used as an inflexible, rigid standard of care; rather, they are intended to be guideposts to help inform clinician-pt decision-making.

Morphine milligram equivalent (MME) doses for commonly prescribed opioids for pain management

opioid	conversion factor
codeine	0.15
fentanyl transdermal (in mcg/hr)	2.4
hydrocodone	1.0
hydromorphone	5.0
methadone	4.7
morphine	1.0
oxycodone	1.5
oxymorphone	3.0
tapentadol	0.4
tramadol	0.2