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

Recommendation 7

Clinicians should evaluate benefits and risks w/ pts w/in 1–4 weeks of starting opioid tx for subacute or chronic pain or of dosage escalation. Clinicians should regularly reevaluate benefits and risks of continued opioid tx w/ pts (recommendation category: A; evidence type: 4).

Implementation Considerations

- In addition to evaluating benefits and risks of opioids before starting opioid tx, clinicians should evaluate pts to assess benefits and risks of opioids w/in 1–4 weeks of starting long-term opioid tx or of dosage escalation.

- Clinicians should consider F/U intervals w/in the lower end of this range when ER/LA opioids are started or increased, because of the increased risk for OD w/in the first 2 weeks of treatment, or when total daily opioid dosage is ≥50 MME/day. (OD risk is doubled across multiple studies for dosages of 50 to <100 MME/day relative to <20 MME/day.)

- Shorter F/U intervals (q2-3days for the first week) should be strongly considered when starting or increasing the dosage of methadone, because of the variable half-life of this drug and the potential for drug accumulation during initiation and during upward titration of dosage.

- An initial F/U interval closer to 4 weeks can be considered when starting IR opioids at a dosage of <50 MME/day.

- Follow up w/ and evaluate pts w/ subacute pain who started opioid tx for acute pain and have been treated w/ opioid tx for 30 days to reassess the pt's pain, function, and treatment course; ensure that potentially reversible causes of chronic pain are addressed; and prevent unintentional initiation of long-term opioid tx. Continuation of opioid tx at this point might represent initiation of long-term opioid tx, which should occur only as an intentional decision that benefits are likely to outweigh risks after discussion between the clinician and pt and as part of a comprehensive pain mgmt approach.

- Regularly reassess all pts receiving long-term opioid tx, including pts who are new to the clinician but on long-term opioid tx, w/ a suggested interval of q3mo or more frequently for most pts.

- Clinicians seeing new pts already receiving opioids should establish treatment goals, including functional goals, for continued opioid tx.

- Reevaluate pts who are at higher risk for OUD or OD (e.g., pts w/ depression or other mental health conditions, a hx of substance use disorder, hx of OD, taking ≥50 MME/day, or taking other CNS depressants w/ opioids) more frequently than q3mo. Clinicians should regularly screen all pts for these conditions, which can change during the course of treatment.

- Clinicians, practices, and health systems can help minimize unintended effects on pts by ensuring all pts can access and afford F/U evaluation.

- In practice contexts where virtual visits are part of standard care (e.g., in remote areas where distance or other context makes F/U visits challenging), or for pts for whom in-person F/U visits are challenging (e.g., frail pts), F/U assessments that allow the clinician to communicate w/ and observe the pt through telehealth modalities might be conducted.

- At F/U, clinicians should review pt perspectives and goals, determine whether opioids continue to meet treatment goals, including sustained improvement in pain and function, and determine whether the pt has experienced common or serious adverse events or early warning signs of serious adverse events or has signs of OUD.

- Ensure that treatment for depression, anxiety, or other psychological comorbidities is optimized.

- Ask pts about their preferences for continuing opioids, considering their effects on pain and function relative to any adverse effects experienced. If risks outweigh benefits of continued opioid tx (e.g., if pts don't experience meaningful, sustained improvements in pain and function compared w/ before initiation of opioid tx; if pts are taking higher-risk regimens [e.g., dosages of ≥50 MME/day or opioids combined w/ BZDs] w/o evidence of benefit; if pts believe benefits no longer outweigh risks; if pts request dosage reduction or discontinuation; or if pts experience OD or other serious adverse events), clinicians should work w/ pts to taper and reduce opioid dosage or taper and D/C opioids when possible.

- Maximize pain treatment w/ nonpharmacologic and nonopioid pharmacologic treatments as appropriate.