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

Recommendation 8

Before starting and periodically during continuation of opioid tx, clinicians should evaluate risk for opioid-related harms and discuss risk w/ pts. Clinicians should work w/ pts to incorporate into the mgmt plan strategies to mitigate risk, including offering naloxone (recommendation category: A; evidence type: 4).

Implementation Considerations

- Ask pts about their drug and alcohol use and use validated tools or consult w/ behavioral specialists to screen for and assess mental health and substance use disorders.

- When considering initiating long-term opioid tx, ensure that treatment for depression and other mental health conditions is optimized, consulting w/ behavioral health specialists when needed.

- Offer naloxone when prescribing opioids, particularly to pts at increased risk for OD, including pts w/ a hx of OD, pts w/ a hx of substance use disorder, pts w/ sleep-disordered breathing, pts taking higher dosages of opioids (e.g., ≥50 MME/day), pts taking BZDs w/ opioids, and pts at risk for returning to a high dose to which they have lost tolerance (e.g., pts undergoing tapering or recently released from prison).

- Practices should educate pts on OD prevention and naloxone use and offer to provide education to household members.

- Naloxone coprescribing can be facilitated by clinics or practices w/ resources to provide naloxone training, by collaborative practice models w/ pharmacists, or through statewide protocols or standing orders for naloxone at pharmacies.

- Resources for prescribing naloxone in primary care and ED settings can be found through Prescribe to Prevent at https://prescribetoprevent.org. Additional resources are at https://www.samhsa.gov.

- In part because of concerns about cost of naloxone and access for some pts and reports that purchasing of naloxone has in some cases been required to fill opioid prescriptions, including for pts w/o a way to afford naloxone, this rec specifies that naloxone should be offered to pts. To that end, clinicians, health systems, and payers can work to ensure pts can obtain naloxone, a potentially lifesaving treatment.

- Avoid prescribing opioids to pts w/ moderate or severe sleep-disordered breathing when possible to minimize risk for resp depression.

- When making decisions about whether to initiate opioid tx for pain during pregnancy, clinicians and pts together should carefully weigh benefits and risks. For pregnant persons already receiving opioids, clinicians should access appropriate expertise if tapering is being considered because of possible risks to the pregnant pt and the fetus if the pt goes into withdrawal.

- For pregnant persons w/ OUD, medication for OUD (buprenorphine or methadone) is the recommended tx and should be offered as early as possible in pregnancy to prevent harms to both the pt and the fetus.

- Clinicians should use additional caution and increased monitoring to minimize risks of opioids prescribed for pts w/ renal or hepatic insufficiency and for pts aged ≥65 years. Clinicians should implement interventions to mitigate common risks of opioid tx among older adults, such as exercise or bowel regimens to prevent constipation, risk assessment for falls, and pt monitoring for cognitive impairment.

- For pts w/ jobs that involve potentially hazardous tasks and who are receiving opioids or other meds that can negatively affect sleep, cognition, balance, or coordination, clinicians should assess pts' abilities to safely perform the potentially hazardous tasks (e.g., driving, use of heavy equipment, climbing ladders, working at heights or around moving machinery, or working w/ high-voltage equipment).

- Use PDMP data and toxicology screening as appropriate to assess for concurrent substance use that might place pts at higher risk for OUD and OD.

- Provide specific counseling on increased risks for OD when opioids are combined w/ other drugs or alcohol; ensure that pts are provided or receive effective treatment for substance use disorders when needed.

- Although substance use disorders can alter the expected benefits and risks of opioid tx for pain, pts w/ co-occurring pain and substance use disorder require ongoing pain mgmt that maximizes benefits relative to risks.

- If clinicians consider opioid tx for chronic pain for pts w/ substance use disorder, they should discuss increased risks for OUD and OD w/ pts, carefully consider whether benefits of opioids outweigh increased risks, and incorporate strategies to mitigate risk into the

mgmt plan (e.g., offering naloxone and increasing frequency of monitoring.

- If pts experience nonfatal opioid OD, clinicians should evaluate for OUD and treat or arrange treatment if needed. Clinicians should work w/ pts to reduce opioid dosage and to D/C opioids when indicated and should ensure continued close monitoring and support for pts prescribed or not prescribed opioids.

- If clinicians continue opioid tx in pts w/ previous opioid OD, they should discuss increased risks for OD w/ pts, carefully consider whether benefits of opioids outweigh substantial risks, and incorporate strategies to mitigate risk into the mgmt plan (e.g., offering naloxone and increasing frequency of monitoring.