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

Recommendation 9

When prescribing initial opioid tx for acute, subacute, or chronic pain, and periodically during opioid tx for chronic pain, clinicians should review the pt's hx of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the pt is receiving opioid dosages or combos that put the pt at high risk for OD (recommendation category: B; evidence type: 4).

Implementation Considerations

- Ideally, PDMP data should be reviewed before every opioid Rx for acute, subacute, or chronic pain. This practice is recommended in all jurisdictions where PDMP availability and access policies, as well as clinical practice settings, make it practicable (e.g., clinician and delegate access permitted).

- At a minimum, during long-term opioid tx, PDMP data should be reviewed before an initial opioid Rx and then q3mo or more frequently. Recommendation category B acknowledges variation in PDMP availability and circumstances. However, because PDMP info can be most helpful when results are unexpected and, to minimize bias in application, clinicians should apply this rec when feasible to all pts rather than differentially on the basis of assumptions about what they will learn about specific pts.

- Clinicians should use specific PDMP info about meds prescribed to their pt in the context of other clinical info, including their pt's hx, physical findings, and other relevant testing, to help them communicate w/ and protect their pt.

- Clinicians should review PDMP data specifically for Rx opioids and other controlled meds pts have received from additional prescribers to determine whether a pt is receiving total opioid dosages or combos (e.g., opioids combined w/ BZDs) that put the pt at risk for OD.

- PDMP-generated risk scores have *not* been validated against clinical outcomes such as OD and should not take the place of clinical judgment.

- Clinicians should not dismiss pts from their practice on the basis of PDMP info. Doing so can adversely affect pt safety and could result in missed opportunities to provide potentially lifesaving info (e.g., about risks of Rx opioids and about OD prevention) and interventions (e.g., safer prescriptions, nonopioid pain treatment, naloxone, and effective treatment for substance use disorders).

- Clinicians should take actions to improve pt safety:

    - Discuss info from the PDMP w/ the pt and confirm that the pt is aware of any additional prescriptions. Because clinicians often work as part of teams, prescriptions might appropriately be written by >1 clinician coordinating the pt's care. Occasionally, PDMP info can be incorrect (e.g., if the wrong name or birthdate has been entered, the pt uses a nickname or maiden name, or another person has used the pt's identity to obtain prescriptions).

    - Discuss safety concerns, including increased risk for resp depression and OD, w/ pts found to be receiving overlapping

prescription opioids from multiple clinicians who are not coordinating the pt's care or pts who are receiving meds that increase risk when combined w/ opioids (e.g., BZDs), and offer naloxone.

- Use particular caution when prescribing opioid pain med and BZDs concurrently, understanding that some pt circumstances warrant prescribing of these meds concomitantly. Communicate w/ others managing the pt to discuss the pt's needs, prioritize pt goals, weigh risks of concurrent BZD and opioid exposure, and coordinate care.

- Consider the total MME/day for concurrent opioid prescriptions to help assess the pt's OD risk. Buprenorphine should *not* be counted in the total MME/day in calculations because of its partial agonist properties at opioid receptors that confer a ceiling effect on resp depression. If a pt is found to be receiving total daily dosages of opioids that put them at risk for OD, discuss safety concerns w/ the pt, consider in collaboration w/ the pt whether or not benefits of tapering outweigh risks of tapering, and offer naloxone.

- Discuss safety concerns w/ other clinicians who are prescribing controlled substances for the pt. Ideally, clinicians should first discuss concerns w/ the pt and inform them that they plan to coordinate care w/ their other clinicians to improve the pt's safety.

- Screen for substance use and discuss concerns w/ the pt in a nonjudgmental manner.

- When diverting (sharing or selling Rx opioids and not taking them) might be likely, consider toxicology testing to assist in determining

whether Rx opioids can be discontinued w/out causing withdrawal. A negative toxicology test for prescribed opioids might indicate the pt is not taking prescribed opioids, although clinicians should consider other possible reasons for this test result (e.g., false-negative results or misinterpretation of results).