2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain

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Disclosures

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In this activity, I have no conflict of interest to report.

Objectives:

- Describe the current state of the opioid epidemic in the United States
- Review recommendations from the 2016 CDC Opioid Prescribing Guidelines
- Evaluate the impact of opioid prescribing practices that resulted from the previous guidelines
- Summarize the key changes in the updated 2022 CDC Opioid Prescribing Guideline

Key abbreviations

- AAPM – American Academy of Pain Medicine
- CDC – Center of Disease Control and Prevention
- IRR – Incidence rate ratio
- IRD – Incidence rate difference
- MAT – Medication assisted therapy
- MMED – Morphine milligram equivalents per day
- NSAID – Nonsteroidal anti-inflammatory drug
- TCA – Tricyclic antidepressants

Opioid Epidemic - Current State

Polling Question

Which of the following statements regarding opioid overdose death rates in the United States is true?

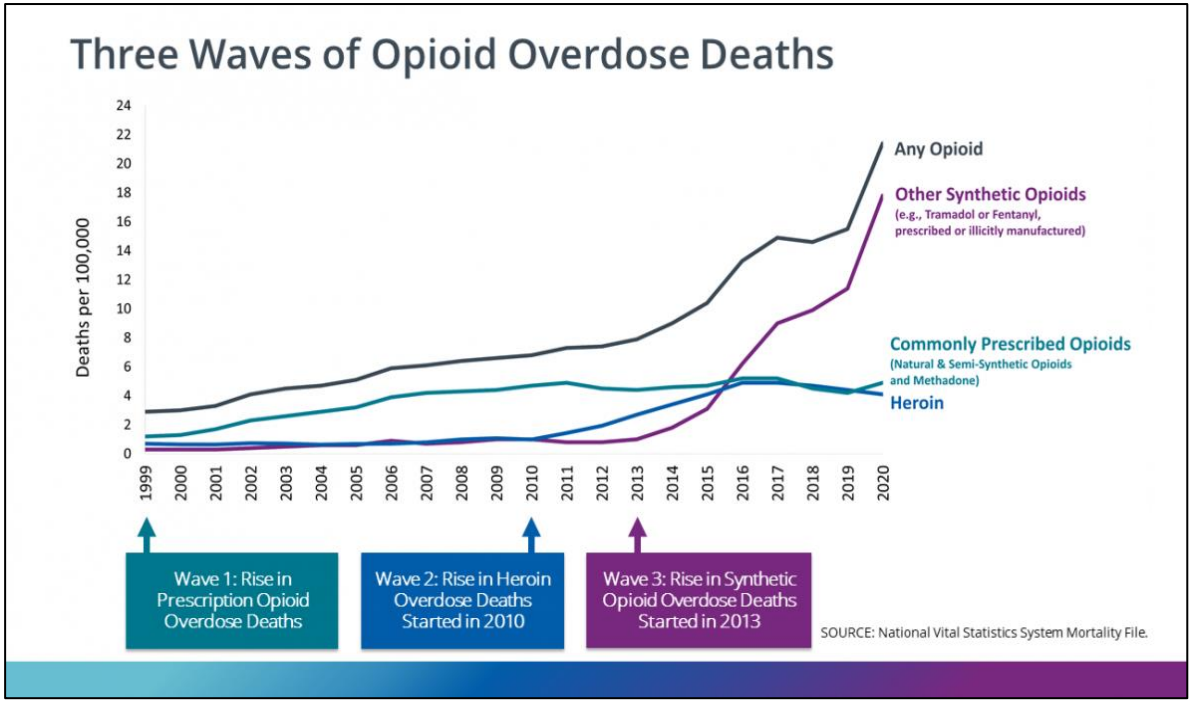
A. Overall opioid overdose death rate has declined since the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain

B. Overall opioid overdose death rate has remained steady since the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain

C. Prescription opioids account for 90% of all opioid overdose deaths

D. Synthetic opioids account for 90% of all opioid overdose deaths

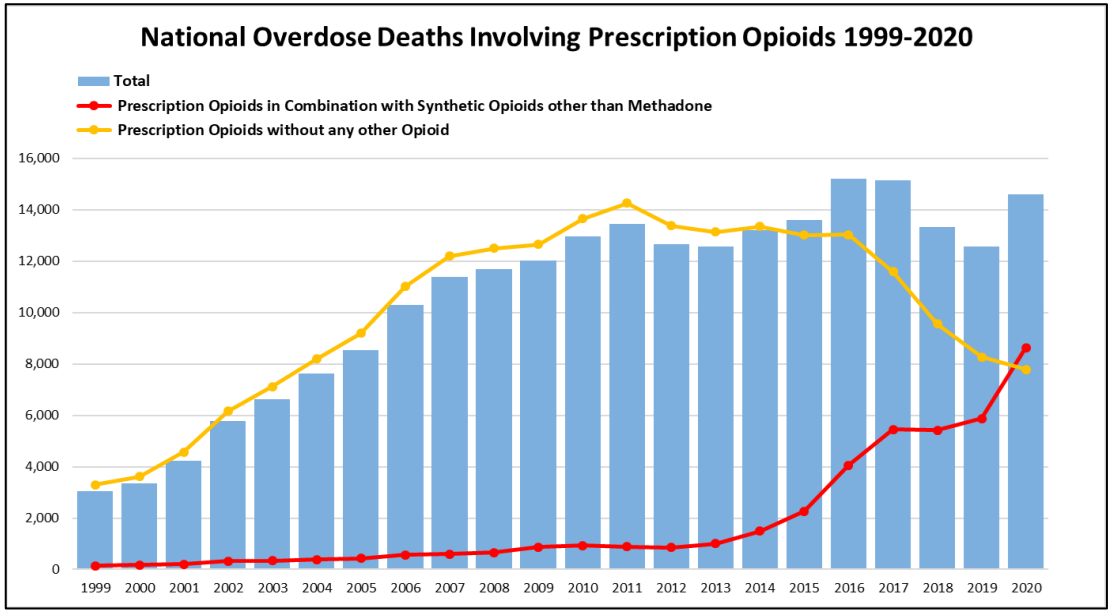
Opioid Epidemic



Hedegaard H, et al. National Center for Health Statistics. 2021.

Opioid Epidemic

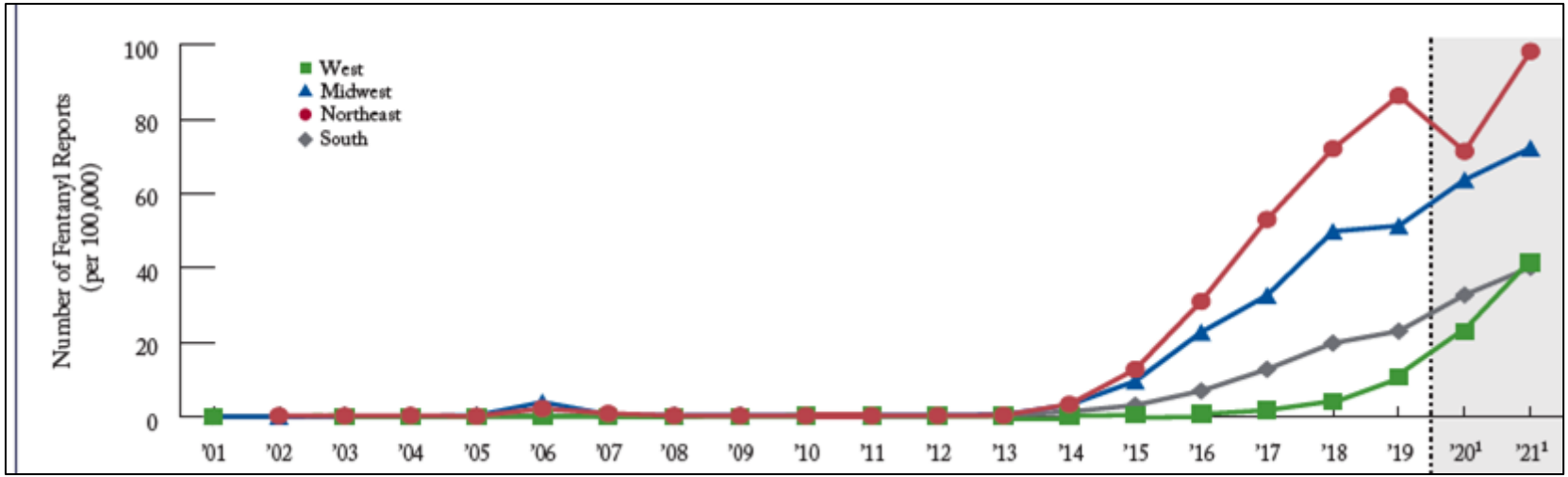
- Prescription opioid deaths declined from 2017 - 2019, then increased 2019-2020
- Prescription opioid deaths in combination with synthetic opioids increased 1999-2020



Hedegaard H, et al. National Center for Health Statistics. 2021.

Regional trends

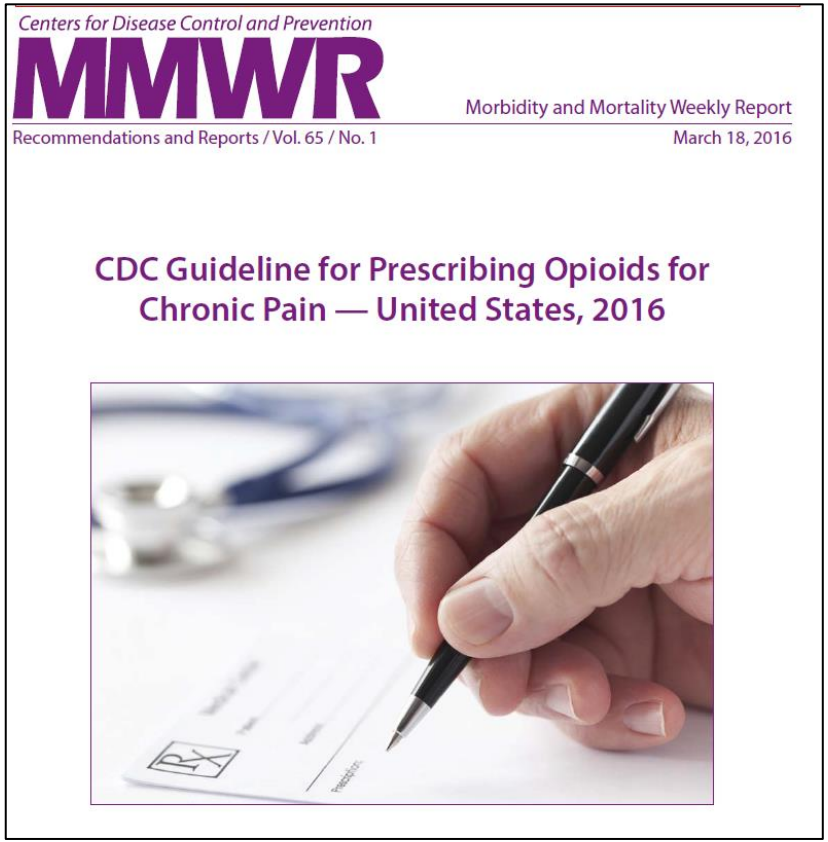
Regional trends in fentanyl reported per 100,000 people aged 15 or older, Jan 2001 - Dec 2021



Diversion Control Division. U.S. Department of Justice, U.S. Drug Enforcement Administration. 2021

CDC Guideline for Prescribing Opioids for Chronic Pain (2016)

2016 Guideline for Prescribing Opioids for Chronic Pain



Guideline Purpose

2016 Clinical Practice Guideline is intended to help clinicians:

- Improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain
- Improve the safety and effectiveness of pain treatment
- Reduce the risks associated with long-term opioid therapy (including opioid use disorder, overdose, and death)

Dowell D, Haegerich TM, Chou R. *JAMA*. 2016;315(15):1624-1645. doi:10.1001/jama.2016.1464

2016 Guideline for Prescribing Opioids for Chronic Pain

- Chronic pain: “pain that typically lasts >3 months or past the time of normal tissue healing”
- Guideline excludes:
  - Active cancer treatment
  - Palliative care
  - End-of-life care

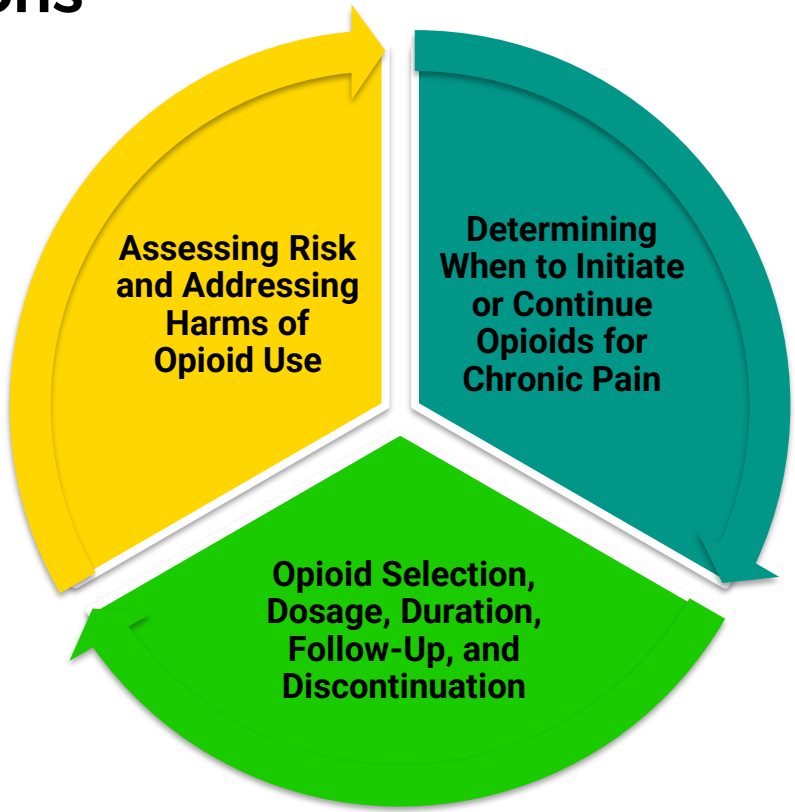
Dowell D, Haegerich TM, Chou R. *JAMA*. 2016;315(15):1624-1645. doi:10.1001/jama.2016.1464

Primary Clinical Questions

1. **Effectiveness** of long-term opioid therapy
2. Risks of **harms** associated with opioids
3. Opioid **dosing** strategies
4. **Risk** assessment and mitigation
5. Effects of opioid therapy for acute pain on **long-term use**

Dowell D, Haegerich TM, Chou R. *JAMA*. 2016;315(15):1624-1645. doi:10.1001/jama.2016.1464

Recommendations



Dowell D, Haegerich TM, Chou R. *JAMA*. 2016;315(15):1624-1645. doi:10.1001/jama.2016.1464

Determining When to Initiate or Continue Opioids for Chronic Pain

1	Nonpharmacologic therapy and nonopioid pharmacologic therapy preferred. Opioids should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy
2	Establish realistic treatment goals before starting therapy, including realistic goals for pain and function, and how therapy will be discontinued if benefits do not outweigh risks
3	Before starting and periodically during therapy, clinicians should discuss with patients known risks and benefits of opioid therapy

Dowell D, Haegerich TM, Chou R. *JAMA*. 2016;315(15):1624-1645. doi:10.1001/jama.2016.1464

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

4	When starting opioids, use immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
5	Start at the lowest effective dosage ● Carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 MMED ● Avoid increasing dosage to ≥90 MMED or carefully justify a decision to titrate dosage to ≥90 MMED.

Dowell D, Haegerich TM, Chou R. *JAMA*. 2016;315(15):1624-1645. doi:10.1001/jama.2016.1464

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation	
6	Prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids ● 3 days or less will often be sufficient ● >7 days will rarely be needed
7	Evaluate benefits/harms 1 - 4 weeks of starting opioid therapy or dose escalation. Evaluate continued therapy every 3 months. If benefits do not outweigh harms of continued therapy, optimize other therapies and/or taper/discontinue opioids

Dowell D, Haegerich TM, Chou R. *JAMA*. 2016;315(15):1624-1645. doi:10.1001/jama.2016.1464

Assessing Risk and Addressing Harms of Opioid Use

8	Before starting and periodically during continuation, evaluate risk factors for opioid-related harms. ● Offer naloxone for patients at risk for opioid overdose ○ History of overdose ○ History of substance use disorder ○ Higher opioid dosages (≥50 MMED) ○ Concurrent benzodiazepine

Dowell D, Haegerich TM, Chou R. *JAMA*. 2016;315(15):1624-1645. doi:10.1001/jama.2016.1464

Assessing Risk and Addressing Harms of Opioid Use	
9	Review history of controlled substance prescriptions (e.g., PDMP) data every prescription to every 3 months
10	Use urine drug testing before starting opioid therapy at least annually
11	Avoid prescribing opioid pain medication and benzodiazepines concurrently
12	Offer/arrange evidence-based treatment for patients with opioid use disorder (e.g., methadone or buprenorphine in combination with behavioral therapy)

Dowell D, Haegerich TM, Chou R. *JAMA*. 2016;315(15):1624-1645. doi:10.1001/jama.2016.1464

Morphine Milligram Equivalent Daily Dose (MMED)

To calculate the total daily dose:

1. Determine the total daily doses of current opioid medications
2. Convert each dose into MMEs by multiplying the dose by the conversion factor
3. If more than one opioid medication, add together.
    - Reduce amount by 25-50% and then divide into appropriate intervals.

Von Korff M, Saunders K, Thomas Ray G, et al. *Clin J Pain*. 2014 Sep;30(9):830.

Morphine Milligram Equivalent Daily Dose (MMED)

Opioid	Conversion Factor
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone ● 1–20 mg/day ● 21–40 mg/day ● 41–60 mg/day ● ≥61–80 mg/day	 4 8 10 12
Morphine	1
Oxycodone	1.5
Oxymorphine	3
Tapentadol	0.4

Von Korff M, Saunders K, Thomas Ray G, et al. *Clin J Pain*. 2014 Sep;30(9):830.

2016 CDC MMED Recommendations

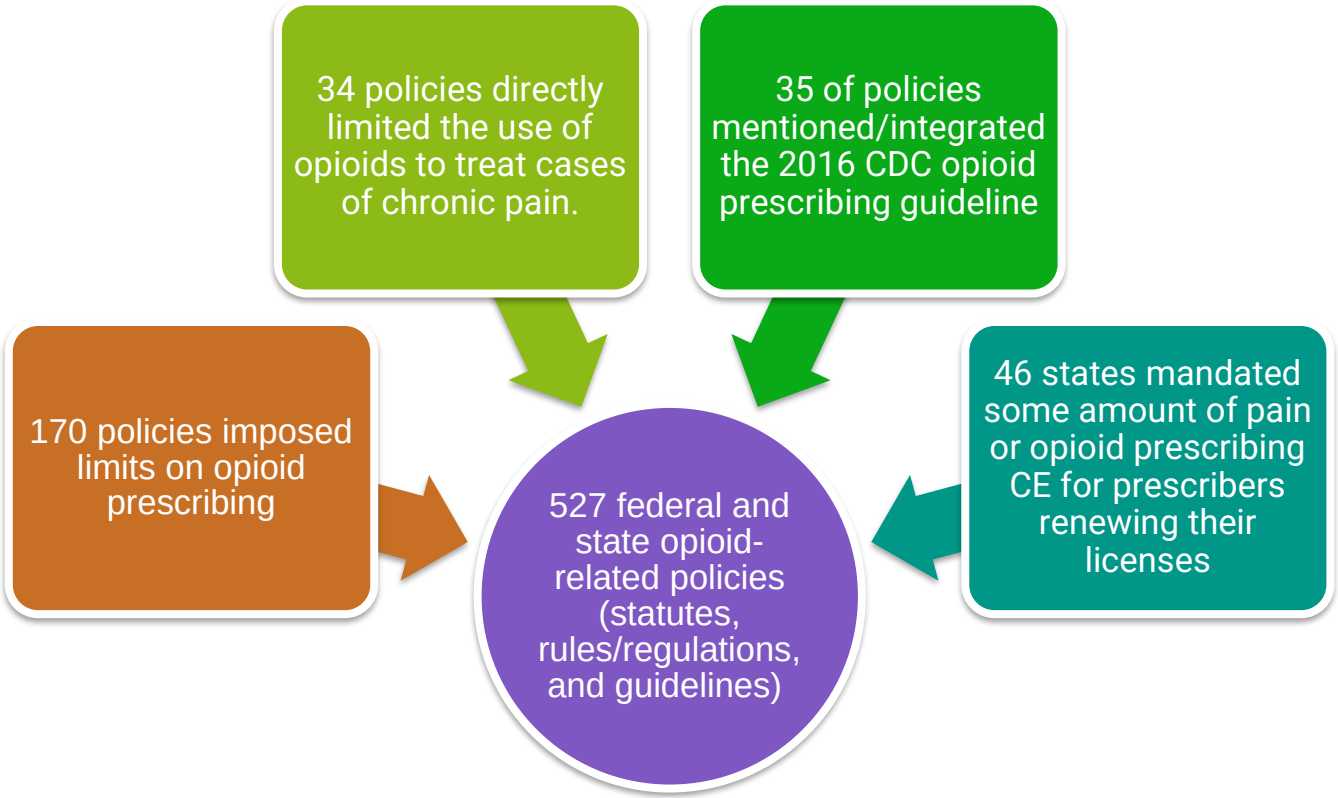
Recommendation 5:

- *"carefully reassess evidence of individual benefits and risks when considering increasing dosage to **>50 MEDD**… avoid increasing dosage to **>90 MEDD**"*
- *"if patients do not experience improvement in pain and function at **> 90 MEDD**, or if there are escalating dosage requirements, clinicians should discuss other approaches to pain management… consider taper opioids to a lower dosage or to taper and discontinue opioids"*

Dowell D, Haegerich TM, Chou R. *JAMA*. 2016;315(15):1624-1645. doi:10.1001/jama.2016.1464

Impact on opioid prescribing practices

Public, regulatory, and third-party policy changes from 2016 - 2018



Duensing K, Twillman R, Ziegler S, et al. A*J Pain Res.* 2020;13:2431-2442. Published 2020 Oct 1. doi:10.2147/JPR.S267448

NEW YORK STATE OF OPPORTUNITY. Department of Health

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HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

February 13, 2019

Dear Practitioner/Facility/Institution:

This letter is to advise you of an important addition to the Public Health Law affecting many patients who have been prescribed, or may be prescribed, opioids for pain that has lasted more than three months or past the time of normal tissue healing.

Effective April 1, 2018, legislation signed by Governor Cuomo with the 2018-2019 State Fiscal Year Budget amends Public Health Law §3331 by adding subparagraph (8), as follows:

> 8. No opioids shall be prescribed to a patient initiating or being maintained on opioid treatment for pain which has lasted more than three months or past the time of normal tissue healing, unless the medical record contains a written treatment plan that follows generally accepted national professional or governmental guidelines. The requirements of this paragraph shall not apply in the case of patients who are being treated for cancer that is not in remission, who are in hospice or other end-of-life care, or whose pain is being treated as part of palliative care practices.

In short, a written treatment plan in the patient's medical record is required if a practitioner prescribes opioids for pain that has lasted for more than three months or past the time of normal tissue healing. There are exceptions for patients being treated for:

- cancer that is not in remission
- hospice or other end-of-life care and
- palliative care.

The treatment plan must follow generally accepted national professional or governmental guidelines, and shall include (but is not limited to) the documentation and discussion of the following clinical criteria within the medical record:

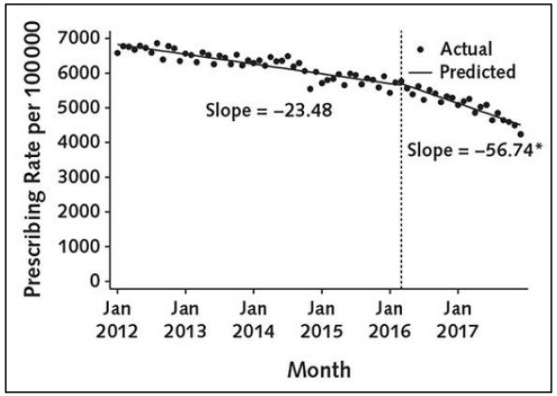
- ✓ goals for pain management and functional improvement based on diagnosis, and a discussion on how opioid therapy would be **tapered to lower dosages or tapered and discontinued** if benefits do not outweigh risks;
- ✓ a review with the patient of the risks of and alternatives to opioid treatment; and
- ✓ an evaluation of risk factors for opioid-related harms.

Such documentation and discussion of the above clinical criteria shall be done, at a minimum, on an annual basis.

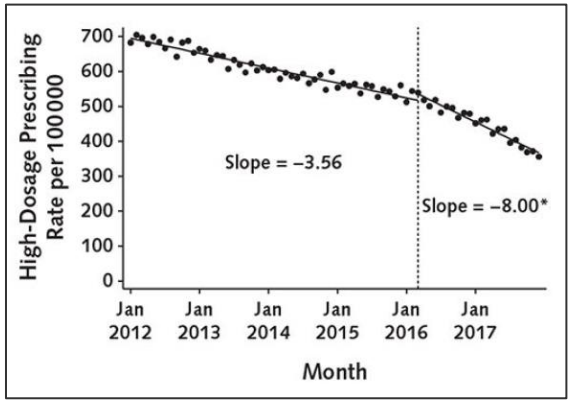
Opioid Prescribing in the United States Before and After the CDC's 2016 Opioid Guideline

- Interrupted time series analysis of monthly opioid prescribing 2012 – 2017
- Overall opioid prescribing rate: 6,577 per 100,000 persons in January 2012; declined by 23.48 (CI, −26.18 to −20.78) each month before the March 2016 and by 56.74 (CI, −65.96 to −47.53) per month afterward
- Rate of high-dosage prescriptions (≥90 morphine equivalent milligrams per day) was 683 per 100,000 persons in January 2012 and declined by 3.56 (95% CI, −3.79 to −3.32) per month before March 2016 and by 8.00 (CI, −8.69 to −7.31) per month afterward

Count of all opioid prescriptions dispensed in a month, per 100,000 persons



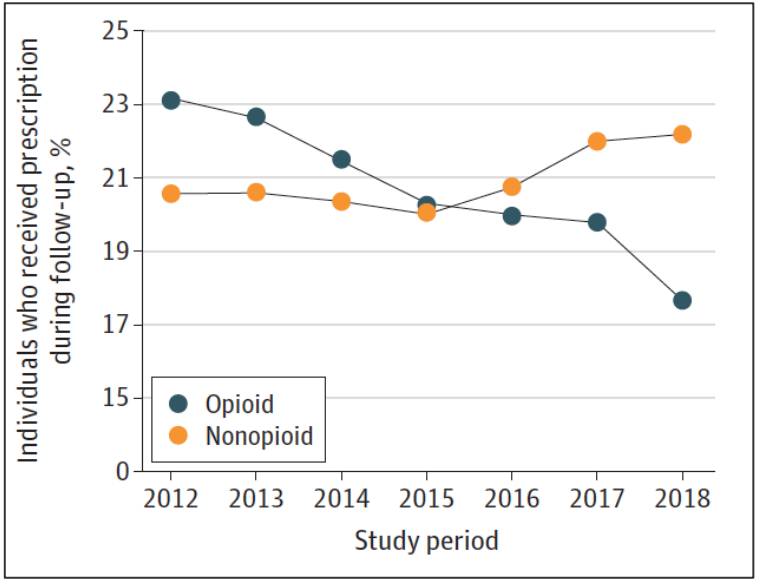
Number of opioid prescriptions dispensed in a month to total a daily dosage >90 MME, per 100,000 persons



Bohnert ASB, Guy GP Jr, Losby JL. *Ann Intern Med.* 2018;169(6):367-375.

Patterns in Nonopioid Pain Medication Prescribing After the Release of the 2016 Guideline for Prescribing Opioids for Chronic Pain

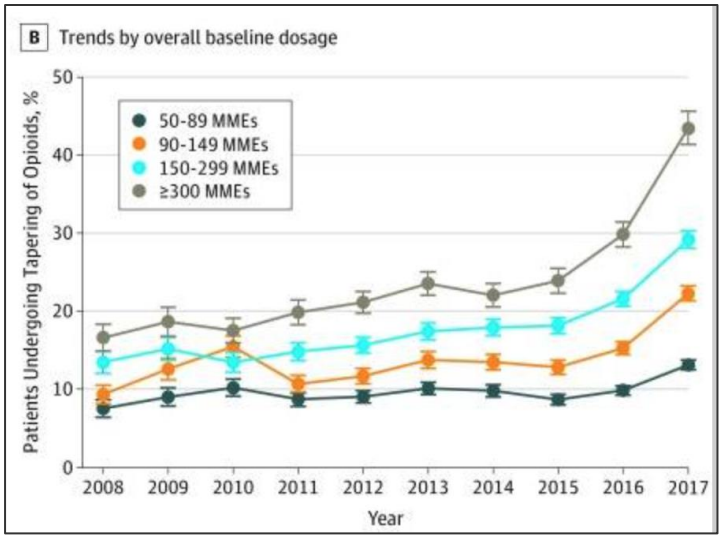
- Cohort study using claims data from 2011 – 2018
- Primary outcome: Receipt of any nonopioid pain medication prescriptions during the follow-up
- Results: Nonopioid pain medication prescribing higher by 3.0% (95% CI, 2.6%-3.3%) in post-guideline year 1, by 8.7% (95% CI, 8.3%-9.2%) in year 2, and by 9.7% (95% CI, 9.2%-10.3%) in year 3
- Largest change among chronic pain patients



Goldstick JE, Guy GP, Losby JL, Baldwin GT, Myers MG, Bohnert ASB *JAMA Netw Open*. 2022;5(6):e2216475.

Dose Tapering Among Patients Prescribed Long-term Opioid Therapy (2008-2017)

- Cohort study for 100,031 adults ≥50 MMED >1 year
- Primary objective: To characterize US trends in opioid dose tapering among patients prescribed long-term opioids from 2008 to 2017 and identify patient-level variables associated with tapering and a more rapid rate of tapering.
- Findings: Percentage of patients tapering opioid doses increased from 10.5% - 13.7% (aIRR per year, 1.05 [95% CI, 1.05-1.06]), 16.2% in 2016, and 22.4% in 2017 (aIRR in 2016-2017 vs 2008-2015, 1.20 [95% CI, 1.16-1.25])
- 18.8% had a maximum tapering rate >40% per month (faster than 10% per week)



Fenton JJ, Agnoli AL, Xing G, et al. *JAMA Netw Open*. 2019;2(11):e1916271.

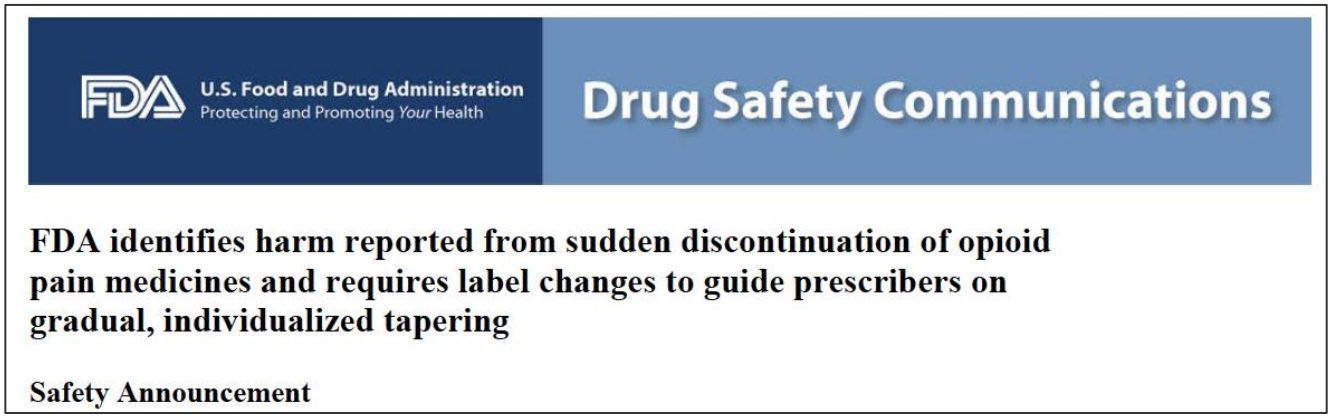
Challenges Implementing the CDC Opioid Guideline (AAPM 2019)

- Confusion in practice on daily opioid dosage ceilings
- Hard limits on dose ceilings → abrupt dose reductions
    - Risks of withdrawal, hyperalgesia, and self-medication
- Dose ceilings are set as policy when payers make coverage and reimbursement decisions
- Unknown consequences of abrupt vs gradual tapers
- Lack of resources toward integrated, multimodal, and comprehensive pain care
- Naloxone co-prescribing is underutilized

Kroenke K, Alford DP, Argoff C, et al. *Pain Med*. 2019;20(4):724-735.

FDA Drug Safety Announcement (2019)

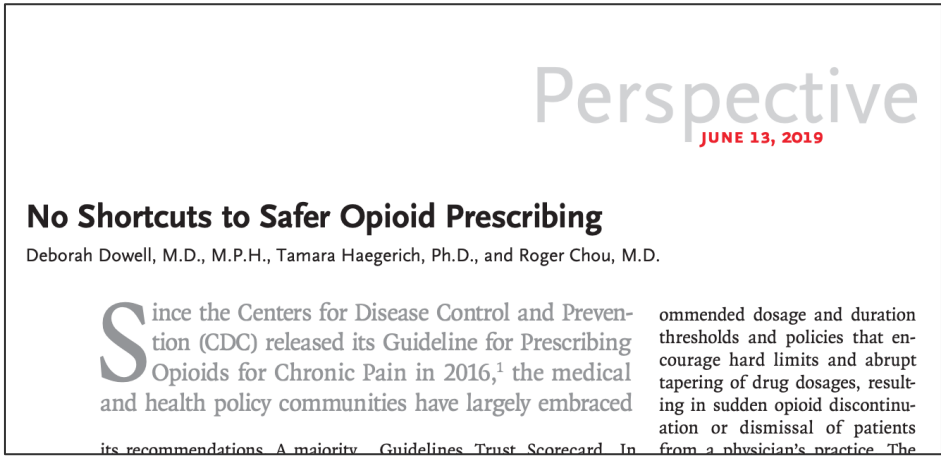
- Reports of serious harm on patients dependent on opioids due to rapid dose decrease/discontinuation
- Clinicians advised to not abruptly discontinue opioids in physically dependent patients
- Patients on long-term treatment advised to not abruptly stop taking opioids



FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering. Available at https://www.fda.gov/media/122935/download

Clarification from CDC Opioid Guideline Authors

- In 2019, CDC guideline authors published a paper in NEJM attempting to clarify flaws
- Guidelines improve patient outcomes when they lead to policies that *reduce harm*



Perspective

JUNE 13, 2019

No Shortcuts to Safer Opioid Prescribing

Deborah Dowell, M.D., M.P.H., Tamara Haegerich, Ph.D., and Roger Chou, M.D.

Since the Centers for Disease Control and Prevention (CDC) released its Guideline for Prescribing Opioids for Chronic Pain in 2016,[1] the medical and health policy communities have largely embraced

its recommendations. A majority ... Guidelines Trust Scorecard. In

ommended dosage and duration thresholds and policies that encourage hard limits and abrupt tapering of drug dosages, resulting in sudden opioid discontinuation or dismissal of patients from a physician's practice. The

"… some policies and practices purportedly derived from the guideline have in fact been inconsistent with, and often go beyond, its recommendations"

Dowell D, Haegerich T, Chou R. *N Engl J Med*. 2019;380(24):2285-2287. doi:10.1056/NEJMp1904190

Clarification from CDC Opioid Guideline Authors

Unintended Consequences of 2016 CDC Guidelines

Policies	Populations outside the guideline's scope	Dosing	Patient care
• Hard limits on dosing • Force abrupt discontinuation/ tapering	• Pain associated with cancer • Pain from surgical procedures • Acute sickle cell crises	• Inflexible application of recommended dosage • Inflexible duration • Opioid agonists for OUD	• Referral/dismissal of patients on high doses • Stop prescribing opioids entirely

Dowell D, Haegerich T, Chou R. *N Engl J Med*. 2019;380(24):2285-2287. doi:10.1056/NEJMp1904190

Long-term Risks After Opioid Dose Tapering

- Cohort study of 30,255 patients that underwent opioid dose tapering from 2008 - 2017 after a 12-month > 50 MMED
- Tapering was associated with increased rates of overdose, withdrawal, and mental health crisis extending up to 2 years after taper

Outcome	Pretaper Incidence rate, events/100 person-years	Postinduction Incidence rate, events/100 person-years	Incidence rate, events/100 person-years	IRR (95% CI)	
				Unadjusted	Adjusted
Overdose or withdrawal	3.5	5.4	1.9 (1.5-2.3)	1.53 (1.39-1.68)	1.57 (1.42-1.74)
Overdose	2.0	2.8	0.8 (0.5 1.1)	1.39 (1.22-1.58)	1.39 (1.22-1.58)
Mental health crisis	3.0	4.4	1.4 (1.0-1.8)	1.48 (1.33-1.64)	1.52 (1.35-1.71)

Fenton JJ, Magnan E, Tseregounis IE, Xing G, Agnoli AL, Tancredi DJ. *JAMA Netw Open*. 2022;5(6):e2216726.

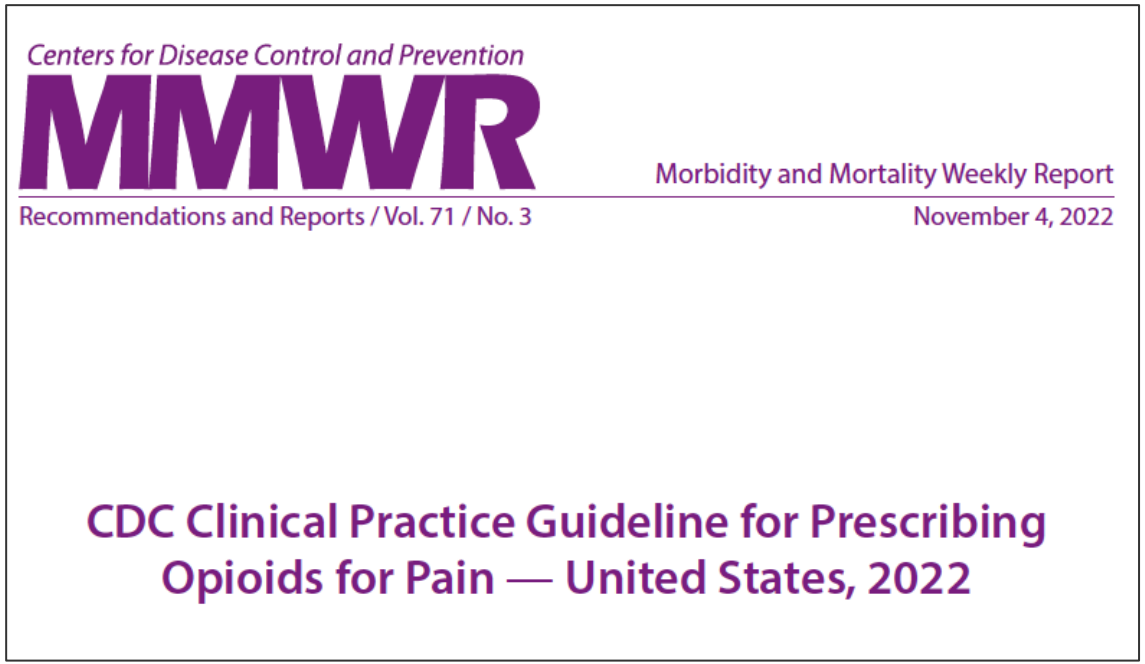
Illicit Drug Use After Opioid Tapering

- Observational study: 22,962 patients prescribed opioid therapy, 125 patients (0.54%) used heroin after opioids
- Results: Patients whose opioid therapy was discontinued were >2x likely to have heroin use (n = 74) than patients without opioid discontinuation patients (n = 1045; mOR = 2.19; 95% CI 1.27-3.78)
- Estimate: >20% of people who use heroin after opioids were tapered/discontinued opioids prior to illicit use

Binswanger IA, Glanz JM, Faul M, et al. *Drug Alcohol Depend* 2020;217:108248.

Changes in the updated 2022 CDC Opioid Prescribing Guideline

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



Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *MMWR Recomm Rep*. 2022;71(3):1-95. Published 2022 Nov 4.

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

“Patients with pain should receive compassionate, safe, and effective pain care. We want clinicians and patients to have the information they need to weigh the benefits of different approaches to pain care, with the goal of helping people reduce their pain and improve their quality of life,”

Christopher M. Jones, PharmD, DrPH, MPH
Acting Director of CDC’s National Center for Injury Prevention and Control.

Guideline Purpose

2022 Clinical Practice Guideline is intended to help clinicians:

- Improve communication with patients about the benefits and risks of pain treatments, including opioid therapy for pain
- Improve the safety and effectiveness of pain treatment
- **Mitigate pain**
- **Improve function and quality of life for patients with pain**
- Reduce the risks associated with opioid pain therapy (including opioid use disorder, overdose, and death)

NEW

Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *MMWR Recomm Rep*. 2022;71(3):1-95. Published 2022 Nov 4.

Five Guiding Principles for Implementing Recommendations

1. Acute, subacute, and chronic pain needs to be appropriately assessed and treated independent of whether opioids are part of a treatment regimen.
2. Recommendations are voluntary and are intended to support, not supplant, individualized, person-centered care. Flexibility to meet the care needs and the clinical circumstances of a specific patient is paramount.
3. A multimodal and multidisciplinary approach to pain management attending to the physical health, behavioral health, long-term services and supports, and expected health outcome and well-being of each person is critical.

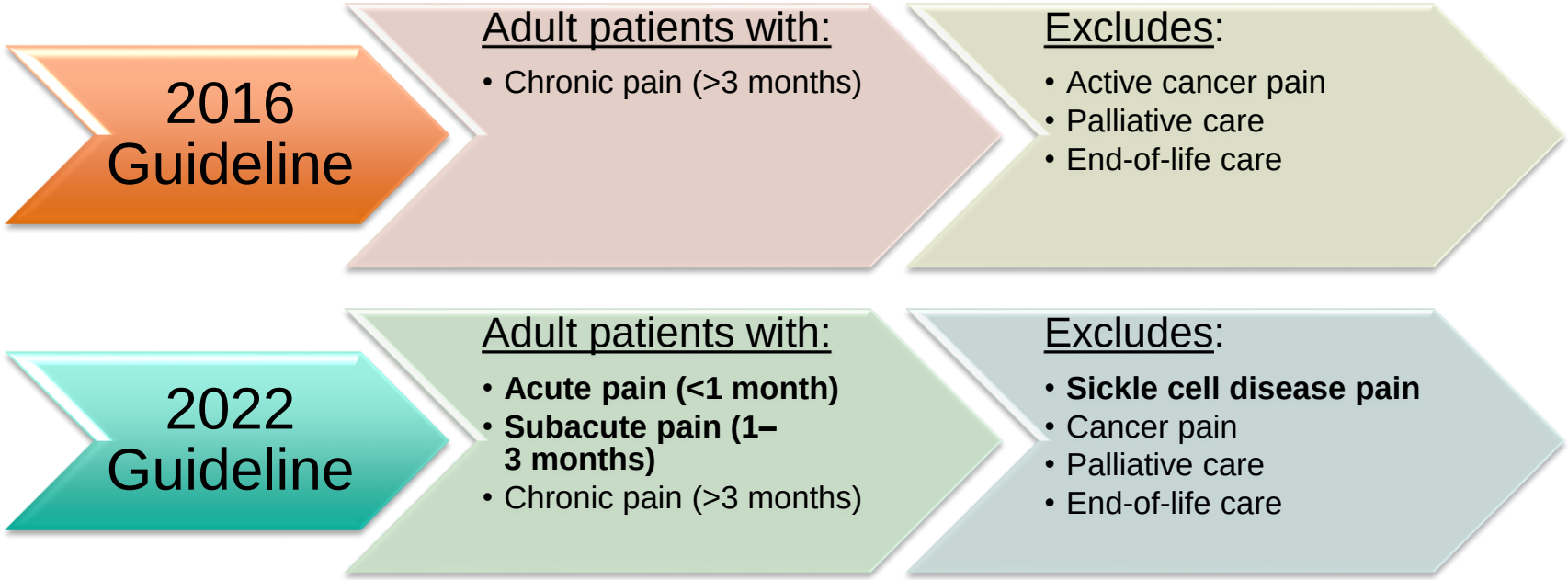
Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *MMWR Recomm Rep*. 2022;71(3):1-95. Published 2022 Nov 4.

Five Guiding Principles for Implementing Recommendations

4. Special attention should be given to avoid misapplying this clinical practice guideline beyond its intended use or implementing policies purportedly derived from it that might lead to unintended and potentially harmful consequences for patients
5. Clinicians, practices, health systems, and payers should vigilantly attend to health inequities; provide culturally and linguistically appropriate communication, including communication that is accessible to persons with disabilities; and ensure access to an *appropriate*, *affordable*, *diversified*, *coordinated*, and *effective* nonpharmacologic and pharmacologic pain management regimen for all persons.

Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *MMWR Recomm Rep*. 2022;71(3):1-95. Published 2022 Nov 4.

Changes: Patients



Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *MMWR Recomm Rep*. 2022;71(3):1-95. Published 2022 Nov 4.

Changes: Scope of Audience

New guideline broadens scope from primary care physicians to other clinicians

Primary Care Clinicians	Outpatient Clinicians	Team members

• Family physicians
• Nurse practitioners
• Physician assistants
• Internists
	• Dental and other oral health clinicians
	• Emergency clinicians for patients being discharged from emergency departments
	• Surgeons
	• Occupational medicine physicians
	• Physical medicine and rehabilitation physicians
	• Neurologists
	• Obstetricians and gynecologists
		• Behavioral health specialists
		  • Social workers
		  • Psychologists
		• Pharmacists
		• Registered nurses

Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *MMWR Recomm Rep*. 2022;71(3):1-95. Published 2022 Nov 4.

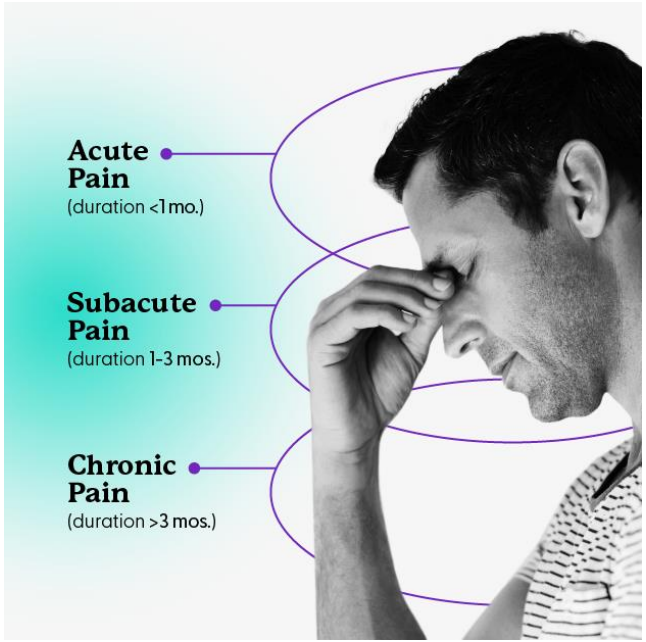
New: Health Equity and Disparities in the Treatment of Pain

- The 2022 Clinical Practice Guideline describes evidence about long-standing health disparities that exist in the treatment of pain, such as geographic disparities and disparities in treatment due to access and affordability
- Addresses health inequities related to race and ethnicity, as a guiding principle for implementation

Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *MMWR Recomm Rep*. 2022;71(3):1-95. Published 2022 Nov 4.

New: Acute Pain (duration <1 month)

- Nonopioid therapies are at least as effective as opioids for many common acute pain conditions
  - Neck pain
  - Dental pain
  - Kidney stone pain
  - Headaches/episodic migraine
  - Low back pain
  - Pain related to other musculoskeletal injuries (e.g., sprains, strains, tendonitis, and bursitis)
  - Pain related to minor surgeries associated with minimal tissue injury/mild postoperative pain (e.g., simple dental extraction)



Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *MMWR Recomm Rep*. 2022;71(3):1-95. Published 2022 Nov 4.

New: Acute Pain (duration <1 month)

- Opioid therapy has an important role for severe acute pain
  - Severe traumatic injuries (including crush injuries and burns)
  - Invasive surgeries typically associated with moderate to severe postoperative pain
  - Other severe acute pain when NSAIDs and other therapies are contraindicated or likely to be ineffective.
- Prescribe immediate-release opioids at the lowest effective dose no longer than the expected duration of pain severe enough to require opioids
- Opioids should be used only as needed (not scheduled)
- Encourage and recommend an opioid taper if opioids are taken around the clock for more than a few days

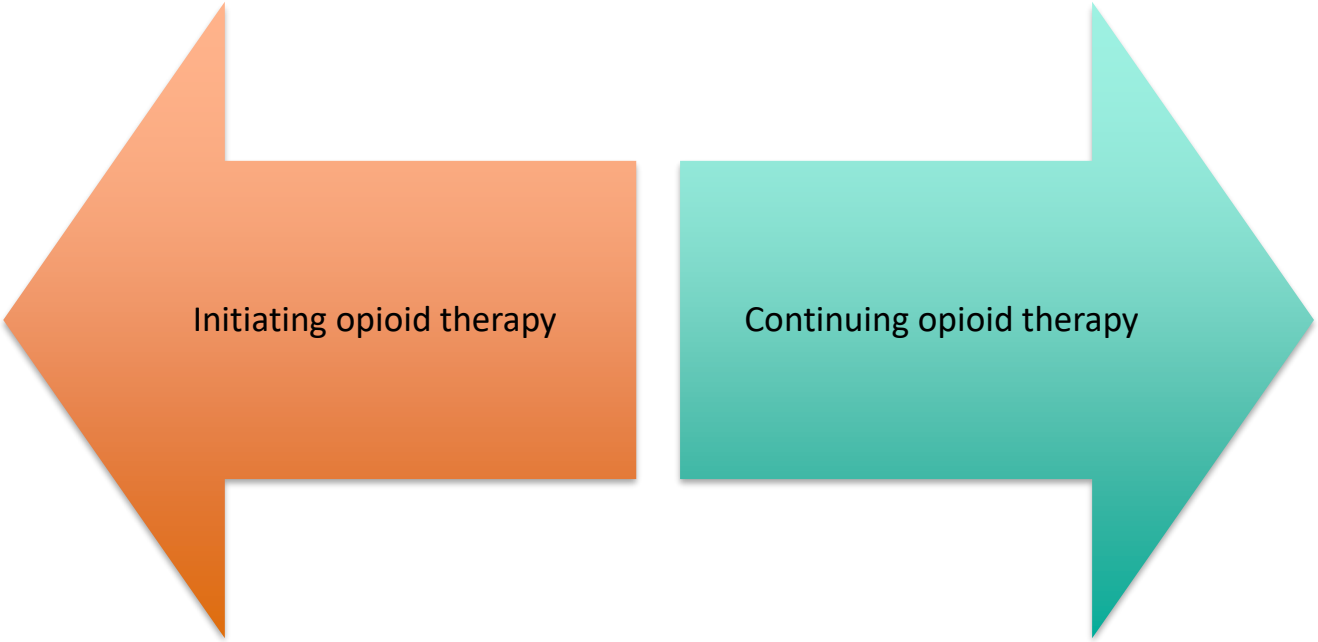
Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *MMWR Recomm Rep*. 2022;71(3):1-95. Published 2022 Nov 4.

New: Subacute pain (duration 1 – 3 months)

- Reassess a patient's prescriptions to ensure that opioid prescribing for acute pain does not unintentionally become long-term opioid therapy
- Ensure potentially reversible causes of chronic pain are addressed

Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *MMWR Recomm Rep*. 2022;71(3):1-95. Published 2022 Nov 4.

Changes: Initial and Ongoing Opioid Therapy



Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *MMWR Recomm Rep*. 2022;71(3):1-95. Published 2022 Nov 4.

Changes: Initial Opioid Therapy

Initiating opioid therapy
• Determining whether or not to initiate opioids • Acute pain vs subacute pain vs chronic pain • Nonopioid and Nonpharmacologic therapies • Selecting opioids and determining doses • Assessing risk and addressing harms • Review patient medication history • Conduct toxicology testing • Caution with concurrent opioids and other CNS depressants

Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *MMWR Recomm Rep*. 2022;71(3):1-95. Published 2022 Nov 4.

Changes: Ongoing Opioid Therapy

Continuing opioid therapy
• Deciding duration of prescription and conducting follow-up • Acute pain vs subacute pain vs chronic pain • Follow-up recommendations • Assessments to increase doses • Assessing risk and addressing harms • Factors that may increase risk of harm • Review patient medication history • Conduct toxicology screening • Caution with concurrent opioids and other CNS depressants

Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *MMWR Recomm Rep*. 2022;71(3):1-95. Published 2022 Nov 4.

Changes: Opioid Dosing

- Clarification that the recommendations on dosages are not intended to be used as an inflexible, rigid standard of care
- Intended to be guideposts to help inform clinician-patient decision-making
- Recommendations based on starting or increasing opioids
    - Separate recommendations on tapering/discontinuing

Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *MMWR Recomm Rep*. 2022;71(3):1-95. Published 2022 Nov 4.

Changes: Opioid Dosing

2016

Reassess evidence of individual benefits and risks when increasing **≥50 MMED**

Avoid increasing dosage to **≥90 MMED**

Carefully justify a decision to titrate dosage to **≥90 MMED**

2022

Carefully evaluate individual benefits and risks when considering increasing dosage

Avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients

Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *MMWR Recomm Rep*. 2022;71(3):1-95. Published 2022 Nov 4.

Changes: Opioid Dosing

- **Starting** dose for opioid-naïve
  - Single ~ 5–10 MME
  - Daily dosage ~ 20–30 MMED
- **Pause/reassess** at ≥50 MMED
  - Lack of benefit in pain/function, increases in risk

	Single dose		Daily dose	
Opioid	**Oral**	**Parenteral**	**Oral**	**Parenteral**
Morphine	5 – 10 mg	2 – 3 mg	20 – 30 mg	6 – 10 mg
Codeine	15 – 30 mg		60 – 90 mg	
Hydrocodone	5 – 10 mg		20 – 30 mg	
Hydromorphone	1 – 2 mg	0.25 – 0.5 mg	5 – 6 mg	1 – 1.5 mg
Oxycodone	5 – 10 mg		15 – 20 mg	
Oxymorphone	5 mg		5 – 10 mg	
Tramadol	25 – 50 mg		100 – 150 mg	

Changes: Opioid Tapering

- Determining whether, when, and how to taper opioids
- Providing advice to patients prior to tapering
- Pain management during tapering
- Behavioral health support during tapering
- Tapering rate
- Management of opioid withdrawal during tapering
- Challenges to tapering
- Continuing high-dosage opioids

Healthcare Professionals Opioid Prescribing Resources. Centers for Disease Control and Prevention. https://www.cdc.gov/opioids/healthcare-professionals/prescribing/guideline/whats-changed.html. Published November 3, 2022. Accessed January 20, 2023.

Changes: Opioid Tapering

2016 recommendations

- Starting point: Reduce by 10% per week
- Reduce dosage by 10%-50% per week
- Rapid taper over 2-3 weeks recommended in case of overdose
- Patients taking opioids for years: Slower taper than 10% per week (e.g. 10% per month)
- Taper successful as patient progresses

2022 recommendations

- Patients taking opioids ≥1 year: Reduce by 10% per month OR SLOWER
- Patients taking opioids weeks to months: Reduce by 10% of original dose per week OR SLOWER until 30% of original dose is reached, then by 10% remaining dose weekly
- Rapid taper/discontinuation ONLY recommended in case of overdose and should be AVOIDED
- Goals of taper vary depending on patient

Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *MMWR Recomm Rep*. 2022;71(3):1-95. Published 2022 Nov 4.

Changes: Nonopioid Therapies

Nonopioid pharmacologic therapies	Nonpharmacologic therapies
• NSAIDs (Topical or oral) • Acetaminophen • TCA • SNRI • Anticonvulsants (e.g., pregabalin, gabapentin enacarbil, oxcarbazepine) • Capsaicin and lidocaine patches	• Ice • Heat • Elevation • Rest • Immobilization and/or exercise

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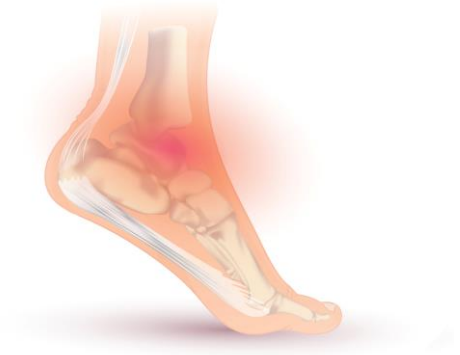
Nonopioid Therapies – Acute back pain

Acute Back Pain	
Nonpharmacologic Therapies	**Nonopioid Pharmacologic Therapies**
Low back pain • Heat therapy • Massage • Acupuncture • Spinal manipulation Neck pain with radiculopathy • Cervical collar • Exercise	• NSAIDs (similarly effective to opioids) • Skeletal muscle relaxant Insufficient evidence for effectiveness of opioids

Nonopioid Therapies – Acute musculoskeletal pain

Acute Musculoskeletal Pain (e.g., sprains, whiplash, and muscle strains, minor pain related to fractures)	
Nonpharmacologic Therapies	**Nonopioid Pharmacologic Therapies**
• Acupressure • Function and transcutaneous electrical nerve stimulation • Ice and elevation	First line • Topical NSAIDs • Menthol gel • Oral NSAIDs • Oral acetaminophen



Nonopioid Therapies – Acute episodic migraine

Episodic Migraine	
Nonpharmacologic Therapies	**Nonopioid Pharmacologic Therapies**
• Remote electrical neuromodulation	• Triptans • NSAIDs • Antiemetics • Ergots • Acetaminophen • CGRP antagonists • Lasmiditan

Nonopioid Therapies – Chronic back pain

Chronic back/neck pain	
Nonpharmacologic Therapies	**Nonopioid Pharmacologic Therapies**
• Exercise • Psychological therapy • Spinal manipulation • Low-level laser therapy • Massage • Mindfulness-based stress reduction • Yoga • Acupuncture • Multidisciplinary rehabilitation	• NSAIDs • Duloxetine

Nonopioid Therapies – Chronic pain - Fibromyalgia

Fibromyalgia	
Nonpharmacologic Therapies	**Nonopioid Pharmacologic Therapies**
• Exercise • Cognitive behavioral therapy • Myofascial release massage • Mindfulness practices • Tai chi • Qigong • Acupuncture • Multidisciplinary rehabilitation	FDA-approved drugs: • Duloxetine • Milnacipran • Pregabalin Benefits of initiating opioids are unlikely to outweigh risks

Nonopioid Therapies – Chronic osteoarthritic pain

Chronic pain from osteoarthritis	
Nonpharmacologic Therapies	**Nonopioid Pharmacologic Therapies**
• Exercise • Cognitive behavioral therapy Hip osteoarthritis: • Manual therapy Knee osteoarthritis: • Weight loss	• Topical and oral NSAIDs • *Celecoxib* • Duloxetine Acetaminophen – no longer 1st line

Nonopioid Therapies – Chronic neuropathic pain

Chronic neuropathic pain
Nonopioid Pharmacologic Therapies
• TCAs • SNRI • Anticonvulsants (e.g., pregabalin, gabapentin, enacarbil, oxcarbazepine) • Capsaicin and lidocaine patches <u>FDA approved drugs</u> Diabetic Neuropathy: • Duloxetine • Pregabalin Postherpetic Neuralgia: • Gabapentin • Pregabalin

Polling Question

In patients with opioid-use disorder, clinicians should:

A. Offer/arrange MAT with buprenorphine or methadone with or without behavioral therapies
B. Offer/arrange MAT with buprenorphine or methadone in combination with behavioral therapies to increase retention during MAT
C. Offer/arrange MAT with buprenorphine or methadone in combination with behavioral therapies to increase compliance with opioid detoxification
D. Offer/arrange detoxification without MAT in a clinically monitored setting with trained specialists

Polling Question

In patients with opioid-use disorder, clinicians should NOT:

A. Offer/arrange treatment with buprenorphine
B. Offer/arrange treatment with buprenorphine/naloxone
C. Offer/arrange treatment with methadone
D. Offer/arrange treatment with oral naltrexone

Changes: Opioid Use Disorder

<u>Offer Medication Assisted Therapy (MAT):</u>

- Buprenorphine
- Methadone
- Naltrexone long-acting injection (NOT oral)

<u>Updates</u>:

- Behavioral therapy should not preclude/delay MAT
- Detox without MAT NOT recommended
    - Increases risk of resuming drug use, overdose, and death

Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *MMWR Recomm Rep*. 2022;71(3):1-95. Published 2022 Nov 4.

Changes: Opioid Use Disorder

Update:

- Opioid dosage thresholds not applicable to MAT
- No recommended duration limit with MAT
    - Discontinuation is associated with risks for return to drug use/overdose

Updated goal:

- Reduce risk of overdose and death

Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *MMWR Recomm Rep*. 2022;71(3):1-95. Published 2022 Nov 4.

Changes: Opioid Use Disorder – Pain Management

Patients with active OUD but not in treatment, consider:

- Methadone
- Buprenorphine

All patients:

- Nonopioid medications
- Behavioral approaches
- Physical therapy
- Procedural approaches (e.g., regional anesthesia)

The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. *J Addict Med*. 2020;14(2S Suppl 1):1-91.

Changes: Opioid Use Disorder – Pain Management

Patients on MAT Methadone

- Pain: Split dosing TID-QID
- Refractory/Moderate/Severe pain: Consider adding short-acting full opioid agonist

Patients on MAT Buprenorphine:

- Pain: Split dosing TID-QID
- Refractory/Moderate/Severe pain: Consider adding buprenorphine PRN.
    - Consider adding short-acting full opioid agonist in monitored setting

The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. *J Addict Med*. 2020;14(2S Suppl 1):1-91.

Changes: Opioid Use Disorder – Pain Management

Patients on Naltrexone:

- Pain: Non-opioid analgesic.
- Refractory/Moderate/Severe pain: Consider adding higher potency NSAID (ketorolac)
    - Consider adding short-acting full opioid agonist in monitored setting

The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. *J Addict Med*. 2020;14(2S Suppl 1):1-91.

Important update: Removal of X-Waiver Requirement

Omnibus Bill 2023:

- As of June 2023 - X-Waiver no longer needed for buprenorphine!

SAMHSA
Substance Abuse and Mental Health Services Administration

Removal of DATA Waiver (X-Waiver) Requirement

Section 1262 of the Consolidated Appropriations Act, 2023 (also known as Omnibus bill), removes the federal requirement for practitioners to submit a Notice of Intent (have a waiver) to prescribe medications, like buprenorphine, for the treatment of opioid use disorder (OUD). With this provision, and effective immediately, SAMHSA will no longer be accepting NOIs (waiver applications).

All practitioners who have a current DEA registration that includes Schedule III authority, may now prescribe buprenorphine for Opioid Use Disorder in their practice if permitted by applicable state law and SAMHSA encourages them to do so. SAMHSA and DEA are actively working on implementation of a separate provision of the Omnibus related to training requirements for DEA registration that becomes effective in June 2023. Please continue to check this webpage for further updates and guidance.

Summary

- New CDC Clinical Practice Guideline for Prescribing Opioids for Pain emphasizes goal to advance pain, function, and quality of life while reducing misuse, diversion, and consequences of prescription misuse
- Opioids should not be first-line treatment for pain
- Recommendations should not replace clinical judgement
- Clinicians should provide individualized care to patients to properly treat pain

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Questions?

2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain

Lisa Yamagishi, BS, PharmD, BCPS, CTTS
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