FAQ: CDC Opioid Prescribing Guideline Updates
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Introduction:

In 2022, the CDC updated its Clinical Practice Guideline for Prescribing Opioids for Pain after evaluating new and emerging science over the six years since the previous guidelines were released. The updated 2022 CDC guideline emphasizes flexible, patient-centered care for pain, and focuses on shared decision making with any treatment changes, including opioid tapers. The 2016 CDC guideline supported morphine milligram equivalent (MME) thresholds which were often rigidly applied in institutional policy development leaving little room for individualized care. While the 2022 update does not eliminate MME guidance, it primarily focuses on providing a full range of pain management options that can help clinicians partner with their patients to provide the best care. Of note, these guidelines do not apply to the treatment of sickle cell related pain, cancer-related pain, palliative care, and end-of-life care.

The purpose of this FAQ is to provide highlights of the changes to the 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain that are most applicable to pharmacists providing care for patients dealing with chronic pain. Not all changes made to the Practice Guideline are addressed within this FAQ. Please also note, the Guideline is voluntary and was created to assist clinicians in making informed decisions in treating patients with chronic pain.

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1. Is there an MME threshold for opioid prescribing?

The 2016 CDC Guideline indicated that clinicians should carefully reassess evidence of individual benefits and risks when considering opioid dosages ≥ 50 MME/day and should avoid increasing dosages to ≥ 90 MME/day without careful justification.[1] This recommendation inadvertently led to the misapplication of opioid dosage thresholds and subsequent patient harm including, but not limited to, increased pain, decreased function, and withdrawal syndromes. The updated 2022 CDC Guideline seeks to dissuade adherence to rigid opioid dosage thresholds and instead provides guidance that allows clinicians the flexibility to develop individualized, patient-centered treatment plans. Although the 2022 CDC Guideline recommendations do not specify MME/day requirements in their formal recommendations, specific information related to dosages are included in the supporting text following each recommendation statement.

The 2022 CDC Guideline does suggest that dosages ≥ 50 MME/day often do not provide additional benefit in pain or function but do increase risks associated with opioid therapy such as misuse, overdose, and death.[2] Therefore, clinicians should carefully reassess the individual benefits and risks before increasing total opioid dosage to ≥ 50 MME/day. If a patient's total opioid dosage is ≥ 50 MME/day, clinicians should increase the frequency of follow-up, provide overdose prevention education, and offer a naloxone prescription.

2. What is the role of non-opioid treatment for pain?

Non-opioid therapies are at least as effective as opioids for many common types of acute pain (duration <1 month)

- A systematic review found NSAIDs to be more effective than opioids for surgical dental pain and kidney stone pain, and similarly effective to opioids for low back pain; acetaminophen was more effective than opioids for kidney stone pain[3]
    - The American College of Physicians (ACP) recommends nonopioid medications for acute low back pain and recommends against opioids for musculoskeletal injury[4]
    - The American Dental Association (ADA) recommends NSAIDs as 1st line therapy for acute pain management[5]
- A review on episodic migraine, found that opioids were associated with a two fold higher risk of development of overuse headache compared with triptans and simple analgesics[6,7]
    - The American Headache Society and American Academy of Neurology recommend against the use of opioids for the treatment of migraine, except as a last-resort[8,9]

Non-opioid therapies are preferred for subacute pain (duration 1-3 months) and chronic pain (duration >3 months)

- Options for osteoarthritis: topical or oral NSAIDs, duloxetine
- Options for chronic low back pain: acetaminophen, NSAIDs, duloxetine
- Options for neuropathic pain: TCA/SNRI antidepressants, select anticonvulsants (e.g., pregabalin, gabapentin, oxcarbazepine), capsaicin and lidocaine patches
- Options for fibromyalgia: TCA/SNRI antidepressants, topical NSAIDs, select anticonvulsants (e.g., pregabalin and gabapentin)

Clinicians should only consider opioid therapy for acute and/or chronic pain if expected benefits are anticipated to outweigh risks to the patient

3. When should prescribers avoid starting a new prescription for opioids?

Recommendation 2 states, "Nonopioid therapies are preferred for subacute and chronic pain. Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient. Before starting opioid therapy for subacute or chronic pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy, should work with patients to establish treatment goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks."

- Example: If the patient has respiratory disease, renal dysfunction, and/or sleep disorders, then providers should be able to justify that the benefits of starting opioid therapy outweighs the risks of said therapy.

4. When should prescribers continue established opioid therapy?

Recommendation 5 states, "If the benefits outweigh the risks of continued opioid therapy, clinicians should work closely with patients to optimize nonopioid therapies while continuing opioid therapy."

- Example:
    - The patient has an appropriate indication for an opioid and continues to benefit from the opioid as evidenced by pain relief, functional gains, and improved quality of life. The patient also exhibits non-aberrant behavior as evidenced by appropriate urine drug screens, and appropriate prescription drug monitoring program fill history. Additionally, the risk of accidental overdose does not outweigh the benefits of opioid therapy.

5. When should prescribers discontinue established opioid therapy?

Recommendation 5 states, "If benefits do not outweigh risks of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper to lower dosages or, if warranted based on the individual circumstances of the patient, appropriately taper and discontinue opioids."

- Examples:
    - The patient has a history of alcohol/drug misuse as evidenced by unexpected UDS results or legal issues.
    - The patient has a concerning fill history based on PDMP report (habitual early fills, not following dosing agreed upon with prescriber, etc.).
    - The patient has liver or kidney dysfunction that may lead to drug accumulation and subsequent overdose.
    - The patient is no longer benefiting from opioid therapy.

6. Should prescribers force patients to taper and discontinue opioids when the risks of opioid therapy outweigh the benefits?

Recommendation 5 states, "Unless there are indications of a life-threatening issue such as warning signs of impending overdose (e.g., confusion, sedation, or slurred speech), opioid therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages from higher dosages." The Recommendation 5 Implementation Considerations state, "Patient agreement and interest in tapering is likely to be a key component of successful tapers. At times, clinicians and patients might not agree on whether tapering is necessary. When patients and clinicians are unable to arrive at a consensus

on the assessment of benefits and risks, clinicians should acknowledge this discordance, express empathy, and seek to implement treatment changes in a patient-centered manner while avoiding patient abandonment."

Ensuring the addition of naloxone, minimizing risks such as concurrent benzodiazepine therapy or other central nervous system (CNS) depressants, and clearly expressing the risk the patient is undertaking are all strategies that prescribers can use to minimize harm and promote patient awareness of risk.

In the case that the provider and patient cannot agree upon an effective therapy plan, providers should clearly and judiciously document their recommendations and acknowledge the patient's awareness of risks in continuing the opioid therapy.

7. How can prescribers collaborate with patients to agree upon a course of action?

- Utilize motivational interviewing
    - Discuss risk/benefits of chronic opioid use and express concern about safety
    - Listen to patient concerns and reflect those back to the patient
    - Include patient in decision-making
    - Set specific, measurable, and realistic goals, and give a timeframe for when these goals will be met
- Discuss potential permanence of chronic pain and limitations of what opioids are able to do long term. Emphasize that using less opioids does not mean not treating the patient's pain condition.
- When the decision to taper is made with the patient, set up support services and outline the tapering schedule. Ensure the patient feels supported and has a clear expectation of the plan. With a slow taper, it is unlikely to experience significant withdrawal symptoms. Stress collaboration, optimism, and commitment to working with the patient to slowly taper their opioid medication and utilize multi modal pain management going forward. Make the next follow up appointment with the patient.
- Opioid therapy should not be initiated without consideration by the clinician and patient of an exit strategy to be used if opioid therapy is unsuccessful

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