These guidelines are intended for primary care clinicians who are treating patients ≥18 years of age with chronic pain outside of active cancer treatment, palliative care, and end-of-life care in outpatient settings. Clinical decision-making should be based on a relationship between the clinician and patient and an understanding of the patient's clinical situation, functioning, and life context. The recommendations in the guidelines are intended to be voluntary, and not prescriptive standards.

**Determining When to Initiate or Continue Opioids for Chronic Pain**

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

**Opioid Selection, Dosage, Duration, Follow-up, and Discontinuation**

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to 50 morphine milligram equivalents (MME) or more per day, and should avoid increasing dosage to 90 MME or more per day or carefully justify a decision to titrate dosage to 90 MME or more per day.

6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than 7 days will rarely be needed.
7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Assessing Risk and Addressing Harms of Opioid Use

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (>50 MME/d), or concurrent benzodiazepine use are present.

9. Clinicians should review the patient’s history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.
Some policies, practices attributed to the Guideline are inconsistent with its recommendations

CDC is raising awareness about the following issues that could put patients at risk:

- **Misapplication of recommendations to populations outside of the Guideline’s scope.** The Guideline is intended for primary care clinicians treating chronic pain for patients 18 and older. Examples of misapplication include applying the Guideline to patients in active cancer treatment, patients experiencing acute sickle cell crises, or patients experiencing post-surgical pain.

- **Misapplication of the Guideline’s dosage recommendation that results in hard limits or “cutting off” opioids.** The Guideline states, “When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should... avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.” The recommendation statement does not suggest discontinuation of opioids already prescribed at higher dosages.

- **The Guideline does not support abrupt tapering or sudden discontinuation of opioids.** These practices can result in severe opioid withdrawal symptoms including pain and psychological distress, and some patients might seek other sources of opioids. In addition, policies that mandate hard limits conflict with the Guideline’s emphasis on individualized assessment of the benefits and risks of opioids given the specific circumstances and unique needs of each patient.

- **Misapplication of the Guideline’s dosage recommendation to patients receiving or starting medication-assisted treatment for opioid use disorder.** The Guideline’s recommendation about dosage applies to use of opioids in the management of chronic pain, not to the use of medication-assisted treatment for opioid use disorder. The Guideline strongly recommends offering medication-assisted treatment for patients with opioid use disorder.

The Guideline was developed to ensure that primary care clinicians work with their patients to consider all safe and effective treatment options for pain management. CDC encourages clinicians to continue to use their clinical judgment, base treatment on what they know about their patients, maximize use of safe and effective non-opioid treatments, and consider the use of opioids only if their benefits are likely to outweigh their risks.
The Guideline includes guidance on management of opioids in patients already receiving them long-term at high dosages, including advice to providers to:

- maximize non-opioid treatment
- empathetically review risks associated with continuing high-dose opioids
- collaborate with patients who agree to taper their dose
- if tapering, taper slowly enough to minimize withdrawal symptoms
- individualize the pace of tapering
- closely monitor and mitigate overdose risk for patients who continue to take high-dose opioids

Patients may encounter challenges with availability and reimbursement for non-opioid treatments, including nonpharmacologic therapies (e.g., physical therapy). Efforts to improve use of opioids will be more effective and successful over time as effective non-opioid treatments are more widely used and supported by payers.

CDC developed the Guideline to be practical and created clinical tools to help primary care providers help patients manage pain more effectively and safely, while mitigating the potential risks of prescription opioids when needed.

References
