



# Knock Out Opioid Abuse in New Jersey:

**A Resource for Safer Prescribing**

# Addiction

Does Not Discriminate...



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# New Jersey's New Prescribing Law

On February 15, 2017, P.L. 2017, c. 28, was signed into law, imposing certain restrictions on how opioids and other Schedule II controlled dangerous substances may be prescribed. The law went into effect on May 16, 2017 and applies to physicians, dentists, optometrists, podiatrists, physician assistants, certified nurse midwives and advance practice nurses authorized to prescribe controlled substances

With regard to prescriptions for opioid drugs, practitioners are not permitted to issue an initial prescription for an opioid drug for treatment of acute pain in a quantity exceeding a 5 day supply. The amendments also require the prescribing practitioner to discuss with the patient or the patient's parent or guardian the reasons why the medication is being prescribed, the possible alternative treatments, and the risks associated with the medication.

Physicians, physician assistants, dentists and optometrists must complete one CME credit on topics that include responsible prescribing practices, alternatives to opioids for managing and treating pain and the risks and signs of opioid abuse, addiction and diversion.

***For information on opportunities to meet CME credit requirements, visit:***

***[knockoutopioidabuse.drugfreenj.org/njsaferx](http://knockoutopioidabuse.drugfreenj.org/njsaferx)***

***to participate in a webinar designed to satisfy this New Jersey one hour continuing education requirement concerning prescription opioids. It is specifically tailored for healthcare professionals including, MDs, DOs, Nurses NPs, PAs, residents and fellows, medical students and dentists.***

***Interested participants with 25% of more of their patients over the age of 55 can take the webinar without cost using the code: DMHAS35***



# GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

## IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

## DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

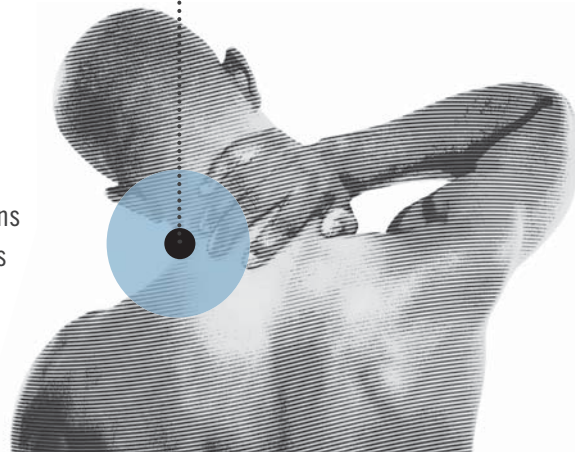
**1** Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic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

### CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient



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# OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

## CLINICAL REMINDERS

- **Use immediate-release opioids when starting**
- **Start low and go slow**
- **When opioids are needed for acute pain, prescribe no more than needed**
- **Do not prescribe ER/LA opioids for acute pain**
- **Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed**

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 considering increasing dosage to  $\geq 50$  morphine milligram equivalents (MME)/day, and should avoid increasing dosage to  $\geq 90$  MME/day or carefully justify a decision to titrate dosage to  $\geq 90$  MME/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 seven 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 other 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 ( $\geq 50$  MME/day), 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.

## CLINICAL REMINDERS

- **Evaluate risk factors for opioid-related harms**
- **Check PDMP for high dosages and prescriptions from other providers**
- **Use urine drug testing to identify prescribed substances and undisclosed use**
- **Avoid concurrent benzodiazepine and opioid prescribing**
- **Arrange treatment for opioid use disorder if needed**

# Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain  $\geq 3$  months, excluding cancer, palliative, and end-of-life care

## CHECKLIST

### When **CONSIDERING** long-term opioid therapy

- Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- Check that non-opioid therapies tried and optimized.
- Discuss benefits and risks (eg, addiction, overdose) with patient.
- Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- Set criteria for stopping or continuing opioids.
- Assess baseline pain and function (eg, PEG scale).
- Schedule initial reassessment within 1–4 weeks.
- Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

### If **RENEWING** without patient visit

- Check that return visit is scheduled  $\leq 3$  months from last visit.

### When **REASSESSING** at return visit

**Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.**

- Assess pain and function (eg, PEG); compare results to baseline.
- Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - If yes: Refer for treatment.
- Check that non-opioid therapies optimized.
- Determine whether to continue, adjust, taper, or stop opioids.
- Calculate opioid dosage morphine milligram equivalent (MME).
  - If  $\geq 50$  MME/day total ( $\geq 50$  mg hydrocodone;  $\geq 33$  mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid  $\geq 90$  MME/day total ( $\geq 90$  mg hydrocodone;  $\geq 60$  mg oxycodone), or carefully justify; consider specialist referral.
- Schedule reassessment at regular intervals ( $\leq 3$  months).

## REFERENCE

### EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

### NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

### EVALUATING RISK OF HARM OR MISUSE

**Known risk factors** include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

**Urine drug testing:** Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

**Prescription drug monitoring program (PDMP):**

Check for opioids or benzodiazepines from other sources.

### ASSESSING PAIN & FUNCTION USING PEG SCALE

**PEG score** = average 3 individual question scores (30% improvement from baseline is clinically meaningful)

**Q1:** *What number from 0–10 best describes your **pain** in the past week?*

0 = “no pain”, 10 = “worst you can imagine”

**Q2:** *What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*

0 = “not at all”, 10 = “complete interference”

**Q3:** *What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?*

0 = “not at all”, 10 = “complete interference”



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### TO LEARN MORE

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# NONOPIOID TREATMENTS FOR CHRONIC PAIN

## PRINCIPLES OF CHRONIC PAIN TREATMENT

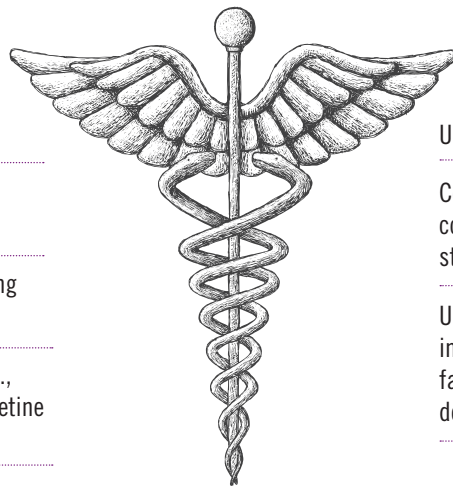
Patients with pain should receive treatment that provides the greatest benefit. Opioids are not the first-line therapy for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. Evidence suggests that nonopioid treatments, including nonopioid medications and nonpharmacological therapies can provide relief to those suffering from chronic pain, and are safer. Effective approaches to chronic pain should:

Use nonopioid therapies to the extent possible

Identify and address co-existing mental health conditions (e.g., depression, anxiety, PTSD)

Focus on functional goals and improvement, engaging patients actively in their pain management

Use disease-specific treatments when available (e.g., triptans for migraines, gabapentin/pregabalin/duloxetine for neuropathic pain)



Use first-line medication options preferentially

Consider interventional therapies (e.g., corticosteroid injections) in patients who fail standard non-invasive therapies

Use multimodal approaches, including interdisciplinary rehabilitation for patients who have failed standard treatments, have severe functional deficits, or psychosocial risk factors

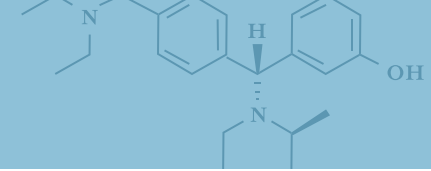
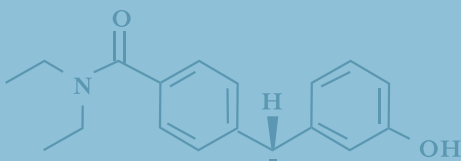
## NONOPIOID MEDICATIONS

MEDICATION	MAGNITUDE OF BENEFITS	HARMS	COMMENTS
Acetaminophen	Small	Hepatotoxic, particularly at higher doses	First-line analgesic, probably less effective than NSAIDs
NSAIDs	Small-moderate	Cardiac, GI, renal	First-line analgesic, COX-2 selective NSAIDs less GI toxicity
Gabapentin/pregabalin	Small-moderate	Sedation, dizziness, ataxia	First-line agent for neuropathic pain; pregabalin approved for fibromyalgia
Tricyclic antidepressants and serotonin/norepinephrine reuptake inhibitors	Small-moderate	TCA's have anticholinergic and cardiac toxicities; SNRIs safer and better tolerated	First-line for neuropathic pain; TCAs and SNRIs for fibromyalgia, TCAs for headaches
Topical agents (lidocaine, capsaicin, NSAIDs)	Small-moderate	Capsaicin initial flare/burning, irritation of mucus membranes	Consider as alternative first-line, thought to be safer than systemic medications. Lidocaine for neuropathic pain, topical NSAIDs for localized osteoarthritis, topical capsaicin for musculoskeletal and neuropathic pain



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# RECOMMENDED TREATMENTS FOR COMMON CHRONIC PAIN CONDITIONS

## Low back pain

**Self-care and education in all patients;** advise patients to remain active and limit bedrest

**Nonpharmacological treatments:** Exercise, cognitive behavioral therapy, interdisciplinary rehabilitation

### Medications

- First-line: acetaminophen, non-steroidal anti inflammatory drugs (NSAIDs)
- Second-line: Serotonin and norepinephrine reuptake inhibitors (SNRIs)/tricyclic antidepressants (TCAs)

## Migraine

### Preventive treatments

- Beta-blockers
- TCAs
- Antiseizure medications
- Calcium channel blockers
- Non-pharmacological treatments (Cognitive behavioral therapy, relaxation, biofeedback, exercise therapy)
- Avoid migraine triggers

### Acute treatments

- Aspirin, acetaminophen, NSAIDs (may be combined with caffeine)
- Antinausea medication
- Triptans-migraine-specific

## Neuropathic pain

**Medications:** TCAs, SNRIs, gabapentin/pregabalin, topical lidocaine

## Osteoarthritis

**Nonpharmacological treatments:** Exercise, weight loss, patient education

### Medications

- First-line: Acetaminophen, oral NSAIDs, topical NSAIDs
- Second-line: Intra-articular hyaluronic acid, capsaicin (limited number of intra-articular glucocorticoid injections if acetaminophen and NSAIDs insufficient)

## Fibromyalgia

**Patient education:** Address diagnosis, treatment, and the patient's role in treatment

**Nonpharmacological treatments:** Low-impact aerobic exercise (e.g., brisk walking, swimming, water aerobics, or bicycling), cognitive behavioral therapy, biofeedback, interdisciplinary rehabilitation

### Medications

- FDA-approved: Pregabalin, duloxetine, milnacipran
- Other options: TCAs, gabapentin





# ASSESSING BENEFITS AND HARMS OF OPIOID THERAPY

## THE EPIDEMIC

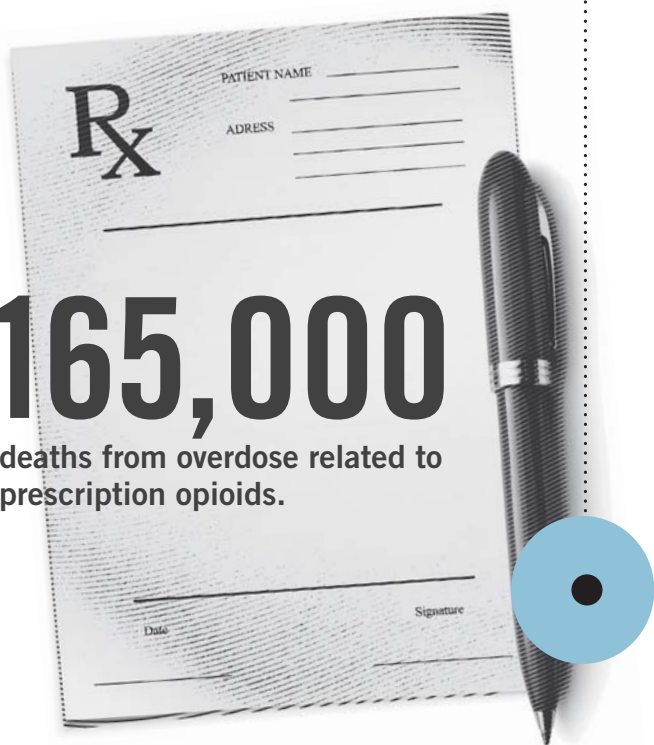
The United States is in the midst of an epidemic of prescription opioid overdose deaths, which killed more than 14,000 people in 2014 alone.

Since 1999, sales of prescription opioids—and related overdose deaths—have quadrupled.

Since 1999, there have been more than

**165,000**

deaths from overdose related to prescription opioids.



## GUIDANCE FOR OPIOID PRESCRIBING

The *CDC Guideline for Prescribing Opioids for Chronic Pain*<sup>1</sup> provides up-to-date guidance on prescribing and weighing the risks and benefits of opioids.

- Before starting and periodically during opioid therapy, discuss the known risks and realistic benefits of opioids.
- Also discuss provider and patient responsibilities for managing therapy.
- Within 1-4 weeks of starting opioid therapy, and at least every 3 months, evaluate benefits and harms with the patient.

## ASSESS BENEFITS OF OPIOID THERAPY

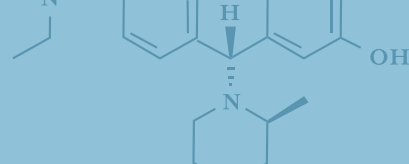
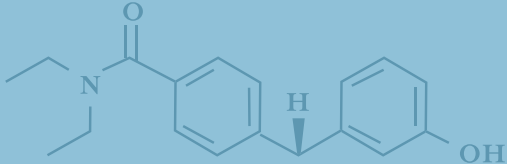
Assess your patient's pain and function regularly. A 30% improvement in pain and function is considered clinically meaningful. Discuss patient-centered goals and improvements in function (such as returning to work and recreational activities) and assess pain using validated instruments such as the 3-item (PEG) Assessment Scale:

1. What number best describes your pain on average in the past week? (from 0=no pain to 10=pain as bad as you can imagine)
2. What number best describes how, during the past week, pain has interfered with your enjoyment of life? (from 0=does not interfere to 10=completely interferes)
3. What number best describes how, during the past week, pain has interfered with your general activity? (from 0=does not interfere to 10=completely interferes)

If your patient does not have a 30% improvement in pain and function, consider reducing dose or tapering and discontinuing opioids. Continue opioids only as a careful decision by you and your patient when improvements in both pain and function outweigh the harms.

<sup>1</sup>Recommendations do not apply to pain management in the context of active cancer treatment, palliative care, and end-of-life care.





## ASSESS HARMS OF OPIOID THERAPY

Long-term opioid therapy can cause harms ranging in severity from constipation and nausea to opioid use disorder and overdose death. Certain factors can increase these risks, and it is important to assess and follow-up regularly to reduce potential harms.

- 1 ASSESS.** Evaluate for factors that could increase your patient's risk for harm from opioid therapy such as:
  - Personal or family history of substance use disorder
  - Anxiety or depression
  - Pregnancy
  - Age 65 or older
  - COPD or other underlying respiratory conditions
  - Renal or hepatic insufficiency

- 2 CHECK.** Consider urine drug testing for other prescription or illicit drugs and check your state's prescription drug monitoring program (PDMP) for:
  - Possible drug interactions (such as benzodiazepines)
  - High opioid dosage ( $\geq 50$  MME/day)
  - Obtaining opioids from multiple providers

- 3 DISCUSS.** Ask your patient about concerns and determine any harms they may be experiencing such as:
  - Nausea or constipation
  - Feeling sedated or confused
  - Breathing interruptions during sleep
  - Taking or craving more opioids than prescribed or difficulty controlling use

- 4 OBSERVE.** Look for early warning signs for overdose risk such as:
  - Confusion
  - Sedation
  - Slurred speech
  - Abnormal gait

If harms outweigh any experienced benefits, work with your patient to reduce dose, or taper and discontinue opioids and optimize nonopioid approaches to pain management.

## TAPERING AND DISCONTINUING OPIOID THERAPY

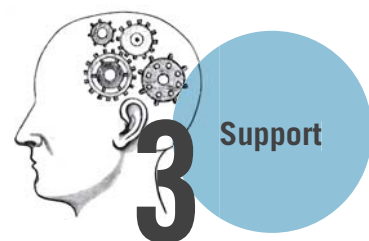
Symptoms of opioid withdrawal may include drug craving, anxiety, insomnia, abdominal pain, vomiting, diarrhea, and tremors. Tapering plans should be individualized. However, in general:



To minimize symptoms of opioid withdrawal, decrease 10% of the original dose per week. Some patients who have taken opioids for a long time might find slower tapers easier (e.g., 10% of the original dosage per month).



Work with appropriate specialists as needed—especially for those at risk of harm from withdrawal such as pregnant patients and those with opioid use disorder.



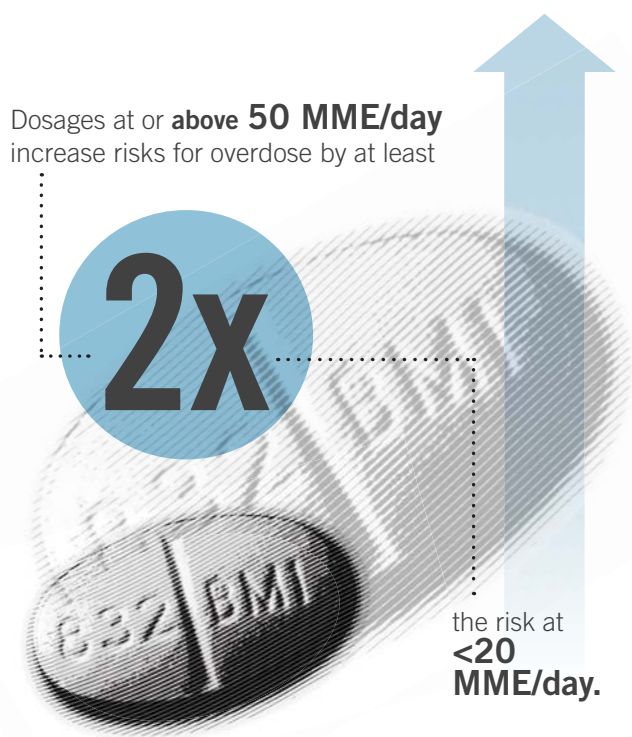
During the taper, ensure patients receive psychosocial support for anxiety. If needed, work with mental health providers and offer or arrange for treatment of opioid use disorder.

Improving the way opioids are prescribed can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse, or overdose from these drugs.

# CALCULATING TOTAL DAILY DOSE OF OPIOIDS FOR SAFER DOSAGE

## Higher Dosage, Higher Risk.

Higher dosages of opioids are associated with higher risk of overdose and death—even relatively low dosages (20-50 morphine milligram equivalents (MME) per day) increase risk. Higher dosages haven't been shown to reduce pain over the long term. One randomized trial found no difference in pain or function between a more liberal opioid dose escalation strategy (with average final dosage 52 MME) and maintenance of current dosage (average final dosage 40 MME).



## WHY IS IT IMPORTANT TO CALCULATE THE TOTAL DAILY DOSAGE OF OPIOIDS?

**Patients prescribed higher opioid dosages are at higher risk of overdose death.**

In a national sample of Veterans Health Administration (VHA) patients with chronic pain receiving opioids from 2004–2009, **patients who died** of opioid overdose were prescribed an average of **98 MME/day**, while **other patients** were prescribed an average of **48 MME/day**.

**Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.**

## HOW MUCH IS 50 OR 90 MME/DAY FOR COMMONLY PRESCRIBED OPIOIDS?

### 50 MME/day:

- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15 mg)
- 12 mg of methadone (<3 tablets of methadone 5 mg)

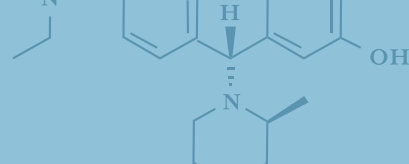
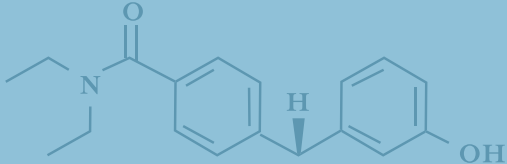
### 90 MME/day:

- 90 mg of hydrocodone (9 tablets of hydrocodone/acetaminophen 10/325)
- 60 mg of oxycodone (~2 tablets of oxycodone sustained-release 30 mg)
- ~20 mg of methadone (4 tablets of methadone 5 mg)



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## HOW SHOULD THE TOTAL DAILY DOSE OF OPIOIDS BE CALCULATED?

1

**DETERMINE** the total daily amount of each opioid the patient takes.

2

**CONVERT** each to MMEs—multiply the dose for each opioid by the conversion factor. (see table)

3

**ADD** them together.



### Calculating morphine milligram equivalents (MME)

OPIOID (doses in mg/day except where noted)	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

*These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.*

#### CAUTION:

- Do not use the calculated dose in MMEs to determine dosage for converting one opioid to another—the new opioid should be lower to avoid unintentional overdose caused by incomplete cross-tolerance and individual differences in opioid pharmacokinetics. Consult the medication label.

#### USE EXTRA CAUTION:

- Methadone:** the conversion factor increases at higher doses
- Fentanyl:** dosed in mcg/hr instead of mg/day, and absorption is affected by heat and other factors

## HOW SHOULD PROVIDERS USE THE TOTAL DAILY OPIOID DOSE IN CLINICAL PRACTICE?

- Use caution when prescribing opioids at any dosage and prescribe the lowest effective dose.
- Use extra precautions when increasing to ≥50 MME per day such as:
  - Monitor and assess pain and function more frequently.
  - Discuss reducing dose or tapering and discontinuing opioids if benefits do not outweigh harms.
  - Consider offering naloxone.
- Avoid or carefully justify increasing dosage to ≥90 MME/day.





# WHY GUIDELINES FOR PRIMARY CARE PROVIDERS?

Primary care providers account for approximately

# 50%

of prescription opioids dispensed



# Nearly 2 million

Americans, aged 12 or older, either abused or were dependent on prescription opioids in 2014

- An estimated 11% of adults experience daily pain
- Millions of Americans are treated with prescription opioids for chronic pain
- Primary care providers are concerned about patient addiction and report insufficient training in prescribing opioids

## MYTH

## VS

## TRUTH

### 1

Opioids are effective long-term treatments for chronic pain

While evidence supports short-term effectiveness of opioids, there is insufficient evidence that opioids control chronic pain effectively over the long term, and there is evidence that other treatments can be effective with less harm.

### 2

There is no unsafe dose of opioids as long as opioids are titrated slowly

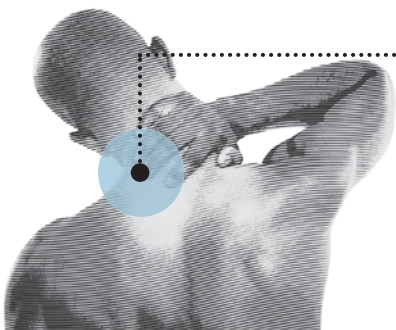
Daily opioid dosages close to or greater than 90 MME/day are associated with significant risks, and lower dosages are safer.

### 3

The risk of addiction is minimal

Up to one quarter of patients receiving prescription opioids long term in a primary care setting struggles with addiction. Certain risk factors increase susceptibility to opioid-associated harms: history of overdose, history of substance use disorder, higher opioid dosages, or concurrent benzodiazepine use.

## WHAT CAN PROVIDERS DO?



First, **do no harm**. Long-term opioid use has uncertain benefits but known, serious risks. CDC's **Guideline for Prescribing Opioids for Chronic Pain** will support informed clinical decision making, improved communication between patients and providers, and appropriate prescribing.

## PRACTICES AND ACTIONS



### USE NONOPIOID TREATMENT

Opioids are not first-line or routine therapy for chronic pain (*Recommendation #1*)

In a systematic review, opioids did not differ from nonopioid medication in pain reduction, and nonopioid medications were better tolerated, with greater improvements in physical function.



### START LOW AND GO SLOW

When opioids are started, prescribe them at the lowest effective dose (*Recommendation #5*)

Studies show that high dosages ( $\geq 100$  MME/day) are associated with 2 to 9 times the risk of overdose compared to  $< 20$  MME/day.



### REVIEW PDMP

Check prescription drug monitoring program data for high dosages and prescriptions from other providers (*Recommendation #9*)

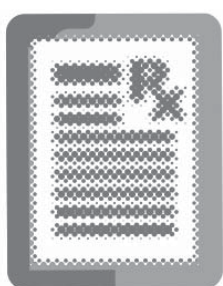
A study showed patients with one or more risk factors (4 or more prescribers, 4 or more pharmacies, or dosage  $> 100$  MME/day) accounted for 55% of all overdose deaths.



### AVOID CONCURRENT PRESCRIBING

Avoid prescribing opioids and benzodiazepines concurrently whenever possible (*Recommendation #11*)

One study found concurrent prescribing to be associated with a near quadrupling of risk for overdose death compared with opioid prescription alone.



### OFFER TREATMENT FOR OPIOID USE DISORDER

Offer or arrange evidence-based treatment (e.g. medication-assisted treatment and behavioral therapies) for patients with opioid use disorder (*Recommendation #12*)

A study showed patients prescribed high dosages of opioids long-term ( $> 90$  days) had 122 times the risk of opioid use disorder compared to patients not prescribed opioids.



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# PRESCRIBING OPIOIDS FOR CHRONIC PAIN

## ADAPTED FROM CDC GUIDELINE

Opioids can provide short-term benefits for moderate to severe pain. Scientific evidence is lacking for the benefits to treat chronic pain.

**IN GENERAL, DO NOT PRESCRIBE OPIOIDS AS THE FIRST-LINE TREATMENT FOR CHRONIC PAIN** (for adults 18+ with chronic pain > 3 months excluding active cancer, palliative, or end-of-life care).

## BEFORE PRESCRIBING

### 1 ASSESS PAIN & FUNCTION

Use a validated pain scale. Example: PEG scale where the score = average 3 individual question scores (30% improvement from baseline is clinically meaningful).

Q1: What number from 0 – 10 best describes your PAIN in the past week?  
(0 = “no pain”, 10 = “worst you can imagine”)

Q2: What number from 0 – 10 describes how, during the past week, pain has interfered with your ENJOYMENT OF LIFE? (0 = “not at all”, 10 = “complete interference”)

Q3: What number from 0 – 10 describes how, during the past week, pain has interfered with your GENERAL ACTIVITY? (0 = “not at all”, 10 = “complete interference”)

### 2

### CONSIDER IF NON-OPIOID THERAPIES ARE APPROPRIATE

Such as: NSAIDs, TCAs, SNRIs, anti-convulsants, exercise or physical therapy, cognitive behavioral therapy.

### 3

### TALK TO PATIENTS ABOUT TREATMENT PLAN

- Set realistic goals for pain and function
- Set criteria for stopping or continuing opioid. Set criteria for regular progress assessment.
- Discuss benefits, side effects, and risks (e.g., addiction, overdose).
- Check patient understanding about treatment plan.

### 4

### EVALUATE RISK OF HARM OR MISUSE. CHECK:

- Known risk factors: illegal drug use; prescription drug use for nonmedical reasons; history of substance use disorder or overdose; mental health conditions; sleep-disordered breathing.
- Urine drug screen to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.
- Medication interactions. AVOID CONCURRENT OPIOID AND BENZODIAZEPINE USE WHENEVER POSSIBLE.
- Prescription drug monitoring program data (if available) for opioids or benzodiazepines from other sources.

## WHEN YOU PRESCRIBE

### START LOW AND GO SLOW. IN GENERAL:

- Start with immediate-release (IR) opioids at the lowest dose for the shortest therapeutic duration. IR opioids are recommended over ER/LA products when starting opioids.
- Avoid ≥ 90 MME/day; consider specialist to support management of higher doses.
- If prescribing ≥ 50 MME/day, increase follow-up frequency; consider offering naloxone for overdose risk.
- For acute pain: prescribe < 3 day supply; more than 7 days will rarely be required.
- Counsel patients about safe storage and disposal of unused opioids.

See below for MME comparisons. For MME conversion factors and calculator, go to [TurnTheTideRx.org/treatment](http://TurnTheTideRx.org/treatment).

### 50 MORPHINE MILLIGRAM EQUIVALENTS (MME)/DAY:

- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15mg)

### 90 MORPHINE MILLIGRAM EQUIVALENTS (MME)/DAY:

- 90 mg of hydrocodone (18 tablets of hydrocodone/acetaminophen 5/300)
- 60 mg of oxycodone (4 tablets of oxycodone sustained-release 15mg)

## AFTER INITIATION OF OPIOID THERAPY

### ASSESS, TAILOR & TAPER

- Reassess benefits/risks within 1-4 weeks after initial assessment.
- Assess pain and function and compare results to baseline. Schedule reassessment at regular intervals (≤ 3 months).
- Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.
- If over-sedation or overdose risk, then taper. Example taper plan: 10% decrease in original dose per week or month. Consider psychosocial support.
- Tailor taper rates individually to patients and monitor for withdrawal symptoms.

## TREATING OVERDOSE & ADDICTION

- Screen for opioid use disorder (e.g., difficulty controlling use; see DSM-5 criteria). If yes, treat with medication-assisted treatment (MAT). MAT combines behavioral therapy with medications like methadone, buprenorphine, and naltrexone. Refer to [findtreatment.samhsa.gov](http://findtreatment.samhsa.gov). Additional resources at [TurnTheTideRx.org/treatment](http://TurnTheTideRx.org/treatment) and [www.hhs.gov/opioids](http://www.hhs.gov/opioids).
- Learn about medication-assisted treatment (MAT) and apply to be a MAT provider at [www.samhsa.gov/medication-assisted-treatment](http://www.samhsa.gov/medication-assisted-treatment).
- Consider offering naloxone if high risk for overdose: history of overdose or substance use disorder, higher opioid dosage (≥ 50 MME/day), concurrent benzodiazepine use.

## ADDITIONAL RESOURCES

CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN:  
[www.cdc.gov/drugoverdose/prescribing/guideline.html](http://www.cdc.gov/drugoverdose/prescribing/guideline.html)

SAMHSA POCKET GUIDE FOR MEDICATION-ASSISTED TREATMENT (MAT):  
[store.samhsa.gov/MAI/guide](http://store.samhsa.gov/MAI/guide)

NIDAMED: [www.drugabuse.gov/nidamed-medical-health-professionals](http://www.drugabuse.gov/nidamed-medical-health-professionals)

ENROLL IN MEDICARE: [go.cms.gov/pecos](http://go.cms.gov/pecos)

Most prescribers will be required to enroll or validly opt out of Medicare for their prescriptions for Medicare patients to be covered. Delay may prevent patient access to medications.

## JOIN THE MOVEMENT

and commit to ending the opioid crisis at [TurnTheTideRx.org](http://TurnTheTideRx.org).



TURN  
THE  
TIDE



If you would like additional information for you or your patients please visit:

**CaresNJ.org**  
**DrugFreeNJ.org**  
**KnowAddiction.NJ.gov**  
**NJHelps.org**  
**TurnTheTideRx.org**

**NJ Addiction Services Hotline:**  
**1-844-276-2777**

*For information on opportunities to meet CME credit requirements, visit:*

**[knockoutopioidabuse.drugfreenj.org/njsaferx](https://knockoutopioidabuse.drugfreenj.org/njsaferx)**

*to participate in a webinar designed to satisfy this New Jersey one hour continuing education requirement concerning prescription opioids. It is specifically tailored for healthcare professionals including, MDs, DOs, Nurses NPs, PAs, residents and fellows, medical students and dentists.*

*Interested participants with 25% or more of their patients over the age of 55 can take the webinar without cost using the code: DMHAS35*