Nonopioid therapies are preferred for acute, subacute and chronic pain. Nonopioid therapies are as effective as opioids for many common types of acute pain.

- Maximize nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider opioid therapy if the benefits outweigh the risk to the patient. Include a discussion of the risks/benefits with the patient.

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

- When opioids are initiated for opioid-naïve patients with acute, subacute, or chronic pain, clinicians should prescribe the lowest effective dosage.
  - If opioids are continued for subacute or chronic pain, clinicians should use caution when prescribing opioids at any dosage, carefully evaluate individual benefits/risks when considering increasing dosage, and avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients.

- For patients already receiving opioid therapy, clinicians should carefully weigh the benefits and risks and exercise care when changing the opioid dosage.
  - If the benefits outweigh the risks of continued opioid therapy, clinicians should work closely with patients to optimize nonopioid therapies while continuing opioid therapy.
  - If the benefits do not outweigh the 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 patient’s circumstances, appropriately taper and discontinue opioids.

- When opioids are needed for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.

- Clinicians should evaluate benefits and risks with patients within one to four weeks of starting opioid therapy for subacute or chronic pain or dosage escalation. Clinicians should regularly reevaluate the benefits and risks of continued opioid therapy with patients.

- Clinicians should work with patients to incorporate strategies to mitigate risk (naloxone).

- When prescribing and periodically, 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 combinations that put the patient at high risk for overdose.

- Clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances.

- Clinicians should use particular caution when prescribing opioid pain medication and benzodiazepines concurrently and consider whether the benefits outweigh the risks of concurrent prescribing of opioids and other central nervous system depressants.

- Clinicians should offer or arrange treatment with evidence-based medications to treat patients with opioid use disorder.
  - Detoxification alone, without medications for opioid use disorder, is not recommended for opioid use disorder because of increased risks of resuming drug use, overdose and overdose death.

Resource: CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States 2022