2022 CDC Opioid Prescribing GUIDELINE HIGHLIGHTS

- **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]

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