CDC CLINICAL PRACTICE GUIDELINE · UNITED STATES, 2022

Recommendations for Prescribing Opioids for Outpatients with Pain

Excludes sickle cell disease, cancer-related pain, palliative care, and end-of-life care

DETERMINING WHETHER OR NOT TO INITIATE OPIOIDS (RECOMMENDATIONS 1–2)

1 Nonopioid therapies are at least as effective as opioids for many common types of acute pain. Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies and only consider opioid therapy if benefits are anticipated to outweigh risks. Before prescribing opioid therapy for acute pain, clinicians should discuss with patients the realistic benefits and known risks.

Category B **Evidence Type 3**

2 Nonopioid therapies are preferred for subacute and chronic pain. Clinicians should only consider initiating opioid therapy if expected benefits for pain and function outweigh risks. Before starting, clinicians should discuss benefits and risks with patients, establish treatment goals, and consider how opioid therapy will be discontinued if benefits do not outweigh risks.

Category A **Evidence Type 2**

SELECTING OPIOIDS AND DETERMINING DOSAGES (RECOMMENDATIONS 3–5)

3 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.

Category A **Evidence Type 4**

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

Category A **Evidence Type 3**

5 For patients already receiving opioid therapy, clinicians should carefully weigh benefits and risks. If benefits outweigh risks, optimize nonopioid therapies while continuing opioid therapy. If benefits do not outweigh risks, work with patients to gradually taper to lower dosages or discontinue opioids. Opioid therapy should not be discontinued abruptly, and clinicians should not rapidly reduce dosages unless there are signs of life-threatening issues (e.g., confusion, sedation, slurred speech).

Category B **Evidence Type 4**

DURATION OF PRESCRIPTION AND FOLLOW-UP (RECOMMENDATIONS 6–7)

6 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.

Category A Evidence Type 4

7 Clinicians should evaluate benefits and risks with patients within 1–4 weeks of starting opioid therapy for subacute or chronic pain or of dosage escalation. Clinicians should regularly reevaluate benefits and risks of continued opioid therapy.

Category A Evidence Type 4

ASSESSING RISK AND ADDRESSING POTENTIAL HARMS (RECOMMENDATIONS 8–12)

8 Before starting and periodically during opioid therapy, clinicians should evaluate risk for opioid-related harms, discuss risk with patients, and work to incorporate risk-mitigation strategies — including offering naloxone.

Category A Evidence Type 4

9 When prescribing initial opioid therapy and periodically during chronic therapy, clinicians should review the patient's history of controlled substance prescriptions using state PDMP data to determine whether the patient is receiving opioid dosages or combinations that put them at high risk for overdose.

Category B Evidence Type 4

10 When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances.

Category B Evidence Type 4

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

Category B Evidence Type 3

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

Category A Evidence Type 1

RECOMMENDATION CATEGORIES & EVIDENCE TYPES

CATEGORY A

Applies to all persons; most patients should receive the recommended course of action.

CATEGORY B

Individual decision-making needed; different choices will be appropriate for different patients. Clinicians help patients arrive at a decision consistent with patient values, preferences, and clinical situations.

TYPE 1

Randomized clinical trials or overwhelming evidence from observational studies.

TYPE 2

Randomized clinical trials with important limitations, or exceptionally strong evidence from observational studies.

TYPE 3

Observational studies or randomized clinical trials with notable limitations.

TYPE 4

Clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations.

GUIDING PRINCIPLES FOR IMPLEMENTATION

1	Acute, subacute, and chronic pain needs to be appropriately assessed and treated independent of whether opioids are part of a treatment regimen.
2	Recommendations are voluntary and are intended to support — not supplant — individualized, person-centered care. Flexibility to meet the care needs and clinical circumstances of a specific patient is paramount.
3	A multimodal and multidisciplinary approach to pain management attending to physical health, behavioral health, long-term services and supports, and expected health outcomes and well-being of each person is critical.
4	Special attention should be given to avoid misapplying this clinical practice guideline beyond its intended use or implementing policies that might lead to unintended and potentially harmful consequences for patients.
5	Clinicians, practices, health systems, and payers should vigilantly attend to health inequities; provide culturally and linguistically appropriate communication; and ensure access to an appropriate, affordable, diversified, coordinated, and effective pain management regimen for all persons.

MORPHINE MILLIGRAM EQUIVALENT (MME) CONVERSION FACTORS

OPIOID	CONVERSION FACTOR*
Codeine	**0.15**
Fentanyl transdermal (mcg/hr)	**2.4**
Hydrocodone	**1.0**
Hydromorphone	**5.0**
Methadone	**4.7**
Morphine	**1.0**
Oxycodone	**1.5**
Oxymorphone	**3.0**

Tapentadol†	**0.4**
Tramadol§	**0.2**

** Multiply daily dose by the conversion factor to calculate MME/day.*

† Tapentadol is a mu-opioid agonist and norepinephrine reuptake inhibitor; MME conversion is not well established.

§ Tramadol is a weak opioid agonist; its active metabolite contributes to analgesic effect.

Reference: CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep. 2022;71(3):1–95.