El Paso Health Medicare Advantage

OPIOIDS FOR CHRONIC PAIN

The following guideline recommends general principles and management for prescribing opioids for chronic pain.

Eligible Population	Key Components	Recommendations
Adults with chronic pain, 65 and or with history of ESRD, not receiving treatment for CA, palliative or end of life care	**Assessment and monitoring**	• Review patient's hx 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 the patient in high risk of overdose. • Review PDMP data when starting opioid therapy for chronic pain • 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.
	Risk Factors	• Incorporate strategies to mitigate risk, including offering naloxone when factors that increase risk for opioid overdose such as: • Hx of overdose • Hx of substance use disorder • Higher opioid dosages (≥50 MME/day} • Concurrent benzodiazepine use • Recognize co-occurring mental health conditions such as depression
	Treatment	• Prescribe immediate-release opioids instead of extended-release/long-acting (ER/LS}opioids. • When using opioids for acute pain, prescribe the lowest effective dose of immediate-release opioids and prescribe no grater quantity than needed for the expected duration of severe enough pain to require opioids. Three days should be sufficient. • When starting opioid treatment, reassess for evidence of individual benefits and risks when considering increasing dosage to ≥ 50 morphine milligram equivalents (MME/day} • Avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage ≥90 MME/day. • Avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible • For patients requiring opioid discontinuation, reduce the dosage by no more than 10% per month to minimize withdrawal symptoms and adverse effects • For patients with opioid disorder, offer or arrange evidence-based treatment such as medication-assisted treatment with buprenorphine or metha-done in combination with behavioral therapies

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Eligible Population	**Key Components**	**Recommendations**
	Evaluation	• Evaluate benefits and harms with patients within 1-4 weeks of starting opioid therapy for chronic pain or of dose escalation • Evaluate benefits and harms of continued therapy with patients every 3 months or more frequently
	Considerations	• Establish realistic treatment goals for pain and function • Consider how opioid therapy will be discontinued if benefits do not outweigh risks. • Continue opioid therapy only if there is clinically meaningful improvement in pain and function. • Prioritize non-opioid therapies (e.g., physical therapy, NSAIDs} and strongly recommends trying these before considering opioids for both chronic and acute pain.

Centers for Disease Control and Prevention (CDC). (2022). *CDC Clinical Practice Guidelines for Prescribing Opioids for Pain — United States, 2022. MMWR Recommendations and Reports*, 71(3), 1-95. https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm Individual patient considerations and advances in medical science may supersede or modify these recommendations

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