Board adds CDC guideline on opioid prescribing to list of resources for chronic pain treatment

DES MOINES, IA – The Iowa Board of Medicine is encouraging physicians to consider a new federal guideline aimed to reduce the risk of addiction when treating chronic pain patients with controlled substances.

The Board recently adopted a new administrative rule to update a list of recommended resources for physicians who treat chronic pain. The list now includes the new Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain.

CDC developed and published the guideline in March to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (pain lasting longer than 3 months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care.

The CDC said that improving the way opioids are prescribed through clinical practice guidelines 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.

Clinical practices addressed in the CDC guideline include:

- Determining when to initiate or continue opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care
- Opioid selection, dosage, duration, follow-up, and discontinuation
- Assessing risk and addressing harms of opioid use

The CDC has produced three brochures (attached) to highlight the message in the non-binding standards:

- Pocketguide summary of the CDC guideline
- A checklist for providers who prescribes opioids for chronic pain
- Non-opioid treatments for chronic pain
In the latter brochure, the CDC emphasizes that 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.

The federal guideline complements the Iowa Board’s administrative rule on appropriate pain management. This rule, 653 IAC 13.2, reinforces that physicians should not fear board action for treating pain with controlled substances as long as the physicians’ prescribing is consistent with appropriate pain management practices.

The Board’s rule encourages physicians to closely monitor patients who are prescribed opioids, including reviewing their controlled substance prescription history, considering the use of pain management agreements, and considering utilizing drug testing to ensure that the patient is receiving appropriate therapeutic levels of prescribed medications.

The Board strongly recommends that physicians consult the following resources regarding the proper treatment of chronic pain:
- American Academy of Hospice and Palliative Medicine
- American Academy of Pain Medicine
- American Pain Society
- DEA Policy Statement: Dispensing Controlled Substances for the Treatment of Pain.
- Interagency Guideline on Prescribing Opioids for Pain (Developed by the Washington State Agency Medical Directors’ Group)
- Responsible Opioid Prescribing: A Physician’s Guide. (By Scott Fishman, M.D.)
- CDC Guideline for Prescribing Opioids for Chronic Pain

For the past five years, the Board has required primary care physicians to complete training on chronic pain management as a part of the mandatory continuing medical education activities needed for licensure renewal.
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 based on diagnosis.
   • Discuss benefits, side effects, and risks (e.g., addiction, overdose).
   • Set criteria for stopping or continuing opioid. Set criteria for regular progress assessment.
   • 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.
   • Prescription drug monitoring program data (if available) for opioids or benzodiazepines from other sources.
   • 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.

WHEN YOU PRESCRIBE

START LOW AND GO SLOW. IN GENERAL:
   • 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.

50 MORPHINE MILLILIGRAM 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 MILLILIGRAM 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. Additional resources at TurnTheTideRx.org/treatment and www.hhs.gov/opioids.
• Learn about medication-assisted treatment (MAT) and apply to be a MAT provider at 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

SAMHSA POCKET GUIDE FOR MEDICATION-ASSISTED TREATMENT (MAT):
store.samhsa.gov/MATguide

NIDAMED: www.drugabuse.gov/nidamed-medical-health-professionals

ENROLL IN MEDICARE: 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.
Checklist for prescribing opioids for chronic pain
For primary care providers treating adults (18+) with chronic pain ≥ 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 ≤ 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 ≥ 50 MME/day total (≥ 50 mg hydrocodone; ≥ 33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥ 90 MME/day total (≥ 90 mg hydrocodone; ≥ 60 mg oxycodone), or carefully justify; consider specialist referral.
- Schedule reassessment at regular intervals (≤ 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”

TO LEARN MORE

www.cdc.gov/drugoverdose/prescribing/guideline.html

March 2016
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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Magnitude of Benefits</th>
<th>Harms</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen</td>
<td>Small</td>
<td>Hepatotoxic, particularly at higher doses</td>
<td>First-line analgesic, probably less effective than NSAIDs</td>
</tr>
<tr>
<td>NSAIDs</td>
<td>Small-moderate</td>
<td>Cardiac, GI, renal</td>
<td>First-line analgesic, COX-2 selective NSAIDs less GI toxicity</td>
</tr>
<tr>
<td>Gabapentin/pregabalin</td>
<td>Small-moderate</td>
<td>Sedation, dizziness, ataxia</td>
<td>First-line agent for neuropathic pain; pregabalin approved for fibromyalgia</td>
</tr>
<tr>
<td>Tricyclic antidepressants and serotonin/norepinephrine reuptake inhibitors</td>
<td>Small-moderate</td>
<td>TCAs have anticholinergic and cardiac toxicities; SNRIs safer and better tolerated</td>
<td>First-line for neuropathic pain; TCAs and SNRIs for fibromyalgia, TCAs for headaches</td>
</tr>
<tr>
<td>Topical agents (lidocaine, capsaicin, NSAIDs)</td>
<td>Small-moderate</td>
<td>Capsaicin initial flare/burning, irritation of mucus membranes</td>
<td>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</td>
</tr>
</tbody>
</table>

Learn More | www.cdc.gov/drugoverdose/prescribing/guideline.html
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

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html