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CDC 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

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 (Prescription Drug Monitoring Program)
- 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).**

    1. If ≥ 50 MME/day total (≥ 50 mg hydrocodone; ≥ 33 mg oxycodone),
    2. Increase frequency of follow-up; consider offering naloxone.
    3. Avoid ≥ 90 MME /day total (≥ 90 mg hydrocodone; ≥ 60 mg oxycodone),
       or carefully justify; consider specialist referral.

- Schedule reassessment at regular intervals (≤ 3 months)
- 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.

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”