Utah Addendum Guidelines and Resources for Prescribing Opioids for Pain, 2024

U.S. Centers for Disease Control and Prevention
for Prescribing Opioids for Pain
United States, 2022

Utah Department of Health
and Human Services

Utah Department of
Health & Human
Services

Background and Introduction

Opioids are a class of drugs that are typically used for their pain-relieving properties. These include prescription drugs as well as illicit drugs. Opioids are commonly prescribed for the management of moderate to severe pain, such as after surgery or for chronic pain conditions. However, opioids also have a high potential for misuse, addiction, and overdose. Provisional data from 2022, indicated that 541 people died from a drug overdose in Utah; nearly three-quarters (74%) involved an opioid[1]. The number of fatal drug overdoses involving any drug in Utah has remained relatively stable in the past three years (2020–2022) as well as the number of opioid-involved fatal drug overdoses.

Deaths from poisoning by prescription pain medications increased by more than 170% in Utah, from 98 to 266, during the years 2000–2017. This increase was mostly due to an increased number of deaths from prescription opioid pain medications, including methadone, oxycodone, hydrocodone, and fentanyl (CDC, 2005). Since 2017, however, Utah has seen a modest but steady decline (33%) in prescription opioid deaths from 266 to 178.

In 2018, the Utah Department of Health and Human Services (DHHS), Violence and Injury Prevention Program (VIPP) in partnership with the Utah Coalition for Opioid Overdose Prevention (UCO-OP) updated the Utah Guidelines on Prescribing Opioids for the Treatment of Pain. These prescriber guidelines, first created in 2008, were developed to promote the safe and effective use of opioids for pain management.

In 2022, the U.S. Centers for Disease Control and Prevention (CDC) released updated guidelines to replace the 2016 CDC Guidelines for Prescribing Opioids for Chronic Pain. These guidelines include evidence-based recommendations for providing pain care for acute, sub-acute, and chronic pain for adults. These national guidelines covered much of what was included in the Utah guidelines, published in 2008 and updated in 2016.

Objective

Prompted by the release of the new CDC guidelines, DHHS conducted a “crosswalk analysis” to map the similarities of the prescribing standards in order to compare and align the recommendations in 2023. This addendum provides supplemental recommendations and resources for Utah prescribers.

[1] Utah Office of Medical Examiner Database, Utah Department of Health and Human Services.

Recommendations

CDC Clinical Practice Guideline for Prescribing Opioids for Pain[2]

CDC recommendation 1

Non-opioid therapies are at least as effective as opioids for many common types of acute pain. Clinicians should maximize use of non-pharmacologic and non-opioid pharmacologic therapies as appropriate for the specific condition and patient and only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient. Before prescribing opioid therapy for acute pain, clinicians should discuss with patients the realistic benefits and know risks of opioid therapy.

Utah supplemental recommendation

No supplemental recommendations

CDC recommendation 2

Non-opioid therapies are preferred for sub-acute and chronic pain. Clinicians should maximize use of non-pharmacologic and non-opioid pharmacologic therapies as appropriate for the specific condition and patient and only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient. Before starting opioid therapy for sub-acute or chronic pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy, should work with patients to establish treatment goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks.

Utah supplemental recommendations

Acute pain recommendation

Consider patient risks

The developing brain may be more susceptible to addiction when exposed to opioid medications and non-medical use is more common among younger people. Those risks should be considered when prescribing to an adolescent[3].

---

[2] Dowell D, Regan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing opioids for Pain - United States, 2002. MMWR Recomm. Rep 2022; 71 (No. 3): 1–95. DOI: https://dx.doi.org/10.15585/mmwr.rr7103a1.

[3] Utah Department of Health (2009). Utah Clinical Guidelines on Prescribing Opioids for Treatment on Pain, p.14 Salt Lake City, UT: Utah Department of Health.

Patients with mental health conditions are at increased risk for developing chronic pain; therefore, physicians should be cognizant of a patient's psychological status and potential for substance use disorder.

"Because psychological distress frequently interferes with improvement of pain and function in patients with chronic pain, using validated instruments such as the Generalized Anxiety Disorder (GAD)-7 and the Patient Health Questionnaire (PHQ)-9 or the (PHQ)-4 to assess for anxiety, post-traumatic stress disorder, and/or depression (205), might help prescribers improve overall pain treatment outcomes. Experts noted that prescribers should use additional caution and increased monitoring to lessen the increased risk for opioid use disorder among patients with mental health conditions (including depression, anxiety disorders, and PTSD), as well as increased risk for drug overdose among patients with depression[4]."

The GAD-7 and PHQ-4 and PHQ-9 can be found in the Tools and resources section.

Chronic pain recommendations

Establishing a written treatment plan

A patient-provider collaborative written opioid treatment plan should be established before opioid therapy and be reviewed and updated on a regular basis.

Prescribers should tailor the treatment goals to the patient's circumstances, cultural preferences, and characteristics and pathophysiology of the pain. The pathophysiologic basis of the pain can help establish a prognosis for future improvement (or worsening) in function and pain, and should influence the treatment goals. Non-opioid treatment modalities should be included in the treatment plan whenever possible to maximize the likelihood of achieving treatment goals.

Patient responsibilities include properly obtaining, filling, and using prescriptions as directed, and adherence to the treatment plan. The treatment plan is usually combined with a consent form.

A sample treatment plan can be found in the Tools and resources section.

Maintain accurate patient records

Prescribers should obtain and document information about the patient's treatment and history.

[4] Centers for Disease Control and Prevention [Patients with Mental Heath Conditions]. MMWR 2016; 65 (No. 1): [27].

Prescribers should document the treatment, interactions, and findings throughout their professional relationship with the patient. Providing thorough documentation throughout the treatment plan is essential for patient safety and prescriber protection.

Plan to modify or discontinue opioid therapy

The treatment plan and goals should explicitly include a plan to modify or discontinue opioid therapy when benefits do not outweigh the risks or when the patient fails to adhere to the agreed upon treatment plan.

Prescribers should evaluate benefits and harms with patient within 1 to 4 weeks of starting opioid therapy or at the time of dose escalation; then continue to evaluate the benefits and harms of therapy with the patient every 3 months or more frequently if needed. If the benefits do not outweigh the harms of continued opioid therapy, prescribers should optimize other therapies and work with the patients to taper opioids to lower dosages or to taper and discontinue opioids .

Obtain signed informed consent form

Prescribers should discuss with patients the known risks and realistic benefits of opioid therapy and patient and prescriber responsibilities for managing therapy, including any conditions for continuation of opioid treatment. This discussion should be documented using a written and signed informed consent form, which is often combined with the treatment plan.

The informed consent form typically includes information about the:

- Potential risks and benefits of controlled substance use, including the risk of misuse, dependence, addiction, overdose, and death
- Adverse effects of opioids
- Likelihood of tolerance and dependence developing
- Possible drug interactions and risk of over-sedation
- Limited evidence of the benefit of long-term opioid therapy
- Risk of impairment while operating motor vehicles or equipment or performing other tasks
- Prescriber’s policies and expectations
- Specific reasons for adapting or discontinuing opioid therapy

Informed consent should also include explaining to patients that they should not expect complete relief of their pain. Improved function is the main criterion for continuing opioid treatment.

[5] U.S. Centers for Disease Control and Prevention. [Patients with Mental Health Conditions]. MMWR 2016.65 (No. 1): [27].

For patient education materials and resources on the risks of taking opioids and signs of an opioid overdose, visit www.opidemic.org. For information on safe storage and disposal, visit www.knowyourscript.org. For information on naloxone, visit www.opidemic.utah.gov/naloxone/.

Discuss with the patient the involvement of family and caregivers in their care and receive written permission from the patient to involve the family or caregivers. This is best done before starting to treat the patient, because it can be more difficult to obtain consent after an issue occurs.

Utah Code Section 58-37f-301(5) allows a person for whom a controlled substance is prescribed to designate a third party who will be notified when a controlled substance is prescribed to the person. Prescribers should discuss this designation with patients.

Note: Consultation with others, in the absence of consent, must be done within the guidelines and constraints of the Health Insurance Portability and Accountability Act (HIPAA).

CDC recommendation 3

When starting opioid therapy for acute, sub-acute, or chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release and long-acting (ER/LA) opioids.

Utah supplemental recommendation

Initiate short-term treatment trial

Opioid medication should be initiated as a short-term trial to assess the effects of opioid treatment on pain intensity, function, and quality of life.

The prescriber should clearly explain to the patient that initiation of opioid treatment is not a commitment to long-term opioid treatment and that treatment will be stopped if the trial is determined to be unsuccessful. The trial should be for a specific time period with pre-determined evaluation points as defined in the treatment plan measures. The decision to continue opioid medication treatment beyond the trial period should be based on the balance between benefits gained in function and quality of life, and adverse effects experienced. Criteria for cessation should be determined before treatment begins.

When a new patient has already been receiving opioid therapy for a chronic condition, the same recommendations apply: assess the patient's chronic pain, complete a comprehensive evaluation, screen for risk of substance use disorder, establish a treatment plan and informed consent, initiate treatment trial, mitigate risks, and consider a multi-disciplinary approach. The evaluation process may require more time than the initial appointment, so the prescriber must use their professional judgment if opioids are deemed necessary. If opioid treatment is necessary, it is suggested that the dose be limited and only long enough to complete an adequate evaluation and to seek consultation, as needed.

CDC recommendation 4

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

Utah supplemental recommendation

Prescribe the lowest effective dose

When opioids are prescribed for the treatment of chronic pain, prescribers should prescribe the lowest effective dose. Prescribers should use caution when prescribing opioids at any dosage, should carefully re-assess evidence of individual benefits and risks when increasing dosage to greater than 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to greater than 90 or carefully justify a decision to titrate dosage to greater than 90 MME/day.

The CDC states that although there is not a single dosage threshold below which overdose risk is eliminated, holding dosages below 50 MME/day would likely reduce risk among most patients who would experience fatal overdose at higher prescribed dosages. Use of any dose should be based on incremental functional gains.

Benefits of high-dose opioids for chronic pain are not established. At the same time, risks for serious harm increase at higher opioid doses. Opioid overdose risk increases in a dose-response manner. Dosages of 50 to 100 MME/day increase risks for opioid overdose by 1.9–4.6 times and dosages greater than 100 MME increase risk by 2.0–8.9 times as compared with the risk at 1–20 MME/day[6].

CDC recommendation 5

For patients already receiving opioid therapy, clinicians should carefully weigh benefits and risks and exercise care when changing opioid dosage. If benefits outweigh risks of continued opioid therapy, clinicians should work closely with patients to optimize non-opioid therapies while continuing opioid therapy. If benefits do not outweigh 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 individual circumstances of the patient, appropriately taper and discontinue opioids. Unless there are indications of a life-threatening issue such as warning signs of impending overdose (e.g., confusion, sedation, or slurred speech), opioid therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages from higher dosages.

[6] Centers for Disease Control and Prevention. [Patients with Mental Health Conditions]. MMWR 2016; 65 (No. 1): [23]

The HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics and a Pocket Guide: Tapering Opioids for Chronic Pain can be found in the Tools and resources section.

Utah supplemental recommendation

No supplemental recommendations

CDC recommendation 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.

Utah supplemental recommendation

No supplemental recommendations

CDC recommendation 7

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

Utah supplemental recommendations

Implement dose titration and re-evaluation

Regular face-to-face visits with the patient and evaluation of progress against goals should be scheduled during the period when the opioid dosage is being adjusted. The opioid trial or long-term treatment should be continually evaluated for functional benefit and achievement of treatment goals, using appropriate tracking tools.

Clinically meaningful improvement has been defined as a 30% improvement in scores for both pain and function. Monitoring progress toward patient-centered functional goals (walking the dog or walking around the block, returning to part-time work, attending family sports or recreational activities) can also contribute to the assessment of functional improvement. Prescribing providers should use these goals in assessing the benefits of opioid therapy for individual patients and in weighing benefits against risks of continued opioid therapy[7].

There are a variety of tracking tools that can be used to set and monitor treatment goals:

- Pain Assessment and Documentation Tool (PADT™)
- Controlled substance agreement
- Patient Health Questionnaire (PHQ-4 or PHQ-9)

These forms can be found in the Tools and resources section.

[7] U.S. Centers for Disease Control and Prevention. [Patients with Mental Health Conditions]. MMWR 2016; 65 (No. 1): [20].

Avoid parenteral opioids

Parenteral (intravenous, intramuscular, or subcutaneous) administration of opioids for chronic pain is strongly discouraged, unless prescribing within an inpatient or palliative care setting.

Any circumstance warranting parenteral administration should be clearly justified by clinical exigencies (bowel obstruction, terminal care, etc.).

These guidelines do not consider intrathecal administration and this recommendation was not intended to discourage trained and qualified physicians from using intrathecal opioid medications when indicated.

Daily intramuscular (IM) or subcutaneous (SC) injections should be avoided except in a highly supervised environment, such as during an admission to the hospital or hospice.

Monitor opioid therapy

Once a stable dose has been established, regular monitoring should be conducted at face-to-face visits. During these visits, treatment goals, affect and mood, analgesia, activity and level of function, adverse effects, and aberrant behaviors should be monitored. These assessments can be remembered as the “5 A’s.”

5 A’s opioid therapy monitoring tool

1. Affect: determine if pain has impacted the patient’s mood
2. Analgesia: inquire about level of pain (current, recent, trends, etc.)
3. Activity: assess both the patient’s function and overall quality of life
4. Adverse events: determine whether the patient is having medication side effects
5. Aberrant behavior: regularly evaluate for possible substance use disorder related behavior

Also, it is recommended to assess the patient’s airway and sleep apnea status[8].

Adjust and prescribe medication during clinic visit

Medication adjustments, if necessary, should be made and prescriptions provided during a clinic visit.

Face-to-face follow-up visits should occur at least every 2 to 4 weeks during any period when dosages are being adjusted. More frequent follow-up visits may be advisable when prescribing opioid medication to a patient with a known addiction problem, suspected aberrant behavior, or co-existing psychiatric or medical problems.

Options for medication adjustments include reducing medication or rotating opioid medication. Opioid rotation can be an effective means of reducing opioid dose, reducing adverse side effects or improving efficacy. However, when switching from one opioid to another, extreme caution is required due to incomplete cross-tolerance among various opioids. Refer to opioid rotation guidelines before attempting an opioid switch (opioid rotation). When it is documented that the patient is compliant with agreed-upon recommendations, the prescriber may consider adding supplemental immediate release/ short-acting (IR/SA) medications for control of break-through pain exacerbation to facilitate increases in activity.

In general, if the patient's underlying medical condition is chronic and unchanging and if opioid associated problems (hyperalgesia, substantial tolerance, important adverse effects) have not developed, it is recommended that the effective dose achieved through titration not be lowered once the patient has reached a plateau of adequate pain relief and functional level[9].

CDC recommendation 8

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss risk with patients. Clinicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone.

Utah supplemental recommendation

Screen for risk of opioid use disorder

Use a validated screening tool to assess the patient's risk of opioid use disorder prior to prescribing an opioid medication long-term for chronic pain.

Long-term use of opioid medications to treat chronic pain safely requires the commitment of adequate resources to regularly monitor and evaluate outcomes and identify occurrence of adverse consequences. The screening tool results are intended to assist the prescriber in determining whether opioid therapy is appropriate and in determining the level of monitoring appropriate for the patient's level of risk.

Prescribers may use one of the standardized screening forms to help determine personal and family risks:

- Patient Health Questionnaire (PHQ-4) or (PHQ-9)
- Opioid Risk Tool (ORT©)
- Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R®)
- Current Opioid Misuse Measure (COMM®)
- Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)

These forms can be found in the Tools and resources section.

[9] Department of Veterans Affairs,Department of Defense. [VA/DoD Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain]. 2003.

CDC recommendation 9

When prescribing initial opioid therapy for acute, sub-acute, or chronic pain, and periodically during opioid therapy for chronic pain, 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.

Utah supplemental recommendations

Obtain urine drug screens

Prescribers should perform drug screening on randomly selected visits and any time aberrant behavior is suspected.

A good practice is to give all patients taking chronic controlled substance prescriptions at least an annual urine test and high-risk patients more frequent random urine tests with no advance notice. Drug testing has been shown to identify the presence of illegal drugs, unreported prescribed medication, unreported alcohol use, and the absence of the patient's prescribed medication. This assists the prescriber in determining whether the opioid therapy is appropriate and in determining the required frequency of monitoring. It also provides an opportunity to discuss the risks of opioid treatment. Random pill counts may also be useful.

Immunoassays can be done in the office. These screening tests determine if opioids are present but do not identify specific ones, which can subsequently be determined by confirmatory laboratory testing. However, in many cases, confirmation testing can be eliminated by carefully going over the results of the initial in-office test with the patient. Prescribers need to recognize that immunoassays have both false positive and false negative results. Over-the-counter medication, for example, can cause a positive result. Many synthetic opioids are not detected by urine immunoassay screening and require confirmation testing if suspected. The prescriber may want to consider confirmatory testing or consultation with a certified medical review officer if drug test results are unclear.

An abnormal drug screen should be specified in the treatment plan as a possible reason to cease treatment.

Prevent prescription fraud

The prescription for opioid therapy should be written on tamper-resistant prescription paper or e-prescribed to prevent prescription fraud.

To reduce the chance of tampering with the prescription, write legibly and keep a copy in your records. According to the Drug Enforcement Administration (DEA), all records related to controlled substances must be maintained and be available for inspection for a minimum of 2 years.

CDC recommendation 10

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

Utah supplemental recommendation

No supplemental recommendations

CDC recommendation 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.

Utah supplemental recommendation

Avoid and counsel against combining opioids with central nervous system (CNS) depressants

Avoid prescribing, and counsel against, concurrent use of opioids and benzodiazepines. Patients should also be counseled against concurrent use of opioids with other sedating substances (alcohol, muscle relaxant drugs) and sedative hypnotics (prescription and over-the-counter sleep aids, etc).

Concurrent use of alcohol, benzodiazepines, and other CNS depressants increases the risk of respiratory depression, which can potentially cause death. Concurrent use of benzodiazepines require explicit medical justification due to the serious risk of respiratory depression. For putative psychiatric indications, psychiatric consultation should be sought to treat the patient's condition with potentially less toxic drug-to-drug interactions. Prescribers should warn patients of the high-risk interaction of opioids and CNS depressants.

CDC recommendation 12

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

Utah supplemental recommendations

Refer to mental health services

Patients with co-existing psychiatric disorders should receive ongoing mental health support and treatment while being treated for chronic pain.

Unless the prescriber treating the patient is qualified to provide the appropriate care and evaluation of the coexisting psychiatric disorder, consultation should be obtained to assist in formulating the treatment plan and establishing a plan for coordinated care of both the chronic pain and psychiatric conditions.

Because psychological distress frequently interferes with improvement of pain and function in patients with chronic pain, use validated instruments such as the Generalized Anxiety Disorder (GAD)-7 and the Patient Health Questionnaire (PHQ)-9 or the (PHQ)-4 to assess for anxiety, post-traumatic stress disorder, and/or depression (205)[10].

Opioid therapy should not be initiated during acute psychiatric instability or uncontrolled suicide risk. Prescribers should consult a behavioral health specialist for any patient with a history of suicide attempt or psychiatric disorder. In addition, patients with anxiety disorders and other mental health conditions are more likely to receive benzodiazepines, which can exacerbate opioid-induced respiratory depression and increase the risk for overdose. For treatment of chronic pain in patients with depression, prescribers should strongly consider using tricyclic or SNRI antidepressants for analgesic as well as antidepressant effects[11].

Discontinuing treatment

Opioid treatment should be discontinued when pain problems have been resolved, treatment goals are not being met, adverse effects outweigh benefits, or dangerous or illegal behaviors are demonstrated.

Dangerous or illegal behaviors may include:

- Frequent requests for refills prior to the expected use date.
- Positive urine drug screens for non-prescribed medications.
- Negative urine drug screens for opiates that have been prescribed that patient states they are taking.
- Suspicion of diverting medications to others.

The decision to discontinue opioid treatment should ideally be made jointly with the patient and the family/caregivers when appropriate (Federation of State Medical Boards, 2004). This decision requires careful consideration of the treatment outcomes and the need to provide ongoing monitoring.

When the patient is discharged, the prescriber is obliged to offer continued monitoring for 30 days post-discharge. Once a provider-patient relationship is established, the prescriber owes a continuing duty to provide care until that relationship is appropriately terminated. Prescribers should adhere to the standard of care for their specific discipline when dismissing a patient. The failure to do so may constitute neglect or abandonment.

---

[10] Centers for Disease Control, 2016.

[11] Centers for Disease Control and Prevention [Patients with Mental Health Conditions]. MMWR 2016; 65

Obtain a second opinion or consultation

Prescribers should obtain a consultation for a patient with complex pain conditions or serious comorbidities.

Reasons to refer patients include:

- The prescriber has reached a limit of what he or she feels comfortable prescribing.
- The treatment needs a multi-disciplinary approach.
- The pain has progressed to a complex level.
- Significant risk factors for substance use disorder are identified.
- There is a need to re-evaluate the patient's diagnosis or confirm the continued diagnosis.

A multidisciplinary approach for chronic pain may result in a better outcome compared to medical management alone. The results generally indicate a reduction in pain, better functional restoration, reduced healthcare costs, higher return-to-work rates, and reduced disability costs.

Patients with serious comorbidities may benefit from a palliative care consultation if the goal is to improve a person's quality of life while living with chronic or serious illness. These patients usually have exhausted other traditional therapies for their illnesses (congestive heart failure, COPD, advanced cancer) or live with a high symptom burden during treatment of their illness. They are not hospice eligible, because they live longer than a traditional hospice patient or may have aggressive medical goals. Patients that receive palliative care may have less frequent hospitalizations, improved quality of life, and improved physical function[12].

[12] April Krutka, Palliative Care Medical Director, McKay Dee Hospital.