# Checklist for Prescribing Opiates for Chronic, Non-Cancer Pain

The following checklist is designed to aid primary care providers who use opiates to improve function in patients with chronic pain. Specifically, this checklist is for treating adults (18+) with chronic pain > 3 months, excluding cancer, palliative, and end-of-life care.

CHECKLIST

## When CONSIDERING long-term opiate therapy

- ☐ Review patient's medical and psychosocial history.
- ☐ Review results of all physical examinations and laboratory tests, including screening assessments.
- ☐ Check that non-opiate therapies tried and optimized.
- ☐ Evaluate risk of harm or misuse.
  - Confirm that the appropriate state prescription drug monitoring program (PDMP) has been accessed.
  - Check urine drug screen.
- ☐ Obtain an informed consent.
  - Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Prescribe short-acting opiates using lowest dosage on product labeling; match duration to scheduled reassessment.
- ☐ Set criteria for stopping or continuing opiates.
- ☐ Schedule initial reassessment within 1-4 weeks.

## If RENEWING without a patient visit

- ☐ Check that return visit is scheduled ≤ 3 months from last visit. Schedule visit earlier than 3 months if patient is requesting a prescription refill earlier than prescription instruction/dosage.

## Continuation versus Initiation - REASSESSING at return visit

- ☐ Check that non-opiate therapies optimized.
- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate progress against agreed-upon treatment for pain relief and function.
  - **Continue opiates only after confirming clinically meaningful improvements in pain and function without significant risks or harm.**
- ☐ Evaluate risk of harm or misuse:
  - Observe patients for signs of over-sedation or overdose risk. If yes – taper dose.
  - Check PDMP.
  - Check for opiate use disorder if indicated (eg, difficulty controlling use). If yes – refer for treatment.
- ☐ Determine whether to continue, adjust, taper, or stop opiates, and document reasoning in clinic record.
- ☐ Calculate opiate dosage morphine milligram equivalent (MME).
  - If ≥ 50 MME/day total (≥ 50mg hydrocodone; ≥ 33mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥ 100 MME/day total (≥ 100 mg hydrocodone; ≥ 66mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (< 3 months).
- ☐ Patients who may need more frequent or intense monitoring include:
  - Those with a prior history of an addictive disorder or past substance abuse;
  - Those in occupations demanding mental acuity;
  - Older adults;
  - Patients with an unstable or dysfunctional social environment;
  - Those with comorbid psychiatric or medical conditions;
  - Those who are taking benzodiazepines; and
  - Those who are taking other medications that may interact with an opiate – to include at-risk alcohol consumers.

REFERENCE

### EVIDENCE ABOUT OPIATE THERAPY

- *Benefits of long-term therapy for chronic, non-cancer pain is 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-OPIATE THERAPIES

- Use alone or combined with opiates as indicated:
- Non-opiate 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.
- At-risk alcohol consumption (eg, binge drinking).

### ASSESSING PAIN AND 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 last 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"

*NOTE: Always document assessments as required by applicable law, including any applicable administrative rules or regulations.*

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