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 (e.g., walk around the block).
- ☐ Check that non-opioid therapies are tried and optimized.
- ☐ Discuss benefits and risks (e.g., 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 (e.g., PEG scale).
- ☐ Schedule initial reassessment within one to four 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 within three 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 (e.g., PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
  - Observe patient for signs of oversedation or overdose risk.
    - – If yes: Taper dose.
  - Check PDMP.
  - Check for Opioid Use Disorder if indicated (e.g., difficulty controlling use).
    - – If yes: Refer for treatment.
- ☐ Check that non-opioid therapies are 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 followup; 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 (within three months).

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REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- Benefits of long-term opioid therapy for chronic pain are 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 (e.g., NSAIDs, TCAs, SNRIs, anticonvulsants)
- Physical treatments (e.g., exercise therapy, weight loss)
- Behavioral treatment (e.g., CBT)
- Procedures (e.g., 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 (e.g., 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 AND FUNCTION USING PEG SCALE

PEG score = average three individual question scores *(30 percent 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”