SOUTH CAROLINA BOARD OF MEDICAL EXAMINERS' 2023 PAIN MANAGEMENT GUIDELINE[1]

The Centers for Disease Control and Prevention (CDC) has recently published the CDC Clinical Practice Guideline for Prescribing Opioids for Pain—United States, 2022 ("Guideline"). This guideline provides recommendations for clinicians providing pain care, including those prescribing opioids, for outpatients aged ≥18 years. It updates the CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016 and includes recommendations for managing acute (duration of <1 month), subacute (duration of 1–3 months), and chronic (duration of >3 months) pain. The guideline addresses the following four areas: 1) determining whether or not to initiate opioids for pain, 2) selecting opioids and determining opioid dosages, 3) deciding duration of initial opioid prescription and conducting follow-up, and 4) assessing risk and addressing potential harms of opioid use.

This clinical practice guideline is a clinical tool to improve communication between clinicians and patients and empower them to make informed, person-centered decisions related to pain care together; it is intended to be flexible to enable person-centered decision-making, taking into account a patient's expected health outcomes and well-being.

This clinical practice guideline is not a replacement for clinical judgment or individualized, person-centered care; intended to be applied as inflexible standards of care across patients or patient populations by health care professionals, health systems, pharmacies, third-party payers, or governmental jurisdictions or to lead to the rapid tapering or abrupt discontinuation of opioids for patients; a law, regulation, or policy that dictates clinical practice or as a substitute for Food and Drug Administration–approved labeling; applicable to (1) management of pain related to sickle cell disease, (2) management of cancer-related pain, (3) palliative care or end-of-life care; or focused on opioids prescribed for opioid use disorder.

The Guideline is designed to communicate to licensees that the South Carolina Board of Medical Examiners ("BME") views pain management as an important area of patient care integral to the practice of medicine; that opioid analgesics may be necessary for the relief of certain pain conditions; and that prescribers will not be sanctioned solely for prescribing opioid analgesics of the dose prescribed for legitimate medical purposes. Further, the Guideline is intended to alleviate prescriber uncertainty and to encourage patient-centered care. The Guideline is intended to reinforce the exercise of sound clinical judgment white discouraging prescriptive behaviors that may lead to misuse or abuse of controlled substances, including opioids.

The Guideline serves to protect South Carolinians' access to pain care while combating prescription drug misuse, abuse, diversion and addiction. Prescribers must be held to a safe and best clinical practice. The Federal Controlled Substances Act defines a "lawful prescription" as

[1] The Board is authorized to "publish advisory opinions and position statements relating to practice procedures or policies authorized or acquiesced to by any agency, facility, institution, or other organization that employs persons authorized to practice under this chapter to comply with acceptable standards of practice." S.C. Code Ann. § 40-47-10(I)(1).

one that is issued for a legitimate medical purpose by a practitioner acting in the usual course of professional practice. The use of opioids for other than legitimate medical purposes poses a threat to the individual and to the public health, thus imposing on prescribers a responsibility to minimize potential for misuse, abuse and diversion of opioids and all other controlled substances.

It is the standard of care to assess and evaluate the current status of pain treatment prior to initiating new treatment or adjusting current treatment. The registration and utilization of SC PMP/SCRIPTS program (SCRIPTS), which provides both a current and historical survey of narcotic, sedative and controlled substance use, is now mandatory for prescribers of Schedule II controlled substances to provide safe, adequate pain treatment The Board encourages licensees to consult SCRIPTS when initiating treatment or adjusting established treatment for patients with controlled substances outside of Schedule II. The Board will consider prescribing, ordering, dispensing or administering controlled substances for pain to be for a legitimate medical purpose if based upon documented, sound clinical judgment. Compliance with applicable state and federal law is required. Chronic pain should not be treated by the use of controlled substances through telemedicine.

The BME hereby adopts, *as best practices*, the CDC Clinical Practice Guideline for Prescribing Opioids for Pain—United States, 2022, and the twelve recommendations and implementation considerations advanced by the CDC, verbatim, except where South Carolina law may conflict. In addition to the Guideline Recommendations and Implementation Considerations, the CDC has published Supporting Rationale for their Recommendations and Implementation Considerations. While the Board has not adopted the Supporting Rationale in its Pain Management Guideline, practitioners should review, and be familiar with, the CDC Clinical Practice Guideline for Prescribing Opioids for Pain—United States, 2022, including the Supporting Rationale, which can be found here.[2]

Recommendations/Implementation Considerations

Recommendation 1

Nonopioid therapies are at least as effective as opioids for many common types of acute pain. Clinicians should maximize use of nonpharmacologic and nonopioid 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 known risks of opioid therapy.

Implementation Considerations

- Nonopioid therapies are at least as effective as opioids for many common acute pain conditions, including low back pain, neck pain, pain related to other musculoskeletal injuries (e.g.,

[2] For purposes of the BME Guideline, the CDC's internal references, including footnotes and categorization of recommendation type, have been deleted.

sprains, strains, tendonitis, and bursitis), pain related to minor surgeries typically associated with minimal tissue injury and mild postoperative pain (e.g., simple dental extraction), dental pain, kidney stone pain, and headaches including episodic migraine.

- Clinicians should maximize use of nonopioid pharmacologic (e.g., topical or oral NSAIDs, acetaminophen) and nonpharmacologic (e.g., ice, heat, elevation, rest, immobilization, or exercise) therapies as appropriate for the specific condition.

- Opioid therapy has an important role for acute pain related to severe traumatic injuries (including crush injuries and burns), invasive surgeries typically associated with moderate to severe postoperative pain, and other severe acute pain when NSAIDs and other therapies are contraindicated or likely to be ineffective.

- When diagnosis and severity of acute pain warrant the use of opioids, clinicians should prescribe immediate-release opioids (see Recommendation 3) at the lowest effective dose (see Recommendation 4) and for no longer than the expected duration of pain severe enough to require opioids (see Recommendation 6).

- Clinicians should prescribe and advise opioid use only as needed (e.g., hydrocodone 5 mg/acetaminophen 325 mg, one tablet not more frequently than every 4 hours as needed for moderate to severe pain) rather than on a scheduled basis (e.g., one tablet every 4 hours) and encourage and recommend an opioid taper if opioids are taken around the clock for more than a few days (see Recommendation 6).

- If patients already receiving opioids long term require additional medication for acute pain, nonopioid medications should be used when possible and, if additional opioids are required (e.g., for superimposed severe acute pain), they should be continued only for the duration of pain severe enough to require additional opioids, returning to the patient's baseline opioid dosage as soon as possible, including a taper to baseline dosage if additional opioids were used around the clock for more than a few days (see Recommendation 6).

- Clinicians should ensure that patients are aware of expected benefits of, common risks of, serious risks of, and alternatives to opioids before starting or continuing opioid therapy and should involve patients meaningfully in decisions about whether to start opioid therapy

Recommendation 2

Nonopioid therapies are preferred for subacute and chronic pain. Clinicians should maximize use of nonpharmacologic and nonopioid 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 subacute 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

Implementation Considerations

- To guide patient-specific selection of therapy, clinicians should evaluate patients and establish or confirm the diagnosis.

- Clinicians should recommend appropriate noninvasive nonpharmacologic approaches to help manage chronic pain, such as exercise (e.g., aerobic, aquatic, or resistance exercises) or exercise therapy (a prominent modality in physical therapy) for back pain, fibromyalgia, and hip or knee osteoarthritis; weight loss for knee osteoarthritis; manual therapies for hip osteoarthritis; psychological therapy, spinal manipulation, low-level laser therapy, massage, mindfulness-based stress reduction, yoga, acupuncture, and multidisciplinary rehabilitation for low back pain; mind-body practices (e.g., yoga, tai chi, or qigong), massage, and acupuncture for neck pain; cognitive behavioral therapy, myofascial release massage, mindfulness practices, tai chi, qigong, acupuncture, and multidisciplinary rehabilitation for fibromyalgia; and spinal manipulation for tension headache.

- Low-cost options to integrate exercise include walking in public spaces or use of public recreation facilities for group exercise. Physical therapy can be helpful, particularly for patients who have limited access to safe public spaces or public recreation facilities for exercise or whose pain has not improved with low-intensity physical exercise.

- Health insurers and health systems can improve pain management and reduce medication use and associated risks by increasing reimbursement for and access to noninvasive nonpharmacologic therapies with evidence for effectiveness.

- Clinicians should review FDA-approved labeling, including boxed warnings, and weigh benefits and risks before initiating treatment with any pharmacologic therapy.

- When patients affected by osteoarthritis have an insufficient response to nonpharmacologic interventions such as exercise for arthritis pain, topical NSAIDs can be used in patients with pain in a single or few joints near the surface of the skin (e.g., knee). For patients with osteoarthritis pain in multiple joints or incompletely controlled with topical NSAIDs, duloxetine or systemic NSAIDs can be considered.

- NSAIDs should be used at the lowest effective dose and shortest duration needed and should be used with caution, particularly in older adults and in patients with cardiovascular comorbidities, chronic renal failure, or previous gastrointestinal bleeding.

- When patients with chronic low back pain have had an insufficient response to nonpharmacologic approaches such as exercise, clinicians can consider NSAIDs or duloxetine for patients without contraindications.

- Tricyclic, tetracyclic, and SNRI antidepressants; selected anticonvulsants (e.g., pregabalin, gabapentin enacarbil, oxcarbazepine); and capsaicin and lidocaine patches can be considered for neuropathic pain. In older adults, decisions to use tricyclic antidepressants should be made judiciously on a case-by-case basis because of risks for confusion and falls.

- Duloxetine and pregabalin are FDA-approved for the treatment of diabetic peripheral neuropathy, and pregabalin and gabapentin are FDA-approved for treatment of postherpetic neuralgia.

- In patients with fibromyalgia, tricyclic (e.g., amitriptyline) and SNRI antidepressants (e.g., duloxetine, milnacipran), NSAIDs (e.g., topical diclofenac), and specific anticonvulsants (i.e., pregabalin and gabapentin) are used to improve pain, function, and quality of life. Duloxetine, milnacipran, and pregabalin are FDA-approved for the treatment of fibromyalgia. In older adults, decisions to use tricyclic antidepressants should be made judiciously on a case-by-case basis because of risks for confusion and falls.

- Patients with co-occurring pain and depression might be especially likely to benefit from antidepressant medication (see Recommendation 8).

- Opioids should not be considered first-line or routine therapy for subacute or chronic pain. This does not mean that patients should be required to sequentially fail nonpharmacologic and nonopioid pharmacologic therapy or be required to use any specific treatment before proceeding to opioid therapy. Rather, expected benefits specific to the clinical context should be weighed against risks before initiating therapy. In some clinical contexts (e.g., serious illness in a patient with poor prognosis for return to previous level of function, contraindications to other therapies, and clinician and patient agreement that the overriding goal is patient comfort), opioids might be appropriate regardless of previous therapies used. In other situations (e.g., headache or fibromyalgia), expected benefits of initiating opioids are unlikely to outweigh risks regardless of previous nonpharmacologic and nonopioid pharmacologic therapies used.

- Opioid therapy should not be initiated without consideration by the clinician and patient of an exit strategy to be used if opioid therapy is unsuccessful.

- Before opioid therapy is initiated for subacute or chronic pain, clinicians should determine jointly with patients how functional benefit will be evaluated and establish specific, measurable treatment goals.

- For patients with subacute pain who started opioid therapy for acute pain and have been treated with opioid therapy for ≥30 days, clinicians should ensure that potentially reversible causes of chronic pain are addressed and that opioid prescribing for acute pain does not unintentionally become long-term opioid therapy simply because medications are continued without reassessment. Continuation of opioid therapy at this point might represent initiation of long-term opioid therapy, which should occur only as an intentional decision that benefits are likely to outweigh risks after informed discussion between the clinician and patient and as part of a comprehensive pain management approach.

- Clinicians seeing new patients already receiving opioids should establish treatment goals, including functional goals, for continued opioid therapy. Clinicians should avoid rapid tapering or abrupt discontinuation of opioids (see Recommendation 5).

- Patient education and discussion before starting opioid therapy are critical so that patient preferences and values can be understood and used to inform clinical decisions.

- Clinicians should review available low-cost options for pain management for all patients and particularly for patients who have low incomes, do not have health insurance, or have inadequate insurance.

- Clinicians should ensure that patients are aware of expected benefits of, common risks of, serious risks of, and alternatives to opioids before starting or continuing opioid therapy and should involve patients in decisions about whether to start opioid therapy.

Recommendation 3

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

Implementation Considerations

- Clinicians should not treat acute pain with ER/LA opioids or initiate opioid treatment for subacute or chronic pain with ER/LA opioids, and clinicians should not prescribe ER/LA opioids for intermittent or as-needed use.

- ER/LA opioids should be reserved for severe, continuous pain. FDA has noted that some ER/LA opioids should be considered only for patients who have received certain dosages of opioids of immediate-release opioids daily for at least 1 week.

- When changing to an ER/LA opioid for a patient previously receiving a different immediate-release opioid, clinicians should consult product labeling and reduce total daily dosage to account for incomplete opioid cross-tolerance.

- Clinicians should use additional caution with ER/LA opioids and consider a longer dosing interval when prescribing to patients with renal or hepatic dysfunction because decreased clearance of medications among these patients can lead to accumulation of drugs to toxic levels and persistence in the body for longer durations.

- Methadone should not be the first choice for an ER/LA opioid. Only clinicians who are familiar with methadone's unique risk profile and who are prepared to educate and closely monitor their patients, including assessing risk for QT prolongation and considering electrocardiographic monitoring, should consider prescribing methadone for pain.

- Only clinicians who are familiar with the dosing and absorption properties of the ER/LA opioid transdermal fentanyl and are prepared to educate their patients about its use should consider prescribing it.

Recommendation 4

When opioids are initiated for opioid-naïve patients with acute, subacute, or chronic pain, clinicians should prescribe the lowest effective dosage. If opioids are continued for subacute 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

Implementation Considerations

- The recommendations related to opioid dosages are not intended to be used as an inflexible, rigid standard of care; rather, they are intended to be guideposts to help inform clinician-patient decision-making. Risks of opioid use, including risk for overdose and overdose death, increase continuously with dosage, and there is no single dosage threshold below which risks are eliminated. Therefore, the recommendation language emphasizes that clinicians should avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients rather than emphasizing a single specific numeric threshold. Further, these recommendations apply specifically to starting opioids or to increasing opioid dosages, and a different set of benefits and risks applies to reducing opioid dosages (see Recommendation 5).

- When opioids are initiated for opioid-naïve patients with acute, subacute, or chronic pain, clinicians should prescribe the lowest effective dosage.

- For patients not already taking opioids, the lowest effective dose can be determined using product labeling as a starting point with calibration as needed based on the severity of pain and other clinical factors such as renal or hepatic insufficiency (see Recommendation 8).

- The lowest starting dose for opioid-naïve patients is often equivalent to a single dose of approximately 5–10 MME or a daily dosage of 20–30 MME/day. A listing of common opioid medications and their doses in MME equivalents is provided (Table).

- If opioids are continued for subacute or chronic pain, clinicians should use caution when prescribing opioids at any dosage and should generally avoid dosage increases when possible.

- Many patients do not experience benefit in pain or function from increasing opioid dosages to ≥50 MME/day but are exposed to progressive increases in risk as dosage increases. Therefore, before increasing total opioid dosage to ≥50 MME/day, clinicians should pause and carefully reassess evidence of individual benefits and risks. If a decision is made to increase dosage, clinicians should use caution and increase dosage by the smallest practical amount. The recommendations related to opioid dosages are not intended to be used as an inflexible, rigid standard of care; rather, they are intended to be guideposts to help inform clinician-patient decision-making.

- Additional dosage increases beyond 50 MME/day are progressively more likely to yield diminishing returns in benefits for pain and function relative to risks to patients as dosage increases further. Clinicians should carefully evaluate a decision to further increase dosage on the basis of individualized assessment of benefits and risks and weighing factors such as diagnosis, incremental benefits for pain and function relative to risks with previous dosage increases, other treatments and effectiveness, and patient values and preferences. The recommendations related to opioid dosages are not intended to be used as an inflexible, rigid standard of care; rather, they are intended to be guideposts to help inform clinician-patient decision-making.

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 nonopioid 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

Implementation Considerations

- Clinicians should carefully weigh both the benefits and risks of continuing opioid medications and the benefits and risks of tapering opioids.

- If benefits outweigh risks of continued opioid therapy, clinicians should work closely with patients to optimize nonopioid therapies while continuing opioid therapy.

- When benefits (including avoiding risks of tapering) do not outweigh risks of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper to a reduced opioid dosage or, if warranted based on the individual clinical circumstances of the patient, appropriately taper and discontinue opioid therapy.

- In situations where benefits and risks of continuing opioids are considered to be close or unclear, shared decision- making with patients is particularly important.

- At times, clinicians and patients might not be able to agree on whether or not tapering is necessary. When patients and clinicians are unable to arrive at a consensus on the assessment of benefits and risks, clinicians should acknowledge this discordance, express empathy, and seek to implement treatment changes in a patient-centered manner while avoiding patient abandonment.

- Patient agreement and interest in tapering is likely to be a key component of successful tapers.

- For patients agreeing to taper to lower opioid dosages and for those remaining on higher opioid dosages, clinicians should establish goals with the patient for continued opioid therapy (see Recommendations 2 and 7) and maximize pain treatment with nonpharmacologic and nonopioid pharmacologic treatments as appropriate (see Recommendation 2).

- Clinicians should collaborate with the patient on the tapering plan, including patients in decisions such as how quickly tapering will occur and when pauses in the taper might be warranted.

- Clinicians should follow up frequently (at least monthly) with patients engaging in opioid tapering. Team members (e.g., nurses, pharmacists, and behavioral health professionals) can support the clinician and patient during the ongoing taper process through telephone contact, telehealth visits, or face-to-face visits.

- When opioids are reduced or discontinued, a taper slow enough to minimize symptoms and signs of opioid withdrawal (e.g., anxiety, insomnia, abdominal pain, vomiting, diarrhea, diaphoresis, mydriasis, tremor, tachycardia, or piloerection) should be used.

- Longer duration of previous opioid therapy might require a longer taper. For patients who have taken opioids long- term (e.g., for ≥1 year), tapers can be completed over several months to years depending on the opioid dosage and should be individualized based on patient goals and concerns.

- When patients have been taking opioids for longer durations (e.g., for ≥1 year), tapers of 10% per month or slower are likely to be better tolerated than more rapid tapers.

- For patients struggling to tolerate a taper, clinicians should maximize nonopioid treatments for pain and should address behavioral distress.

- Clinically significant opioid withdrawal symptoms can signal the need to further slow the taper rate.

- At times, tapers might have to be paused and restarted again when the patient is ready and might have to be slowed as patients reach low dosages.

- Before reversing a taper, clinicians should carefully assess and discuss with the patient the benefits and risks of increasing opioid dosage.

- Goals of the taper might vary (e.g., some patients might achieve discontinuation whereas others might attain a reduced dosage at which functional benefits outweigh risks). If the clinician has determined with the patient that the ultimate goal of tapering is discontinuing opioids, after the smallest available dose is reached the interval between doses can be extended and opioids can be stopped when taken less frequently than once a day.

- Clinicians should access appropriate expertise if considering tapering opioids during pregnancy because of possible risks to the pregnant patient and the fetus if the patient goes into withdrawal.

- Clinicians should advise patients of an increased risk for overdose on abrupt return to a previously prescribed higher dose because of loss of opioid tolerance, provide opioid overdose education, and offer naloxone.[3]

- Clinicians should remain alert to signs of and screen for anxiety, depression, and opioid misuse or opioid use disorder (see Recommendations 8 and 12) that might be revealed by an opioid taper and provide treatment or arrange for management of these comorbidities.

- Clinicians should closely monitor patients who are unable to taper and who continue on high-dose or otherwise high-risk opioid regimens (e.g., opioids prescribed concurrently with benzodiazepines) and should work with patients to mitigate overdose risk (e.g., by providing overdose education and naloxone) (see Recommendation 8).

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[3] South Carolina Code § 44-53-361 mandates when a physician should offer naloxone to a patient.

- Clinicians can use periodic and strategic motivational questions and statements to encourage movement toward appropriate therapeutic changes and functional goals.

- Clinicians have a responsibility to provide or arrange for coordinated management of patients' pain and opioid- related problems, including opioid use disorder.

- Payers, health systems, and state medical boards should not use this clinical practice guideline to set rigid standards or performance incentives related to dose or duration of opioid therapy; should ensure that policies based on cautionary dosage thresholds do not result in rapid tapers or abrupt discontinuation of opioids; and should ensure that policies do not penalize clinicians for accepting new patients who are using prescribed opioids for chronic pain, including those receiving high dosages of opioids, or for refraining from rapidly tapering patients prescribed long- term opioid medications.

- Although Recommendation 5 specifically refers to patients using long-term opioid therapy for subacute or chronic pain, many of the principles in these implementation considerations and supporting rationale, including communication with patients, pain management, behavioral support, and slower taper rates, also are relevant when discontinuing opioids in patients who have received them for shorter durations (see Recommendations 6 and 7).

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

Implementation Considerations

- Nontraumatic, nonsurgical acute pain can often be managed without opioids (see Recommendation 1).

- Opioids are sometimes needed for treatment of acute pain (see Recommendation 1). When the diagnosis and severity of acute pain warrant use of opioids, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. For many common causes of nontraumatic, nonsurgical pain, when opioids are needed, a few days or less are often sufficient, and shorter courses can minimize the need to taper opioids to prevent withdrawal symptoms at the end of a course of opioids. However, durations should be individualized to the patient's clinical circumstances.

- Clinicians should generally avoid prescribing additional opioids to patients just in case pain continues longer than expected.

- For postoperative pain related to major surgery, procedure- specific opioid prescribing recommendations are available with ranges for amounts of opioids needed (on the basis of actual use and refills and on consensus).

- To minimize unintended effects on patients, clinicians, practices, and health systems should have mechanisms in place for the subset of patients who experience severe acute pain that continues longer than the expected duration. These mechanisms should allow for timely

reevaluation to confirm or revise the initial diagnosis and adjust pain management accordingly. Clinicians, practices, and health systems can help minimize disparities in access to and affordability of care and refills by ensuring all patients can obtain and afford additional evaluation and treatment, as needed.

- Longer durations of opioid therapy are more likely to be needed when the mechanism of injury is expected to result in prolonged severe pain (e.g., severe traumatic injuries).

- Patients should be evaluated at least every 2 weeks if they continue to receive opioids for acute pain.

- If opioids are continued for ≥1 month, clinicians should ensure that potentially reversible causes of chronic pain are addressed and that opioid prescribing for acute pain does not unintentionally become long-term opioid therapy simply because medications are continued without reassessment. Continuation of opioid therapy at this point might represent initiation of long-term opioid therapy, which should occur only as an intentional decision that benefits are likely to outweigh risks after discussion between the clinician and patient and as part of a comprehensive pain management approach. Clinicians should refer to recommendations on subacute and chronic pain for initiation (Recommendation 2), follow-up (Recommendation 7), and tapering (Recommendation 5) of ongoing opioid therapy.

- If patients already receiving long-term opioid therapy require additional opioids for superimposed severe acute pain (e.g., major surgery), opioids should be continued only for the duration of pain severe enough to require additional opioids, returning to the patient's baseline opioid dosage as soon as possible, including a taper to baseline dosage if additional opioids were used around the clock for more than a few days.

- If opioids are used continuously (around the clock) for more than a few days for acute pain, clinicians should prescribe a brief taper to minimize withdrawal symptoms on discontinuation of opioids.

- If a taper is needed, taper durations might need to be adjusted depending on the duration of the initial opioid prescription (see Supporting Rationale for this recommendation for additional details).

- Tapering plans should be discussed with the patient before hospital discharge and with clinicians coordinating the patient's care as an outpatient. (See Recommendation 5 for tapering considerations when patients have taken opioids continuously for >1 month.)

Recommendation 7

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

Implementation Considerations

- In addition to evaluating benefits and risks of opioids before starting opioid therapy (see Recommendation 2), clinicians should evaluate patients to assess benefits and risks of opioids within 1–4 weeks of starting long-term opioid therapy or of dosage escalation.

- Clinicians should consider follow-up intervals within the lower end of this range when ER/LA opioids are started or increased, because of the increased risk for overdose within the first 2 weeks of treatment, or when total daily opioid dosage is ≥50 MME/day. (Overdose risk is doubled across multiple studies for dosages of 50 to <100 MME/ day relative to <20 MME/day.) (See Recommendation 4.)

- Shorter follow-up intervals (every 2–3 days for the first week) should be strongly considered when starting or increasing the dosage of methadone, because of the variable half-life of this drug (see Recommendation 3) and the potential for drug accumulation during initiation and during upward titration of dosage.

- An initial follow-up interval closer to 4 weeks can be considered when starting immediate-release opioids at a dosage of <50 MME/day.

- Clinicians should follow up with and evaluate patients with subacute pain who started opioid therapy for acute pain and have been treated with opioid therapy for 30 days to reassess the patient's pain, function, and treatment course; ensure that potentially reversible causes of chronic pain are addressed; and prevent unintentional initiation of long-term opioid therapy. Continuation of opioid therapy at this point might represent initiation of long- term opioid therapy, which should occur only as an intentional decision that benefits are likely to outweigh risks after discussion between the clinician and patient and as part of a comprehensive pain management approach (see Recommendation 2).

- Clinicians should regularly reassess all patients receiving long-term opioid therapy, including patients who are new to the clinician but on long-term opioid therapy, with a suggested interval of every 3 months or more frequently for most patients.

- Clinicians seeing new patients already receiving opioids should establish treatment goals, including functional goals, for continued opioid therapy (see Recommendation 2).

- Clinicians should reevaluate patients who are at higher risk for opioid use disorder or overdose (e.g., patients with depression or other mental health conditions, a history of substance use disorder, a history of overdose, taking ≥50 MME/day, or taking other central nervous system depressants with opioids) more frequently than every 3 months. Clinicians should regularly screen all patients for these conditions, which can change during the course of treatment (see Recommendation 8).

- Clinicians, practices, and health systems can help minimize unintended effects on patients by ensuring all patients can access and afford follow-up evaluation.

- In practice contexts where virtual visits are part of standard care (e.g., in remote areas where distance or other context makes follow-up visits challenging), or for patients for whom in-person follow-up visits are challenging (e.g., frail patients), follow-up assessments that allow the

clinician to communicate with and observe the patient through telehealth modalities might be conducted.

- At follow-up, clinicians should review patient perspectives and goals, determine whether opioids continue to meet treatment goals, including sustained improvement in pain and function, and determine whether the patient has experienced common or serious adverse events or early warning signs of serious adverse events or has signs of opioid use disorder.

- Clinicians should ensure that treatment for depression, anxiety, or other psychological comorbidities is optimized.

- Clinicians should ask patients about their preferences for continuing opioids, considering their effects on pain and function relative to any adverse effects experienced. If risks outweigh benefits of continued opioid therapy (e.g., if patients do not experience meaningful, sustained improvements in pain and function compared with before initiation of opioid therapy; if patients are taking higher- risk regimens [e.g., dosages of ≥50 MME/day or opioids combined with benzodiazepines] without evidence of benefit; if patients believe benefits no longer outweigh risks; if patients request dosage reduction or discontinuation; or if patients experience overdose or other serious adverse events), clinicians should work with patients to taper and reduce opioid dosage or taper and discontinue opioids when possible (see from Recommendation 5).

- Clinicians should maximize pain treatment with nonpharmacologic and nonopioid pharmacologic treatments as appropriate (see Recommendation 2).

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.

Implementation Considerations

- Clinicians should ask patients about their drug and alcohol use and use validated tools or consult with behavioral specialists to screen for and assess mental health and substance use disorders.

- When considering initiating long-term opioid therapy, clinicians should ensure that treatment for depression and other mental health conditions is optimized, consulting with behavioral health specialists when needed.

- Clinicians should offer naloxone when prescribing opioids, particularly to patients at increased risk for overdose, including patients with a history of overdose, patients with a history of substance use disorder, patients with sleep-disordered breathing, patients taking higher dosages of opioids (e.g., ≥50 MME/day), patients taking benzodiazepines with opioids (see Recommendation 11), and patients at risk for returning to a high dose to which they have lost tolerance (e.g., patients undergoing tapering or recently released from prison).

- Practices should educate patients on overdose prevention and naloxone use and offer to provide education to members of their households.

- Naloxone co-prescribing can be facilitated by clinics or practices with resources to provide naloxone training, by collaborative practice models with pharmacists, or through statewide protocols or standing orders for naloxone at pharmacies.

- Resources for prescribing naloxone in primary care and emergency department settings can be found through Prescribe to Prevent at https://prescribetoprevent.org. Additional resources are at https://www.samhsa.gov.

- In part because of concerns about cost of naloxone and access for some patients and reports that purchasing of naloxone has in some cases been required to fill opioid prescriptions, including for patients without a way to afford naloxone, this recommendation specifies that naloxone should be offered to patients. To that end, clinicians, health systems, and payers can work to ensure patients can obtain naloxone, a potentially lifesaving treatment.

- Clinicians should avoid prescribing opioids to patients with moderate or severe sleep-disordered breathing when possible to minimize risk for respiratory depression.

- When making decisions about whether to initiate opioid therapy for pain during pregnancy, clinicians and patients together should carefully weigh benefits and risks. For pregnant persons already receiving opioids, clinicians should access appropriate expertise if tapering is being considered because of possible risks to the pregnant patient and the fetus if the patient goes into withdrawal (see Recommendation 5).

- For pregnant persons with opioid use disorder, medication for opioid use disorder (buprenorphine or methadone) is the recommended therapy and should be offered as early as possible in pregnancy to prevent harms to both the patient and the fetus (see Recommendation 12).

- Clinicians should use additional caution and increased monitoring (see Recommendation 7) to minimize risks of opioids prescribed for patients with renal or hepatic insufficiency and for patients aged ≥65 years. Clinicians should implement interventions to mitigate common risks of opioid therapy among older adults, such as exercise or bowel regimens to prevent constipation, risk assessment for falls, and patient monitoring for cognitive impairment.

- For patients with jobs that involve potentially hazardous tasks and who are receiving opioids or other medications that can negatively affect sleep, cognition, balance, or coordination, clinicians should assess patients' abilities to safely perform the potentially hazardous tasks (e.g., driving, use of heavy equipment, climbing ladders, working at heights or around moving machinery, or working with high-voltage equipment).

- Clinicians should use PDMP data (see Recommendation 9) and toxicology screening (see Recommendation 10) as appropriate to assess for concurrent substance use that might place patients at higher risk for opioid use disorder and overdose.

- Clinicians should provide specific counseling on increased risks for overdose when opioids are combined with other drugs or alcohol (see Recommendation 2) and ensure that patients are

provided or receive effective treatment for substance use disorders when needed (see Recommendation 12).

- Although substance use disorders can alter the expected benefits and risks of opioid therapy for pain, patients with co-occurring pain and substance use disorder require ongoing pain management that maximizes benefits relative to risks. (See Recommendation 12, Pain Management for Patients with Opioid Use Disorder for additional considerations specific to these patients.)

- If clinicians consider opioid therapy for chronic pain for patients with substance use disorder, they should discuss increased risks for opioid use disorder and overdose with patients, carefully consider whether benefits of opioids outweigh increased risks, and incorporate strategies to mitigate risk into the management plan (e.g., offering naloxone [see Offering Naloxone to Patients] and increasing frequency of monitoring [see Recommendation 7]).

- If patients experience nonfatal opioid overdose, clinicians should evaluate for opioid use disorder and treat or arrange treatment if needed. Clinicians should work with patients to reduce opioid dosage and to discontinue opioids when indicated (see Recommendation 5) and should ensure continued close monitoring and support for patients prescribed or not prescribed opioids.

- If clinicians continue opioid therapy in patients with previous opioid overdose, they should discuss increased risks for overdose with patients, carefully consider whether benefits of opioids outweigh substantial risks, and incorporate strategies to mitigate risk into the management plan (e.g., offering naloxone and increasing frequency of monitoring [see Recommendation 7]).

Recommendation 9

When prescribing initial opioid therapy for acute, subacute, 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.

Implementation Considerations

- Ideally, PDMP data should be reviewed before every opioid prescription for acute, subacute, or chronic pain. This practice is recommended in all jurisdictions where PDMP availability and access policies, as well as clinical practice settings, make it practicable (e.g., clinician and delegate access permitted).

- At a minimum, during long-term opioid therapy, PDMP data should be reviewed before an initial opioid prescription and then every 3 months or more frequently. Recommendation category B acknowledges variation in PDMP availability and circumstances. However, because PDMP information can be most helpful when results are unexpected and, to minimize bias in application, clinicians should apply this recommendation when feasible to all patients rather than differentially on the basis of assumptions about what they will learn about specific patients.

- Clinicians should use specific PDMP information about medications prescribed to their patient in the context of other clinical information, including their patient's history, physical findings, and other relevant testing, to help them communicate with and protect their patient.

- Clinicians should review PDMP data specifically for prescription opioids and other controlled medications patients have received from additional prescribers to determine whether a patient is receiving total opioid dosages or combinations (e.g., opioids combined with benzodiazepines) that put the patient at risk for overdose.

- PDMP-generated risk scores have not been validated against clinical outcomes such as overdose and should not take the place of clinical judgment.

- Clinicians should not dismiss patients from their practice on the basis of PDMP information. Doing so can adversely affect patient safety and could result in missed opportunities to provide potentially lifesaving information (e.g., about risks of prescription opioids and about overdose prevention) and interventions (e.g., safer prescriptions, nonopioid pain treatment [see Recommendations 1 and 2], naloxone [see Recommendation 8], and effective treatment for substance use disorders [see Recommendations 8 and 12]).

- Clinicians should take actions to improve patient safety:

    - Discuss information from the PDMP with the patient and confirm that the patient is aware of any additional prescriptions. Because clinicians often work as part of teams, prescriptions might appropriately be written by more than one clinician coordinating the patient's care. Occasionally, PDMP information can be incorrect (e.g., if the wrong name or birthdate has been entered, the patient uses a nickname or maiden name, or another person has used the patient's identity to obtain prescriptions).

    - Discuss safety concerns, including increased risk for respiratory depression and overdose, with patients found to be receiving overlapping prescription opioids from multiple clinicians who are not coordinating the patient's care or patients who are receiving medications that increase risk when combined with opioids (e.g., benzodiazepines) (see Recommendation 11), and offer naloxone (see Recommendation 8).

    - Use particular caution when prescribing opioid pain medication and benzodiazepines concurrently, understanding that some patient circumstances warrant prescribing of these medications concomitantly. Clinicians should communicate with others managing the patient to discuss the patient's needs, prioritize patient goals, weigh risks of concurrent benzodiazepine and opioid exposure, and coordinate care (see Recommendation 11).

    - Consider the total MME/day for concurrent opioid prescriptions to help assess the patient's overdose risk (see Recommendation 4). Buprenorphine should not be counted in the total MME/day in calculations because of its partial agonist properties at opioid receptors that confer a ceiling effect on respiratory depression. If a patient is found to be receiving total daily dosages of opioids that put them at risk for overdose, discuss safety concerns with the patient, consider in collaboration with the patient whether or not benefits

of tapering outweigh risks of tapering (see Recommendation 5), and offer naloxone (see Recommendation 8).

- Discuss safety concerns with other clinicians who are prescribing controlled substances for the patient. Ideally, clinicians should first discuss concerns with the patient and inform them that they plan to coordinate care with their other clinicians to improve the patient's safety.

- Screen for substance use and discuss concerns with the patient in a nonjudgmental manner (see Recommendations 8 and 12).

- When diverting (sharing or selling prescription opioids and not taking them) might be likely, consider toxicology testing to assist in determining whether prescription opioids can be discontinued without causing withdrawal (see Recommendations 5 and 10). A negative toxicology test for prescribed opioids might indicate the patient is not taking prescribed opioids, although clinicians should consider other possible reasons for this test result (e.g., false-negative results or misinterpretation of results) (see Recommendation 10).

Recommendation 10

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

Implementation Considerations

- Toxicology testing should not be used in a punitive manner but should be used in the context of other clinical information to inform and improve patient care. Clinicians should not dismiss patients from care on the basis of a toxicology test result. Dismissal could have adverse consequences for patient safety, potentially including the patient obtaining opioids or other drugs from alternative sources and the clinician missing opportunities to facilitate treatment for substance use disorder.

- Before starting opioids and periodically (at least annually) during opioid therapy, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed opioids and other prescription and nonprescription controlled substances that increase risk for overdose when combined with opioids, including nonprescribed and illicit opioids and benzodiazepines.

- Clinicians, practices, and health systems should aim to minimize bias in testing and should not apply this recommendation differentially on the basis of assumptions about patients.

- Predicting risk is challenging, and available tools do not allow clinicians to reliably identify patients who are at low risk for substance use or substance use disorders. Clinicians should consider toxicology screening results as potentially useful data, in the context of other clinical information, for all patients and consider toxicology screening whenever its potential limitations can be addressed.

- Clinicians should explain to patients that toxicology testing will not be used to dismiss patients from care and is intended to improve their safety.

- Clinicians should explain expected results (e.g., presence of prescribed medication and absence of drugs, including nonprescribed controlled substances not reported by the patient) and ask patients in a nonjudgmental manner about use of prescribed and other drugs and whether there might be unexpected results.

- Limited toxicology screening can be performed with a relatively inexpensive presumptive immunoassay panel that tests for opiates as a class, benzodiazepines as a class, and several nonprescribed substances. Toxicology screening for a class of drugs might not detect all drugs in that class. For example, fentanyl testing is not included in widely used toxicology assays that screen for opiates as a class.

- Clinicians should be familiar with the drugs included in toxicology screening panels used in their practice and should understand how to interpret results for these drugs. For example, a positive opiates immunoassay detects morphine, which might reflect patient use of morphine, codeine, or heroin, but does not detect synthetic opioids and might not detect semisynthetic opioids. In some cases, positive results for specific opioids might reflect metabolites from opioids the patient is taking and might not mean the patient is taking the specific opioid that resulted in the positive test.

- Confirmatory testing should be used when:

    - toxicology results will inform decisions with major clinical or nonclinical implications for the patient;

    - a need exists to detect specific opioids or other drugs within a class, such as those that are being prescribed, or those that cannot be identified on standard immunoassays; or

    - a need exists to confirm unexpected screening toxicology test results.

- Restricting confirmatory testing to situations and substances for which results can reasonably be expected to affect patient management can reduce costs of toxicology testing.

- Clinicians might want to discuss unexpected results with the local laboratory or toxicologist and should discuss unexpected results with the patient.

- Clinicians should discuss unexpected results with patients in a nonjudgmental manner, avoiding use of potentially stigmatizing language (e.g., avoid describing a specimen as testing “clean” or “dirty”).

- Discussion with patients before specific confirmatory testing can sometimes yield a candid explanation of why a particular substance is present or absent and remove the need for confirmatory testing during that visit. For example, a patient might explain that the test is negative for prescribed opioids because they felt opioids were no longer helping and discontinued them. If unexpected results from toxicology screening are not explained, a confirmatory test on the same

sample using a method selective enough to differentiate specific opioids and metabolites (e.g., gas or liquid chromatography–mass spectrometry) might be warranted.

- Clinicians should use unexpected results to improve patient safety (e.g., optimize pain management strategy [see Recommendation 2], carefully weigh benefits and risks of reducing or continuing opioid dosage [see Recommendation 5], reevaluate more frequently [see Recommendation 7], offer naloxone [see Recommendation 8], and offer treatment or refer the patient for treatment with medications for opioid use disorder [see Recommendation 12], all as appropriate).

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.

Implementation Considerations

- Although in some circumstances it might be appropriate to prescribe opioids to a patient who is also prescribed benzodiazepines (e.g., severe acute pain in a patient taking long-term, stable low-dose benzodiazepine therapy), clinicians should use particular caution when prescribing opioid pain medication and benzodiazepines concurrently. In addition, clinicians should consider whether benefits outweigh risks for concurrent use of opioids with other central nervous system depressants (e.g., muscle relaxants, nonbenzodiazepine sedative hypnotics, and potentially sedating anticonvulsant medications such as gabapentin and pregabalin).

- Buprenorphine or methadone for opioid use disorder should not be withheld from patients taking benzodiazepines or other medications that depress the central nervous system.

- Clinicians should check the PDMP for concurrent controlled medications prescribed by other clinicians (see Recommendation 9) and should consider involving pharmacists as part of the management team when opioids are co-prescribed with other central nervous system depressants.

- In patients receiving opioids and benzodiazepines long term, clinicians should carefully weigh the benefits and risks of continuing therapy with opioids and benzodiazepines and discuss with patients and other members of the patient's care team.

- Risks of concurrent opioid and benzodiazepine use are likely to be greater with unpredictable use of either medication, with use of higher-dosage opioids and higher- dosage benzodiazepines in combination, or with use with other substances including alcohol (compared with long- term, stable use of lower-dosage opioids and lower-dosage benzodiazepines without other substances).

- In specific situations, benzodiazepines can be beneficial, and stopping benzodiazepines can be destabilizing.

- Clinicians should taper benzodiazepines gradually before discontinuation because abrupt withdrawal can be associated with rebound anxiety, hallucinations, seizures, delirium tremens, and, rarely, death. The rate of tapering should be individualized.

- If benzodiazepines prescribed for anxiety are tapered or discontinued, or if patients receiving opioids require treatment for anxiety, evidence-based psychotherapies (e.g., cognitive behavioral therapy), specific antidepressants or other nonbenzodiazepine medications approved for anxiety, or both, should be offered.

- Clinicians should communicate with other clinicians managing the patient to discuss the patient's needs, prioritize patient goals, weigh risks of concurrent benzodiazepine and opioid exposure, and coordinate care.

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.

Implementation Considerations

- Although stigma can reduce the willingness of persons with opioid use disorder to seek treatment, opioid use disorder is a chronic, treatable disease from which persons can recover and continue to lead healthy lives.

- If clinicians suspect opioid use disorder, they should discuss their concern with their patient in a nonjudgmental manner and provide an opportunity for the patient to disclose related concerns or problems.

- Clinicians should assess for the presence of opioid use disorder using DSM-5 criteria.

- For patients meeting criteria for opioid use disorder, particularly if moderate or severe, clinicians should offer or arrange for patients to receive evidence-based treatment with medications for opioid use disorder.

- Clinicians should not dismiss patients from their practice because of opioid use disorder because this can adversely affect patient safety.

- Medication treatment of opioid use disorder has been associated with reduced risk for overdose and overall deaths. Identification of opioid use disorder represents an opportunity for a clinician to initiate potentially life-saving interventions, and the clinician should collaborate with the patient regarding their safety to increase the likelihood of successful treatment.

- For pregnant persons with opioid use disorder, medication for opioid use disorder (buprenorphine or methadone) is the recommended therapy and should be offered as early as possible in pregnancy to prevent harms to both the patient and the fetus.

- Clinicians unable to provide treatment themselves should arrange for patients with opioid use disorder to receive care from a substance use disorder treatment specialist (e.g., an office-based buprenorphine or naltrexone treatment provider), or from an opioid treatment program certified by SAMHSA to provide methadone or buprenorphine for patients with opioid use disorder.

- All clinicians, and particularly clinicians prescribing opioids in communities without sufficient treatment capacity for opioid use disorder, should obtain a waiver to prescribe buprenorphine for opioid use disorder.

- Clinicians prescribing opioids should identify treatment resources for opioid use disorder in the community, establish a network of referral options that span the levels of care that patients might need to enable rapid collaboration and referral, when needed, and work together to ensure sufficient treatment capacity for opioid use disorder at the practice level.

- Although identification of an opioid use disorder can alter the expected benefits and risks of opioid therapy for pain, patients with co-occurring pain and opioid use disorder require ongoing pain management that maximizes benefits relative to risks.

Management of Opioid Misuse That Does Not Meet Criteria for Opioid Use Disorder

Clinicians can have challenges distinguishing between opioid misuse behaviors without opioid use disorder and mild or moderate opioid use disorder. For patients with opioid misuse that does not meet criteria for opioid use disorder (e.g., taking opioids in larger amounts than intended without meeting other criteria for opioid use disorder), clinicians should reassess the patient's pain, ensure that therapies for pain management have been optimized (see Recommendation 2), discuss with patients, and carefully weigh benefits and risks of continuing opioids at the current dosage (see Recommendation 5). For patients who choose to but are unable to taper, clinicians can reassess for opioid use disorder and offer buprenorphine treatment or refer for buprenorphine or methadone treatment if criteria for opioid use disorder are met. Even without a diagnosis of opioid use disorder, transitioning to buprenorphine for pain also can be considered because of reduced risk for overdose with buprenorphine compared with risk associated with full agonist opioids (see Recommendation 5).

Pain Management for Patients with Opioid Use Disorder

Although identification of an opioid use disorder can alter the expected benefits and risks of opioid therapy for pain, patients with co-occurring pain and substance use disorder require ongoing pain management that maximizes benefits relative to risks. Clinicians should use nonpharmacologic and nonopioid pharmacologic pain treatments as appropriate (see Recommendations 1 and 2) to provide optimal pain management. For patients with pain who have an active opioid use disorder but are not in treatment, clinicians should consider buprenorphine or methadone treatment for opioid use disorder, which also can help with concurrent management of pain. For patients who are treated with buprenorphine for opioid use disorder and experience acute pain, clinicians can consider temporarily increasing the buprenorphine dosing frequency (e.g., to twice per day) to help manage pain because the duration of effects of buprenorphine is shorter for

pain than for suppression of withdrawal. For severe acute pain (e.g., from trauma or unplanned major surgery) in patients receiving buprenorphine for opioid use disorder, clinicians can consider additional as-needed doses of buprenorphine. In supervised settings, adding a short- acting full agonist opioid to the patient's regular dosage of buprenorphine can be considered without discontinuing the patient's regular buprenorphine dosage; however, if a decision is made to discontinue buprenorphine to allow for more μ-opioid receptor availability, patients should be monitored closely because high doses of a full agonist opioid might be required, potentially leading to oversedation and respiratory depression as buprenorphine's partial agonist effect lessens. For patients receiving naltrexone for opioid use disorder, short-term use of higher-potency nonopioid analgesics (e.g., NSAIDs) can be considered to manage severe acute pain. Patients receiving methadone for opioid use disorder who require additional opioids as treatment for severe acute pain management should be monitored carefully, and when feasible, should optimally be treated by a clinician experienced in the treatment of pain in consultation with their opioid treatment program. The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder (2020 Focused Update) provides additional recommendations (see Part 9) for the management of patients receiving medications for opioid use disorder who have planned surgeries for which nonopioid therapies are not anticipated to provide sufficient pain relief.

Resources

Practitioners should be familiar with both federal and state law in prescribing opioids, as many of these laws mandate specific requirements South Carolina practitioners must follow. Some of these laws include, but are not limited to:

- Healthcare facilities are required to report opioid antidote administrations to DHEC in accordance with **Section 44-130-80**.
- First responders are required to report opioid antidote administrations to DHEC in accordance with **Section 44-130-60**.
- DHEC is required to establish and maintain a program to monitor the administering of opioid antidotes pursuant to Sections 44-130-60 and 44-130-80.
- Practitioners are required to review a patient's controlled substance prescription history and opioid antidote administration history, pursuant to Section 44-130-60 or 44-130-80, before issuing a prescription for a Schedule II controlled substance in accordance with **Section 44-53-1645(A)**.
- Electronic prescription requirements for dispensing are clarified in **Section 44-53-360**(a), (b), and (d).
- Practitioners are required to electronically prescribe controlled substances in Schedules II, III, IV, and V in accordance with **Section 44-53-360**(j).
- South Carolina Overdose Prevention Act **Section 44-130-10**.
- Prescribers to offer naloxone in certain situations **Section 44-53-361**.