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CDC CLINICAL PRACTICE GUIDELINE FOR PRESCRIBING OPIOIDS: 2022 DRAFT UPDATE

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ABBREVIATIONS

ACIP	Advisory Committee on Immunization Practices
AHRQ	Agency for Healthcare Research and Quality
CBT	cognitive behavioral therapy
CDC	Centers for Disease Control and Prevention
CNS	central nervous system
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
DUR	Drug Utilization Review
GRADE	Grading of Recommendations Assessment, Development, and Evaluation
MED	morphine equivalent dosing
MME	morphine milligram equivalents
NCCN	National Comprehensive Cancer Network
NSAIDs	nonsteroidal anti-inflammatory drugs
PA	prior authorization
PDL	Preferred Drug List
PDMP	prescription drug monitoring program
QoL	quality of life
SRs	systematic reviews

1.0 BACKGROUND

In 2016, the Centers for Disease Control and Prevention (CDC) published a guideline for prescribing opioids for chronic pain due to the nationally recognized need for guidance on appropriate opioid prescribing.[1,2] This guideline altered opioid prescribing practices and hastened the decline of high-risk prescribing behaviors and overall opioid prescribing.[1] Despite the positive impact, the 2016 CDC guideline also had unintended consequences for patients affected with chronic pain when the recommendations were misapplied, or applied too strictly.[1]

Recommendations that were interpreted as rules of restraint resulted in patient harm, including inadequate pain management (ie, undertreatment or no treatment), precipitation of withdrawal (eg, due to rapid reductions in opioid use), and psychological distress.[1] Examples of inappropriate application of recommendations included application of the recommendations to patient populations beyond the intended scope (eg, end-of-life care), implementation of strict opioid dosage thresholds, initiation of opioid tapers and/or sudden opioid cessation without patient consent, opioid duration restrictions by payers and pharmacies, and patient abandonment.[1]

The draft 2022 CDC guideline update aimed to emphasize and facilitate open communication between prescribers and patients about the benefits and risks of opioids and other treatment options for pain; to encourage shared decision-making for pain-related care; to improve the patient quality of life (QoL) and symptoms (eg, pain, function); and to reduce opioid-related risks (eg, opioid use disorder, overdose, death).[1]

The objective of this abbreviated report was to review recommendations for opioid prescribing included in the 2022 CDC guideline and contrast these recommendations with the initial 2016 version. For context, background information on the 2022 CDC guideline (ie, scope, target population) was also provided. Although the 2022 CDC guideline provided an evidence summary for non-pharmacologic and non-opioid therapies, details regarding the evidence of these interventions were considered beyond the scope of our review. This report was based on the *draft version* of the 2022 CDC guideline.[1] Since the guideline is not yet finalized, it is possible that additional changes will be made to the updated recommendations.

2.0 METHODS

Since the purpose of this *abbreviated* report was to review recommendations regarding opioid prescribing from the 2022 draft guideline update and contrast it with the 2016 guideline, we did not seek information from other sources. Thus, we did not perform any literature searches.

3.0 SCOPE

The scope of the 2022 CDC opioid guideline expanded on the 2016 CDC guideline.[1] Unlike the initial 2016 guideline that focused only on chronic pain, the updated guideline also contained recommendations for acute and subacute pain.[1] The newer guideline also added greater emphasis on distinguishing between initial opioid therapy and ongoing opioid treatment, with respect to certain recommendations.[1]

Similar to the 2016 iteration,[2] the 2022 CDC guideline addressed the following 4 aspects of opioid prescribing practices[1]:

1. Deciding whether opioids should be started for pain
2. Selecting the appropriate opioid and dosage
3. Duration of opioid therapy and follow-up
4. Evaluating opioid-related risks and potential harms

3.1 Target prescriber audience and patient population

The target prescriber audience for both the 2016 and 2022 CDC guidelines were primary care providers delivering pain-related care in outpatient settings.[1,2] However, the 2022 update expanded the scope to include additional outpatient prescribers (eg, dentists, surgeons, occupational and physical rehabilitation physicians, neurologists). Although inpatient settings (eg, hospitals, emergency departments) were outside the intended scope of both guidelines,[1,2] the updated guideline addressed pain management upon discharge from such facilities.[1]

The target patient population for both iterations of the CDC guidelines (2016 and 2022) included adults (≥ 18 years of age) with chronic pain (symptoms present for >3 months).[1,2] The broader 2022 guideline target population included individuals with procedural-related pain (eg, postoperative, oral surgery), and individuals with acute (symptoms present for <1 month) or subacute (symptoms present for 1–3 months) pain.[1]

Refer to **Table 1** for a comparison of the scope, target prescriber audience, and the target patient population for the 2016 version and the 2022 draft updated version.

The following patient populations and/or settings were **not** addressed by either guideline[1,2]:

- Pediatrics (<18 years of age)
- Pain related to sickle cell disease
- Cancer-related pain in those *actively receiving* cancer treatment
    - The 2016 CDC guideline included cancer-associated chronic pain *only* in patients in remission who were under observation for recurrence (ie, cancer survivors).[2] It is unclear whether the updated guideline also applied to cancer survivors since readers were referred to National Comprehensive Cancer Network (NCCN) practice guidelines.[1] However, the 2022 guideline explicitly stated that patients undergoing cancer treatment were considered outside the guideline scope.[1]
- Patients receiving palliative or end-of-life care
    - Palliative care was defined as “care that provides relief from pain and other symptoms, supports quality of life, and is focused on patients with serious advanced illness.” (page 18)[1]
    - End-of-life care was defined as “care for persons in hospice care and others with a terminal illness at high risk of dying in the near future in hospitals, receiving long-term services and supports (including institutional care, and home and community-based services), or at home.” (page 19)[1]

Appendix A includes a list of pain management guidelines for target populations/settings not addressed by the 2022 CDC guideline, and helpful resources that were mentioned by the 2022 guideline.

Table 1. Comparison of the Target Population and Scope Between the 2022 and 2016 CDC Guidelines

	CDC Clinical Practice Guideline for Prescribing Opioids; 2022[1]	CDC Clinical Practice Guideline for Prescribing Opioids; 2016[2]
Scope	• Deciding whether opioids should be started for pain • Selecting the appropriate opioid and dosage • Duration of opioid therapy and follow-up • Evaluating opioid-related risks and potential harms	• Deciding whether opioids should be started for pain or continued for the treatment of chronic pain • Selecting the appropriate opioid, dosage, duration, follow-up, and cessation • Evaluating opioid-related risks and potential harms

Target Audience and Population	• Adults (≥18 years of age)
	• Pain, including procedural-related
	  ○ Acute (symptom duration of <1 month)
	  ○ Subacute (symptom duration of 1–3 months)
	  ○ Chronic (symptom duration of >3 months)
	• Primary care physicians (eg, family care providers, physician assistants, nurse practitioners) and others:
	  ○ Dentists
	  ○ Surgeons
	  ○ Emergency physicians
	  ○ Occupational and physical rehabilitation physicians
	  ○ Neurologists
	• Outpatient settings, <u>including prescribing medications upon discharge from an inpatient facility</u>
	
	<u>Excludes:</u>
	• Patients with sickle cell disease, undergoing active treatment for cancer, and palliative or end-of-life care
	• Children and teenagers (<18 years of age)
	• Inpatient settings (eg, hospitals, emergency department)
		• Adults (≥18 years of age)
		• Pain
		  ○ Chronic (symptom duration of >3 months)
		• Primary care physicians (eg, family care providers, physician assistants, nurse practitioners)
		• Outpatient settings
		
		<u>Excludes:</u>
		• Post-surgical pain, acute and subacute pain
		• Patients with sickle cell disease, undergoing active treatment for cancer, and palliative or end-of-life care
		• Children and teenagers (<18 years of age)
		• Inpatient settings (eg, hospitals, emergency department)

Abbreviations: CDC, Centers for Disease Control and Prevention

4.0 METHODS USED BY THE GUIDELINE TO FORM RECOMMENDATIONS

4.1 Systematic reviews

The CDC funded the Agency for Healthcare Research and Quality (AHRQ) to conduct 5 systematic reviews (SRs) to evaluate the benefits and risks of opioids, non-opioid pharmacotherapies (eg, acetaminophen, nonsteroidal anti-inflammatory drugs [NSAIDs], benzodiazepines, skeletal muscle relaxants), and nonpharmacologic interventions (eg, meditation, relaxation therapy, massage, cognitive behavioral therapy [CBT]) for the treatment of pain.[1] These 5 SRs and their key topics are as follows[1]:

1. **Skelly et al** (April 2020)[3]: noninvasive, nonpharmacologic interventions for the management of chronic pain
2. **Chou et al** (April 2020)[4]: utilization of opioids for the management of chronic pain
3. **McDonagh et al** (April 2020)[5]: non-opioid pharmacologic therapies for the management of chronic pain
4. **Chou et al** (December 2020)[6]: pharmacologic and nonpharmacologic interventions for the management of acute pain (eg, low back pain, neuropathic pain, musculoskeletal pain, dental pain)
5. **Halker Singh et al** (December 2020)[7]: pharmacologic and nonpharmacologic interventions for the management of acute episodic migraine

4.2 Quality of evidence assessment and recommendation strength

To assess the quality of evidence and to ultimately assign a recommendation category/strength, the CDC used the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach adapted from the Advisory Committee on Immunization Practices (ACIP).[1] The quality of evidence was evaluated based on study limitations, including risk of bias, confounders, robustness of results, and other determinants.[1] The evidence was assigned an "evidence type" of 1 through 4, with 1 being of highest quality.[1] Quality was based on study design and the presence or absence of significant study limitations.[1]

Based on the ACIP's adapted GRADE framework, the 2022 guideline recommendations were categorized into either category A or B (refer to **Table 2**). A recommendation category/strength was not always determined by a specific level of evidence quality.[1] Although it was preferable for strong (category A) recommendations to be based on higher quality evidence (type 1 or type 2), this was not always the case.[1] Despite the significant limitations of lower quality evidence, some category A recommendations were based on lower quality evidence of 3 or 4 and other key factors "when the advantages of a clinical action were assessed as clearly outweighing the disadvantages…" (on page 30)[1] Key factors other than evidence quality that were considered when determining an appropriate recommendation category/strength included the following[1]:

- Patient values and preferences
- Balance between the risks and benefits
- Allocation of resources (eg, spending by the patients or the healthcare system)
- Impact on equity, practicality, and acceptability

Table 2. Summary of Evidence Types and Recommendation Categories for the 2022 CDC Guideline

Guideline-assigned Evidence Types	
Type 1	"Randomized clinical trials or overwhelming evidence from observational studies"[1]
Type 2	"Randomized clinical trials with important limitations, or exceptionally strong evidence from observational studies"[1]
Type 3	"Observational studies or randomized clinical trials with notable limitations"[1]
Type 4	"Clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations"[1]
Guideline-assigned Recommendation Categories	
Category A	The recommendation usually applies to all patients, and it is encouraged for the majority to receive the recommended action
Category B	The recommendation may not apply to all patients, and it is encouraged for shared decision-making between the patient and provider to formulate an individualized plan for the patient, based on their values, preferences, and unique clinical scenario

In general, category A recommendations were intended to be used for the vast majority of patients in *most* clinical situations, whereas category B recommendations were intended for some patients.[1] Category A recommendations tended to be based on higher quality evidence, with clear delineation between benefits and harms, minimal resource allocation, and minimal susceptibility to differing values and preferences.[1] In contrast for category B recommendations, there tended to be greater ambiguity regarding whether the benefits exceeded the harms, or greater equipoise between the advantages and disadvantages.[1] Recommendations assigned to category B may not apply to all patients;[1] thus, shared decision-making incorporating the patient's values and clinical situation were encouraged to formulate an individualized plan.[1]

5.0 GUIDELINE RECOMMENDATIONS

The 2022 CDC updated guideline contained 12 recommendations on the use of opioids for acute, subacute, and chronic pain.[1] The CDC emphasized that these recommendations should not be a substitute for clinical judgement and shared decision-making, and should be considered in the context of patient-specific factors.[1] The guideline recommendations were voluntary, and should not be used to establish strict, absolute restrictions or thresholds of care, especially regarding the opioid duration or dose.[1] In addition, healthcare systems, state medical boards, and payers **"…should ensure that policies based on cautionary dosage thresholds do not result in rapid tapers or abrupt discontinuation of opioids, and that policies do not penalize clinicians for accepting new patients who are using prescribed opioids for chronic pain, including those receiving high doses of opioids."**(page 103)[1]

The 2022 updated guideline contained two new guideline recommendations: one regarding the initiation of opioids for acute pain (*recommendation #1 in Table 3)*, and the other pertaining to patients already on higher doses of opioids (*recommendation #5 in Table 3)*.[1] Other recommendations were revised to include broader language and/or the addition of acute or subacute pain.[1,2] Some recommendations had incorporated only minor revisions, with the overall recommendation unchanged from the previous 2016 version *(recommendation #3 and #8 in Table 3)*.

Subsequent sections of our review describe the updated recommendation, including a comparison between the 2016 guideline iteration (with key changes or considerations underlined), and guidance for implementing the recommendation into clinical practice. **Appendix B** includes author-identified research gaps from the 2022 updated guideline that require additional evidence.

Table 3 shows the 2022 CDC draft recommendations for opioid use, including the recommendation category, level of evidence, and whether the recommendation is new or revised from the 2016 guideline.

Table 3. 2022 CDC Guideline Update Recommendations, Including Recommendation Category, Evidence Type, and Comparison to 2016 Guideline

Recommendations[1]	Recommendation Category	Evidence Type	Comparison to the 2016 Guideline[2]
Deciding whether to start opioids for pain			
1. For the majority of acute pain conditions (eg, low back pain, tendonitis, sprains, dental extraction/pain, headaches), non-opioids are effective.[1] Opioids should only be considered for patients who have a favorable risk/benefit assessment (ie, benefits outweigh risks).[1]	B	Type 3	New
2. Nonpharmacologic and non-opioid pharmacologic treatments are preferred for subacute and chronic pain.[1] The initiation of opioids should only be considered for patients who are likely to have anticipated benefits (eg improvements in pain and function) that outweigh the associated risks.[1] Before starting opioid therapy, prescribers should counsel patients on the risks and practical benefits, set realistic patient-centered goals for functionality and pain, and provide strategies for discontinuing opioids, if needed.[1]	A	Type 2	Revised
Selecting the appropriate opioid and dosage			
3. Prescribers should start with immediate-release opioids rather than extended-release or long-acting opioids for the initial treatment of acute, subacute, or chronic pain.[1]	A	Type 4	Revised[a]
4. The lowest effective dose should be used when starting opioids for the treatment of acute, subacute, or chronic pain in opioid-naïve patients.[1] When continuing opioid therapy in patients with subacute or chronic pain, prescribers "should use caution when prescribing opioids at any dosage,"[1] should evaluate patient-specific factors when determining to escalate the dose, and should avoid exceeding dosages that expose the patient to a greater amount of harm relative to the potential benefits.[1]	A	Type 3	Revised
5. For patients who have been taking higher opioid doses, prescribers should consider the individual's benefit/risk profile, and exert diligence when reducing or maintaining the high opioid dose.[1] For situations in which continued opioid therapy is associated with greater risk than benefit, prescribers "should optimize other therapies"[1] and collaborate with the patient to slowly taper the opioid to a lower dose or to ultimately discontinue the opioid, depending on the patient's clinical scenario.[1] Prescribers should not suddenly discontinue opioids, nor dramatically decrease higher opioid doses, except when there are signs of a life-threatening problem (eg, overdose).[1]	B	Type 4	New

"New" recommendations were those that were not included in the previous 2016 guideline; "Revised" recommendations were those in which the wording was broadened and/or included additional pain symptom durations previously excluded in the 2016 guideline

[a] Recommendation contains minor revisions, with the overall recommendation unchanged from the previous 2016 iteration
Abbreviations: CNS, central nervous system depressants; PDMP, prescription drug monitoring program

Table 3. 2022 CDC Guideline Update Recommendations, Including Recommendation Category, Evidence Type, and Comparison to 2016 Guideline

Recommendations[1]	Recommendation Category	Evidence Type	Comparison to the 2016 Guideline[2]
Duration of opioid therapy and follow-up			
6. When opioids are prescribed for acute pain, prescribers should not supply a quantity greater than required for the anticipated duration that opioid therapy has been deemed necessary for severe pain management.[1]	A	Type 4	Revised
7. After starting opioid therapy for subacute or chronic pain, or upon increasing the dose, prescribers should follow-up with patients within 1–4 weeks to assess the therapeutic benefits and risks.[1] Prescribers should follow-up with all their patients on long-term opioid therapy, at intervals of no more than 3 months, to re-evaluate the benefits and risks of long-term opioid therapy.[1]	B	Type 4	Revised
Evaluating opioid-related risks and potential harms			
8. Prescribers should assess and counsel patients regarding opioid-related risks prior to initiating and during opioid therapy.[1] Prescribers should work collaboratively with patients to integrate techniques to minimize opioid-related risks into the treatment plan, such as offering naloxone to patients who have an increased risk of opioid overdose.[1]	A	Type 4	Revised[a]
9. Before starting opioid therapy, regardless of pain chronicity, prescribers should inspect the patient's use of controlled substances by checking the state PDMP to determine if the patient is at a high risk of opioid overdose (based on dosage or combination of agents). This risk assessment should be done occasionally during the management of chronic pain with opioids.[1]	B	Type 4	Revised
10. Prescribers should consider toxicology screening to evaluate the presence or absence of prescribed medications, as well as other controlled substances (illicit and prescribed) when using opioids for subacute or chronic pain.[1]	B	Type 4	Revised
11. Prescribers should cautiously co-prescribe benzodiazepines, and other CNS depressants with opioids, taking into account the therapeutic benefit outweighs the risk.[1]	B	Type 3	Revised
12. Prescribers should recommend or arrange for pharmacologic treatment to assist patients suffering from opioid use disorder.[1]	A	Type 1	Revised

"New" recommendations were those that were not included in the previous 2016 guideline; "Revised" recommendations were those in which the wording was broadened and/or included additional pain symptom durations previously excluded in the 2016 guideline

[a] Recommendation contains minor revisions, with the overall recommendation unchanged from the previous 2016 iteration
Abbreviations: CNS, central nervous system depressants; PDMP, prescription drug monitoring program

5.1 Deciding whether opioids should be started for pain

A new 2022 guideline recommendation stated that for most acute pain conditions (eg, low back pain, tendonitis, sprains, dental extraction/pain, headaches), non-opioids are effective ***(recommendation #1 in Table 3****; category B)*.[1] This recommendation was of category B, meaning that it may not be appropriate for some patients, as opioids may be vital for patients suffering from severe acute pain related to traumatic injuries (eg, burns, vehicular accidents), moderate-to-severe postsurgical pain, or other acute conditions in which non-opioid therapies (eg, NSAIDs, acetaminophen) are likely to be ineffective for pain management or are contraindicated.[1] Whenever possible and depending on the specific clinical condition, prescribers should optimize nonpharmacological interventions (eg, ice, heat, exercise, elevation) and non-opioid pharmacotherapies, while not excluding the possibility of opioid therapy.[1]

For chronic pain management, both the 2016 and 2022 guideline shared a similar stance that "opioids should not be considered first-line or routine therapy…" (on page 76).[1,2] Both guidelines favored nonpharmacologic treatments (eg, exercise, spinal manipulation, massage, acupuncture, CBT) and non-opioid treatments (eg, NSAIDs, duloxetine) whenever possible in chronic pain management, which the 2022 update also extended to subacute pain ***(recommendation #2 in Table 3****; category A)*.[1,2] However, the 2022 guideline mentioned that this should not be construed to mean that patients should be required to fail non-opioid pharmacologic treatments and nonpharmacologic interventions, or be strictly required to have a trial of any other specific treatment prior to initiating opioid therapy.[1,2] Instead, the decision to initiate opioids should be based upon anticipated benefits and risks of opioid therapy, taking into account the patient's unique clinical situation.[1,2] The initiation of opioids should only be considered for patients who are likely to have benefits (eg, improvements in pain and function) that exceed anticipated risks.[1,2] Although the 2016 guideline recommended that non-opioid interventions should be used with opioids, if appropriate, the 2022 update no longer included this information in the recommendation.[1,2]

5.2 Selecting the appropriate opioid and dosage

The recommendation to prescribe immediate-release opioids rather than extended-release or long-acting opioids when initiating opioids for chronic pain remained unchanged between the 2016 and 2022 guideline,[1,2] but the updated version extended this recommendation to acute and subacute pain ***(recommendation #3 in Table 3****; category A)*.[1] Extended-release/long-acting opioids should be prescribed on a scheduled basis (eg, not intermittently or as-needed) and should be reserved for patients presenting with severe, persistent pain.[1] Extended-release formulations should not be used for acute pain.[1]

When switching from an immediate-release to an extended-release formulation, prescribers should review the product labeling, and decrease the total daily opioid dose due to partial opioid cross-tolerance.[1,2] For patients with hepatic or renal insufficiency, extended-release opioids should be used cautiously, and an extended dosing interval should be considered due to the potential for drug accumulation.[1,2] Due to the unpredictable pharmacokinetic and pharmacodynamic profile, methadone and transdermal fentanyl should be prescribed by experienced physicians familiar with the unique counseling and monitoring parameters to ensure patient safety.[1,2] Furthermore, methadone should not be prescribed as an initial option for an extended-release opioid.[1,2]

The 2016 and 2022 guidelines were generally consistent in recommending that the lowest effective dose should be used when starting opioids for the treatment of pain in opioid-naïve patients *(**recommendation #4 in Table 3**; category A)*.[1,2] Both guidelines recommended that prescribers "should use caution when prescribing opioids at any dosage," (on page 95)[1] and should evaluate patient-specific factors when determining to escalate the dose.[1,2] The 2016 guideline included specific dose limitations of daily morphine milligram equivalent (MME) thresholds such as recommending cautious prescribing of total daily doses ≥50 MME, and to avoid or cautiously escalate to daily doses ≥90 MME; however, the 2022 guideline removed dosage thresholds from the recommendation.[1,2] Instead, the updated guideline recommended to avoid doses that may expose the patient to greater harm relative to the potential benefits.[1]

Although not explicitly stated in the recommendation, the 2022 update provided therapeutic considerations regarding opioid dosage thresholds.[1] The considerations are **not** meant to be strict restrictions or thresholds on appropriate care.[1] Instead, they are intended to guide shared decision-making between the prescriber and the patient when initiating opioids or increasing the dose.[1] Key considerations/guidance for selecting an opioid dose included:

- "The lowest starting dose for opioid-naïve patients is often equivalent to a single dose of approximately 5 to 10 MME or a daily dosage of 20−30 MME/day." (on page 96)[1]
- Prescribers should carefully evaluate individualized benefits/risks, including clinical diagnosis, benefits and risks associated with prior dose escalation, effectiveness of other treatments, and the patient's preferences/values before increasing to total daily doses that are ≥50 MME.[1] If the dose were increased to ≥50 MME per day, prescribers should proceed gradually and escalate based on the lowest, most sensible increment,[1] due to the dose-response relationship of opioid overdose risk.[2]

The 2022 guideline recommended that for patients on higher doses of opioids, prescribers should consider the individualized benefits/risks, and exert diligence when maintaining or reducing high opioid dosages *(**recommendation #5 in Table 3**; category B)*.[1] For individuals on longer-term opioid therapy, the prescriber should collaborate with the patient to determine the best option before implementing any changes to the treatment regimen.[1] If opioid therapy was associated with greater risks than benefits, it was suggested to slowly taper to a lower opioid dose, or ultimately discontinue the opioid.[1] The following are examples in which the risks of continued opioid therapy may outweigh the benefits, and may warrant opioid de-escalation or discontinuation, if feasible[1,2]:

- Relative to the time before opioids were started, the patient no longer experiences sustained, meaningful benefits in function and pain
- Patient no longer experiences any improvement on high-risk opioid regimens (eg, taking a combination of opioids with benzodiazepines, or total daily doses ≥50 MME)
- The patient perceives that the risks outweigh the benefits, or desires to reduce the dose of their opioid or completely discontinue it
- A serious adverse effect or overdose occurred

A shared decision process should be used when determining the tapering plan, such as the duration of the taper, and when halting the taper would be appropriate.[1] The taper should be gradual (typically, ≤10% each month) to reduce the risk for opioid withdrawal symptoms (eg, insomnia, vomiting,

mydriasis, tremor, anxiety), and improve tolerability.[1,2] During the taper, prescribers should pay attention to signs and symptoms of depression, anxiety, and opioid use disorder or misuse, and provide or organize the appropriate care to manage these conditions.[1] For patients actively tapering down their opioid dosage, prescribers should routinely follow-up (at least on a monthly basis) with their patient.[1] After the lowest dose has been achieved, the dosing frequency can be decreased.[1,2] For patients who desire to discontinue their opioid, the short-acting opioid may be completely stopped once the patient has taken it less than once per day.[1,2] Prescribers should not abandon patients,[1] nor should prescribers suddenly discontinue or dramatically decrease high opioid doses, *except* when there are signs of a life-threatening problem (eg, overdose) that may impact patient safety.[1,2]

5.3 Duration of opioid therapy and follow-up

The 2016 guideline was consistent with the updated guideline in recommending that prescribers should not supply an opioid quantity exceeding the duration needed to appropriately manage the severe acute pain condition *(**recommendation #6 in Table 3**; category A)*.[1,2] Unlike the 2016 guideline that included additional details about the expected duration (≤3 days, and in rare cases, >7 days) for acute pain management, the 2022 guideline recommendation did not specify these thresholds.[1,2] Instead, the 2022 iteration advised that opioid durations should be individualized to each patient's unique clinical situation; nonetheless, the guideline also pointed out that a few days or less of opioid therapy was often adequate for common, nontraumatic, nonsurgical acute pain requiring opioid therapy.[1] For short durations of opioid therapy, a taper was less likely to be needed to avoid withdrawal symptoms upon opioid discontinuation.[1,2] In the event opioids are used for ≥1 month, prescribers should refer to follow-up and tapering recommendations (*recommendation #7 and #5, respectively in Table 3*) for subacute and chronic pain.[1] Follow-up at least every 2 weeks was recommended for patients receiving continued opioids for acute pain.[1]

Both iterations of the CDC guideline recommended that prescribers follow-up with chronic pain patients within 1–4 weeks after starting opioid therapy, or after increasing an opioid dose to assess the therapeutic benefits and risks,[1,2] and the updated guideline expanded this recommendation to patients with subacute pain *(**recommendation #7 in Table 3**; category B)*.[1] Prescribers should follow-up regularly, in intervals of no more than 3 months, with all of their patients on long-term opioid therapy (regardless of patient status to the prescriber [eg, new, established]) to re-evaluate the benefits and risks.[1,2] The following considerations presented in the 2022 update should be used as guidance for the frequency of follow-up visits[1]:

- Follow-up visits may consist of evaluating whether existing opioid therapy continues to satisfy therapeutic patient-centered goals, including lasting benefits in function and pain; identifying of any adverse events (serious or common [eg, sedation, drowsiness]), including early warning signs for serious adverse events (eg, slurred speech); and identifying symptoms of opioid use disorder (eg, cravings, trouble controlling frequency or amount of opioid taken, issues with family or work caused by opioid use).[1,2]
    - Follow-up to monitor side effects may occur more frequently in individuals with hepatic/renal dysfunction, substance use disorder, prior history of overdose, or for older adults.[1,2]
    - In remote geographic regions or in situations that may cause in-person visits to be difficult, follow-up evaluations via telehealth may be used.[1]

- When initiating immediate-release opioids at a total daily dose of <50 MME, an initial follow-up closer to 4 weeks may be appropriate.
- Given the increased risk of opioid overdose, especially during the first 2 weeks of starting therapy,[2] patients receiving extended-release/long-acting opioids should be followed-up more frequently when they are initiated or escalated, or when the total daily dose is ≥50 MME.[1,2]
    - Due to methadone's unpredictable half-life, consideration of a shorter follow-up duration (within 3 days) is strongly advised when initiating or escalating the dose.[1,2]
- It is advised that follow-up for re-evaluation of continued opioid therapy should occur more often than every 3 months for patients with an increased risk of opioid use disorder or overdose (eg, patients with comorbid depression or other psychiatric illnesses, a history of overdose or substance use disorder, concomitant use of opioids with other central nervous system [CNS] depressants, or total daily doses ≥50 MME).[1,2]

5.4 Evaluating opioid-related risks and potential harms

The update did not change the 2016 recommendation that prescribers should assess and counsel patients about opioid-related risks and should work with patients to integrate techniques to minimize these risks into the treatment plan, such as offering naloxone ***(recommendation #8 in Table 3**; category A)*.[1,2] Although not explicitly included in the recommendation like the 2016 guideline,[2] as guidance in the explanatory text, the 2022 update listed the following patients as candidates for being offered naloxone due to their increased risk of opioid overdose[1]:

- Individuals who previously experienced an overdose, or have been diagnosed with a substance use disorder
- Individuals with sleep-disordered breathing (eg, sleep apnea)[1]
    - In patients with moderate or severe sleep-disordered breathing, prescribers should avoid using opioids whenever feasible, to mitigate the potential risk for opioid-related overdose.[1,2]
- Individuals receiving higher daily opioid doses (eg, total doses ≥50 MME)
- Patients receiving a combination of opioids with benzodiazepines
- Patients at risk of resuming a higher dose for which they no longer have tolerance (eg, individuals undergoing an opioid taper)

Moreover, recommendation #8 stated that naloxone should be *offered*, and that healthcare organizations, prescribers, and payers should have mechanisms in place (eg, collaborative practice agreements, standing orders, or clinics able to co-prescribe with appropriate training) to ensure patients have accessibility to this potentially lifesaving agent.[1]

Both guideline versions recommended prescribers to inspect patient use of controlled substances by checking the state's prescription drug monitoring program (PDMP) when initiating opioid therapy for chronic pain (revised to also include acute and subacute pain in the updated guideline), and occasionally during ongoing opioid treatment to help determine whether the patient is high-risk for overdose (eg, higher opioid dosages, riskier medication combinations) ***(recommendation #9 in Table 3**; category B)*.[1,2] The category B classification served to acknowledge differences in PDMP accessibility and availability depending on state jurisdictions and healthcare settings; however, when possible, this recommendation

is advised to be applied to all patients rather than selecting patients based on assumptions.[1] The recommendation has been revised to no longer state a particular frequency for checking the PDMP (eg, "every prescription to every 3 months"[2] in the 2016 version), but instead, provided the following guidance in the explanatory text[1,2]:

- During long-term opioid therapy, the PDMP should be examined prior to starting opioid therapy, and at least every 3 months, at a minimum.[1]
- PDMP-generated risk scores should not be a substitute for clinical judgement, and are not validated for safety outcomes, including overdose.[1]
- For patients receiving opioids from ≥1 prescriber with high daily dosages of opioids based on MME (excluding buprenorphine due to the "ceiling effect on respiratory depression"[1]), or that are receiving a high-risk pharmacologic combination (eg, opioids with benzodiazepines), the patient should be counseled on safety concerns and offered naloxone, along with a shared decision approach to taper the opioid based on the patient's preference, if applicable.[1,2]
- Patients should not be abandoned based on the PDMP information due to the potential for patient harm,[2] and missed opportunities for lifesaving education and treatment.[1,2]
- PDMP data should be used in the context of other information (eg, observational testing, history and physical examination results) to optimize the safety of the patient.[1]

In the event the prescriber has clinical suspicion that the patient may be diverting opioids (eg, sharing or selling opioids), toxicology screening should be considered.[1]

Both CDC guidelines (2016 and 2022) recommended laboratory testing to evaluate the presence or absence of prescribed medications, along with other controlled substances (illicit and prescribed) when using opioids for chronic pain *(**recommendation #10 in Table 3**; category B)*.[1,2] However, the update contained changes regarding the duration of pain, type of toxicology screening test, and frequency of toxicology testing: (1) considerations applied to subacute pain in addition to chronic pain; (2) the 2016 guideline specifically recommended urine drug screening whereas, the 2022 guideline generally recommended any screening test for toxicology; and (3) a recommended toxicology testing frequency was no longer specified, unlike the 2016 guideline which recommended urine drug screening at predetermined intervals (ie, prior to initiating opioids and at least yearly).[1,2] The following includes additional guidance from the 2022 guideline regarding toxicology screening[1]:

- Toxicology screening should be considered before initiating opioid therapy and occasionally during the use of opioids to evaluate the risk of overdose.[1]
- Patients should not be abandoned based on their toxicology screening results due to the potential for patient harm (eg, unsafe practices to acquire opioids from alternative sources, missing opportunities for substance use disorder treatment, stigmatization).[1,2] Toxicology results should be explicitly expressed to the patient.[1,2]
- Cost-effective options exist (eg, immunoassay panel) to test toxicology for opiates and benzodiazepines, as drug classes, along with numerous other illicit substances.[1,2]
    - Given the additional expense, confirmatory testing (eg, gas or liquid chromatography[1]) should be used in particular situations to detect certain opioids that may impact patient care such as those undetectable by standard immunoassay panels, or in the event of unanticipated results that are unexplained by the patient.[1,2]

- Unanticipated toxicology results should be used to enhance patient safety, including the following examples, as needed:
  - Adjust the pain management regimen *(recommendation #2 in Table 3)*
  - Consider the individualized benefits/risks of reducing or maintaining the current opioid dose *(recommendation #5 in Table 3)*
  - Consider arranging more frequent following-up visits *(recommendation #7 in Table 3)*
  - Consider offering naloxone *(recommendation #8 in Table 3)*
  - Recommend and coordinate treatment for substance use disorder *(recommendation #12 in Table 3)*

Regarding the recommendation for co-prescribing opioids with benzodiazepines ***(recommendation #11 in Table 3****; category B)*, in contrast to the previous 2016 iteration that recommended avoiding such combination whenever feasible,[2] the updated guideline more explicitly acknowledged that situations may exist where opioid/benzodiazepine combination use may be clinically appropriate.[1] Regardless, the combination of opioids with benzodiazepines or other CNS depressants (eg, non-benzodiazepine hypnotics, muscle relaxants, sedating antiepileptic agents) should be used carefully.[1] The decision to initiate or continue concomitant therapy should be based on individualized risks/benefits.[1]

If the risks of concomitant benzodiazepine and opioid therapy become more prominent than the therapeutic benefits, and a shared decision to taper has been decided, it may be more suitable to taper the opioid before the benzodiazepine due to the lower relative risk of withdrawal and anxiety symptoms associated with opioid tapers compared to benzodiazepines.[1,2] Sudden discontinuation of benzodiazepines can cause withdrawal symptoms including hallucinations, seizures, rebound anxiety, delirium tremens, some of which may be fatal.[1,2] Thus, discontinuation requires gradual tapering tailored to the individualized patient.[1,2]

Both iterations of the CDC guideline (2016 and 2022) recommended that prescribers offer or organize pharmacologic treatment for patients suffering from opioid use disorder ***(recommendation #12 in Table 3****; category A)*.[1,2] Although the 2022 guideline did not indicate which pharmacologic treatments should be offered in this recommendation, the older 2016 guideline specified buprenorphine or methadone, in combination with behavioral interventions as a treatment for opioid use disorder.[1,2] In the presence of clinical suspicion for opioid use disorder, the prescriber should have open-communication with the patient regarding any concerns or issues, and should appropriately diagnose the condition based on criteria from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5).[1,2,8]

To ensure adequate opportunity for treatment, it is advised that all prescribers acquire a waiver to prescribe buprenorphine, especially prescribers working in communities with minimal resources for treatment.[1] It is not advised for prescribers to abandon their patients based on the manifestation of opioid use disorder due to the negative impact on patient safety.[1,2] Pharmacotherapy for opioid use disorder has been shown to decrease the risk of overdose and overall deaths, enabling the prescriber to start potentially lifesaving therapies upon diagnosis.[1,2] It is vital for the prescriber to collaborate with the patient to enhance the chance of successful recovery.[1,2] Prescribers unable to provide opioid use disorder treatment should coordinate the transfer of care to a specialist (eg, naltrexone treatment provider, SAMHSA certified opioid treatment program).[1,2]

6.0 CONSIDERATIONS FOR IMPLEMENTING RECOMMENDATIONS

Similar to the 2016 guideline,[2] the 2022 update contained considerations for implementing the recommendations, which were intended to guide shared decision-making and were **not** created to be strict criteria that require enforcement.[1] The 2022 update added the following 5 guiding principles to inform implementation of the recommendations[1]:

1. Whether or not opioids are included in the treatment regimen, pain (acute, subacute, and chronic) should be appropriately managed.
2. Recommendations are voluntary and should be used to supplement patient-centered care. It is vital to remain versatile in fulfilling the specific care needs of the patient based on their individualized clinical situation.
3. A critical component of pain management for all patients is implementing a multidisciplinary approach addressing physical and behavioral health, "long-term services and supports" (page 209)[1], anticipated health outcomes, and overall wellness.
4. Careful attention should be employed to avoid misinterpreting the guideline beyond its intended purpose, or potentially causing inadvertent patient harm from policies allegedly derived from the guideline.
5. For all patients, healthcare organizations and medical professionals, including payers and prescribers should address health-related disparities, "provide culturally and linguistically appropriate communication" (page 209)[1], including communication mechanisms for patients with disabilities, and guarantee accessibility to appropriate, coordinated, inexpensive, effective, and various treatment options (nonpharmacologic and pharmacologic therapies) for pain.

6.1 Key implementation considerations:

- Prescribers should use shared decision-making in collaboration with the patient when determining to initiate opioid therapy, especially if the patient is pregnant,[2] and counsel patients on the anticipated benefits, risks, and alternative options prior to initiating or continuing opioid treatment.[1]
  - Before initiating opioids, prescribers should provide patient education and discuss the patient's values and preferences to guide clinical decisions.[1]

- Prescribers should review product labeling, including black box warnings prior to starting any pharmacologic treatments, and appropriately evaluate the therapeutic risks and benefits.[1]
  - For opioid-naïve patients, product labeling may be used as a starting point to determine the lowest effective dose based on patient-specific factors such as pain severity, older age (≥65 years), and hepatic/renal function, as needed.[1,2]

- When initiating opioid therapy, prescribers should consider a collaborative approach with the patient to determine an "exit strategy" in the event opioids need to be discontinued.[1]
- Opioid-related risks, including overdose, increase as the dosage is escalated; there is no dosage limit that marginalizes the associated risks of using opioids.[1,2]
- Prescribers should ensure that comorbidities such as depression that may impact pain are adequately treated, and seek advice from behavioral health specialists when appropriate.[1,2]

7.0 DISCUSSION TOPICS FOR POTENTIAL MODIFICATION OF OPIOID POLICIES BY THE PAYER

Currently, the 2022 CDC guideline recommendations may not be finalized since the guideline is a draft.[1] The board may wish to consider whether policy changes would be appropriate based solely on the 2022 draft guideline recommendations, and whether such changes are appropriate for the Utah Medicaid patient population.

Refer to **Appendix C** for the Utah Medicaid Opioid and/or Opioid-Benzodiazepine Combination Prior Authorization (PA) form updated January 1, 2022. **Table 4** summarizes Utah Medicaid's key opioid prescribing policies that limit the opioid dosage or day supply.

Table 4. Summary of Select Utah Medicaid Opioid Prescribing Policies as of July 11, 2022

Policy Referent #	Description
I	Cumulative morphine equivalent dosing (MED; based on morphine milligram equivalents for any combination of opioids) threshold for adjudicating opioid prescription claims for the treatment of non-cancer pain: 90 MED[a] The 90 MED is the prescribing limit at which the claim rejects at the point of sale unless a prior authorization for the prescription has been approved. • 90 MED cumulative limit is applied to all patients regardless of their opioid prescription history (or opioid tolerance) in the prior 90 days • Exceeding 90 MED may be accessible through the prior authorization process Most Utah Medicaid PDL-preferred and non-preferred opioids are also subject to quantity limits[b]
II	Limits on the initial opioid fill (ie, no opioid fill within 60 days of the index opioid prescription) of a short-acting opioid[c]: • 3-day supply limit for dental prescribers • 7-day supply limit for all other prescribers Prior authorization is required to access an initial fill supply of ≥7 days
III	Starting a long-acting opioid requires[c]: • Filling a short-acting opioid first (in the prior 30 days) **OR** prior authorization with rationale for not receiving a recent short-acting opioid • Trial and failure of ≥2 classes of non-opioid pain medications[d]

Key:

[a] Based on the Utah Medicaid Pharmacy Services Provider Manual, last updated April 2022. The 90 MED limit was implemented in July 2020 after reducing from an initial limit of 180 MED for people with opioid use in the prior 90-day period. A 90 MED limit is also applied for people without opioid use in the previous 90 days.

[b] According to the Utah Medicaid Preferred Drug List as of July 1, 2022

[c] According to the Utah Medicaid Opioid and/or Opioid-Benzodiazepine Combination prior authorization form, last updated January 1, 2022.

[d] Based on our interpretation, it is unclear the exact population to which this requirement applies (ie, all patients or only patients without a short-acting opioid claim in the previous 30 days)

Regarding referent policy I (maximal cumulative 90 MED), Utah Medicaid currently employs a pharmacy hard stop for prescriptions exceeding 90 cumulative MED for non-cancer pain, unless a PA has been

approved, and regardless of the patient's prior opioid use in the previous 90-day period.[9] Given the removal of a strict threshold in the 2022 CDC guideline (see details below), the board may wish to discuss this limit and whether changes should be considered.

a. The 2022 CDC guideline emphasizes not to suddenly discontinue patients from an opioid medication by stating that payers **"…should ensure that policies based on cautionary dosage thresholds do not result in rapid tapers or abrupt discontinuation of opioids…"** (page 103)[1]
    i. Since a PA is seldom approved on the initial day of need (ie, the day the prescriber writes the prescription), this may create scenarios in which exacerbation of pain cannot be treated promptly. A delay in access to the opioid prescription while awaiting approval of the dose above the 90 MED limit may have negative consequences on patient care (eg, opioid withdrawal). Prescribers may not be able to predict the day on which a patient may require a higher dosage into the range above 90 MED, thus practitioners may not be able to pre-emptively submit a PA. Additionally, it is unclear if Utah Medicaid allows approval of a PA pre-emptively, prior to the time a patient needs a higher opioid dosage.
b. Based on our interpretation of the 2022 CDC guideline, there is no daily MED threshold that can be used as an overall approach to justify strict dosage restrictions (or coverage denials) for patients who require opioids for pain management. Rather, patient-specific factors must be considered. While the 2022 CDC guideline advises to exercise caution above 50 MME per day, these cautionary ranges do not serve as strict thresholds at which providers must abandon anticipated benefits of pain management for their patient.[1]
    i. "The recommendations related to opioid dosages are not intended to be used as inflexible, rigid standard of care; rather, they are intended to be guideposts to help inform clinician-patient decision making." (page 96)[1]
c. An alternative to the hard stop at pharmacies for prescriptions exceeding the 90 MED threshold, if feasible, is a retrospective DUR (eg, retrospective patient interview by a qualified Utah Medicaid employee). This may be the best approach to ensure patients are not abruptly denied access by the payer to ongoing therapy (or adjustments in opioid therapy).

Regarding referent policy II (initial duration limit for short-acting opioids), policy changes may not be needed; however, since the 2022 guideline removed the suggested 3- and 7-day duration thresholds from the recommendation included in the 2016 guideline, now favoring an individualized approach, the board may wish to discuss whether changes to this policy should be considered.

a. The 2022 CDC draft guideline advised that opioid durations should be individualized based each patient's unique clinical situation.[1] However, the guideline commented that most nontraumatic, nonsurgical acute pain cases required opioid treatment for a few days or less.[1] It is unclear what percentage of initial opioid fills in the Utah Medicaid population are for nontraumatic or nonsurgical acute pain, and how many patients outside this category may require longer initial fill durations. Nonetheless, the current policy allows for a patient to receive an additional supply of an opioid after the initial 3 or 7 day limit; thus, the policy does not ultimately withhold care.
b. The 2016 guideline is consistent with the updated guideline regarding the recommendation that prescribers should not supply a quantity greater than required for the anticipated duration that opioid therapy has been deemed necessary for severe acute pain management.[1,2]

Regarding referent policy III (starting short-acting opioids prior to long-acting opioids), this policy is in agreement with the 2022 guideline recommendations, so it may be reasonable to maintain this criteria. However, the board may consider being less strict on the requirement of members having to fail ≥2 non-opioid classes (ie, NSAIDs, non-opioid analgesics, antidepressants, or anticonvulsants) before proceeding to long-acting opioids.[*]

a. Similar to the previous 2016 guideline recommendation, the 2022 update recommended that prescribers start with immediate-release opioids rather than extended-release or long-acting opioids for the treatment of acute, subacute, or chronic pain.[1]
b. The 2022 CDC guideline highlights that "opioids should not be considered first-line or routine therapy for subacute or chronic pain"(page 76)[1] and that nonpharmacologic and non-opioid treatments are preferred.[1,2] However, it is not intended to mean that patients should be required to fail non-opioid pharmacologic treatments and nonpharmacologic interventions, or be strictly required to have a trial of any other specific treatment prior to initiating opioid therapy.[1,2] Instead, the decision to initiate opioids should be tailored based on the patient's unique clinical situation, weighing the anticipated benefits with the risks.[1]

Additional considerations

For context, if feasible and upon the discretion of Utah Medicaid, it may be of interest for Utah Medicaid to share the following data with the DUR board:

a. Number of rejected pharmacy claims in the last 6 months for opioid prescriptions that caused the patient to exceed the 90 MED threshold. These are scenarios in which the patient was unable to receive the prescribed therapy, requiring a PA to be submitted.
b. Proportion of rejected pharmacy claims that were followed by an approved PA for the medication within 30 days after the indexed rejected claim, and the mean duration from the time of prescription rejection to PA approval.
c. Number of patients with a PA approved for >90 MED in the previous 6 months

[*] *Based on our interpretation, it is unclear from the prior authorization form if all members are required to fail ≥2 non-opioid classes before proceeding to long-acting opioids, or only members that did not receive a short-acting opioid in the prior 30 days. Nonetheless, the consideration to be less strict on the failure requirement of non-opioids may be valid for either situation.*

8.0 SUMMARY

This report summarized the *draft* 2022 Centers for Disease Control (CDC) guideline, updated from the 2016 guideline for prescribing opioids for chronic pain. The scope of the 2022 CDC guideline expanded the target patient population to adults (≥ 18 years of age) with acute, subacute, or procedural-related pain, in addition to chronic pain.[1] The target prescribers were also expanded to include other prescribers working in outpatient settings or that discharge patients from inpatient facilities.[1] Target populations considered outside of the scope of both the 2022 and 2016 guidelines included pediatrics patients, pain related to sickle cell disease, cancer-related pain in patients receiving cancer treatment, and patients receiving palliative or end-of-life care.[1,2] The 2022 draft guideline emphasized the potential harm that can arise from overly rigid application of the recommendations, and encouraged prescribers to use their clinical judgement and shared decision-making with the patient when implementing recommendations.[1]

There were 2 new recommendations in the 2022 guideline: one that remarked on the preference of non-opioids for most acute pain cases, and one that recommended considering individualized benefits/risks when maintaining or reducing high opioid dosages.[1] Other recommendations were revised to include broader language and/or the addition of acute or subacute pain.[1,2] Some recommendations had incorporated minor revisions, but the overall recommendation remained similar to the 2016 version.[1,2]

Key changes in the 2022 guideline compared to the 2016 guideline included the following (see **Table 3**):

New recommendations:

- For the majority of acute pain conditions (eg, low back pain, tendonitis, sprains, dental extraction/pain, headaches), non-opioids are effective.[1] Consider opioids if the benefits outweigh the risks.[1]
- For patients already taking higher doses of opioids, prescribers should consider the individual's benefit/risk profile, and exert diligence when reducing or maintaining high opioid dosages.[1]

Major revisions:

- The 2016 guideline included limitations based on daily MME thresholds such as recommending cautious prescribing of total daily doses ≥50 MME, and to avoid or cautiously escalate to daily doses ≥90 MME; however, the 2022 guideline no longer specified dosage thresholds in the recommendation.[1,2] Instead, the 2022 guideline more generally recommended to avoid exceeding doses that may expose the patient to a greater amount of harm relative to the potential benefits.[1]
- Unlike the 2016 guideline that included additional details about the expected duration (≤3 days, and in rare cases, >7 days) for acute pain management, the 2022 guideline recommendation did not specify these thresholds.[1,2] Instead, the 2022 iteration advised that opioid durations should be individualized to each patient's unique clinical situation; nonetheless, the guideline also pointed out that a few days or less of opioid therapy was often adequate for nontraumatic, nonsurgical acute pain requiring opioid therapy.[1]

Based on the 2022 CDC draft guideline, we provided guidance as to which Utah Medicaid opioid policies may warrant consideration for change based on the board's discretion. The current policies include multiple components: we considered the policy for a cumulative maximal dose of 90 MED potentially disrupting care to patients while awaiting processing of a PA, the duration limits for an initial fill of a short-acting opioid prescription (ie, 3-day supply for dental prescribers and 7-day supply for all other

prescribers), and the requirement for starting a short-acting opioid and the patient's non-opioid history prior to using a long-acting opioid. Since the 2022 CDC guideline is still a draft, we suggest confirming any differences with the finalized guideline before serving as the basis for implementing policy changes.

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APPENDIX A – SUPPLEMENTAL INFORMATION

Other useful guidelines for the management of pain that were not reviewed in this report, but that were mentioned in the 2022 CDC update for prescribing opioids, were:

1. Pain related to cancer
   a. National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology: Adult Cancer Pain[10]
   b. NCCN Clinical Practice Guidelines in Oncology: Survivorship[11]
   c. Management of Chronic Pain in Survivors of Adult Cancers: American Society of Clinical Oncology (ASCO) Clinical Practice Guideline[12]

2. Sickle cell disease pain
   a. American Society of Hematology (ASH) 2020 Guidelines for Sickle Cell Disease: Management of Acute and Chronic Pain[13]

3. Opioid use disorder
   a. The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update[14]

The following website resources were also mentioned in the 2022 CDC update guideline:

- Opioid prescribing recommendations, including for pediatrics: https://michigan-open.org/prescribing-recommendations/[15]
- Prescribing naloxone: https://prescribetoprevent.org/[16]
- Opioid overdose and naloxone information: https://www.samhsa.gov/[17,18]
- SAMHSA's Providers Clinical Support System https://pcssnow.org/[19]

APPENDIX B – REMAINING RESEARCH GAPS NOTED IN THE 2022 UPDATED GUIDELINE

The authors from the 2022 updated guideline identified several research gaps requiring additional evidence, including but not limited to, the following[1]:

- Efficacy of existing screening tools to evaluate the risk or development of opioid use disorder and misuse
- Cultural, social, and moral stigmatization as a barrier for seeking treatment of an opioid use disorder and for seeking pain management
- "Effective management of patients on high dose opioids; the application of multidisciplinary and multimodal models of pain treatment, and service delivery modalities including telehealth." (page 166)[1]
- Comparative effectiveness of long-term evidence for pharmacotherapies and nonpharmacologic interventions
- Evaluation of non-pain outcomes, outcomes for pain associated with specific illnesses, and the assessment of whether risks/benefits differ between subgroups
- Ensuring that pain management and opioid prescribing practices fulfill the requirements for special populations, including those in rural communities, older adults, and various racial/ethnic groups
- Improving patient and prescriber education on the use of opioids for pain management
- Care coordination and transitioning care methods from acute to chronic pain

APPENDIX C – EXISTING PRIOR AUTHORIZATION REQUEST FORM

Opioid and/or Opioid-Benzodiazepine Combination

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	□ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992,** to prevent processing delays.	

Short-Acting Opioids: *Prior Authorization may not be required if member has filled initial script of the same medication for a 7-day supply or 3-day for dental providers.*

□ Clinical rationale for member not receiving initial 7-day fill:

_____ Chart Note Page #: _____

Long-Acting Opioids: *Prior Authorization may not be required if member has filled short acting opioid within 30 days of initiating therapy on a long-acting opioid.*

□ Clinical rationale for member not receiving short acting opioid in past 30 days:

_____ Chart Note Page #: _____

□ Non-opioid pain medication history. Member is using or has tried and failed at least two of the following NSAIDs, non-opioid analgesics, antidepressants, or anticonvulsants.

Medication: _____ Chart Note Page #: _____

Details of failure (including duration): _____

Medication: _____ Chart Note Page #: _____

Details of failure (including duration): _____

Dose, Age, Pregnancy, MME and/or Quantity Limits Exception Criteria for Approval: *Taper plan must be provided for all limit exception requests.*

□ Clinical rationale for member under 18 years of age receiving long-acting opioid or more than 7-day supply short-acting opioid:

_____ Chart Note Page #: _____

□ Clinical rationale for pregnant member receiving long-acting opioid or more than 7-day supply short-acting opioid:

_____ Chart Note Page #: _____

□ Clinical rationale for exceeding Utah Medicaid Quantity Limit or Morphine Milligram Equivalent >90 MME/day:

_____ Chart Note Page #: _____

□ **Details of taper plan** or rationale for the lack thereof:

_____ Chart Note Page #: _____

Opioid Use Disorder (OUD) Criteria for Approval:

□ Clinical rationale for opioid use if member received Medication Assisted Treatment (MAT), in last 45 days:

_____ Chart Note Page #: _____

Opioid and Benzodiazepine Combination: FDA Black Box Warning

□ Clinical rationale and diagnosis for member receiving concomitant benzodiazepine and opioid within last 45 days:

_____ Chart Note Page #: _____

□ Most recent opioid prescription information: Date Prescribed: _____

Medication Name and Strength: _____ Quantity/Day Supply:_____

□ Most recent benzodiazepine prescription information: Date Prescribed: _____

Medication Name and Strength: _____ Quantity/Day Supply:_____

Non-Preferred Opioids: *(Criteria above must also be met)*

□ Trial and failure of preferred opioid in same Utah Medicaid PDL class with appropriate dose and duration:

Medication (s):_____ Chart Note Page #: _____
Dates of therapy: _____Details of Failure:_____

□ Appropriate clinical rationale for non-preferred product: (*i.e. adverse reaction, allergy, or contraindication)*

_____ Chart Note Page #: _____

Provider attests to all the following:

□ Provider has a signed opioid treatment agreement with the member.
□ Provider has checked the Utah's Controlled Substance Database with each prescription.
□ Provider has discussed with the member benefits and potential harm, including combining opioids with other CNS depressants.
□ Provider has counseled members with high-risk conditions (sleep apnea, pregnancy, mental health conditions, substance abuse disorders, or children) about the heightened risk of using opioids.
□ Member has received naloxone education.

Initial authorization: Up to three (3) months

Re-authorization: Up to six (6) months

Authorization for use with MAT: Up to fourteen (14) days, no re-authorization

PROVIDER CERTIFICATION

I certify that the information provided on this form is true and accurate to the best of my knowledge.

_____ _____

Prescriber's Signature Date