Opioid Prescribing Key Strategies:
Quick Reference Guide

	Prescribing	Management/Tapering	Care Coordination
Addiction/Overdose Prevention	• Check your state's Prescription Drug Monitoring Program (PDMP); in Utah, it is the Controlled Substance Database (CSD) • Calculate the morphine milligram equivalents (MMEs); **prescribe the lowest effective dosage.** • Set criteria for use, tapering, and discontinuation with a Medication Management Agreement (MMA): Opioids.[1] • Offer naloxone; counsel on overdose risk/ need to keep naloxone on hand.	• Schedule follow-up visits based on dose, risk, and comorbidities. • Have patient agree to and perform random drug testing to confirm illicit drug abstinence/confirm compliance with opioid therapy. • **At every follow-up visit:** Perform a urine drug screen and check PDMP in your state. In Utah, access the Controlled Substance Database (CSD). • Monitor for Opioid Misuse Red Flags or potential harms due to side effects, comorbidities, pregnancy, etc. (see Resources).	• If Opioid Misuse Red Flags exist, consult/refer to a pain specialist **OR** refer for a substance use disorder evaluation. • Refer patient to chronic pain self-management education programs in your community.
Treatment Considerations	• Assess pain, function, and risks with validated tools; initiate non-pharmacological or non-opioid treatment whenever possible. • **Avoid concurrent prescriptions** of opioids and benzodiazepines/other sedative hypnotics. Have patient taper off of these medications unless medically necessary to be taken with opioids. • Initiate short-term trial (≤7 days) with short-acting opioid to determine appropriateness. If appropriate, follow with short-acting medication for ≥2 weeks before transitioning to a long-acting form (with a scheduled dose).	• **At each visit**, verify that continued opioid therapy outweighs risks (side effects, misuse, sedation, etc.), and evaluate tapering and/or discontinuation appropriateness (see Tapering Checklist).[2] • Because no single approach for tapering is appropriate for all patients, **prefer a "Go-Slow" approach** to minimize withdrawal symptoms and mitigate seizure/death risk. Reduce doses by 10%/week at most (10%/ month for long-term opioid use). • Set goals and schedules with patients based on their risks, desires, and needs. • Ensure that patients have the support and encouragement they need (see Resources). • Adjust taper to the patient's response (slow or pause), but **never reverse the taper**. Warn patients of overdose risk with returning to a previous dose. • As patient adjusts to new doses, monitor and manage withdrawal symptoms (e.g., cramps, nausea, vomiting, diarrhea, body aches, increased pain, trouble sleeping).	• Consider consultation with a pain specialist and extra care when managing tapering for patients who are: — Being treated for comorbidities that complicate their condition — Pregnant — Pre-operative — Taking multiple opioids — At risk of self-harm — Demonstrating Opioid Misuse Red Flags or diversion • If overdose or aberrant behavior suspected, consider consultaion/ referral to an addiction specialist. • **If seen by a pain clinic**, ensure that patients only get their pain medication and controlled substances from that clinic. **Do not prescribe additional medication** without consulting the patient's pain specialist.

1. For Intermountain physicians, always scan MMA into iCentra.
2. In some instances, it may be appropriate for the member to remain on high dose opioids. However, it is important to do a tapering evaluation at every visit and weigh the benefits of continued therapy vs. the costs.

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