

OPIOID PRESCRIBING | Section 4

OVERVIEW

While opioids are not recommended for first-line treatment of chronic pain, there are instances when opioids should be considered based on patient preferences. These include effects of pain on function and quality of life, tolerance of other pharmacologic treatments, and availability of alternative therapy with a favorable balance of benefits to harms.

Before initiating opioid therapy, physicians and other clinicians should document the patient's medical history and conduct a physical examination and appropriate testing, including an assessment of risk of substance abuse, misuse, or addiction. Clinicians and patients should regard initial treatment with opioids as a therapeutic trial to determine whether the treatment is appropriate. The prescribing of opioids should be considered in the context of shared decision making with clear goals of improving function.

Some general recommendations for initiating opioid treatment for chronic, noncancer pain includes:

- Avoiding prescribing opioids on the first visit
- Conducting a thorough risk assessment
- Creating a care plan that includes functional goals
- Discussing the risks versus benefit of opioids
- Obtaining a signed informed consent and treatment agreement
- Discussing and planning for dose escalation and reduction
- Considering prescribing a naloxone rescue kit to a family member, loved one, or caregiver
- Anticipating, identifying, and treating common opioid-associated adverse effects
- Recommending co-interventions, such as psychological therapy, functional restoration, interdisciplinary therapy, and other adjunctive non-opioid therapies
- Counseling patients on the effects of opioids on other aspects of life, such as driving and work safety

Guidelines for Opioid Prescribing

In response to the opioid epidemic, the Centers for Disease Control and Prevention (CDC) published [guidance for primary care clinicians for opioid prescribing](#).¹ These guidelines were based on limited evidence with many recommendations relying solely on expert opinion. As such, these recommendations are considered more good practice, and the [AAFP cautions in their use](#) without further evidence.²

The guideline recommendations summarized by the AAFP are as follows:²

- “Nonpharmacologic and nonopioid pharmacologic therapies are preferred for chronic pain. Opioid therapy should be considered only when benefits for both pain and function are anticipated to outweigh the risks.”
- “When starting opioid therapy for chronic pain, the lowest effective dose of immediate-release opioids should be prescribed instead of extended-release/long acting (ER/LA) opioids.”
- Benefits and risks should be routinely assessed, particularly before increasing dosages of opioids, with plans for discontinuing or tapering developed.
- “Risk factors for opioid-related harms should be evaluated prior to initiation and periodically during treatment. Strategies to mitigate risk should be developed, including offering naloxone to those at increased risk for overdose.”
- “A patient's history of controlled substance prescriptions using a prescription drug monitoring program (PDMP). PDMP data should be reviewed when starting opioid therapy and periodically during treatment.”

Risk Mitigation

The guideline recommendations found limited evidence of the benefits and harms of risk mitigation strategies for opioid use. However, all patients taking opioids for a prolonged period of time should be monitored to ensure these medications are still helpful and being taken appropriately. Physicians and other clinicians should be careful to avoid stigmatizing language and keep all processes centered on the patient. To ensure this monitoring is consistent, at every visit, patients should be:¹

- Evaluated for progress toward functional goals. Strong consideration should be given to tapering and discontinuing the use of opioids in the absence of functional improvement when using the medications.
- Assessed for appropriate medication use and problematic medication behavior.

It is also recommended that clinicians periodically conduct a risk mitigation assessment of patients' opioid therapy at least every three months. This assessment includes:²

- Developing an opioid management plan
- Providing patient education
- Screening urine for drugs
- Reviewing PDMP data
- Counting pills
- Scheduling more frequent monitoring visits

Opioid Prescribing Tools

The table below includes opioid prescribing tools and resources included in this toolkit, along with additional resources for patients, physicians, and other clinicians.

Opioid Prescribing Tools and Resources in Toolkit

Resources	Description	Location
Risk Assessment and Monitoring Checklist	A checklist for physicians and other clinicians to document risk assessment and monitor red flags for opioid use (i.e., opioid risk, alcohol use, substance use), as well as review PDMP data, and screen urine for drugs	Jump to tool in toolkit.
Opioid Risk Tool (ORT)	Brief, self-reporting screening tool designed for adult patients in primary care settings to assess risk for opioid abuse Patients categorized as high risk are at an increased likelihood of future abusive drug-related behavior. Takes about one minute to complete	Jump to tool in toolkit.
Opioid Conversion Table	Table and conversion chart for calculating total daily doses of opioids in morphine milligram equivalents to facilitate appropriate prescribing and/or tapering	Jump to tool in toolkit.
Patient Agreement	Sample patient agreement form used for patients beginning long-term treatment with opioid analgesics or other controlled substances Statements in the agreement help patients understand their role and responsibilities regarding their treatment (e.g., how to obtain refills, conditions of medication use), as well as the conditions in which treatment may be terminated, and the responsibilities of the health care provider. Helps facilitate communication between patients and the health care team to resolve questions or concerns before initiation of long-term treatment	Jump to tool in toolkit.
Tapering Resource and Tapering Worksheet	Resources and recommendations for tapering of opioid medications, including a worksheet to record and manage tapering doses	Jump to tool in toolkit.
Urine Drug Testing Resource	Brief overview for urine drug testing, including a table outlining the tests used and potential false positives	Jump to tool in toolkit.
Patient Education Resource	Referral resource for patients detailing important aspects of opioids for patients to know, including risks and side effects	Jump to tool in toolkit.

Additional Opioids Prescribing Tools and Resources

Resources	Description	Location
Patient Communication Resource	Communication resource for patients prescribed opioids to help communicate with physicians about medications Six questions/conversation starters are included	www.oregonpainguidance.org/wp-content/uploads/2020/06/18.-CDC-Handout-Conversation-Starter-If-You-Are-Prescribed-Opioids-compressed.pdf
Words That Work for Opioid Conversations	Resource for physicians offering suggested principles and language to use when communicating with patients about safe management of opioid use	https://knowledgeplus.nejm.org/wp-content/uploads/2020/03/words_that_work.jpg
Current Opioid Misuse Measure (COMM) TM	Patient self-assessment to monitor patients experiencing chronic pain who are in opioid therapy	http://mytopcare.org/wp-content/uploads/2013/05/COMM.pdf
Training and Technical Assistance	Opioid Response Network provides technical assistance for prevention, treatment, and recovery for opioid use disorders (OUDs)	www.aafp.org/family-physician/patient-care/care-resources/pain-management/opioid-response-network.html
Opioid Use Disorder Training	Free medication-assisted treatment (MAT)-waiver training courses and peer-support resources	https://pcssnow.org/
Opioid Overdose Guideline Resources	Training videos and courses to aid with tapering and other questions	www.cdc.gov/drugoverdose/prescribing/resources.html
Tapering Resource	Evidence-based best practices for primary care physicians and other clinicians for initiating and managing of tapering off opioids for patients	https://nam.edu/best-practices-research-gaps-and-future-priorities-to-support-tapering-patients-on-long-term-opioid-therapy-for-chronic-non-cancer-pain-in-outpatient-settings/
Opioid Use Disorder Practice Manual	Guide for implementing MAT in family medicine practices	www.aafp.org/dam/AAFP/documents/patient_care/pain_management/OU-DC-Condition.pdf

References

1. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain - United States, 2016. *MMWR Recomm Rep.* 2016;65(1):1-49.
2. American Academy of Family Physicians. Opioid prescribing for chronic pain. Accessed January 11, 2021. www.aafp.org/family-physician/patient-care/clinical-recommendations/all-clinical-recommendations/opioid-prescribing.html



Risk Assessment and Monitoring Checklist



Prior to initiation of opioid therapy, it is imperative to assess the patient's risk for misuse/abuse. This toolkit provides resources to identify possible red flags for opioid misuse, links to find your state's prescription drug monitoring program (PDMP), opioid risk assessment, and mental health assessment tools. Use the table below to track completion and results for each potential risk item.

Document completion, results, and any action needed		
Tool/Test	Completed (Results)	Additional action or comments
Opioid Risk Tool (ORT) or Another Tool		
Alcohol Use		
Other Substance/Drug Use		
Mental Health Screening		
State PDMP		
Urine Drug Test		

Additional resources: Use the link below to find your state's PDMP and other resources.

[Links to State PDMPs](#)

Opioid Risk Tool



		Item Score if Female	Item Score if Male
1. Family History of Substance Abuse	Alcohol	<input type="checkbox"/> 1	<input type="checkbox"/> 3
	Illegal Drugs	<input type="checkbox"/> 2	<input type="checkbox"/> 3
	Prescription Drugs	<input type="checkbox"/> 4	<input type="checkbox"/> 4
2. Personal History of Substance Abuse	Alcohol	<input type="checkbox"/> 3	<input type="checkbox"/> 3
	Illegal Drugs	<input type="checkbox"/> 4	<input type="checkbox"/> 4
	Prescription Drugs	<input type="checkbox"/> 5	<input type="checkbox"/> 5
3. Age (<i>Mark box if 16-45</i>)		<input type="checkbox"/> 1	<input type="checkbox"/> 1
4. History of Preadolescent Sexual Abuse		<input type="checkbox"/> 3	<input type="checkbox"/> 0
5. Psychological Disease	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	<input type="checkbox"/> 2	<input type="checkbox"/> 2
	Depression	<input type="checkbox"/> 1	<input type="checkbox"/> 1
	TOTAL	_____	_____

Total Score Risk Category

Low Risk 0-3

Moderate Risk 4-7

High Risk ≥ 8

Opioid Conversion Table

Calculating total daily doses of opioids is important to appropriately and effectively prescribe, manage, and taper opioid medications. There are a number of conversion charts available, so caution is needed when performing calculations. As with all medications, consulting the package insert for dose titration instructions and safety information is recommended. Treatment should be individualized and begin with lower doses and gradual increases to manage pain.

Once the dose is calculated, the new opioid should not be prescribed at the equivalent dose. The starting dose should be reduced by 25-50% to avoid unintentional overdose due to incomplete cross-tolerance and individual variations in opioid pharmacokinetics. This dose can then be gradually increased as needed.

To calculate the total daily dose:

1. Determine the total daily doses of current opioid medications (consult patient history, electronic health record, and PDMP as necessary).
2. Convert each dose into morphine milligram equivalents (MMEs) by multiplying the dose by the conversion factor.
3. If more than one opioid medication, add together.
4. Determine equivalent daily dose of new opioid by dividing the calculated MMEs of current opioid by new opioid's conversion factor. Reduce this amount by 25-50% and then divide into appropriate intervals.

Calculating Morphine Milligram Equivalents (MME)*			
Opioid	Conversion Factor (convert to MMEs)	Duration (hours)	Dose Equivalent Morphine Sulfate (30 mg)
Codeine	0.15	4-6	200 mg
Fentanyl (mcg/hr)	2.4		12.5 mcg/hr**
Hydrocodone	1	3-6	30 mg
Hydromorphone	4	4-5	7.5 mg
Morphine	1	3-6	30 mg
Oxycodone	1.5	4-6	20 mg
Oxymorphone	3	3-6	10 mg
Methadone†			
1-20 mg/d	4		7.5 mg
21-40 mg/d	8		3.75 mg
41-60 mg/d	10		3 mg
≥61 mg/d	12		2.5 mg

*The dose conversions listed above are an estimate and cannot account for an individual patient's genetics and pharmacokinetics.

**Fentanyl is dosed in microgram per hour (mcg/hr) instead of milligram per day (mg/day), and absorption is affected by heat and other factors.

†Methadone conversion factors increase with increasing dose.

Sample Case

Your patient is a 45-year-old man who is taking oxymorphone 10 mg four times a day for chronic pain. You have determined he is an appropriate candidate for a long-acting regimen and decide to convert him to extended release oxycodone.

1. Total daily dose of oxymorphone → 10 mg X 4 times/day = 40 mg/day
2. Convert to MMEs (oxymorphone conversion factor = 3) → 40 X 3 = 120 MME
3. Determine MMEs of oxycodone (oxycodone conversion factor = 1.5) → 120/1.5 = 80 mg/day
4. Decrease dose by 25% → 25% of 80 = 20 → 80 - 20 = 60
5. Divide by interval (q 12 hours) → 60/2 = 30

The starting dose of extended release oxycodone is 30 mg every 12 hours (q 12h).

Additional Resource

CDC Opioid Conversion Guide

https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

Opioid Medication for Chronic Pain Agreement



This is an agreement between _____ (patient) and Dr. _____.

I am being treated with opioid medication for my chronic pain, which I understand may not completely rid me of my pain, but will decrease it enough that I can be more active. I understand that, because this medication has risks and side effects, my doctor needs to monitor my treatment closely in order to keep me safe. I acknowledge my treatment plan may change over time to meet my functional goals, and that my doctor will discuss the risks of my medicine, the dose, and frequency of the medication, as well as any changes that occur during my treatment. In addition, I agree to the following statements:

Patient Initials	Please read the statements below and initial in the box at the left.
	I understand that the medication may be stopped or changed to an alternative therapy if it does not help me meet my functional goals.
	To reduce risk, I will take medication as prescribed. I will not take more pills or take them more frequently than prescribed.
	I will inform my doctor of all side effects I experience.
	To reduce risk, I will not take sedatives, alcohol, or illegal drugs while taking this medication.
	I will submit to urine and/or blood tests to assist in monitoring my treatment.
	I understand that my doctor or his/her staff may check the state prescription drug database to prevent against overlapping prescriptions.
	I will receive my prescription for this medication only from Dr. _____.
	I will fill this prescription at only one pharmacy. (Fill in pharmacy information below.)
	I will keep my medication in a safe place. I understand if my medicine is lost, damaged, or stolen, it will not be replaced.
	I will do my best to keep all scheduled follow-up appointments. I understand that I may not receive a prescription refill if I miss my appointment.

Medication name, dose, frequency _____

Pharmacy name _____

Pharmacy phone number _____

By signing below, we agree that we are comfortable with this agreement and our responsibilities.

Patient signature

Date

Physician signature

Date

Tapering Resource

The objective of a taper is to prevent significant withdrawal symptoms while reducing or discontinuing opiates.

Potential Reasons to Taper Opioids

- Patient request
- Lack of improvement in pain and/or function
- Nonadherence to treatment plan
- Signs of misuse and/or abuse
- Serious adverse events

Recommendations for Tapering

There is no evidence to support one tapering strategy over another. Any tapering protocol should be individualized as some patients may tolerate a more rapid taper, while others will require a more gradual decrease in medication. In general, the longer the patient has been on opiates, the more conservative (slow) the taper will need to be to minimize or avoid withdrawal symptoms. It is important to remember that tapering is unidirectional, and should not be reversed. However, tapering can be slowed or paused if needed. A starting point for tapering is to decrease the dose 10-20% every 1-2 weeks and adjust the rate according to patient response. Once the patient has reached about 1/3 of the original dose, smaller decreases of 5% every 2-3 weeks may be necessary.

For individuals on high dose or multiple opioids, switching to a single long-acting opioid or methadone can be considered (see conversion table). Once stable on the

long-acting regimen, proceed with a slow taper, 10-20% every 1-2 weeks, followed by an even slower taper once 1/3 of the original dose is reached. A worksheet to record and track doses for tapering is provided in this toolkit.

Caution patients that they may quickly lose their tolerance to opioids, so they are at risk for overdose if they abruptly resume their original dose.

It is important to note that pregnant patients on chronic opiate therapy should not be weaned due to risks to both the mother and the fetus. Patients with signs of misuse and/or abuse who are pregnant should be considered for MAT.

Management of Withdrawal

Physical withdrawal symptoms generally resolve 5-10 days after dose reduction/cessation, while psychological symptoms may take longer. Not all patients will experience the same withdrawal symptoms. The goal is to minimize these symptoms with a gradual taper. There are additional treatments that may help with specific symptoms (see chart below).

Additional Resources

CDC Tapering Pocket Guide

http://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf

VA Tapering Fact Sheet

<http://www.healthquality.va.gov/guidelines/Pain/cot/OpioidTaperingFactSheet-23May2013v1.pdf>

Washington State Guideline

<http://www.agencymeddirectors.wa.gov/Files/2015AMDG0pioidGuideline.pdf>

Stage	Grade*	Physical Signs and Symptoms	Treatment Options
Early Withdrawal (8-24 hours after last use)	1	Lacrimation, Rhinorrhea, Diaphoresis, Yawning, Restlessness, Insomnia	- Antihistamines or trazodone for insomnia/restlessness
	2	Piloerection, Myalgias, Arthralgias, Abdominal pain	- NSAIDs/Acetaminophen for muscle and joint pain - Loperamide/bismuth subsalicylate for abdominal cramping
Fully Developed Withdrawal (1-3 days after last use)	3	Tachycardia, Hypertension, Tachypnea, Fever, Anorexia, Nausea	- Clonidine for autonomic symptoms - Ondasetron/H2 blockers for nausea
	4	Diarrhea, Vomiting, Dehydration, Hypotension	- Loperamide for diarrhea - Oral rehydrating solutions
Post Acute Withdrawal Syndrome (PAWS)		Mood swings, Anxiety, Irritability, Anhedonia, Fatigue, Poor concentration, Insomnia	- Recovery services - Relapse prevention strategies

*The severity of opioid withdrawal is defined by symptoms and described by four categories or grades.

Opioid Tapering Worksheet



Current Dose: _____

Target Dose: _____

Timeline: _____

Medication: _____

Date	Dose	Frequency	# of weeks	Total dose/day
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg

Urine Drug Testing

(see chart on next page)

Most guidelines recommend screening patients to determine risks of drug misuse and abuse and to mitigate those risks as much as possible. Unfortunately, there are no risk assessment tools that have been validated in multiple settings and populations. Screening is typically based on risk factors that can be identified through a thorough patient history, the use of prescription drug monitoring programs (PDMPs), the Opioid Risk Tool (provided in this toolkit), and, on occasion, drug screening. However, it is important to standardize testing as cited risk factors (e.g., sociodemographic factors, psychological comorbidity, substance use disorders, etc.) might unfairly impact certain vulnerable populations. Involvement of the whole health care team and full disclosure and discussion of the screening protocol with patients is central to providing patient-centered and comprehensive pain management. Prior to drug testing, physicians should inform the patient of the reason(s) for testing, how often they will be tested, and what the results might mean. This gives patients an opportunity to disclose any additional drug or substance use which may help with identification of false positives and appropriate interpretation of test results.

Physicians must understand the limitations of the urine and confirmatory tests available, including what substances are detected by a particular test, and the reasons for false-positive and false-negative tests. Changes in prescribing for a particular patient should not be based on the result of one abnormal screening test, but should only occur after looking at all available monitoring tools, as well as repeating the drug screen with the most specific test available.

Interpretation of Results

Following initial testing, physicians should request confirmatory testing for the following results:

- Negative for the opioid(s) prescribed
- Positive for drugs not prescribed
- Positive for other substances such as alcohol, amphetamines, or cocaine (or metabolites)

Additional Resources

Washington State Medical Directors Guideline

<http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf>

SAMHSA Guideline for Drug Testing

<https://store.samhsa.gov/shin/content/SMA12-4668/SMA12-4668.pdf>

Urine Drug Testing, page 2

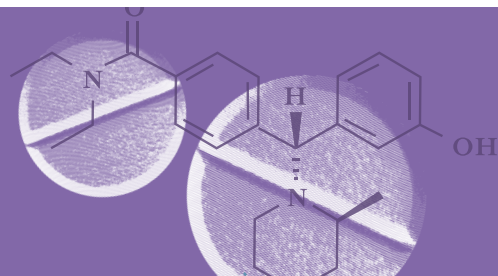
Urine Drug Testing for Commonly Used and Misused Drugs			
OPIATES			
Drug	Detection Time	Test Order	False Positive
Codeine	1-3 days	Opiates Immunoassay* Confirmatory test: GC/MS or LC/MS/MS**	Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates
Morphine	1-3 days	Opiates Immunoassay* Confirmatory test: GC/MS or LC/MS/MS	Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates
Fentanyl	1-3 days	GC/MS or LC/MS/MS Fentanyl	n/a
Meripidine	1-3 days	GC/MS or LC/MS/MS Meperidine	n/a
Methadone	3-7 days	Methadone Immunoassay Confirmatory test: GC/MS or LC/MS/MS Methadone	Diphenhydramine, clomipramine
Hydrocodone	1-3 days	Opiates immunoassay Confirmatory test: GC/MS or LC/MS/MS	Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates
Hydromorphone	1-3 days	Opiates immunoassay Confirmatory test: GC/MS or LC/MS/MS	Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates
Oxycodone	1-3 days	Opiates immunoassay Confirmatory test: GC/MS or LC/MS/MS	Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates
Oxymorphone	1-3 days	Opiates immunoassay Confirmatory test: GC/MS or LC/MS/MS	Dextromethorpan, diphenhydramine, heroin, poppy seeds, quinine, quinolones, rifampin, verapamil, other opiates
ADDITIONAL SUBSTANCES			
Drug	Detection Time	Test Order	False Positive
Alcohol	Up to 8 hours	Alcohol	n/a
Amphetamines	2-3 days	Amphetamines, methamphetamines, or MDMA immunoassay	Ephedrine, pseudoephedrine, selegiline
Barbiturates	1-3 days short acting Up to 30 days long-acting	Barbiturates Immunoassay	NSAIDs
Benzodiazepines	1-3 days short acting Up to 30 days long-acting	Benzodiazepines Immunoassay*** Confirmatory test: GC/MS or LC/MS/MS Alprazolam, Diazepam, Clonazepam, Lorazepam, etc.	Sertraline, oxaprozin
Cocaine	2-4 days	Cocaine metabolites immunoassay	Coca leaf tea
Marijuana	2-4 days Up to 30 days with chronic use	Cannabinoids (THC) Immunoassay	NSAIDs, proton pump inhibitors, food containing hemp, efavirenz

*Opiates Immunoassay – Confirmatory test required to determine which opiate is present

** GC/MS/LC – Gas Chromatography/Mass Spectrometry/Liquid Chromatography

***Benzodiazepine Immunoassay – High false-negative rate; consider confirmatory testing if high suspicion of use

PRESCRIPTION OPIOIDS: WHAT YOU NEED TO KNOW



Prescription opioids can be used to help relieve moderate-to-severe pain and are often prescribed following a surgery or injury, or for certain health conditions. These medications can be an important part of treatment but also come with serious risks. It is important to work with your health care provider to make sure you are getting the safest, most effective care.

WHAT ARE THE RISKS AND SIDE EFFECTS OF OPIOID USE?

Prescription opioids carry serious risks of addiction and overdose, especially with prolonged use. An opioid overdose, often marked by slowed breathing, can cause sudden death. The use of prescription opioids can have a number of side effects as well, even when taken as directed:

- Tolerance—meaning you might need to take more of a medication for the same pain relief
- Physical dependence—meaning you have symptoms of withdrawal when a medication is stopped
- Increased sensitivity to pain
- Constipation
- Nausea, vomiting, and dry mouth
- Sleepiness and dizziness
- Confusion
- Depression
- Low levels of testosterone that can result in lower sex drive, energy, and strength
- Itching and sweating

As many as
1 in 4
PEOPLE*



receiving prescription opioids long term in a primary care setting struggles with addiction.

* Findings from one study

RISKS ARE GREATER WITH:

- History of drug misuse, substance use disorder, or overdose
- Mental health conditions (such as depression or anxiety)
- Sleep apnea
- Older age (65 years or older)
- Pregnancy

Avoid alcohol while taking prescription opioids. Also, unless specifically advised by your health care provider, medications to avoid include:

- Benzodiazepines (such as Xanax or Valium)
- Muscle relaxants (such as Soma or Flexeril)
- Hypnotics (such as Ambien or Lunesta)
- Other prescription opioids



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KNOW YOUR OPTIONS

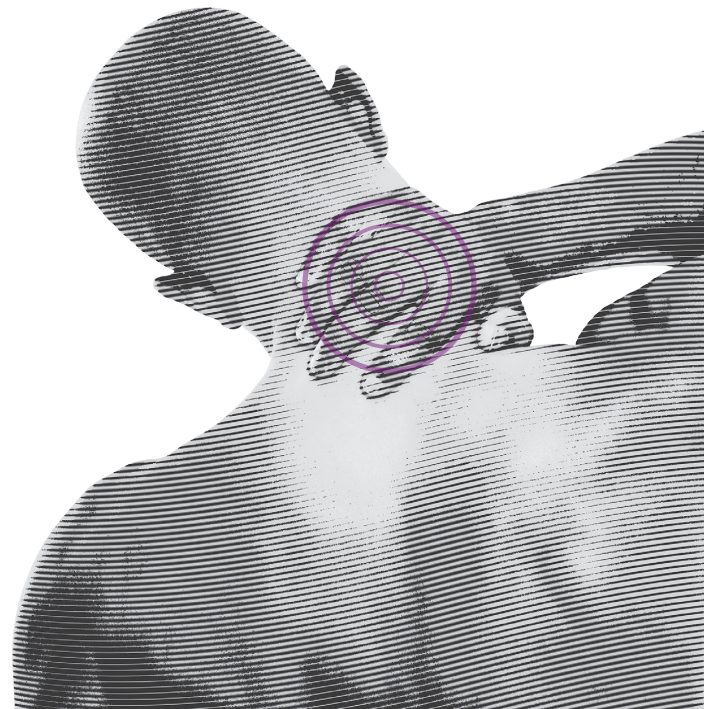
Talk to your health care provider about ways to manage your pain that don't involve prescription opioids. Some of these options **may actually work better** and have fewer risks and side effects. Options may include:

- ❑ Pain relievers such as acetaminophen, ibuprofen, and naproxen
- ❑ Some medications that are also used for depression or seizures
- ❑ Physical therapy and exercise
- ❑ Cognitive behavioral therapy, a psychological, goal-directed approach, in which patients learn how to modify physical, behavioral, and emotional triggers of pain and stress.



Be Informed!

Make sure you know the name of your medication, how much and how often to take it, and its potential risks & side effects.



IF YOU ARE PRESCRIBED OPIOIDS FOR PAIN:

- ❑ Never take opioids in greater amounts or more often than prescribed.
- ❑ Follow up with your primary health care provider within ___ days.
 - Work together to create a plan on how to manage your pain.
 - Talk about ways to help manage your pain that don't involve prescription opioids.
 - Talk about any and all concerns and side effects.
- ❑ Help prevent misuse and abuse.
 - Never sell or share prescription opioids.
 - Never use another person's prescription opioids.
- ❑ Store prescription opioids in a secure place and out of reach of others (this may include visitors, children, friends, and family).
- ❑ Safely dispose of unused prescription opioids: Find your community drug take-back program or your pharmacy mail-back program, or flush them down the toilet, following guidance from the Food and Drug Administration (www.fda.gov/Drugs/ResourcesForYou).
- ❑ Visit www.cdc.gov/drugoverdose to learn about the risks of opioid abuse and overdose.
- ❑ If you believe you may be struggling with addiction, tell your health care provider and ask for guidance or call SAMHSA's National Helpline at 1-800-662-HELP.

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html