Michigan Quality Improvement Consortium
Clinical Practice Guideline Update Alert

Guideline: Opioid Prescribing in Adults Excluding Palliative and End-of-Life Care

Released: November 2018

This alert provides a summary of only the recommendations which were updated. Refer to the complete guideline for all recommendations and level of evidence.

Updated recommendations include:

Avoid starting opioids

Treat pain with non-drug therapy (e.g., physical/behavioral modalities), and non-opioid medications (e.g., acetaminophen, NSAIDS), if possible. Opioids are rarely used in chronic pain.

Before starting opioids, assess risk of dependence, overdose or death

- Review history of controlled substance use, mental health and substance misuse. Obtain a Prescription Drug Monitoring Program (PDMP) report, e.g., MAPS. Refer to local laws[1].
- Screen for risk of dependence; consider using as instrument such as SOAPP-R or ORT.
- Discuss the risks including dependency, overdose, permanent brain injury, and death. Discuss lack of evidence of superiority to NSAIDs.

When starting opioids

- Even when starting, strongly consider developing a formalized treatment plan, informed consent and/or an opioid treatment agreement (controlled substance agreement).
- Document your discussion (in Michigan use the Start Talking form).
- Prescribe the lowest effective dose of immediate-release opioids and no greater quantity than needed for the expected duration of pain severe enough to require opioids; three days or fewer for acute pain; more than seven days will rarely be needed. Michigan limits initial prescription to seven (7) days.
- Use opioids as part of a pain management plan that includes instructions for tapering, non-opioid medications and non-drug therapy, as appropriate.
- Avoid opioids with benzodiazepines, muscle relaxants, hypnotics or alcohol, and educate patient about the dangers of mixing, due to the higher risk of death.
- Consider offering patient and family naloxone when risk factors for overdose are present; e.g., history of overdose or substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use. Educate patient and family on naloxone use and efficacy noting that duration is less than an hour and following any naloxone use Call 911 and perform rescue breathing, if needed. Patient should be seen immediately in a hospital Emergency Department.

If continuing opioid, or adjusting dose

- Periodically re-evaluate pain and function (consider using an assessment tool such as PEG-3); recheck PDMP (MAPS) and consider urine drug screen.
- Use urine drug testing to assess for prescribed medications as well as other controlled or illegal substances. Absence of prescription medication may indicate diversion. Any unexpected result should warrant a confirmatory test. Perform testing at least annually, more frequently (every 3-6 months) if warranted.
- When considering increasing dosage to ≥ 50 MME/day, reassess evidence of individual benefits and risks. Avoid increasing dosage to ≥ 90 MME/day, carefully justify and document the decision. Patients treated long-term with > 100 MME/day should slowly be tapered to lower doses. Consider referral to a pain specialist.
- Avoid renewal without clinical reassessment.

[1]Michigan (michigan.gov/opioids)