

## SUMMARY GUIDELINES FOR THE TREATMENT OF ACUTE AND CHRONIC PAIN

There are more than two Arizonans dying every day from an opioid overdose, and the majority of deaths are due to prescription opioids. It is imperative that Arizona clinicians have prescribing practices that maintain safety for their patients and community, while also addressing their patients' pain.

The following seventeen guidelines for non-cancer, non-terminal pain are designed to provide information and assist decision-making for providers. Each patient and clinical presentation is unique, however, and these statements must not supersede medical judgment and risk-benefit analyses.

### ACUTE PAIN

- 1 Use non-opioid medications and therapies as first-line treatment for mild and moderate acute pain.
- 2 If opioids are indicated for acute pain, initiate therapy at the lowest effective dose for no longer than a 3-5 day duration; reassess if pain persists beyond the anticipated duration.
- 3 Do not use long-acting opioids for the treatment of acute pain.

### CHRONIC PAIN

- 4 Prescribe self-management strategies, non-pharmacologic treatments and non-opioid medications as the preferred treatment for chronic pain.
- 5 Do not initiate long-term opioid therapy for most patients with chronic pain.
- 6 Coordinate interdisciplinary care for patients with high-impact chronic pain to address pain, substance use disorders and behavioral health conditions.

### RISK MITIGATION

- 7 For patients on long-term opioid therapy, document informed consent which includes the risks of opioid use, options for alternative therapies and therapeutic boundaries.
- 8 Do not use long-term opioid therapy in patients with untreated substance use disorders.
- 9 Avoid concurrent use of opioids and benzodiazepines. If patients are currently prescribed both agents, evaluate tapering or an exit strategy for one or both medications.
- 10 Check the Arizona Controlled Substances Prescription Monitoring Program before initiating an opioid or benzodiazepine, and then at least quarterly.
- 11 Discuss reproductive plans and the risk of neonatal abstinence syndrome and other adverse neonatal outcomes prior to prescribing opioids to women of reproductive age.
- 12 If opioids are used to treat chronic pain, prescribe at the lowest possible dose and for the shortest possible time. Reassess the treatment regimen if prescribing doses  $\geq 50$  MEDs.
- 13 Counsel patients who are taking opioids on safety, including safe storage and disposal of medications, not driving if sedated or confused while using opioids and not sharing opioids with others.
- 14 Reevaluate patients on long-term opioid therapy at least every 90 days for functional improvements, substance use, high-risk behaviors and psychiatric comorbidities through face-to-face visits, PDMP checks and urine drug tests.
- 15 Assess patients on long-term opioid therapy on a regular basis for opioid use disorder and offer or arrange for medication-assisted therapy (e.g. methadone and buprenorphine) to those diagnosed.
- 16 Offer naloxone and provide overdose education for all patients at risk for opioid overdose.
- 17 Individualize an exit strategy from the use of long-term opioid therapy for chronic pain, while carefully monitoring for risks.