



	Draft of Updated CDC Guidelines Published July 2021	New Draft of updated 2022 CDC Guidelines Published Feb 2022 CDC wants comments on this draft	Evidence Rating (1-4)	Category (A or B)
1	Nonopioid therapies are preferred for many common types of acute pain. Clinicians should only consider opioid therapy for acute pain only if benefits are anticipated to outweigh risks to the patient	Nonopioid therapies are effective for many common types of acute pain. Clinicians should only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient	3	B
2	Nonopioid therapies are preferred for subacute and chronic pain. Clinicians should only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient. Before starting opioid therapy for subacute or chronic pain, clinicians should discuss with patients known risks and realistic benefits of opioid therapy, should establish treatment goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. If opioids are used, they should be combined with other therapies as appropriate.	Nonopioid therapies are preferred for subacute and chronic pain. Clinicians should only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient. Before starting opioid therapy for subacute or chronic pain, clinicians should discuss with patients the known risks and realistic benefits of opioid therapy, should work with patients to establish treatment goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks	2	A
3	When starting opioid therapy for acute, subacute, or chronic pain, clinicians should prescribe immediate-release opioids instead of 1 extended-release/long-acting (ER/LA) opioids.	When starting opioid therapy for acute, subacute, or chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids	4	A
4	When opioids are started for opioid-naïve patients with acute, subacute, or chronic pain, clinicians should prescribe the lowest effective dosage. If opioids are continued for subacute or chronic pain, clinicians	When opioids are initiated for opioid-naïve patients with acute, subacute, or chronic pain, clinicians should prescribe the lowest dosage to achieve expected effects. If opioids are continued for subacute or	3	A



	should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to >90 MME/day.	chronic pain, clinicians should use caution when prescribing opioids at any dosage, should carefully evaluate individual benefits and risks when considering increasing dosage, and should avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients		
5	For patients already receiving higher opioid dosages (e.g., >90 MME/day), clinicians should carefully weigh benefits and risks and exercise care when reducing or continuing opioid dosage. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.	For patients already receiving higher opioid dosages, clinicians should carefully weigh benefits and risks and exercise care when reducing or continuing opioid dosage. If risks outweigh benefits of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper to lower dosages or, if warranted based on the individual clinical circumstances of the patient, to appropriately taper and discontinue opioids. Unless there are indications of a life-threatening issue, such as warning signs of impending overdose, e.g., confusion, sedation, or slurred speech, opioid therapy should not be discontinued abruptly, and clinicians should not abruptly or rapidly reduce opioid dosages from higher dosages	4	B
6	When opioids are used for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. One to three days or less will often be sufficient; more than seven days will rarely be needed.	When opioids are needed for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids	4	A



7	<p>Clinicians should continue opioid therapy for subacute or chronic pain only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for subacute or chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently.</p>	<p>Clinicians should evaluate benefits and risks with patients within 1 to 4 weeks of starting opioid therapy for subacute or chronic pain or of dose escalation. Clinicians should evaluate benefits and risks of continued therapy with patients every 3 months or more frequently</p>	4	A
8	<p>Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss with patients. Clinicians should incorporate into the management plan strategies to mitigate risk, including offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present</p>	<p>Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss with patients. Clinicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone when factors that increase risk for opioid overdose are present</p>	4	A
9	<p>Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review 3 PDMP data when starting opioid therapy for acute or chronic pain and periodically during opioid therapy for</p>	<p>When prescribing initial opioid therapy for acute, subacute, or chronic pain, and periodically during opioid therapy for chronic pain, clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose</p>	4	B



	chronic pain, ranging from every prescription to every 3 months.			
10	When prescribing opioids for chronic pain, clinicians should use drug testing before starting opioid therapy and consider drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.	When prescribing opioids for subacute or chronic pain, clinicians should consider toxicology testing to assess for prescribed medications as well as other prescribed and non-prescribed controlled substances	4	B
11	Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants.	Clinicians should use extreme caution when prescribing opioid pain medication and benzodiazepines concurrently and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants	3	B
12	Clinicians should offer or arrange treatment with medication for patients with opioid use disorder.	Clinicians should offer or arrange treatment with medication for patients with opioid use disorder	1	A



Evidence is categorized into four types within the GRADE framework (1-4):

- Type 1, or high-quality evidence: Randomized controlled trials (RCTs) or overwhelming evidence from clinical studies
- Type 2, or moderate-quality evidence: RCTs with important limitations, or exceptionally strong evidence from observational studies
- Type 3, or low-quality evidence: Observational studies or RCTs with notable limitations
- Type 4, or very low-quality evidence: Clinical experience and observations, observational studies with important limitations, or RCTs with several major limitations

Category A or B

Category A: applies to all patients; most patients should receive recommended course of action

Category B: individual decision making required; providers help patients arrive at decision consistent with values/preferences and clinical situation