Opioids can provide short-term relief of moderate to severe acute pain, but there is little evidence supporting their effectiveness for chronic pain, and they have substantial risks. Long-term opioid use should be reserved for patients with cancer-related pain, or patients receiving palliative or end-of-life care. If you prescribe opioids for other conditions, use safety principles as embodied by Limiting Use and Avoiding Adverse Consequences.

### Limiting Use

1. **Do not prescribe opioids as first-line or routine therapy for chronic pain**; use nonpharmacologic and nonopioid pharmacologic therapies first (see Chronic Pain Treatment Principles).
2. **Discuss benefits, risks, and side effects of opioid therapy (e.g., addiction, overdose)**; continue to discuss the risks and benefits of opioids throughout treatment.
3. **Set realistic and measurable goals for pain and function**; plan for how opioid therapy will be stopped if benefits do not outweigh risks.
4. **Use short-acting opioids when starting opioid therapy for chronic pain.**
   - **Prescribe the lowest effective dosage when starting opioid therapy**, and reassess risks and benefits when increasing dosages to 50 morphine milligram equivalents (MME) per day or more, and avoid increasing dosages to 90 MME per day or more.

### Avoiding Adverse Consequences

1. **Follow-up regularly to re-evaluate risk of harm and reduce dose or taper if needed**; follow-up should occur within one to four weeks of starting opioid therapy or increasing dosage and continue quarterly.
2. **Prescribe naloxone to individuals who are undergoing long-term opioid therapy**, due to the higher risk of an overdose while taking these drugs.
3. **Check the Prescription Drug Monitoring Program (PDMP)** for prescriptions from other providers when starting opioid therapy and each time before writing a prescription.
4. **Use urine drug screening to identify prescribed substances and undisclosed use of other drugs** before starting opioid therapy and periodically thereafter.
5. **Avoid concurrent benzodiazepine and opioid prescribing.**
6. **Arrange treatment for opioid use disorder if needed, including medication-assisted treatment** (buprenorphine or methadone). Philadelphia’s Department of Behavioral Health and Intellectual disAbility Services can help you identify treatment options through its website. (http://bit.ly/DBHResources)
7. **Consider incorporating buprenorphine treatment into your own practice.** Find out how through the SAMHSA website. (http://bit.ly/BUPTraining)
Chronic Pain Treatment Principles

Use non-opioid therapies whenever possible. The principles below provide guidance on therapy for chronic pain, based on the type of condition.

1. **Use first-line medications as the preferred option:**
   a. Acetaminophen
   b. NSAIDs
   c. Gabapentin/pregabalin for neuropathic pain or fibromyalgia
   d. Tricyclic antidepressants and SNRIs for neuropathic pain or fibromyalgia; TCAs for headaches
   e. Topical agents such as lidocaine or capsaicin

2. **Focus on functional goals and improvement**, engaging patients actively in their pain management.

3. **Use disease-specific treatments when available** (e.g., triptans for migraines, gabapentin/pregabalin/duloxetine for neuropathic pain).

4. **Identify and address co-existing mental health conditions** (e.g., depression, anxiety, PTSD).

5. **Consider interventional therapies** (e.g., corticosteroid injections) in patients who fail standard non-invasive therapies.

6. **Use treatments with multiple modes**, including interdisciplinary rehabilitation for patients who have failed standard treatments, have severe functional deficits, or psychosocial risk factors.

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Benzodiazepine Prescribing

1. **Do not initiate benzodiazepines for first-line treatment of anxiety disorders**; other pharmacologic and nonpharmacologic treatments can be safe and effective.

2. **Do not prescribe benzodiazepines to treat insomnia without appropriate evaluation, and do not prescribe them chronically**; when they are used, do not prescribe them other than for short-term, situational insomnia, or for more than ten days.

3. **Do not prescribe benzodiazepines to patients with substance use disorders**; use treatment history, information from other providers (including from the Prescription Drug Monitoring Program, or PDMP) and urine drug screenings as potential indicators of abuse.

4. **Do not prescribe benzodiazepines to patients enrolled in medication-assisted treatment for opioid use disorders or who are prescribed opioid medications.**