

# Opioid Prescribing Guidelines

**FOR PATIENTS IN THE EMERGENCY DEPARTMENT  
AND IMMEDIATE CARE CENTERS**



These guidelines are meant to assist clinicians in treating patients with acute and chronic pain in the emergency department (ED) and immediate/urgent care settings. These guidelines are not intended for patients who are receiving treatment for cancer, palliative care or end-of-life care. The guidelines' purpose is to:

- ▶ **Provide safer, more effective care for patients with acute and chronic pain;**
- ▶ **Improve communication between clinicians and patients about the benefits and risks of using prescription opioids for chronic pain; and**
- ▶ **Help reduce opioid use disorder and overdose.**

Please see full document for more information.

## ACUTE PAIN IN OPIOID-NAÏVE PATIENTS

**1**

Opioids are not first-line therapy for many patients with acute pain from minor injuries: Non-pharmacological therapy (e.g. heat, ice and physical therapy) and non-opioid analgesic therapy are preferred when clinically indicated.

**2**

When starting opioid therapy for pain control, clinicians should evaluate patients for risk factors associated with opioid-related harm, including sleep apnea, being 65 or older, mental health conditions, alcohol and/or substance use disorder, and history of opioid overdose.

**3**

Clinicians should provide information on the risks and benefits of opioid use to patients prior to starting opioid therapy so that they understand the treatment goals and have appropriate expectations for pain relief.

**4**

When providing an opioid prescription for pain control, clinicians should consider prescribing:

- a. Immediate-release products. Extended-Release/Long-Acting (ER/LA) opioid products should be avoided;
- b. The lowest effective starting dose for a given medication when providing an initial prescription; and
- c. The minimum amount needed to control the patient's pain. A three-day course or less is often sufficient; more than seven days of medication is rarely necessary.

**5**

When starting opioid therapy, clinicians are strongly encouraged to use the Illinois Prescription Monitoring Program (ILPMP). ILPMP data can help determine if a patient is already receiving other prescriptions for opioids or sedating medications such as benzodiazepines.

6

Clinicians should avoid concurrent prescribing of opioid pain medication and benzodiazepines when possible, as the Centers for Disease Control and Prevention (CDC) has determined there is an association between unintentional overdose and the use of opioid pain medication and benzodiazepines together.



7

Clinicians should provide patients who receive opioid prescriptions with information about the risks of developing opioid use disorder, the potential dangers to themselves and their family in misusing opioids, and appropriate storage and disposal of unused medications.

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## CHRONIC PAIN IN PATIENTS RECEIVING LONG-TERM OPIOID THERAPY

In addition to the acute pain guidelines, these recommendations provide information for treating patients on chronic opioid therapy who experience an exacerbation of chronic pain in the ED or immediate care setting.

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Care coordination is important when treating patients receiving chronic opioid therapy. When possible, clinicians should:

- a. Contact the provider who prescribes routine opioid therapy for the patient to discuss care options; and
- b. Review medical records and case management plans for patients who frequently visit the ED or acute care facilities with pain-related complaints.

9

Clinicians should exercise extreme caution when asked to provide replacement prescriptions for opioids that were lost, destroyed or stolen.

10

Clinicians should exercise extreme caution before prescribing replacement doses of medications used in the treatment of opioid use disorder, including buprenorphine products and methadone.

11

A review of CDC literature indicates that in patients receiving chronic opioid therapy, fatal overdoses occurred in those receiving average doses of  $\geq 90$  morphine milligram equivalents (MME) per day. Patients taking more than 50 MME/day have double the risk of overdose of patients taking  $\leq 20$  MME/day.

Clinicians should carefully assess patients receiving more than 50 MME/day and use extreme caution when considering providing additional opioid therapy to patients with a dosage of  $\geq 90$  MME/day. (See MME conversion table in Addendum.)



## PATIENTS WITH OPIOID USE DISORDER AND ADDICTION

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Hospitals and health systems should have a method for providing naloxone to patients deemed at risk of developing opioid use disorder or their family members (e.g. referral to a pharmacy that provides naloxone, provide a prescription for naloxone or other mechanism for patients to obtain the drug).

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Hospitals and health systems should develop a method to refer patients with opioid use disorder to medication-assisted treatment and behavioral healthcare.



## Commonly Prescribed Opioids and Morphine Milligram Equivalent (MME) Conversion Calculator

Generic Name	Extended-Release/ Long-Acting Formulation Common Brand Names	Immediate- Release Formulation Common Brand Names	MME Conversion Factor
Morphine	Arymo ER Kadian Morphabond MS Contin Embeda <i>Generic available</i>	Roxanol <i>Generic available</i>	1
Codeine		Tylenol #3 or #4 <i>Generic available</i>	0.15
Hydrocodone	Hysingla ER Zohydro ER	Vicodin Norco <i>Generic available</i>	1
Hydromorphone	Exalgo ER <i>Generic available</i>	Dilaudid Dilaudid-5 Hydrostat IR <i>Generic available</i>	4
Oxycodone	OxyContin Targiniq ER Troxyca ER Xtampza ER <i>Generic available</i>	Roxicodone Percolone Percocet	1.5
Oxymorphone	Opana ER	Opana Numorphan	3
Methadone	Dolphine Methadose <i>Generic available</i>		Dose Dependent Conversion: 1 - 20 mg/day: 4 21 - 40 mg/day: 8 41 - 60 mg/day: 12
Tapentadol	Nucynta ER Palexia		0.4

### EXAMPLE CALCULATION

Percocet 5 mg tablets every 6 hours = 20 mg oxycodone per day.

20 mg oxycodone X 1.5 (conversion factor) = 30 MME per day

# WORKGROUP

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**Convened by the Illinois Health and Hospital Association (IHA) and the Illinois College of Emergency Physicians (ICEP) in April 2017, the workgroup includes the following physicians:**

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## IMPORTANT NOTICE – DISCLAIMER

This document brings together recommendations of other organizations, including the Centers for Disease Control and Prevention, The Joint Commission, the American Medical Association, the American College of Emergency Physicians, the American Academy of Emergency Medicine and the State of Illinois Opioid Action Plan. This document is for informational purposes only. It does not establish a standard of care. It does not constitute professional advice or opinion. Treatment decisions must be based upon professional judgment given a patient's medical history and condition, a provider's policies and procedures, and other relevant facts and circumstances.

### FOR MORE INFORMATION

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### ABOUT THE SPONSORS

#### IHA

With offices in Chicago, Naperville, Springfield and Washington D.C., IHA is dedicated to advocating for Illinois' more than 200 hospitals and nearly 50 health systems as they serve patients and communities throughout the state.

#### ICEP

Dedicated to the support of quality emergency medical care in Illinois, ICEP is the state medical specialty society representing more than 1,340 emergency physicians in Illinois.

