



## General

### Guideline Title

VA/DoD clinical practice guideline for opioid therapy for chronic pain.

### Bibliographic Source(s)

Opioid Therapy for Chronic Pain Work Group. VA/DoD clinical practice guideline for opioid therapy for chronic pain. Version 3.0. Washington (DC): Department of Veterans Affairs, Department of Defense; 2017 Feb. 192 p. [259 references]

### Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Management of Opioid Therapy for Chronic Pain Working Group. VA/DoD clinical practice guideline for management of opioid therapy for chronic pain. Washington (DC): Department of Veterans Affairs, Department of Defense; 2010 May. 159 p.

This guideline meets NGC's 2013 (revised) inclusion criteria.

## Regulatory Alert

### FDA Warning/Regulatory Alert

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- [August 31, 2016 – Opioid pain and cough medicines combined with benzodiazepines](#) : A U.S. Food and Drug Administration (FDA) review has found that the growing combined use of opioid medicines with benzodiazepines or other drugs that depress the central nervous system (CNS) has resulted in serious side effects, including slowed or difficult breathing and deaths. FDA is adding Boxed Warnings to the drug labeling of prescription opioid pain and prescription opioid cough medicines and benzodiazepines.

## Recommendations

### Major Recommendations

*Note from the Department of Veterans Affairs and the Department of Defense (VA/DoD) and the National Guideline Clearinghouse (NGC):* The recommendations for the management of opioid therapy for chronic pain are organized into 4 modules with 4 algorithms. The accompanying recommendations are provided below. See the [original guideline document](#)  for the algorithms and

evidence tables associated with recommendations, including strength of recommendation, recommendation category, and supporting evidence citations.

The strength of recommendation grading (Strong For, Weak For, Strong Against, Weak Against) and recommendation categories (Reviewed, Not reviewed, New-added, New-replaced, Not changed, Amended, Deleted) are defined at the end of the "Major Recommendations" field.

### Initiation and Continuation of Opioids

#### Recommendation 1

- a. The Work Group recommends against initiation of long-term opioid therapy for chronic pain. (Strong against; Reviewed, New-replaced)
- b. The Work Group recommends alternatives to opioid therapy such as self-management strategies and other non-pharmacological treatments. (Strong for; Reviewed, New-replaced)
- c. When pharmacologic therapies are used, the Work Group recommends non-opioids over opioids. (Strong for; Reviewed, New-replaced)

#### Recommendation 2

If prescribing opioid therapy for patients with chronic pain, the Work Group recommends a short duration. (Strong for; Reviewed, New-added)

Note: Consideration of opioid therapy beyond 90 days requires re-evaluation and discussion with patient of risks and benefits.

#### Recommendation 3

For patients currently on long-term opioid therapy, the Work Group recommends ongoing risk mitigation strategies (see Recommendations 7-9), assessment for opioid use disorder, and consideration for tapering when risks exceed benefits (see Recommendation 14). (Strong for; Reviewed, New-replaced)

#### Recommendation 4

- a. The Work Group recommends against long-term opioid therapy for pain in patients with untreated substance use disorder. (Strong against; Reviewed, Amended)
- b. For patients currently on long-term opioid therapy with evidence of untreated substance use disorder, the Work Group recommends close monitoring, including engagement in substance use disorder treatment, and discontinuation of opioid therapy for pain with appropriate tapering (see Recommendations 14 and 17). (Strong for; Reviewed, Amended)

#### Recommendation 5

The Work Group recommends against the concurrent use of benzodiazepines and opioids. (Strong against; Reviewed, New-added)

Note: For patients currently on long-term opioid therapy and benzodiazepines, consider tapering one or both when risks exceed benefits and obtaining specialty consultation as appropriate (see Recommendation 14 and the NGC summary of the [VA/DoD clinical practice guideline for the management of substance use disorders](#)).

#### Recommendation 6

- a. The Work Group recommends against long-term opioid therapy for patients less than 30 years of age secondary to higher risk of opioid use disorder and overdose. (Strong against; Reviewed, New-replaced)
- b. For patients less than 30 years of age currently on long-term opioid therapy, the Work Group recommends close monitoring and consideration for tapering when risks exceed benefits (see Recommendations 14 and 17). (Strong for; Reviewed, New-replaced)

### Risk Mitigation

#### Recommendation 7

The Work Group recommends implementing risk mitigation strategies upon initiation of long-term opioid therapy, starting with an informed consent conversation covering the risks and benefits of opioid therapy as well as alternative therapies. The strategies and their frequency should be commensurate with risk factors and include:

- Ongoing, random urine drug testing (including appropriate confirmatory testing)
- Checking state prescription drug monitoring programs
- Monitoring for overdose potential and suicidality
- Providing overdose education
- Prescribing of naloxone rescue and accompanying education

(Strong for; Reviewed, New-replaced)

#### Recommendation 8

The Work Group recommends assessing suicide risk when considering initiating or continuing long-term opioid therapy and intervening when necessary. (Strong for; Reviewed, Amended)

#### Recommendation 9

The Work Group recommends evaluating benefits of continued opioid therapy and risk for opioid-related adverse events at least every three months. (Strong for; Reviewed, New-replaced)

#### Type, Dose, Follow-up, and Taper of Opioids

#### Recommendation 10

If prescribing opioids, the Work Group recommends prescribing the lowest dose of opioids as indicated by patient-specific risks and benefits. (Strong for; Reviewed, New-replaced)

Note: There is no absolutely safe dose of opioids.

#### Recommendation 11

As opioid dosage and risk increase, the Work Group recommends more frequent monitoring for adverse events including opioid use disorder and overdose. (Strong for; Reviewed, New-replaced)

Note:

- Risks for opioid use disorder start at any dose and increase in a dose dependent manner.
- Risks for overdose and death significantly increase at a range of 20-50 mg morphine equivalent daily dose.

#### Recommendation 12

The Work Group recommends against opioid doses over 90 mg morphine equivalent daily dose for treating chronic pain. (Strong against; Reviewed, New-replaced)

Note: For patients who are currently prescribed doses over 90 mg morphine equivalent daily dose, evaluate for tapering to reduced dose or to discontinuation (see Recommendations 15 and 16).

#### Recommendation 13

The Work Group recommends against prescribing long-acting opioids for acute pain, as an as-needed medication, or on initiation of long-term opioid therapy. (Strong against; Reviewed, New-replaced)

#### Recommendation 14

The Work Group recommends tapering to reduced dose or to discontinuation of long-term opioid therapy when risks of long-term opioid therapy outweigh benefits. (Strong for; Reviewed, New-added)

Note: Abrupt discontinuation should be avoided unless required for immediate safety concerns.

#### Recommendation 15

The Work Group recommends individualizing opioid tapering based on risk assessment and patient needs and characteristics. (Strong for; Reviewed, New-added)

Note: There is insufficient evidence to recommend for or against specific tapering strategies and schedules.

#### Recommendation 16

The Work Group recommends interdisciplinary care that addresses pain, substance use disorders, and/or mental health problems for patients presenting with high risk and/or aberrant behavior. (Strong for; Reviewed, New-replaced)

#### Recommendation 17

The Work Group recommends offering medication assisted treatment for opioid use disorder to patients with chronic pain and opioid use disorder. (Strong for; Reviewed, New-replaced)

Note: See the NGC summary of the VA/DoD clinical practice guideline for the management of substance use disorders.

## Opioid Therapy for Acute Pain

### Recommendation 18

- a. The Work Group recommends alternatives to opioids for mild-to-moderate acute pain. (Strong for; Reviewed, New-added)
- b. The Work Group suggests use of multimodal pain care including non-opioid medications as indicated when opioids are used for acute pain. (Weak for; Reviewed, New-added)
- c. If take-home opioids are prescribed, the Work Group recommends that immediate-release opioids are used at the lowest effective dose with opioid therapy reassessment no later than 3-5 days to determine if adjustments or continuing opioid therapy is indicated. (Strong for; Reviewed, New-added)

Note: Patient education about opioid risks and alternatives to opioid therapy should be offered.

### Definitions

The relative strength of the recommendation is based on a binary scale, "Strong" or "Weak." A strong recommendation indicates that the Work Group is highly confident that desirable outcomes outweigh undesirable outcomes. If the Work Group is less confident of the balance between desirable and undesirable outcomes, they present a weak recommendation.

Similarly, a recommendation for a therapy or preventive measure indicates that the desirable consequences outweigh the undesirable consequences. A recommendation against a therapy or preventive measure indicates that the undesirable consequences outweigh the desirable consequences.

The grade of each recommendation is presented as part of a continuum:

- Strong For (or "The Work Group recommends offering this option ...")
- Weak For (or "The Work Group suggests offering this option ...")
- Weak Against (or "The Work Group suggests not offering this option ...")
- Strong Against (or "The Work Group recommends against offering this option ...")

Note that weak (For or Against) recommendations may also be termed "Conditional," "Discretionary," or "Qualified." Recommendations may be conditional based upon patient values and preferences, the resources available, or the setting in which the intervention will be implemented. Recommendations may be at the discretion of the patient and clinician or they may be qualified with an explanation about the issues that would lead decisions to vary.

### Recommendation Categories and Definitions

For the use in the 2017 opioid treatment (OT) clinical practice guideline (CPG), a set of recommendation categories was adapted from those used by the United Kingdom National Institute for Health and Care Excellence (NICE). These categories, along with their corresponding definitions, were used to account for the various ways in which recommendations could have been updated.

Evidence Reviewed*	Recommendation Category*	Definition*
<b>Reviewed</b>	New-added	New recommendation following review of the evidence
	New-replaced	Recommendation from previous CPG that has been carried over to the updated CPG that has been changed following review of the evidence
	Not changed	Recommendation from previous CPG that has been carried forward to the updated CPG where the evidence has been reviewed but the recommendation is not changed
	Amended	Recommendation from the previous CPG that has been carried forward to the updated CPG where the evidence has been reviewed and a minor amendment has been made
	Deleted	Recommendation from the previous CPG that has been removed based on review of the evidence
<b>Not reviewed</b>	Not changed	Recommendation from previous CPG that has been carried forward to the updated CPG, but for which the evidence has not been reviewed
	Amended	Recommendation from the previous CPG that has been carried forward to the updated CPG where the evidence has not been reviewed and a minor amendment has been made

Evidence Reviewed*	Deleted Recommendation Category*	Recommendation from the previous CPG that has been removed because it was deemed out of scope for the updated CPG Definition*
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\*Adapted from the NICE guideline manual (2012) and Garcia et al. (2014).

Abbreviation: CPG: clinical practice guideline

## Clinical Algorithm(s)

The following algorithms are provided in the original guideline document:

- Module A: Determination of Appropriateness for Opioid Therapy
- Module B: Treatment with Opioid Therapy
- Module C: Tapering or Discontinuation of Opioid Therapy
- Module D: Patients Currently on Opioid Therapy

## Scope

### Disease/Condition(s)

Chronic pain

### Guideline Category

Counseling

Evaluation

Management

Risk Assessment

Treatment

### Clinical Specialty

Family Practice

Geriatrics

Internal Medicine

Neurology

Pharmacology

Physical Medicine and Rehabilitation

Psychiatry

Psychology

### Intended Users

Advanced Practice Nurses

Health Care Providers

Nurses

Occupational Therapists

Other

Pharmacists

Physical Therapists

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Social Workers

Substance Use Disorders Treatment Providers

## Guideline Objective(s)

- To provide healthcare providers with a framework by which to evaluate, treat, and manage the individual needs and preferences of patients with chronic pain who are on or being considered for long-term opioid therapy (LOT)
- To improve safe and appropriate prescribing and use of opioids to treat chronic pain

## Target Population

Adults 18 years or older including Veterans as well as deployed and non-deployed Active Duty Service Members, their beneficiaries, and retirees and their beneficiaries, with chronic pain who are receiving care from the Department of Veterans Affairs (VA) or Department of Defense (DoD) healthcare delivery systems

Note: This clinical practice guideline (CPG) is not intended for and does not provide recommendations for the management of pain with long-term opioid therapy (LOT) in children or adolescents, in patients with acute pain, or in patients receiving end-of-life care. As is so for any pharmacotherapy, any decision about prescribing opioids, or alternative medications for pain, for pregnant women should be made with due caution and cognizance of applicable U.S. Food and Drug Administration (FDA) labeling

## Interventions and Practices Considered

1. Initiation and continuation of opioid therapy (initiation of long-term opioid therapy for chronic pain is not recommended)
2. Concurrent use of benzodiazepines and opioids (not recommended)
3. Risk mitigation strategies upon initiation of long-term opioid therapy
  - Informed consent conversation covering the risks and benefits of opioid therapy as well as alternative therapies
  - Ongoing, random urine drug testing (including appropriate confirmatory testing)
  - Checking state prescription drug monitoring programs
  - Monitoring for overdose potential and suicidality
  - Providing overdose education
  - Prescribing of naloxone rescue and accompanying education
4. Assessment of suicide risk
5. Type, dose, follow-up, and tapering of opioid therapy
6. Opioid therapy for acute pain
  - Alternative to opioid therapy
  - Use of multimodal pain care
  - Use of intermediate-release opioids

## Major Outcomes Considered

- Pain relief
- Quality of life
- Cognitive/functional status
- Mortality
- Opioid abuse/misuse
- Adverse events

## Methodology

### Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

### Description of Methods Used to Collect/Select the Evidence

#### Developing the Scope and Key Questions

The clinical practice guideline (CPG) Champions, along with the Work Group, were tasked with identifying key questions (KQs) to guide the systematic review of the literature on long-term opioid therapy (LOT). These questions, which were developed in consultation with the Lewin Team, addressed clinical topics of the highest priority for the Department of Veterans Affairs (VA) and Department of Defense (DoD) populations. The KQs follow the population, intervention, comparison, outcome, timing, and setting (PICOTS) framework for evidence questions, as established by the Agency for Healthcare Research and Quality (AHRQ). Table E-1 in the original guideline document provides a brief overview of the PICOTS typology.

The Champions, Work Group, and evidence review team carried out several iterations of this process, each time narrowing the scope of the CPG and the literature review by prioritizing the topics of interest. Due to resource constraints, all developed KQs were not able to be included in the systematic review. Thus, the Champions and Work Group determined which questions were of highest priority, and those were included in the review. Table E-4 in the original guideline document contains the final set of KQs used to guide the systematic review for this CPG.

#### Conducting the Systematic Review

Extensive literature searches using the search terms and strategy included in Appendix J of the original guideline document identified 15,554 citations potentially addressing the KQs of interest to this evidence review. Of those, 11,633 were excluded upon title review for clearly not meeting inclusion criteria (e.g., not pertinent to the topic, not published in English, published prior to study inclusion publication date, not a full-length article). Overall, 3,921 abstracts were reviewed with 2,995 of those being excluded for the following reasons: not a systematic review or clinical study, did not address a KQ of interest to this review, did not enroll a population of interest, or published prior to March 1, 2009. A total of 926 full-length articles were reviewed. Of those, 478 were excluded at a first pass review for the following: not addressing a KQ of interest, not enrolling the population of interest, not meeting inclusion criteria for clinical study or systematic review, not meeting inclusion criteria for any KQ, or being a duplicate. A total of 448 full-length articles were thought to address one or more KQs and were further reviewed. Of these, 385 were ultimately excluded. Reasons for their exclusion are presented in Figure E-1 in the original guideline document.

Overall, 63 articles addressed one or more of the KQs and were considered as evidence in this review. Table E-4 in the original guideline document indicates the number of studies that addressed each of the questions.

At the face-to-face meeting, a sub-question of KQs 3 and 4 was added assessing the safety and effectiveness of non-invasive treatments for chronic pain in patients not receiving opioid therapy (OT). Searches to address this KQ were highly targeted to include systematic reviews only. Searches of EMBASE, PubMed, and PsycINFO were conducted through April 20, 2016. Five systematic reviews were included in the evidence base. Additionally, one systematic review was identified through hand searches of the literature and was also included in the final evidence base.

During the drafting process, two additional searches were performed. An additional search was added assessing the safety and effectiveness of take-home naloxone kits, a sub-question of KQ 7. Searches to address this intervention were highly targeted to include systematic reviews assessing use of take-home naloxone. Searches of EMBASE, PubMed, and PsycINFO were conducted through October 5, 2016. Two systematic reviews were included in the evidence base.

An additional sub-question assessing the need for follow-up after the prescription of opioids for acute pain was added to KQ 2 and an additional search was conducted. Searches to address this sub-question were broad, but the selection criteria were highly targeted to focus on prospective studies assessing risks associated with acute opioid use to treat acute pain. Searches of EMBASE, PubMed, and PsycINFO were conducted through December 20, 2016. Four retrospective cohorts and one secondary data analysis were included in the evidence base. Additionally, four studies already included in the evidence base for KQ 2 were used to inform the sub-question.

## Criteria for Study Inclusion/Exclusion

### *General Criteria*

- Clinical studies or systematic reviews published on or after March 1, 2009 to January 18, 2016. If multiple systematic reviews addressed a KQ, the most recent and/or comprehensive review was selected. Systematic reviews were supplemented with clinical studies published subsequent to the systematic review.
- Studies must have been published in English.
- Publication must have been a full clinical study or systematic review; abstracts alone were not included. Similarly, letters, editorials, and other publications that were not full-length clinical studies were not accepted as evidence.
- Study must have enrolled at least 20 patients (10 per study group) unless otherwise noted (see "Key Question Specific Criteria" section below).
- Study must have reported on an outcome of interest. Study must have enrolled a patient population in which at least 80% of patients were receiving OT for chronic pain of at least 12 weeks' duration (except for the sub-question of KQ 2a pertaining to risks associated with acute opioid use in acute pain, and KQ 7d on naloxone rescue). If the percentage is less than 80%, then data must have been reported separately for this patient subgroup.
- For outcomes measuring treatment effectiveness, patients must have been followed for at least 12 weeks.
- For KQ specific criteria, in the event that one or more KQs did not have sufficient evidence from the study designs specified below, lower-level evidence was evaluated for that KQ(s). Lower-level evidence was considered on a question-by-question basis.

### *Key Question Specific Criteria*

- For KQ 1, acceptable study designs included systematic reviews, randomized controlled studies (RCTs), or prospective cohort studies that statistically compared outcomes for patients with chronic pain and a co-occurring medical or mental health condition on OT to patients with chronic pain and no additional medical or mental health condition on OT. Large retrospective database studies (200 patients minimum) that performed multivariate statistical analyses of the effect of co-occurring conditions on patient outcomes were also acceptable.
- For KQ 2, acceptable study designs included systematic reviews, RCTs, or prospective cohort studies that statistically compared outcomes for patients with chronic pain and differences in potential risk factors for developing opioid misuse or opioid use disorder (OUD). For LOT, large retrospective database studies (200 patients minimum) that performed multivariate statistical analyses of the effect of risk factors on patient outcomes were also acceptable. For KQ 2a, studies were limited to prospective study design.
- For KQs 3-6, 8, and 9, acceptable study designs included systematic reviews of RCTs and/or individual RCTs.
- For KQ 7, acceptable study designs included systematic reviews of RCTs, individual RCTs, or nonrandomized comparative studies.

## Literature Search Strategy

### *Bibliographic Databases*

- The Cochrane Central Register of Controlled Trials (CENTRAL) - 11/24/15 (Wiley)
- The Cochrane Database of Methodology Reviews (Methodology Reviews) - 11/24/15 (Wiley)
- The Cochrane Database of Systematic Reviews (Cochrane Reviews) - 11/24/15 (Wiley)
- Database of Abstracts of Reviews of Effects - 11/24/15 (Wiley)
- EMBASE (Excerpta Medica) - 12/20/16 (Elsevier)
- Health Technology Assessment Database (HTA) - 11/24/15 (Wiley)
- MEDLINE/PreMEDLINE - 12/20/16 (OVIDSP)
- PsycINFO - 12/21/16 (OVIDSP)
- PubMed (In-process and Publisher records) - 12/20/16 (National Library of Medicine [NLM])



## Gray Literature Resources

- Agency for Healthcare Research and Quality (AHRQ) - 11/30/15 (AHRQ)
- Healthcare Standards database - 11/30/15 (ECRI Institute)
- National Guideline Clearinghouse™ - 11/30/15 (AHRQ)
- National Institute of Health and Care Excellence - 11/30/15 (National Health Service [NHS])

Information on the search strategies, including topic-specific search terms can be found in Appendix J in the original guideline document.

## Number of Source Documents

Overall, 63 articles addressed one or more of the key questions (KQs) and were considered as evidence in this review. Table E-4 in the original guideline document indicates the number of studies that addressed each of the questions. See also Figure E-1 in the original guideline document for a study flow diagram.

Thirteen additional studies were added during later searches. These studies were added as the search criteria for some of the key questions was expanded to further inform the recommendations (see "Conducting the Systematic Review" in the original guideline document).

## Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

### Rating Scheme for the Strength of the Evidence

#### Quality of Evidence and Definitions\*

High quality — Further research is very unlikely to change confidence in the estimate of effect.
Moderate quality — Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate.
Low quality — Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate.
Very low quality — Any estimate of effect is very uncertain.

\*Guyatt, G. H., Oxman, A. D., Vist, G. E., Kunz, R., Falck-Ytter, Y., Alonso-Coello, P., Schünemann, H. J. & the GRADE Working Group. (2008). GRADE; An emerging consensus on rating quality of evidence and strength of recommendations. *BMJ*, 336, 924-926.

## Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

### Description of the Methods Used to Analyze the Evidence

#### Abstracting and Managing Data

For each study included in the systematic review, the reviewers abstracted the following study level details: country, purpose, and quality rating. For previous systematic reviews, the reviewers reported the search strategy used, study selection criteria, and overall information about the evidence base, including number of included studies and overall patients enrolled. For all studies, they abstracted data about characteristics of the included patients and interventions being assessed.

#### Assessing Individual Studies' Methodological Quality (i.e., Internal Validity or Risk of Bias)

As per the Department of Veterans Affairs/Department of Defense (VA/DoD) *Guidelines for Guidelines* document, risk-of-bias (or study

quality) of individual studies and previous systematic reviews was assessed using the U.S. Preventive Services Task Force (USPSTF) method. Each study was assigned a rating of Good, Fair, or Poor based on sets of criteria that vary depending on study design. Detailed lists of criteria and definitions of Good, Fair, or Poor ratings for different study designs appear in Appendix VII of the [USPSTF procedure manual](#)

Because the USPSTF does not have criteria specific for evaluation of prognostic studies, reviewers rated the quality of prognostic studies using the recently-developed Quality in Prognosis Studies tool. This instrument assesses potential bias related to six domains: study participation, study attrition, prognostic factor measurement, outcome measurement, study confounding, and statistical analysis and reporting.

### Data Synthesis

The evidence review team used a narrative approach to synthesizing the evidence for all the key questions. As indicated in the VA/DoD *Guidelines for Guidelines* document, the first line of evidence was previous systematic reviews. For questions in which a previous review was available, individual studies that met this review's inclusion criteria were used to supplement or update the previous review. The reviewers considered whether subsequent evidence supports the conclusions reported in the previous review. For questions for which no previous review was available, the reviewers summarized the overall findings for the outcomes of interest of the studies that addressed a key question.

### Assessing the Overall Quality of the Body of Evidence for an Outcome

The overall quality of the body of evidence supporting the findings for the outcomes of interest in this report was assessed using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system. The GRADE system primarily involves consideration of the following factors: overall study quality (or overall risk of bias or study limitations), consistency of evidence, directness of evidence, and precision of evidence. Given time and resources, other factors such as publication bias may also be considered. For more information on the GRADE system go to the [GRADE working group Web site](#)

The GRADE system rates the overall quality of the evidence as high, moderate, low, and very low (see the "Rating Scheme for the Strength of the Evidence" field). For instance, a body of evidence that consists of randomized controlled trials (RCTs) automatically starts with a rating of high quality. This rating can be downgraded if some of the RCTs have serious flaws such as lack of blinding of outcome assessors, not reporting concealment of allocation, or high dropout rate. Similarly, the quality can be downgraded or further downgraded if inconsistencies of findings are present or if there is a lack of precision surrounding an outcome's effect size.

### Assessing Applicability

When describing the evidence base addressing a key question, the reviewers discussed aspects of the included studies, such as characteristics of included patients and treatments being assessed that may make the overall findings of the studies more or less applicable to the population, treatments, or outcomes of interest to the review.

## Methods Used to Formulate the Recommendations

### Expert Consensus

## Description of Methods Used to Formulate the Recommendations

### Methods

The current guideline is an update to the 2010 *Department of Veterans Affairs/Department of Defense (VA/DoD) Clinical Practice Guideline (CPG) for the Management of Opioid Therapy for Chronic Pain*. The methodology used in developing the 2017 CPG follows the VA/DoD *Guideline for Guidelines*, an internal document of the VA and DoD Evidence-Based Practice Working Group (EBPWG) (see the "Availability of Companion Documents" field). This document provides information regarding the process of developing guidelines, including the identification and assembly of the Guideline Champions ("Champions") and other subject matter experts from within the VA and DoD, known as the "Work Group," and ultimately, the development and submission of an updated opioid therapy (OT) CPG. The VA Office of Quality, Safety and Value, in collaboration with the Office of Evidence Based Practice, U.S. Army Medical Command, the proponent for CPGs for the DoD, identified two clinical leaders as Champions for the 2017 CPG.

The Champions and Work Group for this CPG were charged with developing evidence-based clinical practice recommendations and writing and publishing a guideline document to be used by providers within the VA and DoD healthcare systems. Specifically, the Champions and the Work Group were responsible for identifying the key questions (KQs) – those considered most clinically relevant, important, and interesting with respect

to the management of patients with chronic pain on or being considered for long-term opioid therapy (LOT). The Champions and the Work Group also provided direction on inclusion and exclusion criteria for the evidence review and assessed the level and quality of the evidence. The amount of new scientific evidence that had accumulated since the previous version of the CPG was taken into consideration in the identification of the KQs. In addition, the Champions assisted in:

- Identifying appropriate disciplines of individuals to be included as part of the Work Group
- Directing and coordinating the Work Group
- Participating throughout the guideline development and review processes

The Lewin Team, including The Lewin Group, Duty First Consulting, ECRI Institute, and Sigma Health Consulting, LLC, was contracted by the VA and DoD to support the development of this CPG and conduct the evidence review. The first conference call was held in October 2015, with participation from the contracting officer's representative (COR), leaders from the VA Office of Quality, Safety and Value and the DoD Office of Evidence Based Practice, and the Champions. During this call, participants discussed the scope of the guideline initiative, the roles and responsibilities of the Champions, the project timeline, and the approach for developing and prioritizing specific research questions on which to base a systematic review about the management of LOT. The group also identified a list of clinical specialties and areas of expertise that were important and relevant to the management of LOT, from which Work Group members were recruited. The specialties and clinical areas of interest included: anesthesiology, addictive disorders and addiction medicine, clinical neurophysiology, family medicine, geriatrics, internal medicine, mental/behavioral health, neurology, nursing, pain management, pain medicine, pain psychology, palliative care, pharmacy, physical medicine and rehabilitation, physical therapy, primary care, psychiatry, psychology, and social work.

The guideline development process for the 2017 CPG update consisted of the following steps:

1. Formulating and prioritizing KQs (or evidence questions)
2. Conducting the systematic review of the literature
3. Convening a face-to-face meeting with the CPG Champions and Work Group
4. Drafting, revising, and submitting a final CPG about the management of LOT to the VA/DoD EBPWG

Appendix E in the original guideline document provides a detailed description of each of these tasks.

#### Convening the Face-to-face Meeting

In consultation with the COR, the Champions, and the Work Group, the Lewin Team convened a three and a half day face-to-face meeting of the CPG Champions and Work Group on April 5-8, 2016. These experts were gathered to develop and draft the clinical recommendations for an update to the 2010 OT CPG. Lewin presented findings from the evidence review of KQs 1-9 in order to facilitate and inform the process.

Under the direction of the Champions, the Work Group was charged with interpreting the results of the evidence review, and asked to categorize and carry forward recommendations from the 2010 OT CPG, modifying the recommendations as necessary. The members also developed new clinical practice recommendations not presented in the 2010 OT CPG, based on the 2016 evidence review. The subject matter experts were divided into two smaller subgroups at this meeting.

As the Work Group drafted clinical practice recommendations, they also assigned a grade for each recommendation based on a modified Grading of Recommendations Assessment, Development and Evaluation (GRADE) and U.S. Preventive Services Task Force (USPSTF) methodology. Each recommendation was graded by assessing the quality of the overall evidence base, the associated benefits and harms, the variation in values and preferences, and other implications of the recommendation.

In addition to developing recommendations during the face-to-face meeting, the Work Group also revised the 2010 OT CPG algorithm to reflect the new and amended recommendations. They discussed the available evidence as well as changes in clinical practice since 2010, as necessary, to update the algorithm.

#### Grading Recommendations

This CPG uses the GRADE methodology to assess the quality of the evidence base and assign a grade for the strength for each recommendation. The GRADE system uses the following four domains to assess the strength of each recommendation:

- Balance of desirable and undesirable outcomes
- Confidence in the quality of the evidence
- Values and preferences
- Other implications, as appropriate, e.g.:
  - Resource Use

- Equity
- Acceptability
- Feasibility
- Subgroup considerations

The framework presented in Table E-6 in the original guideline document was used by the Work Group to guide discussions on each domain.

The strength of a recommendation is defined as the extent to which one can be confident that the desirable effects of an intervention outweigh its undesirable effects and is based on the framework in Table E-6, which combines the four domains. GRADE methodology does not allow for recommendations to be made based on expert opinion alone. While strong recommendations are usually based on high or moderate confidence in the estimates of effect (quality of the evidence) there may be instances where strong recommendations are warranted even when the quality of evidence is low. In these types of instances where the balance of desirable and undesirable outcomes and values and preferences played large roles in determining the strength of a recommendation, this is explained in the discussion section for the recommendation (see the original guideline document).

The GRADE of a recommendation (see the "Rating Scheme for the Strength of the Recommendations" field) is based on the following elements:

- Four decision domains used to determine the strength and direction
- Relative strength (Strong or Weak)
- Direction (For or Against)

### Reconciling 2010 CPG Recommendations

Evidence-based CPGs should be current, which typically requires revisions of previous guidelines based on new evidence or as scheduled, subject to time-based expirations. For example, USPSTF has a process for refining or otherwise updating its recommendations pertaining to preventive services. Further, the inclusion criteria for the National Guideline Clearinghouse (NGC) specify that a guideline must have been developed, reviewed, or revised within the past five years.

The 2017 OT CPG is an update of the 2010 CPG. Thus, the structure and content of the 2017 CPG is reflective of the previous version of the CPG, but modified where necessary to reflect new evidence and new clinical priorities.

The Work Group focused largely on developing new and updated recommendations based on the evidence review conducted for the priority areas addressed by the KQs. In addition to those new and updated recommendations, the Work Group considered the current applicability of other recommendations that were included in the previous 2010 OT CPG without complete review of the relevant evidence, subject to evolving practice in today's environment.

To indicate which recommendations were developed based on the updated review of the evidence versus recommendations that were carried forward from the 2010 version of the CPG, a set of recommendation categories was adapted from those used by the National Institute for Health and Care Excellence (NICE). These categories, along with their corresponding definitions, were used to account for the various ways in which older recommendations could have been updated. In brief, the categories took into account whether or not the evidence that related to a recommendation was systematically reviewed, the degree to which the recommendation was modified, and the degree to which a recommendation is relevant in the current patient care environment and inside the scope of the CPG (see the "Rating Scheme for the Strength of the Recommendations" field). Additional information regarding these categories and their definitions can be found in Appendix E in the original guideline document. The categories for the recommendations included in the 2017 CPG can be found in the "Major Recommendations" field. The categorizations for each 2010 CPG recommendation is provided in Appendix H in the original guideline document.

Between the development of the 2010 and 2017 versions of the OT CPG, VA/DoD adopted a new evidence rating system. The CPG Work Group recognized the need to accommodate this transition in evidence rating systems from the USPSTF system in the 2010 CPG to the GRADE system in the 2017 CPG. In order to report the strength of all recommendations using a consistent format (i.e., the GRADE system) the Work Group converted the USPSTF evidence grades accompanying the carryover recommendations from the 2010 guideline to the GRADE system. As such, the CPG Work Group considered the strength of the evidence cited for each recommendation in the 2010 OT CPG as well as harms and benefits, values and preferences, and other implications, where possible.

In cases where a 2010 OT CPG recommendation was covered by a 2017 KQ, peer-reviewed literature published since the 2010 OT CPG was considered along with the evidence base used for the 2010 CPG. Where new literature was considered in converting the strength of the recommendation from the USPSTF to the GRADE system, it is referenced in the discussion following the corresponding recommendation, as well as in Appendix G in the original guideline document.

The CPG Work Group recognizes that, while there are practical reasons for incorporating findings from a previous systematic review, previous

recommendations, or recent peer-reviewed publications into an updated CPG, doing so does not involve an original, comprehensive systematic review and, therefore, may introduce bias.

### Summary of Patient Focus Group Methods and Findings

When forming guideline recommendations, consideration should be given to the values of those most affected by the recommendations: patients. Patients bring perspectives, values, and preferences into their healthcare experience, and more specifically their pain care experience, that can vary from those of clinicians. These differences can affect decision making in various situations, and should thus be highlighted and made explicit due to their potential to influence a recommendation's implementation. Focus groups can be used as an efficient method to explore ideas and perspectives of a group of individuals with an a priori set of assumptions or hypotheses and collect qualitative data on a thoughtfully predetermined set of questions.

Therefore, as part of the effort to update this CPG, VA and DoD Leadership, along with the OT CPG Work Group, held a patient focus group on December 14, 2015, at the Washington DC VA Medical Center. One additional family caregiver was interviewed separately at a later date. The aim of the focus group and interview was to further the understanding of the perspectives of patients receiving OT within the VA and/or DoD healthcare systems. The focus group and interview explored patient perspectives on a set of topics related to management of OT in the VA and DoD healthcare systems, including knowledge of OT and other pain treatment options, delivery of care, and the impact of and challenges with OT and chronic pain.

It is important to note the focus group was a convenience sample and the Work Group recognizes the limitations inherent in the small sample size. Less than 10 people were included in the focus group so the additional time needed for the Office of Management and Budget (OMB) clearance would not be necessary. The Work Group acknowledges that the sample of patients included in this focus group may not be representative of all VA and DoD patients on or being considered for OT for chronic pain. Further, time limitations for the focus group prevented exhaustive exploration of all topics related to pain care in the VA and DoD and the patients' broader experiences with their care. Thus, the Work Group made decisions regarding the priority of topics to discuss at the focus group and interview. These limitations, as well as others, were considered as the information collected from the discussion was used for guideline development. Recruitment for participation in the focus group was managed by the Champions and VA and DoD Leadership, with assistance from coordinators at the facility at which the focus group took place.

The OT CPG Focus Group Concepts are ideas and suggestions about aspects of care that are important to patients and family caregivers and that emerged from the discussion and are listed in the original guideline document. These concepts were needed and important parts of the participants' care and added to the Work Group's understanding of patient values and perspectives. Additional details regarding the patient focus group methods and findings can be found in Appendix F.

### Drafting and Submitting the Final Clinical Practice Guideline

Following the face-to-face meeting, the Champions and Work Group members were given writing assignments to craft discussion sections to support each of the new recommendations and/or to update discussion sections from the 2010 OT CPG to support the amended "carried forward" recommendations. The Work Group also considered tables, appendices, and other sections from the 2010 OT CPG for inclusion in the update. During this time, the Champions and Work Group also made additional revisions to the algorithm, as necessary.

## Rating Scheme for the Strength of the Recommendations

The relative strength of the recommendation is based on a binary scale, "Strong" or "Weak." A strong recommendation indicates that the Work Group is highly confident that desirable outcomes outweigh undesirable outcomes. If the Work Group is less confident of the balance between desirable and undesirable outcomes, they present a weak recommendation.

Similarly, a recommendation for a therapy or preventive measure indicates that the desirable consequences outweigh the undesirable consequences. A recommendation against a therapy or preventive measure indicates that the undesirable consequences outweigh the desirable consequences.

Using these elements, the grade of each recommendation is presented as part of a continuum:

- Strong For (or "The Work Group recommends offering this option ...")
- Weak For (or "The Work Group suggests offering this option ...")
- Weak Against (or "The Work Group suggests not offering this option ...")
- Strong Against (or "The Work Group recommends against offering this option ...")

Note that weak (For or Against) recommendations may also be termed "Conditional," "Discretionary," or "Qualified." Recommendations may be conditional based upon patient values and preferences, the resources available, or the setting in which the intervention will be implemented. Recommendations may be at the discretion of the patient and clinician or they may be qualified with an explanation about the issues that would lead decisions to vary.

### Recommendation Categories and Definitions

For use in the 2017 opioid therapy (OT) Clinical Practice Guideline (CPG), a set of recommendation categories was adapted from those used by the United Kingdom National Institute for Health and Care Excellence (NICE). These categories, along with their corresponding definitions, were used to account for the various ways in which recommendations could have been updated from the 2010 CPG.

<b>Evidence Reviewed*</b>	<b>Recommendation Category*</b>	<b>Definition*</b>
<b>Reviewed</b>	New-added	New recommendation following review of the evidence
	New-replaced	Recommendation from previous CPG that has been carried over to the updated CPG that has been changed following review of the evidence
	Not changed	Recommendation from previous CPG that has been carried forward to the updated CPG where the evidence has been reviewed but the recommendation is not changed
	Amended	Recommendation from the previous CPG that has been carried forward to the updated CPG where the evidence has been reviewed and a minor amendment has been made
	Deleted	Recommendation from the previous CPG that has been removed based on review of the evidence
<b>Not reviewed</b>	Not changed	Recommendation from previous CPG that has been carried forward to the updated CPG, but for which the evidence has not been reviewed
	Amended	Recommendation from the previous CPG that has been carried forward to the updated CPG where the evidence has not been reviewed and a minor amendment has been made
	Deleted	Recommendation from the previous CPG that has been removed because it was deemed out of scope for the updated CPG

\*Adapted from the NICE guideline manual (2012) and Garcia et al. (2014).

Abbreviation: CPG: clinical practice guideline

See Appendix A in the original guideline document for further details on categorization.

## Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

## Method of Guideline Validation

External Peer Review

Internal Peer Review

## Description of Method of Guideline Validation

After developing the initial draft of the updated clinical practice guideline (CPG), an iterative review process was used to solicit feedback on and make revisions to the CPG. Once they were developed, the first two drafts of the CPG were posted on a wiki Web site for a period of 14 to 20 business days for internal review and comment by the Work Group. All feedback submitted during each review period was reviewed and discussed by the Work Group and appropriate revisions were made to the CPG.

Draft 3 of the CPG was made available for peer review and comment. This process is described in the "Peer Review Process" section in the original guideline document. After revisions were made based on the feedback received during the peer review and comment period, the

Champions presented the CPG to the Evidence Based Practice Work Group (EBPWG) for their approval. Changes were made based on feedback from the EBPWG and the guideline was finalized.

The final 2017 opioid therapy (OT) CPG was submitted to the EBPWG in February 2017.

## Evidence Supporting the Recommendations

### Type of Evidence Supporting the Recommendations

Table E-4 in the original guideline documents indicates the number and type of studies that addressed each of the questions. The evidence base consists of systematic reviews, randomized controlled trials, prospective and retrospective cohort studies, nested case-control studies, a post-hoc pooled analysis, and a case-cohort study.

## Benefits/Harms of Implementing the Guideline Recommendations

### Potential Benefits

- Appropriate use of opioids to control chronic pain
- The expected outcome of successful implementation of this guideline is to:
  - Assess the patient's condition, provide education, and determine the best treatment methods in collaboration with the patient and a multidisciplinary care team
  - Optimize the patient's health outcomes and function and improve quality of life
  - Minimize preventable complications and morbidity
  - Emphasize the use of patient-centered care

Refer to the "Discussion" sections following each recommendation in the original guideline document for information on the balance between benefits and harms for specific recommendations.

### Potential Harms

Adverse events of opioids include substance use disorder (SUD); aberrant use; overdose; non-pain use of opiates; abuse; addictions; cardiovascular events; respiratory depression; gastrointestinal complications (including constipation); endocrinological complications (including impotence); weight gain; cognitive performance; psychiatric decompensation; psychological symptoms (e.g., depression, loss of libido, nightmares); headaches; suicide; accidents (including falls); infections; increased risk of human immunodeficiency virus (HIV) and hepatitis A, B, and C; and loss to follow-up/medical care.

Refer to the "Discussion" sections following each recommendation in the original guideline document for information on the balance between benefits and harms for specific recommendations.

See also Appendix D in the original guideline document for more information regarding potential harms of specific short-term and long-term opioid drugs used to manage chronic pain.

## Contraindications

### Contraindications

- The clinician should communicate to patients that drug diversion is a crime and constitutes an absolute contraindication to prescribing additional medications.
- Concomitant use of benzodiazepines is considered a contraindication to initiation of opioid therapy (OT).
- Refer to the "Major Recommendations" for additional recommendations against initiation of OT or long-term OT.

See Appendix D in the original guideline for more information on contraindications including contraindications to use of other drugs while on OT.

## Qualifying Statements

### Qualifying Statements

- The Department of Veterans Affairs (VA) and the Department of Defense (DoD) guidelines are based on the best information available at the time of publication. They are designed to provide information and assist in decision-making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.
- This Clinical Practice Guideline (CPG) is based on a systematic review of both clinical and epidemiological evidence. Developed by a panel of multidisciplinary experts, it provides a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendation.
- Variations in practice will inevitably and appropriately occur when clinicians take into account the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every healthcare professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation.
- These guidelines are not intended to represent TRICARE policy. Further, inclusion of recommendations for specific testing and/or therapeutic interventions within these guidelines does not guarantee coverage of civilian sector care. Additional information on current TRICARE benefits may be found at [www.tricare.mil](http://www.tricare.mil)  or by contacting your regional TRICARE Managed Care Support Contractor.

## Implementation of the Guideline

### Description of Implementation Strategy

This clinical practice guideline (CPG), including its recommendations and algorithms, is designed to be adapted by healthcare providers for the treatment of individual patients, bearing in mind patient-level considerations as well as local needs and resources. The algorithms serve as a tool to prompt providers to consider key decision points in the course of care.

Although this CPG represents the state of the recommended practice on the date of its publication, medical practice is evolving and this evolution requires continuous updating of published information. New technology and more research will improve patient care in the future. Identifying areas where evidence was lacking for the 2017 CPG can help identify priority areas for future research. Future studies examining the results of opioid therapy (OT) CPG implementation may lead to the development of new evidence particularly relevant to clinical practice.

### Implementation Tools

Chart Documentation/Checklists/Forms

Clinical Algorithm

Patient Resources

Pocket Guide/Reference Cards

Quick Reference Guides/Physician Guides

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

## Institute of Medicine (IOM) National Healthcare Quality Report Categories



## IOM Care Need

Living with Illness

## IOM Domain

Effectiveness

Patient-centeredness

Safety

## Identifying Information and Availability

### Bibliographic Source(s)

Opioid Therapy for Chronic Pain Work Group. VA/DoD clinical practice guideline for opioid therapy for chronic pain. Version 3.0. Washington (DC): Department of Veterans Affairs, Department of Defense; 2017 Feb. 192 p. [259 references]

### Adaptation

Not applicable: The guideline was not adapted from another source.

### Date Released

2017 Feb

### Guideline Developer(s)

Department of Defense - Federal Government Agency [U.S.]

Department of Veterans Affairs - Federal Government Agency [U.S.]

Veterans Health Administration - Federal Government Agency [U.S.]

### Source(s) of Funding

United States Government

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The Opioid Therapy for Chronic Pain Work Group

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## Financial Disclosures/Conflicts of Interest

At the start of this guideline development process and at other key points throughout, the project team was required to submit disclosure statements to reveal any areas of potential conflict of interest (COI) in the past 24 months. Verbal affirmations of no COI were also used as necessary during meetings throughout the guideline development process. The project team was also subject to random web-based surveillance (e.g., ProPublica).

If a project team member reported a COI (actual or potential), measures were in place to mitigate the introduction of bias into the guideline development process. Identified COIs would be reported to the Office of Evidence Based Practice and disclosed to the clinical practice guideline (CPG) Work Group in tandem with their review of the evidence and development of recommendations. The Office of Evidence Based Practice and the opioid therapy (OT) CPG Work Group would then determine whether or not action, such as restricting participation and/or voting on sections related to the conflict or removal from the Work Group, was necessary. If deemed necessary, action would have been taken by the co-chairs and the Office of Evidence Based Practice, based on the level and extent of involvement, to mitigate the COI.

No OT CPG Work Group members reported relationships and/or affiliations which had the potential to introduce bias; thus, no further action was taken to mitigate COIs for this particular CPG.

## Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Management of Opioid Therapy for Chronic Pain Working Group. VA/DoD clinical practice guideline for management of opioid therapy for chronic pain. Washington (DC): Department of Veterans Affairs, Department of Defense; 2010 May. 159 p.

This guideline meets NGC's 2013 (revised) inclusion criteria.

## Guideline Availability

Available from the [Department of Veterans Affairs Web site](#) .

## Availability of Companion Documents

The following are available:

- VA/DoD clinical practice guideline for opioid therapy for chronic pain. Clinician summary. Washington (DC): Department of Veterans Affairs, Department of Defense; 2017 Feb. 30 p. Available from the [Department of Veterans Affairs \(VA\) Web site](#)

[redacted]

- VA/DoD clinical practice guideline for opioid therapy for chronic pain. Pocket card. Washington (DC): Department of Veterans Affairs, Department of Defense; 2017 Feb. 7 p. Available from the [VA Web site](#) [redacted].
- Guideline for guidelines. Washington (DC): Department of Veterans Affairs; 2013 Apr 10. 26 p. Available from the [VA Web site](#) [redacted].
- Putting clinical practice guidelines to work in VHA. Washington (DC): Department of Veterans Affairs. 64 p. Available from the [VA Web site](#) [redacted].

In addition, the following are available in the appendices of the [original guideline document](#) [redacted]:

- VA signature informed consent form for long-term opioid therapy for pain
- Benefits of urine drug testing
- Types of urine drug testing
- Diagnostic and Statistical Manual of Mental Disorders for opioid use disorders
- Drug tables (for short-acting, orally administered opioids; long-acting/extended-release opioids; morphine milligram equivalent doses; and methadone dosing guidance)
- Patient focus group methods and findings

## Patient Resources

The following is available:

- VA/DoD clinical practice guideline for opioid therapy for chronic pain. Patient summary. Washington (DC): Department of Veterans Affairs, Department of Defense; 2017 Feb. 6 p. Available from the [Department of Veterans Affairs \(VA\) Web site](#) [redacted].

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

## NGC Status

This NGC summary was completed by ECRI on August 2, 2004. This summary was updated on May 3, 2005 following the withdrawal of Bextra (valdecoxib) from the market and the release of heightened warnings for Celebrex (celecoxib) and other nonselective nonsteroidal anti-inflammatory drugs (NSAIDs). This summary was updated by ECRI on June 16, 2005, following the U.S. Food and Drug Administration advisory on COX-2 selective and non-selective non-steroidal anti-inflammatory drugs (NSAIDs). This summary was updated by ECRI on July 15, 2005 following the FDA advisory on Duragesic. This summary was updated by ECRI Institute on April 1, 2009 following the FDA advisory on Reglan (metoclopramide). This summary was updated by ECRI Institute on October 11, 2010. This summary was updated by ECRI Institute on March 16, 2011 following the U.S. Food and Drug Administration advisory on acetaminophen-containing prescription products. This summary was updated by ECRI Institute on October 28, 2013 following the U.S. Food and Drug Administration advisory on Acetaminophen. This summary was updated by ECRI Institute on September 18, 2015 following the U.S. Food and Drug Administration advisory on non-aspirin nonsteroidal anti-inflammatory drugs (NSAIDs). This summary was completed by ECRI Institute on April 12, 2017. The information was verified by the guideline developer on April 19, 2017.

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