



RECOMMENDATION 4

When opioids are initiated 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 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 (recommendation category: a; evidence type: 3).

SUPPORTING RATIONALE

“When opioids are used for acute, subacute, or chronic pain, clinicians should start opioids at the lowest possible effective dosage. For patients not already taking opioids, the lowest effective dose can be determined using product labeling as a starting point with calibration as needed on the basis of the severity of pain and other clinical factors, such as renal or hepatic insufficiency (see Recommendation 8). The lowest starting dose for opioid-naïve patients is often equivalent to a single dose of approximately 5–10 MME or a daily dosage of 20–30 MME/day. A listing of common opioid medications and their doses in MME equivalents is provided (Table). For example, a label for hydrocodone bitartrate (5 mg) and acetaminophen (300 mg) (207) states that the usual adult dosage is one or two tablets every 4–6 hours as needed for pain, and the total daily dosage should not exceed eight tablets. Clinicians should use additional caution when initiating opioids for patients aged ≥ 65 years and patients with renal or hepatic insufficiency because of a potentially smaller therapeutic window between safe dosages and dosages associated with respiratory depression and overdose (see Recommendation 8). Formulations with lower opioid doses (e.g., hydrocodone bitartrate 2.5 mg/acetaminophen 325 mg) are available and can facilitate dosing when additional caution is needed. Product labeling regarding tolerance includes guidance for patients already taking opioids. In addition to opioids, clinicians should consider cumulative dosages of other medications, such as acetaminophen, that are combined with opioids in many formulations and for which decreased clearance of medications might result in accumulation of medications to toxic levels.”

TABLE. Morphine milligram equivalent doses for commonly prescribed opioids for pain management

Opioid	Conversion factor*
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1.0
Hydromorphone	5.0
Methadone	4.7
Morphine	1.0
Oxycodone	1.5
Oxymorphone	3.0
Tapentadol [†]	0.4
Tramadol [§]	0.2



CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022: Recommendation 4

CHAMBERLAIN UNIVERSITY

Reference

Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: <http://dx.doi.org/10.15585/mmwr.rr7103a1>