



## Opioids Prescribing Guidelines for Emergency Departments and Emergency Physicians

***These guidelines are to provide a general approach in the prescribing of opioids and other controlled substances in an emergency setting. They are not intended to take the place of clinical judgment, which should always be utilized to provide the most appropriate care to meet the unique needs of each patient.***

1. Prior to prescribing opioids, consider if non-opioids or non-pharmacologic therapies are adequate for pain control.
2. Prior to prescribing opioids, consider a patient's risk of abuse or diversion.
3. Whenever indicated, review the patient's history of controlled substance prescriptions using the Wisconsin 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. Starting April 2017, Wisconsin state law requires prescribers to review the PDMP before prescribing any controlled substance for greater than a three-day supply.
4. Use urine drug testing to assess for controlled prescription drugs and other illicit drugs if the results of such urine testing would help determine if opioid medications are a safe prescription option for a patient.
5. When prescribing opioid therapy, use immediate-release opioids rather than extended-release or long-acting opioids.
6. When prescribing opioids, determine strength and quantity of the prescription as the lowest effective dose and the shortest duration of time necessary to treat the condition. Prescriptions for three days or less will often be sufficient; more than seven days will rarely be needed.
7. Avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
8. Avoid using intravenous or intramuscular opioid injections for patients with exacerbations of chronic non-cancer pain.
9. Avoid prescribing controlled substances for patients who have run out of previously prescribed medication or have had previous prescriptions lost or stolen. A dedicated provider, such as a primary care provider or pain specialist, should provide all opioids to treat chronic pain.
10. Communicate with a patient's dedicated provider whenever necessary to best honor existing patient-physician pain contracts, to ensure they have realistic expectations about the opioid use practices in the emergency department, and discuss if an outpatient plan exists that would allow safe variance from typical emergency provider opioid prescribing practice.
11. Identify patients at risk of opioid abuse or misuse and refer them to appropriate psychiatric, substance abuse, or pain management specialists.

*Approved by WACEP Board of Directors, October 4, 2016*