B. Module B: Treatment with Opioid Therapy

1. Candidate for trial of OT with consent (in conjunction with comprehensive pain care plan)

2. Initiate OT using the following approach:
   - Short duration (e.g., 1 week initial prescription; no more than 3 months total)
   - Use lowest effective dose, recognizing that no dose is completely safe
   - A strategy of escalating dose to achieve benefit increases risk and has not been shown to improve function
   - Dose escalation above 20-50 mg MEPP has not been shown to improve function and increases risk
   - Long-acting opioids should not be prescribed for opioid-naive individuals (see Recommendation 13 and Appendix D)
   - Consider alternatives to methadone and transdermal fentanyl (see Recommendation 13 and Appendix D)
   - Assessment of improvement in pain and functional status and adverse effects
   - Offer OEND

3. Is patient medically or psychiatrically unstable?
   - Yes: Admit/provide medical and psychiatric treatment to stabilize as indicated
   - No: Proceed to step 5

4. Is there a clinically meaningful improvement in function in the absence of significant risk factors?
   - Yes: Taper to discontinuation (consult Module C if needed)
   - No: Exit algorithm
   - Manage with non-opioid modalities

5. Review and optimize comprehensive pain care plan (e.g., non-opioid treatments, self-management strategies)

6. Follow-up frequently based on patient risk factors (e.g., 1-4 weeks with any dose change; up to every 3 months without dose change if clinically and functionally stable)
   - Assess:
     - Function, risks, and benefits of OT
     - Progress toward functional treatment goals
     - Adverse effects
     - Adherence to treatment plan
     - Complications or co-occurring conditions (e.g., medical, mental health, and/or SUD)
   - Complete risk mitigation strategies (see Sidebar A)
   - Review and optimize comprehensive pain care plan

7. Are factors that increase risks of OT present (e.g., non-adherence, co-occurring conditions, behaviors suggesting OUD, indications for referral)?
   - Yes: Consider one or more of the following:
     - Shortening prescribing interval
     - Intensifying risk mitigation strategies
     - Increasing intensity of monitoring
     - Referring to interdisciplinary care
     - Consulting with or referring to specialty care
   - No: Proceed to step 10

8. Are there indications to discontinue or taper? (see Sidebar B)
   - Yes: Taper to reduced dose or taper to discontinuation; proceed to Module C
   - No: Proceed to step 11

9. Reassess in 1-3 months or more frequently as determined by patient risk factors (see Sidebar C)

Sidebar A: Necessary Risk Mitigation Strategies
- OEND
- UD
- PDMP
- Face-to-face follow-up with frequency determined by risk

Sidebar B: Indications for Tapering and Discontinuation
- Risks of OT outweigh benefits
- Lack of clinically meaningful improvement in function
- Concomitant use of medications that increase risk of overdose
- Co-occurring medical or mental health conditions that increase risk
- Concerns about OUD or other SUD
- Patient non-compliance with opioid safety measures and opioid risk mitigation strategies
- Patient non-participation in a comprehensive pain care plan
- Prescribed dose higher than the maximal recommended dose (which increases risk of adverse events)
- Pain condition not effectively treated with opioids (e.g., back pain with normal MRI; fibromyalgia)
- Medical or mental health comorbidities that increase risk
- Improvement in the underlying pain condition being treated
- Unmanageable side effects
- Patient preference
- Diversion

Sidebar C: Factors That May Indicate Need for More Frequent Follow-up
- Non-adherence to comprehensive pain care plan (e.g., attendance at appointments)
- Unexpected UD and PDMP results
- Non-adherence to opioid prescription (e.g., using more than prescribed and/or running out early)
- Higher risk medication characteristics (e.g., high-dose opioids, combination of opioids and benzodiazepines)
- Patients with mental health, medical, or SUD comorbidities that increase risk for adverse outcomes

Abbreviations: MEPP: morphine equivalent daily dose; mg: milligram(s); MRI: magnetic resonance imaging; OEND: Overdose Education and Naloxone Distribution; OT: opioid therapy; UD: opioid use disorder; PDMP: Prescription Drug Monitoring Program; SUD: substance use disorders; UD: urine drug test