Treatment of Acute Pain in Opioid Use Disorder

full update July 2026

The FAQ below covers common clinical questions that arise about treating pain in patients with OUD. **Keep in mind that high-level evidence to guide management in these patients is lacking**.[15] Most of the information below is based on expert opinion. For information on non-opioid options, see our chart, *Analgesics for Acute Pain in Adults*.

Clinical Question	Pertinent Information or Resources
What are some special **considerations for patient assessment** before treating acute pain in this patient population?	• Identify all opioids the patient might be using. Check your prescription drug monitoring program.[16] Confirm prescribed MOUD dose with MOUD prescriber or pharmacy.[5,12] Verify that this is how the patient is actually taking it. • If a urine drug screen is ordered, confirm that the assay includes methadone, buprenorphine, and fentanyl.[4] • Obtain a pain history.[16] Assess pain using your institution's usual pain assessment tool.[2] • Assess for withdrawal symptoms using COWS.[6] • Identify any medications which, if discontinued, could cause withdrawal symptoms.[16] This would be of particular concern if the patient is undergoing surgery.[4] • If taking MOUD, document time dose, adherence, and time of last dose.[6,16] • Ask about comorbidities, including psychiatric disorders.[4,16] ○ Psychiatric comorbidities may complicate pain control.[4] Brief screening tools validated in the primary care setting can be used to screen for depression, anxiety, and substance abuse.[4] • Consider comorbidities when choosing non-opioids (e.g., consider duloxetine if the patient has neuropathic pain).[6,18]

What are some **points to address with patients** with opioid use disorder regarding acute pain treatment?	• Patients with OUD may have the following concerns regarding control of acute pain:
	  ○ fear that their pain will be untreated or undertreated.[5]
	  ▪ Reassure the patient that their pain will be treated in the context of shared decision-making.[2,12]
	  ▪ Explain that although being pain-free is not the goal, being functional is a reasonable expectation.[2]
	  ○ fear of relapse triggered by exposure to opioids or untreated pain.[5]
	  ▪ Non-opioids will be optimized.[5]
	  ▪ In acute care settings, parenteral formulations will be switched to oral as soon as possible.[5]
	  ▪ If needed, opioids will be titrated to effect with careful monitoring for side effects, and tapered off as pain resolves.[2,5]
	  ○ fear that if they need to be treated at a hospital or emergency department, they will miss doses of their substitution therapy (buprenorphine or methadone).[5]
	  ▪ Opioid substitution therapy will be continued (after dose verification).[5]
	• If an opioid will be prescribed, set patient expectations for pain resolution and opioid tapering.[16]

Clinical Question	Pertinent Information or Resources
What is the **general approach to treatment** of acute pain in patients with opioid use disorder?	• Individualize the treatment plan, taking into account patient preferences.[12] Patients with a history of opioid misuse may not want to take opioids.[12] • Patients with a history of opioid misuse are at risk for relapse triggered by anxiety or pain associated with injury or surgery.[4] Therefore, pain control in these patients requires planning (when possible), education, monitoring, and increased support.[4] o Involve the patient's family and the patient's MOUD prescriber (if applicable).[2,4] o Consider initiating buprenorphine (low-dose protocol) or methadone MOUD while also addressing acute pain with short-acting full opioid agonists (e.g., hydromorphone).[6,25] o Consider referral to a substance abuse clinic.[4] Arrange this before hospital discharge.[4] • Try non-opioids first (including nonpharmacologic options like rest and ice, as appropriate).[25,26] But keep in mind: o gabapentinoids pose abuse risk, and might increase the risk of misuse of buprenorphine and methadone.[24,28] o some antidepressants (e.g., tricyclic antidepressants, venlafaxine) may increase the risk of QT-prolongation with methadone.[12,24,29] • In the inpatient setting, consult the pain management service and/or anesthesia for patient-controlled analgesia, nerve blocks, ketamine infusion, lidocaine infusion, dexmedetomidine, or other specialized interventions.[16,25] • When opioids are appropriate: o High doses may be needed; ensure close monitoring and hold orders for oversedation.[25] o Use caution prescribing an opioid the patient has previously misused; pill appearance could trigger relapse.[27] o In the hospital, switch from parenteral to oral opioids as soon as possible.[2] The oral route is less reinforcing.[5] o Taper opioids as pain resolves.[2] o **Prescribe naloxone**[25] or nalmefene (US). • At discharge: o Arrange follow-up with outpatient prescriber.[25] o Include in the discharge summary information about opioids administered during admission, MOUD dosage and any dosage changes, and the tapering plan for any opioids prescribed for home use.[3,25] o Prescribe/dispense opioids in small quantities (e.g., three to seven days), and only for patients not intending to return to illicit use.[2,25] Consider enlisting a reliable family member to serve as the custodian of the medication.[21]
What are some considerations for patients actively abusing an opioid (e.g., **heroin)**? *Continued…*	• Accurately assess the patient's current opioid use and convert to morphine equivalents.[18] This can be used as the patient's baseline opioid requirement.[18] Additional opioid will be added for analgesia.[18] o See our chart, *Equianalgesic Dosing of Opioids for Pain Management*. o Be aware that potency and purity of street **heroin** varies, and that the weight of heroin is not the same as the dose of heroin.[2] ▪ One rule of thumb is that one bag of heroin is approximately equivalent to 15 to 30 mg of parenteral morphine.[2] Due to tolerance, patients may need to be dosed with a parenteral or oral opioid every two to three hours, as needed for pain or withdrawal.[2]

Clinical Question	Pertinent Information or Resources
Considerations for patients actively abusing an opioid, continued	• Example: a patient using a bag of heroin daily might require 2.5 to 5 mg of IV morphine every three hours, plus non-opioids to reduce opioid requirements.[2]
How should pharmacists handle **acute opioid prescriptions** for patients with a history of opioid use disorder?	• Consider contacting the prescriber if more than a week's supply of opioid is prescribed. • Consider providing naloxone or nalmefene (US). • If the patient is on MOUD, ensure that the MOUD prescriber is aware of the opioid prescription. • If the prescriber of the acute opioid prescription is not the patient's usual prescriber, ensure that their primary care prescriber is aware of the prescription. • If a MOUD patient's buprenorphine regimen has been changed to address acute pain (e.g., higher dose, more frequent dosing), a new prescription might be needed for insurance coverage. Chose the most appropriate buprenorphine product to provide the patient's new dose to avoid cutting tablets or films.
What are some special considerations for treating acute pain in patients receiving **buprenorphine** MOUD? *Continued…*	**Patient taking buprenorphine/naloxone**: • Try non-opioids first (e.g., acetaminophen and an NSAID).[16,25] For more severe pain, consider other non-opioid options (e.g., local or regional anesthesia, ketamine, IV lidocaine), short-acting oral or IV opioids (see below).[16] There is no information on the use of suzetrigine (Journavx [US]) with buprenorphine. • Prescribers can divide the total daily buprenorphine dose every 6 to 8 hours to enhance buprenorphine's analgesic effects.[16] (Buprenorphine's long half-life and high receptor affinity allows once-daily dosing for opioid dependence, but its analgesic effect may only last six hours.[20,22]) This approach allows the patient to continue on a stable buprenorphine dose.[12] More buprenorphine (sublingual or IV) can be added to their maintenance dose for pain in those taking less than 32 mg daily (of sublingual tablet, or equivalent).[7] (Note that the max buprenorphine dose is 24 mg per Canadian labeling.)[8] Taper toward the home dose as pain allows.[6,16] • High doses of other opioids may be needed to overcome strong mu receptor blockade by buprenorphine, as well as tolerance.[25,] Hydromorphone or fentanyl (e.g., in inpatients) might be good choices due to their relatively high affinity for mu opioid receptors.[25] If buprenorphine is subsequently stopped with mu agonists on board, monitor for sedation and respiratory depression due to mu receptor hypersensitivity.[9] o If pain control is inadequate, a reduction in buprenorphine dose (e.g., to ≤16 mg/day) to free up opioid receptors can be tried.[16] • In surgical patients, continue buprenorphine perioperatively, perhaps with dose reduction to a total daily dose of 16 mg.[1,16] A less desirable option is to discontinue buprenorphine the day before or the day of surgery, with high-potency, intravenous opioids used for perioperative pain control.[1,24] • In the event that buprenorphine was held during hospitalization, the pre-op dose can usually be restarted if it was held for less than two to three days and the patient is not taking an opioid.[24] Otherwise, re-titrate using a "traditional" protocol, or

Clinical Question	Pertinent Information or Resources
Patients receiving **buprenorphine** MOUD, continued.	with a low-dose protocol if the patient is taking an opioid.[16] See our resource, *Management of Opioid Use Disorder,* for more information. **Patient treated with Sublocade**: • Use non-opioid if possible.[13,14] • Can use a "full opioid" if needed, with monitoring for respiratory depression. High doses may be needed.[13,14]
What are some special considerations for treating acute pain in patients receiving **methadone** MOUD?	**Patient taking methadone**: • Methadone maintenance can be continued in the hospital.[12,25] Contact the prescribing clinic to confirm the dose, date of last dose, and whether take-home doses were dispensed.[12] • Try non-opioids first.[25] Note that there is no information on the use of suzetrigine (Journavx [US]) with methadone • Consider dividing the methadone maintenance dose two or three times daily for analgesia.[25] • If an opioid is needed, the methadone maintenance dose is considered the patient's baseline, and another opioid (e.g., hydromorphone) is added for pain control.[6,12] A relatively high dose may be needed.[2] • Avoid mixed agonist/antagonists or partial agonists like buprenorphine, pentazocine, butorphanol, or nalbuphine; they may precipitate withdrawal.[4,17]
What are some special considerations for treating acute pain in patients receiving **naltrexone** MOUD?	**Patient taking naltrexone**: • Do not prescribe opioids for outpatient use in a patient on naltrexone.[23] If a nonpharmacologic therapeutic modality is used (e.g., physical therapy, massage, acupuncture), the Vivitrol injection site should be avoided.[19] • If a patient on Vivitrol requires **elective surgery that may require opioids**, try to delay surgery to allow naltrexone levels to drop (e.g., at least four weeks after last injection).[4,19] For oral naltrexone, ideally allow a 72-hour washout.[4,30] Keep in mind, these patients can have an exaggerated response to opioids administered perioperatively.[4] o Post-op, if a home opioid is needed, prescribe a limited amount, educate patient about safe use, and coordinate with the naltrexone prescriber to ensure close monitoring and resumption of treatment for opioid dependence.[4] o Do not restart naltrexone until the patient has been opioid-free for at least 7 days (≥10 days for longer-acting opioids like methadone).[12] • **In an emergency:** o naltrexone's effects can be overcome with higher than usual opioid doses. These high doses increase the risk of respiratory depression.[19] If a patient on oral naltrexone requires continued high dose opioids in an emergency, the patient may experience toxicity as oral naltrexone levels wane.[23] Inpatient or prolonged emergency department monitoring is needed so that patients can be monitored by professionals trained in the use of anesthetic drugs, management of respiratory depression, and cardiopulmonary resuscitation (CPR).[19,23] o maximize multimodal, non-opioid analgesics (e.g., ketamine) for an opioid-sparing effect.[10,30]

Abbreviations: BID = twice daily; COWS = Clinical Opioid Withdrawal Scale; IV = intravenous; MOUD = medications for opioid use disorder; NSAID = nonsteroidal anti-inflammatory drug; OUD = opioid use disorder.

Users of this resource are cautioned to use their own professional judgment and consult any other necessary or appropriate sources prior to making clinical judgments based on the content of this document. Our editors have researched the information with input from experts, government agencies, and national organizations. Information and internet links in this article were current as of the date of publication.

References

1. Kohan L, Potru S, Barreveld AM, et al. Guidelines for the use of buprenorphine for opioid use disorder in the perioperative setting. Reg Anesth Pain Med. 2021 Oct;46(10):860-861.
2. Raub JN, Vettese TE. Acute Pain Management in Hospitalized Adult Patients with Opioid Dependence: A Narrative Review and Guide for Clinicians. J Hosp Med. 2017 May;12(5):375-379.
3. Buresh M, Ratner J, Zgierska A, et al. Treating Perioperative and Acute Pain in Patients on Buprenorphine: Narrative Literature Review and Practice Recommendations. J Gen Intern Med. 2020 Dec;35(12):3635-3643.
4. Ward EN, Quaye AN, Wilens TE. Opioid Use Disorders: Perioperative Management of a Special Population. Anesth Analg. 2018 Aug;127(2):539-547.
5. Quinlan J, Cox F. Acute pain management in patients with drug dependence syndrome. Pain Rep. 2017 Jul 27;2(4):e611.
6. Uritsky TJ, Miskle BA, Kral LA. The role of buprenorphine in patients with opioid use disorder in need of acute or chronic pain management. Am J Health Syst Pharm. 2026 Apr 22;83(9):e317-e326.
7. Darves B. Treating pain in patients maintained on methadone or buprenorphine. Today's Hospitalist. March 2009. https://www.todayshospitalist.com/treating-pain-in-patients-maintained-on-methadone-or-buprenorphine/. (Accessed May 24, 2026).
8. Product monograph for Suboxone. Pharma Importing. Toronto, ON M4A 1V9. March 2023.
9. Alford DP, Compton P, Samet JH. Acute pain management for patients receiving maintenance methadone or buprenorphine therapy. Ann Intern Med. 2006 Jan 17;144(2):127-34. Erratum in: Ann Intern Med. 2006 Mar 21;144(6):460.
10. Henriksen M, Ellingsen S, Kaldheim HKA. Intraoperative pain management for patients undergoing medication-assisted rehabilitation: a scoping review. BMC Anesthesiol. 2025 Dec 10;26(1):40.
11. Lembke A, Ottestad E, Schmiesing C. Patients Maintained on Buprenorphine for Opioid Use Disorder Should Continue Buprenorphine Through the Perioperative Period. Pain Med. 2019 Mar 1;20(3):425-428.
12. Substance Abuse and Mental Health Services Administration. Medications for opioid use disorder. Treatment Improvement Protocol (TIP) series 63. Publication No. PEP21-02-01-002. Rockville, MD: Substance Abuse and Mental Health Services Administration, July 2021. https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf. (Accessed May 23, 2026).
13. Product monograph for Sublocade. Pharma Importing. Toronto, ON M4A 1V9. December 2025.
14. Product information for Sublocade. Indivior. North Chesterfield, VA 23235. December 2025.
15. Buonora MJ, Mackey K, Khalid L, et al. Acute Pain Management in People With Opioid Use Disorder : A Systematic Review. Ann Intern Med. 2025 Apr;178(4):558-570.
16. Sandhu S, Calcaterra SL. How Do I Manage Acute Pain for Patients Prescribed Buprenorphine for Opioid Use Disorder? NEJM Evid. 2024 May;3(5):EVIDccon2300275.
17. Sen S, Arulkumar S, Cornett EM, et al. New Pain Management Options for the Surgical Patient on Methadone and Buprenorphine. Curr Pain Headache Rep. 2016 Mar;20(3):16.
18. Vadivelu N, Lumermann L, Zhu R, et al. Pain Control in the Presence of Drug Addiction. Curr Pain Headache Rep. 2016 May;20(5):35.
19. Substance Abuse and Mental Health Services Administration. (2012). An introduction to extended-release injectable naltrexone for the treatment of people with opioid dependence. Advisory, Volume 11, Issue 1. https://store.samhsa.gov/sites/default/files/d7/priv/sma12-4682.pdf. (Accessed May 24, 2026).
20. Harrison TK, Kornfeld H, Aggarwal AK, Lembke A. Perioperative Considerations for the Patient with Opioid Use Disorder on Buprenorphine, Methadone, or Naltrexone Maintenance Therapy. Anesthesiol Clin. 2018 Sep;36(3):345-359.
21. Anderson TA, Quaye ANA, Ward EN, et al. To Stop or Not, That Is the Question: Acute Pain Management for the Patient on Chronic Buprenorphine. Anesthesiology. 2017 Jun;126(6):1180-1186.
22. Khanna IK, Pillarisetti S. Buprenorphine - an attractive opioid with underutilized potential in treatment of chronic pain. J Pain Res. 2015 Dec 4;8:859-70.
23. Substance Abuse and Mental Health Services Administration. Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders. Treatment Improvement Protocol (TIP). Series 54. HHS Publication No. (SMA) 12-4671. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011. https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4671.pdf. (Accessed May 24, 2026).
24. The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. J Addict Med. 2020 Mar/Apr;14(2S Suppl 1):1-91. Erratum in: J Addict Med. 2020 May/Jun;14(3):267.
25. South AM, Calcaterra SL, Martin M. Things We Do for No Reason™: Withholding opioids among patients with acute pain and opioid use disorder. J Hosp Med. 2026 Feb 23.

26. CDC. Nonopioid therapies for pain management. January 31, 2025. https://www.cdc.gov/overdose-prevention/hcp/clinical-care/nonopioid-therapies-for-pain-management.html. (Accessed July 13, 2026).
27. McHugh RK, Park S, Weiss RD. Cue-induced craving in dependence upon prescription opioids and heroin. Am J Addict. 2014 Sep-Oct;23(5):453-8.
28. Ellis MS, Buttram ME, Kasper ZA. Nonmedical use of gabapentin and opioid agonist medications in treatment-seeking individuals with opioid use disorder. Drug Alcohol Depend. 2022 May 1;234:109400.
29. Clinical Pharmacology powered by ClinicalKey. Tampa (FL): Elsevier. 2026. http://www.clinicalkey.com. (Accessed February 18, 2026).
30. Whatley Y, Stead M. Perioperative management of patients on naltrexone. In Cheung B, editor. Australia Anesthesia 2023: invited papers and selected continuing education lectures. pp. 103-112.

Cite this document as follows: **Clinical Resource*, Treatment of Acute Pain in Opioid Use Disorder. Pharmacist's Letter/Pharmacy Technician's Letter/Prescriber's Letter.* July 2026. [420761]**