

OPIOID MANAGER

The Opioid Manager is designed to be used as a point of care tool for providers prescribing opioids for chronic non cancer pain. It condenses key elements from the Canadian Opioid Guideline and can be used as a chart insert.

A Before You Write the First Script

Patient Name: _____

Pain Diagnosis: _____

Date of Onset: _____

Goals decided with patient:

Initiation Checklist

| | Y | N | Date |
|---|---|---|------|
| Are opioids indicated for this pain condition | | | |
| Explained potential benefits | | | |
| Explained adverse effects | | | |
| Explained risks | | | |
| Patient given information sheet | | | |
| Signed treatment agreement (as needed) | | | |
| Urine drug screening (as needed) | | | |

Opioid Risk Tool

By Lynn R. Webster MD

| Item (circle all that apply) | Item score if female | Item score if male |
|--|----------------------|--------------------|
| 1. Family History of Substance Abuse: | | |
| Alcohol | 1 | 3 |
| Illegal Drugs | 2 | 3 |
| Prescription Drugs | 4 | 4 |
| 2. Personal History of Substance Abuse: | | |
| Alcohol | 3 | 3 |
| Illegal Drugs | 4 | 4 |
| Prescription Drugs | 5 | 5 |
| 3. Age (mark box if 16-45) | 1 | 1 |
| 4. History of Preadolescent Sexual Abuse | 3 | 0 |
| 5. Psychological Disease | | |
| Attention Deficit Disorder, Obsessive-Compulsive Disorder, or Bipolar, Schizophrenia | 2 | 2 |
| Depression | 1 | 1 |
| Total | | |
| Total Score Risk Category: | | |
| Low Risk: 0 to 3, Moderate Risk: 4 to 7, High Risk: 8 and above | | |

Overdose Risk

Patient Factors

- Elderly
- On benzodiazepines
- Renal impairment
- Hepatic impairment
- COPD
- Sleep apnea
- Sleep disorders
- Cognitive impairment

Provider Factors

- Incomplete assessments
- Rapid titration
- Combining opioids and sedating drugs
- Failure to monitor dosing
- Insufficient information given to patient and/or relatives

Opioid Factors

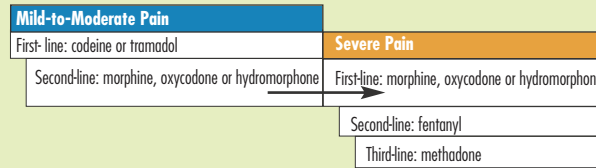
- Codeine & Tramadol - lower risk
- CR formulations - higher doses than IR

Prevention

- Assess for Risk Factors
- Educate patients /families about risks & prevention

- Start low, titrate gradually, monitor frequently
- Careful with benzodiazepines
- Higher risk of overdose - reduce initial dose by 50%; titrate gradually
- Avoid parenteral routes
- Adolescents; elderly - may need consultation
- Watch for Misuse

Stepped Approach to Opioid Selection



B Initiation Trial

A closely monitored trial of opioid therapy is recommended before deciding whether a patient is prescribed opioids for long term use.

Suggested Initial Dose and Titration (Modified from Weaver M., 2007 and the e-CPS, 2008) Notes: The table is based on oral dosing for CNCP. Brand names are shown if there are some distinct features about specific formulations. Reference to brand names as examples does not imply endorsement of any of these products. CR = controlled release, IR = immediate release, NA = not applicable, ASA: Acetylsalicylic Acid

| Opioid | Initial dose | Minimum time interval for increase | Suggested dose increase | Minimum daily dose before converting IR to CR |
|---|--|--------------------------------------|---|---|
| Codeine (alone or in combination with acetaminophen or ASA) | 15-30 mg q. 4 h. as required | 7 days | 15-30 mg/day up to maximum of 600 mg/day (acetaminophen dose should not exceed 3.2 grams/day) | 100 mg |
| CR Codeine | 50 mg q. 12 h. | 2 days | 50 mg/day up to maximum of 300 mg q. 12 h. | NA |
| Tramadol (37.5 mg) + acetaminophen (325 mg) | 1 tablet q. 4-6 h. as needed up to 4/day | 7 days | 1-2 tab q. 4-6 h. as needed up to maximum 8 tablets/day | 3 tablets |
| CR Tramadol | a) Zytrom XL®: 150 mg q. 24 h. b) Tridural™: 100 mg q. 24 h. c) Ralivia™: 100 mg q. 24 h. | a) 7 days b) 2 days c) 5 days | Maximum doses: a) 400 mg/day b) 300 mg/day c) 300 mg/day | NA |
| IR Morphine | 5-10 mg q. 4 h. as needed maximum 40 mg/day | 7 days | 5-10 mg/day | 20-30 mg |
| CR Morphine | 10-30 mg q. 12 h. Kadian®: q. 24 h. Kadian® should not be started in opioid-naïve patients | Minimum 2 days, recommended: 14 days | 5-10 mg/day | NA |
| IR Oxycodone | 5-10 mg q. 6 h. as needed maximum 30 mg/day | 7 days | 5 mg/day | 20 mg |
| CR Oxycodone | 10-20 mg q. 12 h. maximum 30 mg/day | Minimum 2 days, recommended: 14 days | 10 mg/day | NA |
| IR Hydromorphone | 1-2 mg q. 4-6 h. as needed maximum 8 mg/day | 7 days | 1-2 mg/day | 6 mg |
| CR Hydromorphone | 3 mg q. 12 h. maximum 9 mg/day | Minimum 2 days, recommended: 14 days | 2-4 mg/day | NA |

Initiation Trial Chart

| Date | D/M/Y | D/M/Y | D/M/Y | D/M/Y |
|---|-------------------|--------------------------|-------|-------|
| Opioid prescribed | | | | |
| Daily dose | | | | |
| Daily morphine equivalent | | | | |
| | 400 | | | |
| | 300 | | | |
| | 200 | Watchful Dose > than 200 | | |
| | 100 | | | |
| Goals achieved → Yes, No, Partially | | | | |
| Pain intensity | | | | |
| Functional status → Improved, No Change, Worsened | | | | |
| Adverse effects | Nausea | | | |
| | Constipation | | | |
| | Drowsiness | | | |
| | Dizziness/Vertigo | | | |
| | Dry skin/Pruritis | | | |
| | Vomiting | | | |
| | Other? | | | |
| Complications? (Reviewed: Y/N) | | | | |
| Other Monitoring | | | | |

0 = None
1 = Limits ADLs
2 = Prevents ADLs

To access the Canadian Guideline for Safe and Effective Use for Non Chronic Cancer Pain, to download the Opioid Manager and to provide feedback visit <http://nationalpaincentre.mcmaster.ca/opioid/>

Maintenance & Monitoring

Morphine Equivalence Table

| Opioid | Equivalent Doses (mg) | Conversion to MEQ |
|--------------------------|---------------------------------|-------------------|
| Morphine | 30 | 1 |
| Codeine | 200 | 0.15 |
| Oxycodone | 20 | 1.5 |
| Hydromorphone | 6 | 5 |
| Meperidine | 300 | 0.1 |
| Methadone & Tramadol | Dose Equivalents unreliable | |
| Transdermal fentanyl | 60 – 134 mg morphine = 25 mcg/h | |
| | 135 – 179 mg = 37 mcg/h | |
| | 180 – 224 mg = 50 mcg/h | |
| | 225 – 269 mg = 62 mcg/h | |
| | 270 – 314 mg = 75 mcg/h | |
| | 315 – 359 mg = 87 mcg/h | |
| 360 – 404 mg = 100 mcg/h | | |

Maintenance & Monitoring Chart

| Date | D / M / Y | D / M / Y | D / M / Y | D / M / Y | D / M / Y | D / M / Y |
|---|-----------|-----------|-----------|-----------|-----------|-----------|
| Opioid prescribed | | | | | | |
| Daily dose | | | | | | |
| Daily morphine equivalent | | | | | | |
| 400 | | | | | | |
| 300 | | | | | | |
| 200 | | | | | | |
| 100 | | | | | | |
| Goals achieved → Yes, No, Partially | | | | | | |
| Pain intensity | | | | | | |
| Functional status → Improved, No Change, Worsened | | | | | | |
| Adverse effects | | | | | | |
| Nausea | | | | | | |
| Constipation | | | | | | |
| Drowsiness | | | | | | |
| Dizziness/Vertigo | | | | | | |
| Dry skin/Pruritis | | | | | | |
| Vomiting | | | | | | |
| Other? | | | | | | |
| Complications? | | | | | | |
| Other Monitoring | | | | | | |

0 = None
1 = Limits ADLs
2 = Prevents ADLs

Watchful Dose > than 200

When is it time to Decrease the dose or Stop the Opioid completely?

| When to stop opioids | Examples and Considerations |
|---|--|
| Pain Condition Resolved | Patient receives definitive treatment for condition. A trial of tapering is warranted to determine if the original pain condition has resolved. |
| Risks Outweighs Benefits | Overdose risk has increased. Clear evidence of diversion. Aberrant drug related behaviours have become apparent. |
| Adverse Effects Outweighs Benefits | Adverse effects impairs functioning below baseline level. Patient does not tolerate adverse effects. |
| Medical Complications | Medical complications have arisen (e.g. hypogonadism, sleep apnea, opioid induced hyperalgesia) |
| Opioid Not Effective | Opioid effectiveness = improved function or at least 30% reduction in pain intensity Pain and function remains unresponsive. Opioid being used to regulate mood rather than pain control. Periodic dose tapering or cessation of therapy should be considered to confirm opioid therapy effectiveness. |

How to Stop – the essentials

How do I stop? The opioid should be tapered rather than abruptly discontinued.

How long will it take to stop the opioid? Tapers can usually be completed between 2 weeks to 4 months.

When do I need to be more cautious when tapering? Pregnancy: Severe, acute opioid withdrawal has been associated with premature labour and spontaneous abortion.

How do I decrease the dose? Decrease the dose by no more than 10% of the total daily dose every 1-2 weeks. Once one-third of the original dose is reached, decrease by 5% every 2-4 weeks. Avoid sedative-hypnotic drugs, especially benzodiazepines, during the taper.

Aberrant Drug Related Behaviour (Modified by Passik, Kirsh et al 2002).

| Indicator | Examples |
|---------------------------------------|---|
| *Altering the route of delivery | • Injecting, biting or crushing oral formulations |
| *Accessing opioids from other sources | • Taking the drug from friends or relatives • Purchasing the drug from the "street" • Double-doctoring |
| Unsanctioned use | • Multiple unauthorized dose escalations • Binge rather than scheduled use |
| Drug seeking | • Recurrent prescription losses • Aggressive complaining about the need for higher doses • Harassing staff for faxed scripts or fit-in appointments • Nothing else "works" |
| Repeated withdrawal symptoms | • Marked dysphoria, myalgias, GI symptoms, craving |
| Accompanying conditions | • Currently addicted to alcohol, cocaine, cannabis or other drugs • Underlying mood or anxiety disorders not responsive to treatment |
| Social features | • Deteriorating or poor social function • Concern expressed by family members |
| Views on the opioid medication | • Sometimes acknowledges being addicted • Strong resistance to tapering or switching opioids • May admit to mood-leveling effect • May acknowledge distressing withdrawal symptoms |

★ = behaviours more indicative of addiction than the others.