Providence HEALTH CARE
How you want to be treated.

ST. PAUL'S HOSPITAL
PROVIDENCE HEALTH CARE

# Safer Opioid Prescribing

## Opioid Stewardship Program

## STEP 1 What is the **indication**?

- Pain → Consider adding opioid-sparing agents!
  - Nociceptive? → acetaminophen and/or NSAID
  - Neuropathic? → Neuropathic pain agent
- Opioid Use Disorder → Consult Addiction Medicine Consult Team (AMCT)!

*See reverse for AMCT contact info

## STEP 2 Does the patient have any **risk factors** for adverse events?

**Opioid naive, elderly, cognitive impairment**
Increased sensitivity to opioid effects puts patients at increased risk of adverse events

**Lung/respiratory disease**
Pre-existing lung disease & reduced respiratory reserve puts patients at increased risk of respiratory depression

**Renal or hepatic impairment**
Accumulation of medication puts patients at higher risk of adverse events

**Mental illness or substance use disorder(s)**
Patients with these pre-existing conditions are at increased risk of long-term opioid dependence

Opioid Risk Tool

**Concurrent sedating medications**
Additive CNS depression puts patients at increased risk of adverse events

## STEP 3 Are there any **non-opioid alternatives** you could use for **multimodal analgesia**?

### acetaminophen

325-975 mg PO or PR QID

NOTE
Cirrhosis *without* active alcohol use: maximum less than 2g/day
Cirrhosis *with* active alcohol use: avoid

### NSAIDs

NOTE
CV disease: limit to short-term use
High risk GIB or liver impairment: short-term celecoxib or diclofenac gel
Renal impairment: diclofenac gel

**Topical**
diclofenac BID-QID 1.16%, 2.32%, 10%

**Oral**
ibuprofen 300-600 mg PO TID
naproxen 125-500 mg PO BID
celecoxib 100-200 mg PO BID

### Neuropathic pain agents

e.g. gabapentin, pregabalin, DULoxetine, venlafaxine, nortriptyline, etc.

## STEP 4 **Writing an opioid prescription**

**Drug**
Choose HYDROmorphone in patients with renal impairment
&
Avoid combinations of different opioids for acute pain

**Dose**
Use low initial doses for patients who are opioid naive and/or have risk factors for adverse events (STEP 2)

*See reverse for initial dosing recommendations in opioid naive patients

**Route**
PO preferred unless the patient is unable to tolerate oral intake

**Duration**
Set a target stop date

Opioids for acute pain should be limited to 5 days

## STEP 5 **Monitoring** & **management** of opioid-related **adverse effects**

Reassess opioid regimen & consider dose reduction or alternate drug

### CNS & respiratory depression
POSS score -3: no more opioids
POSS score -4: administer naloxone

→ naloxone should be ordered for every patient prescribed opioids

### Renal & liver function
if worsening renal and/or liver function: consider dose reduction

### Constipation
consider sennosides or bisaCODYL or glycerin suppository

→ Bowel protocol should be ordered for every patient prescribed opioids

### Pruritus
consider alternative drug

← diphenhydrAMINE only under exceptional circumstances due to concomitant sedation

### Nausea
consider dose reduction

← dimenhyDRINATE, metoclopramide, ondansetron

## STEP 6 **Discharge planning**

Re-evaluate opioid use within past 24-48 hours

### Frequent PRN opioid use
Reassess pain control, optimize opioid-sparing agents, optimize regular opioid regimen

### Risk factors for opioid misuse or dependence?
Limit quantity/frequency of opioid dispensing, connect with community team for follow-up

### Prolonged duration of opioid use
Prescribe a taper

### Using greater than 50 morphine milligram equivalents per day
Provide naloxone teaching & naloxone kit on discharge

# Tools & Resources

Need help? Contact a consult service!

| | | |
|---|---|---|
| Opioid Stewardship Program | Any patient on an opioid, or for whom you would like to start an opioid, where support around safe and effective prescribing is required | Call switchboard or call 604-209-6909 |
| Addiction Medicine Consult Team (AMCT) | Patients with substance use disorder(s) with or without associated pain | Consult via Cerner or call switchboard |
| Acute Pain Service | Pain associated with recent injury, procedure, or operation | Consult via Cerner or call switchboard |
| Complex Pain Service | Complex, chronic, multi-modal pain that may or may not be associated with other conditions (e.g. fibromyalgia) | Consult via Cerner or call switchboard |
| Palliative Care Team | Frail elderly with multiple comorbid conditions and/or pain secondary to a life-limiting illness | Consult via Cerner or call switchboard |

### Initial Dosing for Opioid Naive Patients

| | PO | IV* | SC** |
|---|---|---|---|
| morphine | 2.5-10 mg Q4H | 0.5-1.5 mg Q1H | 1.25-5 mg Q4H |
| HYDROmorphone | 0.5-2 mg Q4H | 0.1-0.3 mg Q1H | 0.25-1 mg Q4H |
| oxyCODONE | 2.5-7.5 mg Q4H | -- | -- |

NOTE: Avoid ordering multiple types of opioids and/or multiple routes of administration for one patient
*Please observe the following recommendations for ordering IV opioids:
- IV should be ordered as **PRN**
- IV should be used ONLY for severe breakthrough pain or if patient is unable to take PO medication
**SC should be used ONLY if patient is unable to take PO medication

### Morphine Milligram Equivalency Chart*

| | Conversion Factor |
|---|---|
| morphine | 5 |
| HYDROmorphone | 1 |
| oxyCODONE | 1.5 |

*Conversion factor assumes the medication is given as the same dosage form (IV vs. PO)

### IV/PO Opioid Conversion Chart

| | IV/SC (mg) | PO (mg) |
|---|---|---|
| morphine | 5 | 10-15 |
| HYDROmorphone | 1 | 2 |
| oxyCODONE | -- | 7.5-10 |

### Abbreviations
CV: Cardiovascular
GIB: Gastrointestinal bleed
NSAID: Non-steroidal anti-inflammatory drug
POSS: Pasero Opioid-induced Sedation Scale