

# Protocol for Opioid Prescribing in Tasmania

This protocol is intended for GPs and other specialists working in Tasmania. It provides guidance on how to manage patients who have inadequately controlled pain where there may be the need for initiation, maintenance or cessation of opioids. Management includes consideration of pain, function and psychological distress.



## Patient with inadequately controlled pain

### ASSESSMENT

- Medical History- include cause , description and impact of pain
- Psycho-Social history (see box)
- Drug history –medications, alcohol, other drugs . include questions of dependence (see box over )
- Examination– area of pain & associated system , check injection sites
- Supporting evidence- imaging, reports

### Psycho– social history

(adapted from NZ Psychological yellow flags)

1. How do you cope with your pain?
2. How much can you reduce your pain?
3. How tense or anxious have you felt in the last week?
4. How much have you felt bothered by feeling depressed in the past week?
5. Have there been any traumatic episodes in your life/childhood?
6. How is your home and work life?

See: Reference 1 (over)

### DIAGNOSIS

- \* Pain– type/cause. Identify pathology
- \* Co-morbidities eg mental health, medical
- \* Drug dependency

### Relevant specialist

eg rheumatologist, psychiatrist, neurosurgeon

### MANAGEMENT

Patient education  
Coordinate team approach  
Physical therapies  
Non drug approaches  
WHO analgesic ladder

### EARLY REFERRAL or ADVICE

- Alcohol & Drug Service
- Mental Health Services– include community psychologists
- Pain Unit

Care when crossing the line

### OPIATE PRESCRIBING

#### Check the 8 Cs

- Clinical Indication- right pathology vs right drug
- Clinical risks - drug & disease interactions, adverse effects
- Consider warning flags- : (see box over)
- Control dose Use lowest effective dose & don't exceed max
- Contract to be signed by patient and prescriber
- Contact PSB - apply for authority. Ask about "risk status". (see Resources box over )
- Contain prescription- by single prescriber & single pharmacy
- Consensus between parties about outcomes (function, goals)

#### Not to exceed max dose

**Dose Recommendations** *Not to exceed the indicated dose unless endorsed by a specialist (at a consultation) and their recommendation put in writing and accompanied by your next authority application to PSB.*

- A) Morphine 120mg/d (MS Contin or Kapanol 60mg bd)
- B) Oxycodone 80mg daily (Oxycontin 40mg bd)
- C) Methadone 40mg daily (Physeptone 20mg bd)
- D) Fentanyl transdermal patch 25 mcg/hr applied 3rd daily
- E) Burpenorphine transdermal patches 40mcg/hr applied weekly
- F) Tramadol 400mg daily

This is the total dose– ie no additional short acting opioids

### MONITORING

- Consider checking compliance with random urine checks for opioid & other drugs
- Assess function and pain status routinely
- Monitor for medication misuse and drug seeking behaviors (see Warning Flags box over)

## IMPORTANT NOTES

### Points to be discussed with a patient before a trial of oral opioids

- Stress that oral opioids are only one part of the treatment plan, and that data are lacking on the long-term effects of medically prescribed opioids.
- Set realistic functional goals (eg, to commence or maintain an exercise program, improve self-care ability, get out to the shops, etc).
- Explain that the aim is for controlling pain rather than no pain.
- Explain that dependence is a physiological effect of opioids and that withdrawal symptoms occur if the drug is stopped. (This should not be a problem with medically prescribed opioids.)
- Warn of the potential for cognitive impairment which may affect driving ability, especially while commencing opioid therapy and around the time of dose escalation. Point out the increased likelihood of sedation if benzodiazepines and/or alcohol are used in conjunction with opioid therapy.
- Explain the indications for ceasing treatment with opioids:
  - lack of improvement in function, or evidence of deterioration in function;
  - unsanctioned dose escalation and requests for early repeat prescriptions;
  - losing prescriptions;
  - unapproved use of the drug to treat other symptoms.
- Stress that patients must accept responsibility for:
  - ensuring their supply of medication does not run out after hours;
  - security of their medication;
  - keeping review appointments;
  - using only one doctor to supply this medication.
- Discuss side effects and their management (eg, constipation, nausea, sedation, dry mouth, urinary hesitancy, and depression of sex hormones, with associated risk of osteoporosis with long term use).
- After 6-8 weeks opioids often cease to be effective and can lead to hyperalgesia

Reference: Goucke, R .MJA Vol 178 5 May 2003

### Legal requirements

- \* Authority required to continue to prescribe opioids after 2 months-- application to be made to the PSB
- \* Authority required to prescribe alprazolam with an opioid after 2 months.—application to PSB
- \* Authority required immediately if patient drug dependant
- \* Notice of drug seeking or other aberrant behaviour required if you have prescribed or are prescribing opioids to a patient

### Screening for drug dependency:

The Severity of Dependence Scale (Gossop et al 1992)

- Did you think your alcohol/drug use was out of control?
- Did the thought of not being able to get any (name) drugs make you anxious or worried?
- Did you worry about your (name) drug use?
- Did you wish you could stop?
- How difficult would you find it to stop or go without?

### WARNING FLAGS FOR PRESCRIBING OPIOIDS:

- Deterioration in functioning at work, in the family, or socially
- Illegal activities e.g. selling medicine, forging prescriptions, stealing drugs from other patients, buying prescription drugs from non-medical sources
- Previous treatment on an opioid pharmacotherapy program
- Mental health problems
- Indeterminate cause of pain
- Previous or current opioid or other substance abuse disorder
- Resistance to changes in treatment & requesting increased doses
- Refusal to comply with random drug screens
- Multiple episodes of lost or stolen prescriptions

### Exit strategies

Consider weaning off opioids if :

1. Completion of time limited maintenance phase
2. Inadequate analgesia or excessive adverse effects
3. Evidence of aberrant drug related behaviour
4. Development of a predominance of psychological issues

Get advice from ADS or PMU

Consider various approaches –slow weaning, rotating opioids, Norspan patches, managing withdrawal (NSAIDs, clonidine ,diazepam)

## RESOURCES

**Pharmaceutical Services Branch (PSB)** Dept Health & Human Services. GPO Box 125 Hobart. Tel 62332064- contact for a) authority required under legislation - after 2 months or earlier if anticipate long term prescription. Application immediately if have a warning flag. On going authorities may depend on specialist approval or b) to check if patient “ risk status’ (authorised with another prescriber, previously on methadone program, ,declared drug dependant, aberrant behaviour)

**Alcohol & Drug Service** A 24 hours alcohol and drug information service can be accessed free on 1800 811 994

**Pain Management Unit** RHH 62228308 LGH ?? Australian Pain Society Physician on call

**Mental Health Services** 1800 332 388 24 hr service

### References:

1. New Zealand Low Back Pain Guide. [http://www.nzgg.org.nz/guidelines/0072/acc1038\\_col.pdf](http://www.nzgg.org.nz/guidelines/0072/acc1038_col.pdf)
2. Hunter Integrated Pain Service (NSW Health) 2008 Opioid use in Persistent Pain