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Clinical Management of Patients on Prescription Opioid Analgesics

Policy Number 1.302

Policy Function Continuum of Care

Issue Date 09 April 2021

Summary This policy outlines the clinical framework for management of patients using Prescription Opioid Analgesics. It encompasses the issues of patients with Chronic Non-Malignant Pain.

Responsible Officer Executive Director Clinical Operations

Applicable Sites

☐ Administration Centres

☒ Community Sites (e.g. Court Liaison Service, Community Integration Team, etc.)

☒ Health Centres (Adult Correctional Centres or Police Cells)

☒ Health Centres (Juvenile Justice Centres)

☒ Long Bay Hospital

☒ The Forensic Hospital

Previous Issue(s) Policy 1.302 (June 2017)

Change Summary

- Adolescent Mental Health management of adolescent patients included
- Updated references to NSW Ministry Pharmaceutical Regulatory Unit and to the ACI Pain Management Network
- Updated for dosages of Prescription Opioid Analgesics to not exceed equivalent oral 60mg morphine per day without a Multidisciplinary Multispecialty Joint Case Management or a Specialist Pain Service
- Updated tables, charts & figures

TRIM Reference POLJH/1302

Authorised by Chief Executive, Justice Health and Forensic Mental Health Network

1. Preface

Managing chronic non-malignant pain (CNMP) for patients in custody presents a number of challenges surrounding diagnosis, management, measuring meaningful outcomes of therapy and issues related to security. Most CNMP is musculoskeletal pain but may also be neuropathic pain, visceral pain and sometimes be poorly defined pain.

Pharmaceutical use of **Prescription Opioid Analgesics (POA)** has increased substantially in Australia over the last decade, for CNMP. There is increasing diversion of this medication both in the custodial and community setting possibly related to the shortage of heroin and unmet demand for Opioid Agonist Treatment programs (OAT). The recent CDC publication (2016) states that the "risks associated with long-term opioid therapy; include opioid use disorder, overdose, and death".

The recent CDC review (Dowell et al 2016) provides important information. There is no evidence of benefit of for long-term opioid therapy for chronic pain. There is evidence for small to moderate short-term benefits for pain, but evidence is inconsistent for function. In particular, there is insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.

Reviewing patients entering custody with chronic non-malignant pain is a unique opportunity to promote patient education and self-management and provide evidence-based clinically appropriate care including clear goals of opioid therapy.

Prisoners have a number of risk factors for chronic pain, including mental health and substance misuse disorders, physical and emotional trauma. Generally, it is agreed that routine investigations and tests may not be helpful in making a diagnosis. Common antecedents of persistent pain may include a history of trauma or a defined episode of tissue damage. The symptoms should bear an intuitive temporal relationship with the putative cause and onset/exacerbation of pain.

Patients with pain management issues should be able to continue on analgesics, including POAs, as clinically appropriate whilst in custody. Clinicians need to be aware that even if patients lack a history of addiction and are using their POAs as prescribed, most will demonstrate withdrawal symptoms if POAs are ceased abruptly due to neuroadaptation.

It can be difficult to distinguish patients who need medication for pain from those who want to misuse it or trade it as a commodity. Clinicians are justly concerned about the safe use of POAs and it is important to consider appropriate safeguards.

POAs for acute pain or for malignant pain are not part of this policy. Patients with acute pain and requiring POAs for are managed by GP/NPs accordingly, such as 3-5 day courses for non-surgical or non-acute trauma health problems, a week course following discharge from hospital (e.g. for post-operative POAs).

This policy applies to those patients entering custody and currently on POA, and for patients already in custody being assessed for Chronic Non-Malignant Pain (CNMP). The accompanying Flowchart: Clinical Management for POA (Appendix 1) is to be used to assist clinicians.

2. Policy Content

2.1 Mandatory Requirements

- Individual patient assessment for all patients entering custody, (or sometimes already in custody), requiring POA medication for chronic non-malignant pain issues.

- General Practitioners (GP) or Nurse Practitioners (NP) will assess and manage patients reporting chronic non-malignant pain that is associated with functional physical impairment and reporting current use of POAs, to determine appropriate investigation and management of their pain including requirement for appropriate analgesic regime.
- Drug & Alcohol (D&A) clinicians will assess and co-manage any adult patient referred by the GP/NP where the patient may be displaying signs of addiction or dependence such as drug-seeking and/or demonstrating other aberrant behaviours (Appendix 2). For adolescent patients with these issues, consultation with the Dual Diagnosis Clinical Nurse Consultant and visiting Adolescent Psychiatrist is required.
- Multidisciplinary Multispecialty Joint Case Management should occur involving the Health Centre Nursing Unit Manager (NUM) and GP/NP for significant clinical issues and with D&A Clinicians (or adolescent mental health clinicians), for patients with both chronic pain and addiction, and a Multidisciplinary Care Plan should be completed (in JHeHS).
- Dosages of POA must not exceed the equivalent of oral 60mg morphine per day, oxycodone 40 mg per day, or dose equivalent of other POAs, see Table: Approximate Opioid Equianalgesic Doses (Appendix 3), without a Multidisciplinary Multispecialty Joint Case Management or a Specialist Pain Service.
- Doses for Adolescents must be tailored as advised by relevant guidelines.
- If higher doses than the equivalent of oral 60mg morphine per day, oxycodone 40 mg per day, or dose equivalent of other POAs, see Table: Approximate Opioid Equianalgesic Doses (Appendix 3), are prescribed there should be an Individual Patient Use (IPU) request form submitted as well as a Multidisciplinary Care Plan.
- JHeHS *POA Patient Agreement Form* to be used for communication and management.
- A documented Initial POA Treatment Plan, trialling low doses of a sustained release formulation, within the patient's progress notes, is developed to allow POA usage in the first 4 weeks with a prescription for 4 weeks only on the Long Stay Medication Chart (LSMC) or National Inpatient Medication Chart (NIMC).
- A documented Revised POA Treatment Plan and clinical review must occur within the first 4 weeks, for patients to continue on POAs. Patients on POA can only be prescribed for 3-6 months total (4 weeks initial and then 2-5 months revised) on the LSMC/NIMC and then require a clinical review.
- Initial and Revised POA Treatments are prescribed in the LSMC or National Inpatient Medication Chart.
- Revised POA Treatment Plans and prescriptions should be obtained from the initiating GP/NP during regular clinic hours, or liaise with the Clinical Director or Deputy Clinical Directors Primary Care (CD PC or DCDs PC).
- Preferably, ROAMS will not be asked to provide any telephone orders for ongoing POAs.
- Transdermal formulations of POA must not be prescribed in the custodial setting due to the risk of diversion (Gibson et al 2007)

- Legislative Requirements of NSW MoH Health Pharmaceutical Regulatory Unit Section 28 and other relevant sections of the NSW *Poisons and Therapeutic Goods Act 1966* and policy requirements of the NSW MoH Pharmaceutical Regulatory Unit (PRU) must be adhered.

2.2 Implementation - Roles & Responsibilities

2.2.1. Assessment Nurse (Reception Nurse/Health Centre Nurse/Police cell nurses) is responsible for:

- Identifying if patients are currently on POA medication
- Identifying if there is a risk of withdrawal for patients that have had a recent or sudden cessation of POA
- Identify if there is a history of chronic non-malignant pain for patients on POA.
- Identifying if the patient has a current history of misuse of POAs / aberrant behaviours or addiction
- Obtaining a "ROI – Release of Information", providing a clinical perspective of the patient's history and prescribed medications, when a patient (i) enters custody reporting to be on POAs, or (ii) sometimes newly presents with CNMP. Patients must provide to the Assessment Nurse a signed *Consent to Obtain Health Information* form (JUS020.010), which is sent to the patient's treating community doctor(s).
- Assess level of physical incapacity and physical functioning for patients with a history of POA and CNMP.
- Consulting with the ROAMS GP On-call if new receptions are on POA in situations when
    - Physical incapacity and/or functioning is impaired by pain and medical management is urgent
    - Patients may have been inappropriately on POAs and on high doses and need to be weaned off POA medications
- Waitlisting on PAS to see the Clinic GP/NP if medical evaluation is needed
- Consult with ROAMS On-call D&A for further clinical advice for adult patients; ROAMS psychiatry for adolescent patients
    - if there is a current history of misuse of POAs / aberrant behaviours or addiction or withdrawal issues.
- Where appropriate, D&A ROAMS will ensure that the patient is waitlisted for PAS appointment with the D&A Clinic nurse for a brief intervention.

2.2.2. GP/NPs are responsible for:

- ROAMS GPs – review initial prescribing if patient reports POAs
    - Consideration of weaning off medications (if inappropriately taken)
    - Provision of telephone orders for patients with obvious incapacitating pain
- Clinic GP/NP will provide initial assessment and management of patients complaining of chronic pain keeping in mind the issues discussed in this policy's preface, including issues such as:
    - Addressing fears and mistaken beliefs about the causes and consequences of pain

- Investigating the patient for treatable causes of the pain
- Awareness that routine investigations and tests may not be helpful in making a diagnosis.
- Common antecedents of persistent pain may include a history of trauma or a defined episode of tissue damage
- Symptoms should bear an intuitive temporal relationship with the putative cause and onset/exacerbation of pain
- Consideration of non-opioid analgesics and adjuvant analgesia
- If neuropathic pain is considered to take a slow stepwise approach with tricyclic antidepressants, duloxetine and only if indicated gabapentin or pregabalin (these medications require IPU application due to their risk profile as these medications are unsuitable first-line drugs in secure environments)
- Implementing non-pharmacological interventions, e.g. lifestyle changes, self-massage, physiotherapy, increased movement (see BPI 2013, RACP 2009 and SIGN 2013)

- Prescribing POAs safely when clinically appropriate. At times discussion with the community GP may be needed to review the medical history and previous findings. Some community GPs may not recognise the circumscribed role of opioid analgesics in managing long-term pain symptoms, resulting in lack of confidence in resisting unsuitable requests for analgesic medication.
- Ensuring that opioids are not routinely prescribed for non-malignant chronic pain states. The GP/NP must determine if CNMP is a valid diagnosis. For complex cases, treatment decisions may need to be made in consultation with other specialties.
- Prescribing POAs requires a JHeHS *Prescribed Opioid Analgesics Patient Agreement* to be discussed with the patient and to be signed by the patient.

2.2.3. D&A Clinicians are responsible for adult patients:

- Assessing the patient when there are any concerns about misuse of POA, dependence, addiction or complex D&A issues as part of joint management with GP/NPs.
- Providing clinical management options such as the Opioid Agonist Treatment (OAT) program as well as other measures to prevent, screen, intervene and treat substance use and addiction. Fast tracking the commencement of these patients onto the OAT program will be considered where clinically appropriate.

2.2.4. Adolescent Mental Health (AMH) Clinicians are responsible for adolescent patients:

- Assessing the patient when there are any concerns about misuse of POA, dependence, addiction or complex D&A issues as part of joint management with GP/NPs.
- Providing clinical management options such as the Opioid Agonist Treatment (OAT) program as well as other measures to prevent, screen, intervene and treat substance use and addiction. Fast tracking the commencement of these patients onto the OAT program will be considered where clinically appropriate.

2.2.5. Nurse Unit Manager is responsible for:

- Ensuring Patients have PAS appointments and timely review at health centre clinics if appropriate.
- Ensuring the Health Centre has systems to flag review of the LSMC prior to cessation of POA medication orders.
- Ensuring nursing staff perform 6 monthly reviews according to the Chronic Conditions Clinical Pathways: Arthritis & Musculoskeletal Problems, prior to medical staff assessment for patients

2.2.6. Pharmacists are responsible for:

- Completing a medication review of the patient's medication regimen in Long Bay Hospital and Forensic Hospital. Medication review to be completed for custodial settings if available.
- Dispensing of opioids in accordance to the legal requirements of the Poisons and Therapeutics Goods Regulation.

2.2.7. Multidisciplinary Multi-Speciality (MDMS) Review & Joint Case Management- Health Centre NUMs, GP/NP and D&A or AMH Services are responsible for:

- Providing MDMS - Joint Case Management and Continuity of Care for patients who have both addiction and pain management issues.
    - GP/NP or D&A/AMH services may take the lead in initiating Joint Case Management.
    - Case management regarding suitability of POA prescribing will incorporate review of history, examination, investigations and daily functioning.
    - Multidisciplinary Care Plan must be created in JHeHS and referred to as the record regarding healthcare management and outcomes.

3. Procedure Content

3.1 Flowchart: Clinical Management for POA

- A Flowchart: Clinical Management for POA (Appendix 1) has been developed to guide clinicians how to manage patients who report CNMP and requiring POAs. The flowchart highlights the importance of multidisciplinary care for patients with both addiction and pain issues and the need for clear documentation of a patient's management plan.

3.2 Assessment

- A comprehensive documented assessment that includes a history and physical examination is required. This establishes the need for POA therapy and the likely balance of benefit and harm and whether investigations or referrals are indicated. Well established guidelines should be used to manage the patient such as BPI 2010, RACP 2009 and SIGN 2013 and the specific guidelines "*Managing persistent pain in secure settings"* (PHE 2013).
- A patient's prior history of prescribed POA does not necessarily indicate that this should be continued as there may have been overreliance on pharmacological treatment in the past. Consideration should be given to the appropriateness of prescribing opioid based medication.
- At the regular clinical reviews – the process should regularly assess the following four components (often known as 'the 4 A's'): Analgesia, Activities, Adverse effects, Aberrant

behaviours. The comprehensive approach looks at the patient's pain, response to his or her POA, and functioning.

- Assess for aberrant opioid related behaviours (Appendix 2). Direct contact should be made with the treating community doctor to discuss the patient's history. Assessment may include contacting the Medicare Prescription Shopping Program.

3.3 Management

- Many treatment options exist for CNMP including physical, psychological, pharmacological and surgical options as well as self-management components (see RACP 2009 and SIGN 2013).
- Complete relief of pain is rarely achieved with opioids. The goal should be to reduce symptoms sufficiently to support improvement in physical, social and emotional functioning. Prescribing POAs requires a JHeHS *Prescribed Opioid Analgesics Patient Agreement* to be discussed with the patient ensuring they are fully informed regarding POAs.
- Complex patients or patients where staff may be uncertain how to best manage should be discussed with the Clinical Director Primary Care (CD PC and/or the Clinical Director Drug and Alcohol (CD D&A) and considered for Multidisciplinary Multi Specialty Joint Case Management.
- Any patient whose POA medication is ceased whilst in custody must have the clinical reasons for this decision occurring documented in the health record by the relevant prescriber.
- Refer to the Network High Risk Medicine Management Framework and the Policy Directive PD2020_045 High Risk Medicines Management

3.4 Management of POA Prescriptions from GPs outside of Custody

- ROAMS GPs, can make an initial assessment and decision regarding appropriateness of ongoing POA prescribing and use.
- POAs may be continued or prescribed long term only for patients assessed as not having aberrant behaviours by GPs. Dose reduction may be considered as appropriate.
- Short term prescribing of POAs may be appropriate whilst undergoing comprehensive assessment and awaiting information from community service providers.
- If deemed clinically appropriate, initial POA Treatment Plan x 4 weeks is to be prepared and written in the patient's progress notes.
- The plan will include trialled low dose sustained release medications that must be supervised and regularly reviewed. The LSMC/NIMC will have clearly prescribed only 4 weeks of Supervised Initial POA Treatment.
- If there is a Revised POA Treatment Plan for 2-5 months, then the LSMC/NIMC will have clearly prescribed additional 2-5 months of supervised POA medication.
- The Revised POA Treatment Plan may only be provided by the Initiating GP/NP or CD/DCDs PC.
- Preferably ROAMS will not be asked to provide any telephone orders for ongoing POAs
- POA therapy should be time-limited e.g. every 3 months (4 weeks initially).

- This limited duration of opioid analgesic treatment encourages patients and clinicians to discuss other management strategies. This may involve consultation with other health professionals such as a psychologist or physiotherapist, and potential consideration of opioid dose tapering, at 10% per week with improving function, as well as regular exercise and stretching.
- Patients on POAs should ideally be regularly reviewed. There should be an ongoing emphasis on a broad based management approach and regular discussion of goals of therapy with the patient. Other treatment options should be considered and trialled such as lifestyle changes, physiotherapy, increased movement
- Patients on POAs are at risk from intimidation from other inmates, and if there are ongoing safety issues, the patient should be considered for the Opioid Agonist Treatment (OAT) program where clinically appropriate
- Patients on POAs may have the options of

  (i) tapered termination of POA or

  (ii) transfer to methadone in consultation with Drug and Alcohol, may be considered if the patient has aberrant behaviours, has been unsuccessfully treated with non-opioid medications and the GP/NP recommends that the patient may require long term opioids for pain management.

3.5 Management of Pain and Addiction – dual clinical issues

- Management of these patients is complex and neural responses of tolerance or hyperalgesia may increase the pain experience. When in custody, these patients may need to be jointly managed by Drug & Alcohol and Primary Care Services.

3.6 Management Regulation of Opioid Prescribing

- In the community, prescribing has some regulations that relate to Medicare and the Pharmaceutical Benefits Scheme (PBS) that are not applicable to patients in custody. Therefore this policy only outlines the NSW Ministry of Health Pharmaceutical Regulatory Unit (PRU) Authority scheme which does apply to patients in custody. Refer to NSW MoH *Application for Authority to Prescribe a S8 Drug of Addiction-pain management.*
- **NSW Ministry of Health Pharmaceutical Regulatory Unit (NSW PRU) Authority** (in the form of an authority approval letter) is always required when prescribing opioids to a drug dependent person.
- The NSW MoH - Pharmaceutical Regulatory Unit (NSW PRU) Authority approval letter should be placed in the patients' health record.
- NSW Ministry of Health Pharmaceutical Regulatory Unit (NSW PRU) Authority is also required for patients not deemed drug dependent, whenever they are prescribed any injectable opioid, any drug of addiction for intranasal use, for spray or application to mucous membranes, hydromorphone (including Dilaudid® and Jurnista®), methadone (including Physeptone®), buprenorphine (excluding transdermal patches), flunitrazepam and alprazolam for a period of longer than two months.
- An exemption to obtaining a NSW Health authority applies for hospital inpatients for a period of up to 14 days. Inpatients (both drug dependent or non-drug dependant) may be prescribed any

Schedule 8 medication for a period of up to 14 days following admission. This provides for patient being prescribed the medication immediately prior to admission or where the medication is being initiated in the hospital. Following this 14 days period the authorised prescriber must hold or obtain the necessary authority from the Pharmaceutical Regulatory Unit in the particular circumstance as detailed above to provide for the continuing treatment of the patient with the Schedule 8 medication.

4. Definition

Aberrant Behaviour – Directed or concerted effort by patient to obtain opioid medication or to ensure an adequate medication supply (an appropriate response to inadequately treated pain) (also termed Drug Seeking Behaviour) (see Appendix 2)

Addiction – Psychosocial disorder or disease characterised by compulsive use of a substance and preoccupation with obtaining it, despite evidence that continued use results in physical, emotional, social or economic harm

CNMP – Chronic Non-Malignant Pain defined as a pain that is non-cancerous in origin and that persists beyond normal tissue healing time, which is assumed to be approximately three months.

Dependence – Physiological adaptation to substance whereby abrupt reduction in dose leads to withdrawal abstinence syndrome

LSMC – Long Stay Medication Chart of the Network

MDMS – Multi-Disciplinary Multi-Speciality

Must – Indicates a mandatory action required that must be complied with

NIMC – National Inpatient Medication Chart

POA – Prescription Opioid Analgesia (*e.g. morphine, oxycodone*).

Should – Indicates a recommended action that should be followed unless there are sound reasons for taking a different course of action.

Tolerance – Decrease in effect of substance over time so that increased amount is required to achieve the same effect

5. Legislation and Related Documents

Legislation	*Poisons and Therapeutic Goods Act 1966*
NSW MoH Policy Directives, and Guidelines	*Pharmaceutical Services Information for Medical Practitioners* *Chronic Pain Management* *PD2020_045 High Risk Medicines Management*
Other Resources	*Agency for Clinical Innovation: Pain Management Network 2020* *ANZCA (2020). Statement regarding the use of opioid analgesics in patients with chronic non-cancer pain.*

Blyth FM, March LM, Brnabic AJM, et al. Chronic pain in Australia: a prevalence study. Pain 2001; 89: 127-134

Blyth FM, March LM, Shellard D, Cousins MJ. The experience of using random digit dialling methods in a population-based chronic pain study. Aust N Z J Public Health 2002; 26: 511-514

CDC FACTSHEET - GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN - Improving Practice Through Recommendations (2016)

Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016 MMWR Recomm Rep 2016;65(No. RR-1)1-52

The British Pain Society's - Opioids for persistent pain: Good practice January 2010

Gibson A, et al The Extent of Diversion of Fentany l For Non-Medical Purposes In Australia: What Do We Know? Ndarc Technical Report No 265 Ndarc 2007

Gourlay DL, Heit HA, Almahrezi A. Universal precautions in pain medicine: a rational approach to the treatment of chronic pain. Pain Med. 2005 Mar-Apr; 6(2):107-12.

Graziotti PJ, Goucke CR. The use of oral opioids in patients with chronic non-cancer pain. Management strategies. MJA 1997; 167:30-34

Harrison CM, Charles J, Henderson J and Britt H. Opioid prescribing in Australian general practice.. Med J Aust 2012; 196 (6): 380-381

Media release from The Medical Journal of Australia. MJA Oxycodone prescribing Sept 2011.pdf..

National Pain Strategy Pain Management for all Australians National Pain Summit in March 2010.

National Prescribing Service Limited

National Prescribing Service; Opioids in chronic non-cancer pain: a planned response

National Prescribing Service; Neuropathic Pain: Current Definition and Review of Drug Treatment

Pharmaceutical Drug Misuse in Australia: Complex Problems, Balanced Responses. Nicholas. R., Lee. N., & Roche, A. 2011

Public Health England Managing persistent pain in secure settings 2013

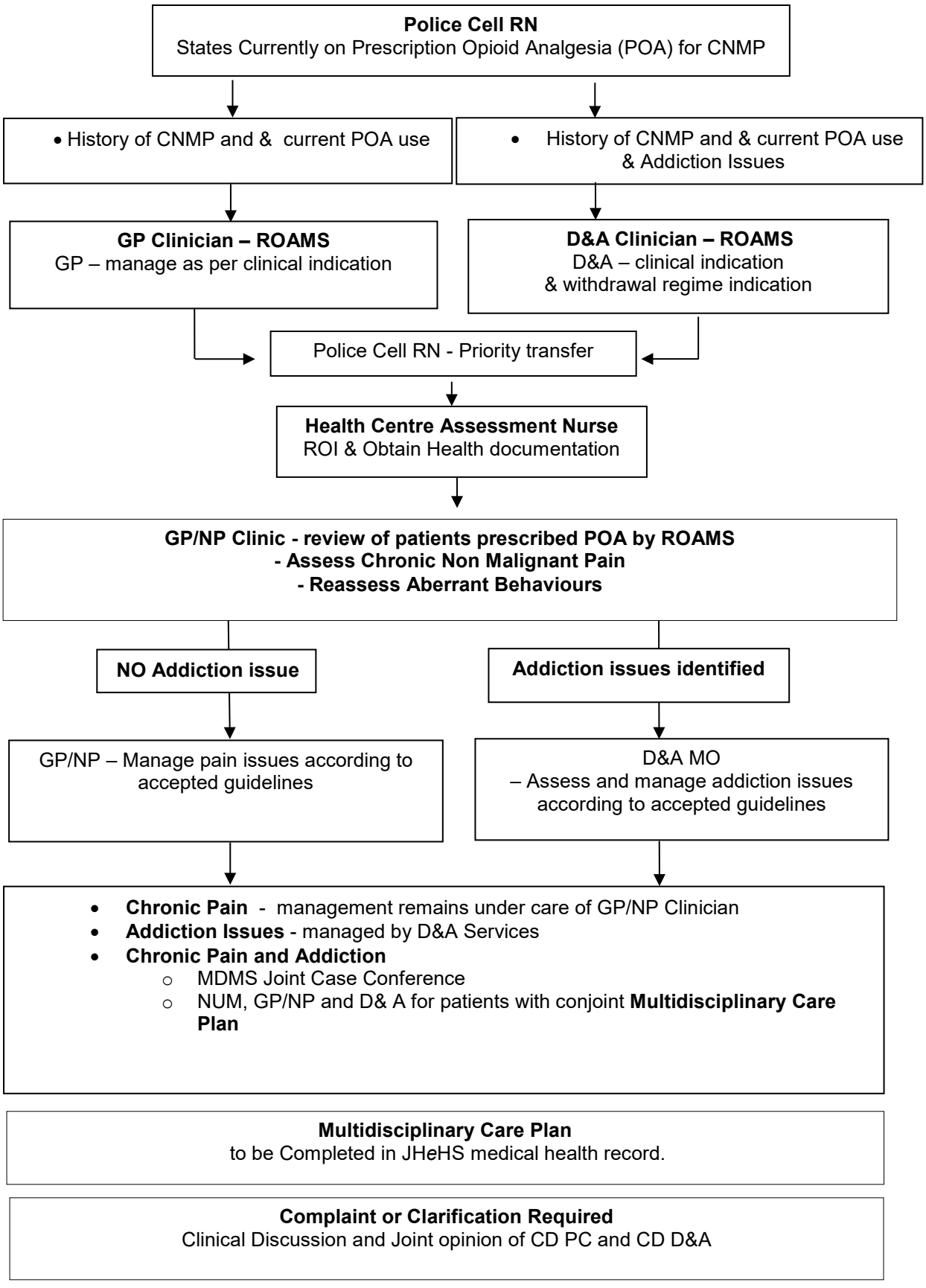
Prescription Opioid Policy: Improving management of chronic non-malignant pain and prevention of problems associated with prescription opioid use

Safer prescribing in prisons - Guidance for clinicians, RCGP Secure Environments Group

Scottish Intercollegiate Guidelines Network (SIGN) – SIGN 136 Management of chronic pain December 2013

Therapeutic Guidelines. Analgesics, Version 54, 2020

Appendix 1: Flowchart - Clinical Management for POA (Adults)



Appendix 2: Table - Aberrant opioid related behaviours

- Impaired control over use of drug
- Compulsive drug use
- Continued use despite harm
- Unmanageable drug craving
- History of, or current injecting drug use
- History of poly-drug use
- Concurrent misuse of alcohol or illicit drugs
- Injecting or snorting of medication
- History of diversion of medication
- Crushing modified-release preparations
- Illegal activities
- Selling medicine, forging prescriptions, stealing drugs from other patients, buying prescription drugs from non-medical sources
- Use of multiple GPs and pharmacists
- Report to doctors repeated loss of medication or scripts
- Repeatedly run out of medication early
- Multiple episodes of “lost” or “stolen” prescriptions
- Resistance to changes in treatment, regardless of adverse effects
- Refusal to comply with random urine drug screens or referral to pain management specialists
- Seeking increasing doses of POA medication
- Deterioration in functioning at work, in the family, or socially
- The individual regularly uses more of the drug than they intended
- They find it difficult to cut down on their intake of the drug
- They become anxious when they are unsure about having access to the substance
- They continue to use the drug even when it is obviously causing problems in their life
- They feel the need to hide their substance abuse
- The individual feels guilty about their substance abuse
- They have lost interest in activities they once enjoyed
- They have developed financial difficulties as a result of their drug intake
- The substance abuse is starting to interfere with their ability to meet work, family, or social responsibilities
- The individual engages in inappropriate behavior such as lying or acting secretively

Appendix 3: Chart - Approximate Opioid Equianalgesic Doses

The equianalgesic dose in any transfer from one POA preparation to another will be affected by a number of factors. It may be worthwhile reducing the dose of the new opioid analgesic medication by about 30-50% to allow a safety margin. The below tables are based on single doses, not accumulative repeated dosing so length of time on medication and half-life will effect transfer.

OPIOID CONVERSION to oral MORPHINE EQUIVALENT DAILY DOSE (oMEDD) *Toolkit for estimate of oMEDD only*				
	CONVERSION FACTOR		**PROPRIETARY NAMES**	*Equivalent Morphine 60mg oral dose of Opioid*
	From:	*To:*		
ORAL				
Swallowed				
morphine	mg/day	1	Ordine, Sevredol, Anamorph, MS Contin, Kapanol	60 mg
oxycodone	mg/day	1.5	Endone, OxyNorm (o), OxyContin, Targin	40 mg
hydromorphone*	mg/day	5	Dilaudid, Jurnista	12 mg
codeine	mg/day	0.13	Panadeine, Panadeine Forte, Mersyndol, Aspalgin, Codalgin, Nurofen Plus, others	461 mg
dextropropoxyphene	mg/day	0.1	Capadex, DiGesic, Doloxene, Paradex	600 mg
tramadol	mg/day	0.2	Tramal, Xydol, generic*	300 mg
tapentadol*	mg/day	0.3	Palexia-IR, Palexia-SR*	200 mg
Buccal/Sublingual				
buprenorphine (s/l)	mg/day	40	Temgesic, Subutex, Suboxone,	1.5 mg
TRANSDERMAL				
Buprenorphine*	mcg/hr	2	Norspan	30 mcg
Fentanyl*	mcg/hr	3	Durogesic, generic	20 mcg
PARENTERAL				
morphine (sc, iv)	mg/day	3	morphine sulphate, morphine tartrate FI	20 mg
oxycodone (sc, iv)*	mg/day	3	OxyNorm FI	20 mg
hydromorphone	mg/day	15	Dilaudid FI, Dilaudid-HP	4 mg
codeine (sc, iv)*	mg/day	0.25	codeine phosphate FI	240 mg
pethidine (iv, im)*	mg/day	0.4	pethidine injection	150 mg
fentanyl (iv,im,sc)*	mcg/da	0.2	fentanyl citrate FI (DBL, AstraZeneca,	300 mcg
sufentanil (iv, sc)*	mcg/da	2		30 mcg
RECTAL PREPARATION				
oxycodone (pr)*	mg/day	1.5	Proladone (** highly variable absorption)	40 mg
All patient opioid dose rotations to be based on individual clinical evaluation, with 30-50% dose reduction for incomplete cross-tolerance				
***Faculty of Pain Medicine ANZCA*, March 2019**				
Doses for Adolescents must be tailored as advised by relevant guidelines				