

Safe prescribing and supply of opioid medicines

Information for health professionals



Opioids present a unique challenge to prescribers. Despite these medicines having an important therapeutic role to play in the management of acute and cancer-related pain, existing evidence is insufficient to support the efficacy and safety of opioid therapy in chronic non-cancer pain.¹

Opioids also carry well-established risks of dependency and tolerance, and high doses can lead to significant harm, particularly at > 100 mg morphine equivalent dosage (MED).²⁻⁶ In addition, the prescription of opioid medicines carries societal risks such as misuse and diversion, making it a public health concern in Australia.⁷⁻⁹

Safe prescribing of opioids offers patients in pain the opportunity to benefit optimally from these medicines and helps to minimise potential harms. The implementation of practice-wide policies and an understanding of legal obligations around the prescription and supply of opioid medicines further contribute to safe prescribing.



Considerations for safe prescribing of opioids

Opioids are not first-line treatment for chronic non-cancer pain

Opioids should not be considered first-line or routine therapy for chronic pain outside of active cancer, palliative, or end-of-life care, given their small to moderate short-term benefits, uncertain long-term benefits, and potential for serious harms.¹

Long-term opioid use often begins with treatment of acute pain, and guidelines recommend that, when using opioids for acute pain, clinicians prescribe only for the expected duration of severe pain. A prescription of 3 days or less is suggested, and more than 7 days will rarely be required.

The 2015 RACGP clinical governance framework recommends prescribing an opioid dose of no more than 80-100 mg MED/day.⁸ The more recent Centers for Disease Control and Prevention guidelines recommend providers use caution when prescribing opioids at any dose.¹⁰

Non-opioid therapy is preferred for the treatment of chronic pain

Before starting a patient on opioids, explore all other treatment options.

If trials of non-opioid alternatives have been found to be insufficient in controlling pain and improving function, opioids may be helpful as part of a multidisciplinary pain management plan that also includes non-pharmacological strategies, such as exercise, physiotherapy, relaxation, etc.²

Avoid sole reliance on opioids for managing chronic non-cancer pain.²

Trial opioids for short periods in selected patients

The initiation of opioids in chronic non-cancer pain should be considered a trial to determine whether the patient is responsive to opioids and tolerant of adverse effects.²

- Look for improvements in function, such as participation in activities and sleep quality, as well as using pain scores to gauge the effectiveness of opioids during the trial phase.²
- Goals should be set in conjunction with the patient and significant others, including spouse and other healthcare professionals. When a functional improvement is not seen within 4 weeks, long-term use is not recommended.²

Pain is a common symptom of depression, they share biological pathways and neurotransmitters, and this has implications for the treatment of both.¹¹ Patients with anxiety and depression need these conditions specifically addressed to avoid opioids becoming surrogate treatments for the underlying psychopathology.

Use an [opioid risk tool](#) to screen patients for possible aberrant drug-related behaviours when prescribing opioids. Risk factors that are most predictive of development of a substance abuse disorder include personal or family history of alcohol or other drug abuse, and other mental illnesses. Research strongly suggests that smoking may also be a predictor of more frequent use of opioids.¹²

If a patient is assessed as high risk, prescribers should consider seeking advice from a pain or addiction specialist before prescribing an opioid. If an opioid must be prescribed before advice can be obtained, consider:

- using an opioid contract
- urine drug testing
- prescribing low doses and avoiding dose escalation
- specifying collection at short intervals from the pharmacy named on the prescription
- not exceeding 50 mg MED/day.

Start low, go slow

When prescribing an opioid, 'start low and go slow' and review regularly for ongoing need and adverse effects.² Titrate dose according to response.

Adjust the dose of controlled-release opioids, rather than the frequency of dosing/administration. Occasionally, it may be appropriate to prescribe more frequent doses for patients whose pain regularly occurs shortly before the next dose is due.¹³

Caution should be used when prescribing opioids at any dose; however, increasing the dose beyond 50 mg MED/day results in an increased risk of overdose without necessarily reducing pain scores and improving function.¹⁴ Doses above 50 mg MED/day require reassessment, including specialist advice if possible.²

Monitor for signs of tolerance or opioid-induced hyperalgesia

Tolerance and opioid-induced hyperalgesia reduce the effectiveness of opioids over time.¹⁵ Both result in reduced analgesic effects of opioids, and differentiation within a clinical setting may not be possible.¹⁶

Tolerance can be treated by dose escalation of the primary analgesic, although this may not always be effective¹⁷ and can lead to increased adverse effects and risk.¹⁸

Opioid-induced hyperalgesia should be treated with dose reduction and possibly an alternative analgesic.^{16, 19} Opioid-induced hyperalgesia should be suspected when opioids are entirely ineffective or when pain increases and becomes more widespread (diffuse allodynia), particularly in the absence of disease progression.^{2, 16, 19}

Coprescribing an antihyperalgesic agent, such as paracetamol, non-steroid anti-inflammatory drugs (NSAIDs), clonidine, or tricyclic antidepressants with the opioid can limit the development of opioid-induced hyperalgesia and tolerance and provide an opioid-sparing effect.

Also review the dose or need for opioids if there has been an opioid overdose, or if the nociceptive condition progresses or new pathology emerges.

Avoid dose escalation to 'chase pain'

Consider alternative options before increasing opioid dose.² The linear relationship between opioid dose and analgesic effect is counterbalanced by the concurrent linear relationship between opioid dose and adverse effects.^{6, 18, 20} Attempts to restore analgesia via dose escalation of the primary opioid may lead to increased adverse events.^{2, 18, 20}

Consider deprescribing or tapering at every visit

Therapeutic Guidelines recommend ceasing opioids:

- if there is evidence of abuse or misuse
- the patient is experiencing adverse events
- no improvement in wellbeing or function is seen within 4 weeks.²

When the decision to deprescribe has been made, reduce the dose gradually and monitor for withdrawal symptoms, level of pain and effect on quality of life.¹⁵ Explain reasons for stopping and use a shared decision-making approach to agree on a timeline for gradual reduction.²¹

See the fact sheet '[Recommendations for deprescribing or tapering opioids](#)' and the [online opioid dose-tapering calculator](#) for more information.

Consider non-opioid analgesics

As part of a multidisciplinary approach to pain management, opioids should only be trialled for a short period.² Consider moving patients from opioids to non-opioid analgesics.²

Paracetamol can be used as an adjunct to non-pharmacological or other pharmacological therapies.² Paracetamol rarely relieves pain completely but, when used optimally, it can modify the severity and be opioid sparing.²

If using NSAIDs, use the lowest possible dose for the shortest possible time.²

Adjuvant analgesics, including tricyclic antidepressants, serotonin-noradrenaline reuptake inhibitors and anticonvulsants, can be considered before opioids.² Adjuvant analgesics are indicated for trial in patients with unexplained pain conditions that may have a neuropathic component.²



Practice-wide initiatives

Implement practice-wide policies on safe opioid prescribing

- General practices should agree on policies for safe opioid prescribing and advertise this to all patients. In their clinical governance framework, the RACGP provides templates that can be adapted for use within your practice:
• [Prescribing drugs of dependence in general practice, Part A.](#)

Patients who are prescribed opioids respond best when:²²⁻²⁴

- opioid management practices, such as establishing a written contract or urine testing, are employed uniformly across the practice
- opioid adherence monitoring and ground rules for opioid prescribing are used because physicians have their patients' best interests in mind
- conversations are framed as protecting patients from opioid-related harms.

Use management plans and opioid contracts, where practical, with patients

Opioid contracts that stipulate conditions of use, and management plans that detail the range of interventions agreed, including self-management strategies, can help structure conversations and set realistic expectations for patients in higher doses.^{2, 8, 21} Hunter New England Area Health Service has a sample [opioid treatment agreement](#).



Know the laws that apply and safeguard you and your patients

If you are going to prescribe a drug of dependence for a patient, there are some legal obligations to follow.

- You are required to obtain a permit from the Victorian Department of Health and Human Services before prescribing a Schedule 8 medicine to a person who is drug dependent, or when treatment with a Schedule 8 medicine exceed eight weeks. See [Policy for issuing Schedule 8 permits](#) for further information.
- You should contact Medicare Australia's Prescription Shopping Information Service (Tel: 1800 631 181) if you are concerned that the patient may be seeking medicines from other prescribers, or has received medicines in excess of medical need.
- You may also contact Drugs and Poisons Regulation (Tel: 1300 364 545 or email: dpcs@dhhs.vic.gov.au) to check if permits have been issued or notifications of drug dependency have been received in relation to a patient you intend to treat.



Resources

Australian Pain Society – Facility Directory: www.apsoc.org.au/facility-directory

Faculty of Pain Medicine ANZCA

- ***Recommendations Regarding the Use of Opioid Analgesics in Patients with Chronic Non-Cancer Pain***
<http://fpm.anzca.edu.au/Documents/PM1-2010.pdf>
- ***Quick Reference Recommendations for Conduct of an Opioid Trial in Chronic Non-Cancer Pain***
http://fpm.anzca.edu.au/Documents/4462_001.pdf

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