

# Essential Clinical Skills for Opioid Prescribers

## Safer Opioid PRESCRIBING

### ACUTE PAIN in the Emergency Department or Walk-in Clinic

- **Avoid opioids if possible.**
- Prescribe a small supply of weak opioids (codeine, buprenorphine patch, tramadol) for only 3 days, until patients can see their family doctor.
- Do not prescribe potent opioids (morphine, oxycodone, hydromorphone, fentanyl) for minor pain, e.g., muscle strains.

### CHRONIC PAIN: Patient selection

- Reserve opioids for severe pain that impairs daily function (e.g., spinal stenosis, neuropathic pain) that has not responded to an adequate trial of all appropriate non-opioid treatments.
- Do not prescribe for fibromyalgia, headaches, low back or neck pain.
- Get a second opinion before prescribing to patients at high risk for opioid use disorder (younger, have an underlying psychiatric disorder (e.g., anxiety, PTSD) or have current or past problematic substance use).

## PATIENT WARNINGS

- Explain tolerance: a safe dose for you can be lethal to a non-tolerant individual.
- Keep opioids away from children and adolescents living at home.
- Do not share opioids with anyone and do not borrow opioids from anyone.
- Do not drink alcohol or take sedating drugs while taking your opioid.
- Be careful about driving for a few days after initiation and dose increases.
- If you have stopped opioids for more than 2-3 days, contact your doctor before resuming – you may need a lower dose.

### Inform patients that:

- Long-term effectiveness of opioids is unknown.
- Opioids will be discontinued if they do not significantly improve function and pain, or have complications or problematic side effects.

## OPIOID SELECTION AND INITIATION

- Taper and discontinue benzodiazepines when starting opioids.
- Always start with weak opioids first.
- Maximum starting dose 30 mg MED/D.\*

\* MED/D: Morphine equivalent dose/day

**30 mg** morphine = **20 mg** oxycodone = **6 mg** hydromorphone

### Dose Titration:

- Increase by no more than 25% for doses less than 50 mg MED/D, and by no more than 10% for doses more than 50 mg MED/D.
- Most patients respond to doses of less than 50 mg MED/D; get a second opinion if doses above 90 mg MED/D are contemplated.

**Naloxone:** Recommend take-home naloxone for patients who are on greater than 90 mg MED/D, on benzodiazepines, or have a history of respiratory impairment, past overdose, or substance use disorder. Naloxone kits are available for free and without a prescription in many pharmacies.

### Elderly:

- Initial opioid dose should be less than 20 mg MED/D, with lower dose increases (5–10 mg MED/D).
- **Avoid transdermal fentanyl.**
- Taper and discontinue benzodiazepines.
- Avoid opioids at night, especially long-acting opioids.

## Opioid TAPERING

- **High doses (greater than 90 mg MED/D) are not safe and usually not necessary:** Most pain patients respond to doses of 50 mg MED/D or less. High doses increase the risk of overdose, addiction, motor vehicle collisions, and falls.
- Tapering can improve mood, pain, and function in patients with severe pain despite a high opioid dose.
- **Abrupt cessation of high opioid doses is dangerous:** Patients will seek other sources of opioids to relieve withdrawal. Opioid tolerance is lost within days, putting patients at high risk of overdose.

### INDICATIONS FOR OPIOID TAPERING:

- **Opioid failure:** Severe pain and impaired function despite adequate dose.
- **Overdose, fall, or harm risk** (e.g., heavy alcohol use, benzodiazepine use, advancing age or worsening co-morbidities).
- **Opioid complications** (e.g., hyperalgesia, sleep apnea, fatigue, or dysphoria).
- **Suspected opioid use disorder** with patient unwilling to pursue methadone or buprenorphine treatment.

## TAPERING PROTOCOL

**Opioid formulation:** Long-acting preferred (until low dose reached).

**Dosing interval:** Scheduled doses at constant interval (BID or TID) rather than PRN.

**Rate of taper:** No more than 10% of total daily dose every 1–2 weeks.

**Endpoint of taper:** Lowest dose that does not markedly exacerbate pain, at least less than 90 mg MED/D.

### Dealing with patient resistance:

- Explain that tapering will improve pain, mood, energy level, and function.
- If patient runs out early, increase dispensing frequency (e.g., daily).

### Opioid use disorder with suspected injection, diversion, or street use:

Taper quickly (1-3 months) with daily dispensing. Stop prescribing after the taper is completed, even if the patient refuses methadone or buprenorphine treatment.

# Clinical features of opioid use disorder in pain patients

- Very high opioid dose for underlying pain condition.
- Aberrant behaviours (running out early, crushing or biting oral tabs, accessing opioids from other sources).
- Strong resistance to tapering.
- Current or past problematic substance use.
- Low mood and functioning.
- Concerns expressed by family members.
- Recurrent withdrawal symptoms (e.g., dramatic spike in pain, anxiety, myalgias).
- Experiences immediate improvement in mood after taking the opioid.

## OVERDOSE PREVENTION ADVICE for patients with opioid use disorder

### Avoiding a fatal overdose

- **Always use opioids with someone else present**; if you overdose, your friend can contact 911 and use a naloxone kit.
- Use a small amount as a test dose if unsure about the source.
- Only pharmaceutical opioids obtained from a prescription and a pharmacy are guaranteed to be free of added fentanyl or other dangerous substances.
- Do not combine opioids with alcohol or benzodiazepines.
- If you have recently used less or been abstinent, take a much smaller dose.
- Get a **naloxone rescue kit**. These are available in many areas without the need for a prescription.
- Always carry your naloxone kit with you.

### What to do if a friend has an overdose

- Never leave a friend alone if they are drowsy or passed out after taking opioids.
- Shake them to keep them awake, and **call 911**.
- If unconscious, start chest compressions and use a naloxone kit.

### Fentanyl and other adulterants

- Fentanyl and other dangerous substances are being added to street opioids and other drugs.
- Very small doses of fentanyl can kill you, even if you have a high tolerance to opioids.

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## BUPRENORPHINE/NALOXONE PROTOCOL

Offer all patients with opioid use disorder buprenorphine/naloxone (buprenorphine) treatment. Buprenorphine has a very low overdose risk and can be prescribed by physicians in most provinces, even if they are not authorized to prescribe methadone. If possible, contact an addiction physician for advice when you first start prescribing buprenorphine. Prior to starting buprenorphine, **stop prescribing all opioids**. Office initiation is preferred, but home initiation has been shown to be safe.

### OFFICE INITIATION

- **Before 1st dose:**
  - **Patient must abstain from all opioids for at least 12 hours**, preferably longer.
  - **Patient must be in moderate withdrawal** (insomnia, myalgias, nausea, anxiety); a score of 12+ on the Clinical Opiate Withdrawal Scale indicates buprenorphine can be initiated safely.
- Initial dose **4 mg sublingual (SL); 2 mg SL** if elderly or on benzodiazepines.
- Reassess in 2 hours. If patient still in withdrawal, give another 4 mg in office, or prescribe two 2 mg tabs to take home.
- Maximum dose first day **12 mg**.
- **Ensure frequent follow-up**. Prescribe enough of the determined dose once daily to last until next reassessment in 1 to 3 days.

### HOME INITIATION

**Indications:** Unable to abstain from opioids long enough to attend the office in withdrawal or unlikely to keep office appointment (e.g., uses injection opioids).

**Protocol:** Prescribe **2 mg SL every 4 hours prn, up to 6 doses over 24 hours**, for 1-3 days (e.g., eighteen 2 mg tabs all as take-home, or six 2 mg tabs daily dispensed x 3 days).

- Warn patients to wait at least 12 hours after their last opioid dose and be in at least moderate withdrawal before taking the first buprenorphine dose.
- Follow up within 1–3 days.

### DISPENSING

- For the first 4-8 weeks, **dispense dose once daily under observation of pharmacist**.
- Prescribe take-home doses (up to 1 week at a time) when patient is no longer using opioids.
- Prescribe take-home doses before 4-8 weeks if the patient is unable to attend pharmacy daily because of work or family responsibilities and is unlikely to divert (e.g., does not acquire opioids from other sources).

### TITRATION

- Reassess in 1–3 days.
- Increase dose by 2–4 mg at each visit for withdrawal symptoms or opioid use.

### MAINTENANCE DOSE

- Usually **12–16 mg SL daily; maximum dose is 24 mg SL daily**.
- Maintenance dose should relieve withdrawal symptoms for 24 hours, with no sedation.
- **Refer to methadone clinic** if continued opioid use or withdrawal symptoms.

### URINE TESTING

Check at least monthly for:

- Buprenorphine
- Fentanyl
- Hydromorphone
- Morphine
- Oxycodone
- Cocaine
- Benzodiazepines