Section A: Important Consideration for Opioid Therapy Trials

- For patients starting or continuing an opioid trial, discuss and document patients’ goals (SMART goals: Specific, Measurable, Agreed-upon, Realistic, Time-base), on a regular basis.

<table>
<thead>
<tr>
<th>Dose</th>
<th>Fatal overdose</th>
<th>Non-fatal overdose</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 100 mg MED/d</td>
<td>0.23 %/yr</td>
<td>1.8 %/yr</td>
</tr>
<tr>
<td>50 – 99 mg MED/d</td>
<td>0.18 %/yr</td>
<td>0.7 %/yr</td>
</tr>
<tr>
<td>&lt; 20 mg MED/d</td>
<td>0.1 %/yr</td>
<td>0.2 %/yr</td>
</tr>
</tbody>
</table>

Legend: d = day, MED = morphine equivalent dose, yr = year

CHECKLIST
These are important considerations to discuss and document for patients starting or continuing an opioid therapy trial.

- Has non-pharmacological therapy\[i\] been optimized?
- Has non-opioid pharmacotherapy\[i\] been optimized?
- Stable psychiatric disorder(s) or mental illness?
- Current or past substance use disorder?
- Cannabis use?
- Thorough baseline assessment conducted\[ii\] (as needed)?
- Explained potential benefits\[i\]?
- Explained adverse effects\[i\]?
- Explained risks\[i\]?
- Explained opioid safety\[i\]?
- Signed treatment agreement\[iii\] (as needed)?
- Patient given information handouts\[iv\]?
- Urine drug screening (as needed)?
- Naloxone prescription (as needed)?

Clinical pearls
- Opioids may have similar effects on pain relief when compared to NSAIDs, tricyclic antidepressants or nabilone
- Opioids may result in similar improvements in physical function when compared to NSAIDs, anticonvulsants, tricyclic antidepressants or nabilone
- Opioids are not recommended for patients with current or past substance use disorder (e.g. alcohol use disorder, opioid use disorder)
- Opioids NOT recommended for initiating a trial of therapy include fentanyl, meperidine, methadone and pentazocine
- Opioids that ARE recommended are listed in the Suggested Initial Dose and Titration table
- Oral preparations are preferred
- Prescriptions for chronic pain should be provided by the primary treating provider only, for no more than 28 days at a time

Section B: Opioid Therapy Trial

- This section is intended to support providers starting a patient on opioid therapy. For patients continuing opioid therapy, see Section C: Maintenance & Monitoring.
- A reasonable trial of opioid therapy should be accomplished within 3–6 months; opioids provide less pain relief after 3 months, due to tolerance.
- Restrict the prescribed dose to < 90 mg morphine equivalents daily for patients beginning long-term opioid therapy.
**SUGGESTED INITIAL DOSE AND TITRATION**

This table provides practical guidance regarding optimal dosing when beginning patients on a trial of opioid therapy. For opioids with multiple dosage forms and singular values in subsequent columns, subsequent column values are applicable across all dosage forms.

**Note:** Brand names are shown if formulations vary from that of the generic. Reference to brand names does not imply endorsement of any of these products.

Note: Information on the buprenorphine transdermal patch and buprenorphine/naloxone sublingual tablets is available in Section D: Switching and Section E: Tapering, respectively. Buprenorphine/naloxone sublingual tablets are NOT recommended for an initiation trial of opioid therapy.

### Legend:
- = approximately equal to, cap = capsule, CR = controlled release, d = day, ER = extended release, g = gram, h = hour, IR = immediate release, MED = morphine equivalent dose, mg = milligram, mL = milliliter, µg = microgram, N/A = not available, PR = prolonged release, prn = as needed, q = every, SL = sublingual, tab = tablet

*The maximum recommended daily dose of tramadol is 300 mg – 400 mg depending on the formulation.*

**Note:** Cut tablet in half to start at 25 mg. Pharmacy can cut tablets in half if required.

### Suggested Initial Dose and Titration

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Dosage forms</th>
<th>Initial dose</th>
<th>Minimum time interval for increase</th>
<th>Suggested dose increase</th>
<th>Maximum dose/day</th>
<th>50 MED</th>
<th>90 MED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine CR</td>
<td>• Tab: 50, 100, 150, 200 mg</td>
<td>50 mg q 12 h</td>
<td>2 days</td>
<td>50 mg/d</td>
<td>300 mg q 12 h</td>
<td>334 mg/d</td>
<td>600 mg/d</td>
</tr>
<tr>
<td>Codeine IR</td>
<td>• Tab: 15, 30 mg; Syrup: 5 mg/mL; Elixir: 16 mg/10 mL with Acetaminophen 320 mg; Tab: 8, 15, 30, 60 mg with Acetaminophen 300 mg; Tab: 15, 30 mg with Acetaminophen 325 mg; Tab: 15, 30 mg with Acetylsalicylic acid 375 mg</td>
<td>15–30 mg q 4 h prn</td>
<td>7 days</td>
<td>15–30 mg/d</td>
<td>600 mg/d or Acetaminophen 4 g/d</td>
<td>334 mg/d</td>
<td>600 mg/d</td>
</tr>
<tr>
<td>Hydromorphone CR, PR</td>
<td>• CR: 3, 4, 5, 6, 12, 18, 24, 30 mg; Oral solution: 1, 5, 10, 20, 25, 30, 50 mg; Tab: 5, 10, 20, 30 mg</td>
<td>3 mg q 12 h, maximum 9 mg/d; 4 mg q 24 h, maximum 8 mg/d</td>
<td>Minimum 2 days; Minimum 4 days, recommended 14 days</td>
<td>3 mg/d; 4 mg/d</td>
<td>N/A; 10 mg/d</td>
<td>10 mg/d</td>
<td>18 mg/d</td>
</tr>
<tr>
<td>Hydromorphone IR</td>
<td>• Tab: 1, 2, 4, 8 mg; Syrup: 1 mg/mL</td>
<td>1–2 mg q 4–6 h prn, maximum 8 mg/d</td>
<td>7 days</td>
<td>1–2 mg/d</td>
<td>N/A; 10 mg/d</td>
<td>10 mg/d</td>
<td>18 mg/d</td>
</tr>
<tr>
<td>Morphine CR, ER</td>
<td>• Tab: 15, 30, 60, 100, 200 mg; Cap (12 h): 10, 15, 30, 60, 100, 200 mg; Cap (24 h): 10, 20, 50, 100 mg</td>
<td>10–15 mg q 12 h; 10 mg q 24 h; 10 mg q 24 h</td>
<td>Minimum 2 days; Minimum 4 days; recommended 14 days</td>
<td>5–10 mg/d; N/A; 50 mg/d</td>
<td>90 mg/d; 50 mg/d</td>
<td>90 mg/d</td>
<td></td>
</tr>
<tr>
<td>Morphine IR</td>
<td>• Oral solution: 1, 5, 10, 20, 50 mg/mL; Tab: 5, 10, 20, 30 mg; Cap: 5, 10, 20, 30 mg</td>
<td>5–10 mg q 4 h prn, maximum 40 mg/d</td>
<td>7 days</td>
<td>5–10 mg/d</td>
<td>N/A; 50 mg/d; N/A; 90 mg/d</td>
<td>50 mg/d</td>
<td>90 mg/d</td>
</tr>
<tr>
<td>Oxycodone CR with naloxone CR</td>
<td>• Tab: 5/2.5, 10/5, 20/10, 40/20 mg</td>
<td>5 mg/2.5 mg q 12 h</td>
<td>Minimum 1–2 days; recommended 14 days</td>
<td>5/2.5 mg/d; 80 mg/d oxycodone and 40 mg/d naloxone; 33 mg/d oxycodone; 60 mg/d oxycodone</td>
<td>60 mg/d</td>
<td>60 mg/d</td>
<td></td>
</tr>
<tr>
<td>Oxycodone CR</td>
<td>• Tab: 5, 10, 15, 20, 30, 40, 60, 80 mg</td>
<td>10 mg q 12 h</td>
<td>Minimum 2 days; recommended 14 days</td>
<td>10 mg/d</td>
<td>N/A; 33 mg/d; 33 mg/d; 60 mg/d</td>
<td>33 mg/d</td>
<td>60 mg/d</td>
</tr>
<tr>
<td>Oxycodone IR</td>
<td>• Tab: 5, 10, 20 mg; Tab: 5 mg with Acetylsalicylic acid or Acetaminophen 325 mg; Tab: 2.5 mg with Acetaminophen 325 mg</td>
<td>5–10 mg q 6 h prn, maximum 30 mg/d; 1–2 tab q 6 h prn</td>
<td>7 days</td>
<td>5 mg/d; N/A; Acetaminophen 4 g/d</td>
<td>33 mg/d</td>
<td>60 mg/d</td>
<td></td>
</tr>
<tr>
<td>Tapentadol ER</td>
<td>• Tab: 50, 100, 150, 200, 250 mg</td>
<td>50 mg q 12 h</td>
<td>3 days</td>
<td>50 mg q 12 h; Not recommended &gt; 500 mg/d; 160 mg/d; 300 mg/d</td>
<td>160 mg/d</td>
<td>300 mg/d</td>
<td></td>
</tr>
<tr>
<td>Tapentadol IR</td>
<td>• Tab: 50, 75, 100 mg</td>
<td>50 mg q 4–6 h prn</td>
<td>On the first day of dosing, the 2nd dose may be administered 1 hour after the first dose, if adequate pain relief is not attained with the first dose</td>
<td>50 mg q 4–6 h; Not recommended daily doses &gt; 700 mg on the first day of therapy and 600 mg on subsequent days; 160 mg/d; 300 mg/d</td>
<td>160 mg/d</td>
<td>300 mg/d</td>
<td></td>
</tr>
<tr>
<td>Tramadol CR</td>
<td>• Tab (Zytram XL®): 75, 100, 150, 200, 300, 400 mg; Tab (Tridural®): 100, 200, 300 mg; Tab (Ralivia®): 100, 200, 300 mg; Tab (Durela®): 100, 200, 300 mg</td>
<td>150 mg q 24 h; 100 mg q 24 h; 100 mg q 24 h; 100 mg q 24 h</td>
<td>7 days; 2 days; 5 days; 5 days</td>
<td>75–100 mg q 24 h; 400 mg/d; 300 mg/d; 300 mg/d; 300 mg/d</td>
<td>300 mg/d</td>
<td>540 mg/d*; Over maximum dose</td>
<td></td>
</tr>
<tr>
<td>Tramadol IR</td>
<td>• Tab: 50 mg; Tab: 37,5 mg with Acetaminophen 325 mg</td>
<td>25 mg once daily; 1 tablet q 4–6 h prn</td>
<td>4 days; Depends on patient’s clinical response; 25 mg/d; 8 tabs/day or Acetaminophen 4 g/d</td>
<td>400 mg/d; 300 mg/d; 300 mg/d; 300 mg/d</td>
<td>300 mg/d</td>
<td>540 mg/d*; Over maximum dose</td>
<td></td>
</tr>
</tbody>
</table>
SUGGESTED INITIAL DOSE AND TITRATION FOR BUPRENORPHINE TRANSDERMAL PATCH

This section is intended to support providers with patients continuing opioid therapy. Monitor and document a patient’s response to the opioid therapy through regularly scheduled appointments.

INITIATION, MAINTENANCE & MONITORING

These are the key elements to document upon initiating a trial of opioid therapy (3–6 month) and on an ongoing basis for monitoring purposes. See Appendix B - Initiation, Maintenance & Monitoring Chart for a fillable version of this table that can be inserted into the patient medical record.

<table>
<thead>
<tr>
<th>Date (patient seen)</th>
<th>Presence of clinical features of opioid use disorder (see Clinical Features of Opioid Use Disorder table)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date and result of last urine drug screening</td>
<td>Date of new dose to be administered</td>
</tr>
<tr>
<td>Naloxone prescription written</td>
<td>Status of patient goals</td>
</tr>
<tr>
<td>Tapering offered</td>
<td>Pain intensity (Brief Pain Inventory)</td>
</tr>
<tr>
<td>Non-pharmacological therapies being used for pain</td>
<td>Adverse effects (e.g. fatal and non-fatal overdose, motor vehicle accident, addiction, sleep apnea, osteoporosis, drowsiness, constipation, dizziness/vertigo, hypogonadism, vomiting, nausea, sexual dysfunction, opioid induced hyperalgesia, dry skin/pruritis)</td>
</tr>
</tbody>
</table>

Section D: Switching

Consider switching opioids if problematic pain and/or adverse effects persist. While switching over to the new opioid, it is important to warn the patient (and family, caregivers or friends) about signs of overdose: slurred or drawing speech, ataxia, “nodding off” during conversation or activity. Consider a 3-day follow-up to assess withdrawal symptoms and pain; contact the patient 3 days after the new opioid to check for signs of over-sedation and to ensure that pain relief is at least comparable to the pre-switch treatment. Switching opioids may be done as a way of facilitating a dose reduction.

MORPHINE EQUIVALENCE TABLE

Opioid conversion table.

<table>
<thead>
<tr>
<th>Opioids* Oral preparations (mg/d)</th>
<th>To convert to oral morphine equivalent, multiply by:</th>
<th>To convert from oral morphine, multiply by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine**</td>
<td>• 5 µg/h patch = 9–14 mg MED/d</td>
<td>• 15 µg/h patch = 27–41 mg MED/d</td>
</tr>
<tr>
<td></td>
<td>• 10 µg/h patch = 18–28 mg MED/d</td>
<td>• 20 µg/h patch = 36–55 mg MED/d</td>
</tr>
<tr>
<td></td>
<td><strong>Fentanyl</strong>*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>60–134 mg morphine = 25 µg/h patch</td>
<td></td>
</tr>
<tr>
<td></td>
<td>135–178 mg morphine = 37 µg/h patch</td>
<td></td>
</tr>
<tr>
<td></td>
<td>180–224 mg morphine = 50 µg/h patch</td>
<td></td>
</tr>
<tr>
<td></td>
<td>225–269 mg morphine = 62 µg/h patch</td>
<td></td>
</tr>
<tr>
<td></td>
<td>270–314 mg morphine = 75 µg/h patch</td>
<td></td>
</tr>
<tr>
<td></td>
<td>315–359 mg morphine = 87 µg/h patch</td>
<td></td>
</tr>
<tr>
<td></td>
<td>360–404 mg morphine = 100 µg/h patch</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Methadone</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dose equivalents unreliable</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Codeine</strong></td>
<td>0.15 (0.1–0.2)</td>
</tr>
<tr>
<td></td>
<td><strong>Hydromorphone</strong></td>
<td>5.0</td>
</tr>
<tr>
<td></td>
<td><strong>Oxycodone</strong></td>
<td>1.5</td>
</tr>
<tr>
<td></td>
<td><strong>Tapentadol</strong></td>
<td>0.3–0.4</td>
</tr>
<tr>
<td></td>
<td><strong>Tramadol</strong></td>
<td>0.1–0.2</td>
</tr>
</tbody>
</table>

Section C: Maintenance & Monitoring

- Consider switching opioids if problematic pain and/or adverse effects persist.
- While switching over to the new opioid, it is important to warn the patient (and family, caregivers or friends) about signs of overdose: slurred or drawing speech, ataxia, “nodding off” during conversation or activity.
- Consider a 3-day follow-up to assess withdrawal symptoms and pain; contact the patient 3 days after starting the new opioid to check for signs of over-sedation and to ensure that pain relief is at least comparable to the pre-switch treatment.
- Switching opioids may be done as a way of facilitating a dose reduction.

When to switch opioids:

- Uncontrolled pain
- Intolerable adverse effects
- Switching route of administration (e.g. oral to transdermal)

How to switch:

The two methods for switching opioids are presented below. There is no evidence that favours one method over another. Careful attention must be taken when switching an opioid to ensure the patient is seen each week and understands prescription instructions.

Method 1: Decrease the total daily dose of the current opioid by 25–50% and convert to a new opioid equivalent dose.
Method 2 (Cross Taper Method): Decrease the total daily dose of the current opioid by 10–25% per week while titrating up the total daily dose of the new opioid weekly by 10–20% with a goal of switching over 3–4 weeks (also consider dose formulations available). Consider more regular (e.g. weekly) follow-ups, weekly dispensing and/or dosette/blisterpack if required.

See Appendix C - Switching Opioids for succinct steps and examples on how to switch opioid therapies, and filling switching templates that can be completed and inserted into the patient medical record.

Legend:
- h = hour
- MED = morphine equivalent dose
- mg = milligram
- mL = milliliter
- µg = microgram
- SL = sublingual
- *Conversion ratio for opioids are subject to variation in kinetics governed by genetics and other drugs
- **The maximum recommended daily dose of tramadol is 300 mg—400 mg depending on the formulation
- ***The information provided can be used to determine the morphine equivalents for a patient on fentanyl. If used for switching opioids the dose conversions are for unidirectional conversion to fentanyl in patients for chronic use and not opioid naive patients. The dose conversions were not intended to covert patients from fentanyl to other opioids; doing so may result in overdose and toxicity.

SUGGESTED INITIAL DOSE AND TITRATION FOR BUPRENORPHINE TRANSDERMAL PATCH

The buprenorphine transdermal patch is indicated for the management of pain severe enough to require daily, continuous, long-term opioid treatment and for which alternative options are inadequate. It can be prescribed to opioid naive patients.

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Dosage forms</th>
<th>Initial dose</th>
<th>Minimum time interval for increase</th>
<th>Suggested dose increase</th>
<th>Maximum dose/day</th>
<th>50 MED</th>
<th>90 MED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine*</td>
<td>Patch: 5, 10, 15, 20 µg/h</td>
<td>5 µg/h every 7 days</td>
<td>7 days</td>
<td>5 µg/h every 7 days</td>
<td>20 µg/h every 7 days</td>
<td>20 µg/h</td>
<td>Not available</td>
</tr>
</tbody>
</table>

Legend:
- h = hour
- MED = morphine equivalent dose
- µg = microgram

*The oral morphine to buprenorphine transdermal patch ratio can range from 75:1 to 115:1, therefore the mid-point of this range (i.e. 95:1) is suggested.
Section E: Tapering

- Consider a discontinuation of the opioid therapy if improvement in pain or function is not achieved.
- Consider tapering opioids to the lowest effective dose for patients with a prescribed dose ≥ 90 mg morphine equivalents daily.
- Opioid withdrawal symptoms are unpleasant, but not life-threatening. What is life-threatening with opioids is overdose. Careful consideration needs to be taken with patients who are pregnant; severe, acute opioid withdrawal has been associated with premature labour and spontaneous abortion.
- Careful attention must be taken when tapering an opioid to ensure the patient is seen each week and understands prescription instructions.

WHEN TO CONSIDER TAPERING OPIOIDS

<table>
<thead>
<tr>
<th>Conditions and Considerations</th>
<th>Examples and consideration (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain condition resolved</td>
<td>Patient receives definitive treatment for condition</td>
</tr>
<tr>
<td></td>
<td>A trial of tapering is warranted to determine if the original pain condition has resolved</td>
</tr>
<tr>
<td>Risk outweigh benefits</td>
<td>Overdose risk has increased</td>
</tr>
<tr>
<td></td>
<td>Clear evidence of diversion</td>
</tr>
<tr>
<td></td>
<td>Clinical features of opioid use disorder have become apparent (see Clinical Features of Opioid Use Disorder table)</td>
</tr>
<tr>
<td>Adverse effects outweighs benefits</td>
<td>Adverse effects impair functioning below baseline level</td>
</tr>
<tr>
<td></td>
<td>Patient does not tolerate adverse effects</td>
</tr>
<tr>
<td></td>
<td>Non-adherence to the treatment plan</td>
</tr>
<tr>
<td>Patient requests</td>
<td>Patient requests opioid prescription to be tapered or stopped</td>
</tr>
<tr>
<td>Medical complications</td>
<td>Medical complications have arisen (e.g. hypogonadism, sleep apnea, opioid induced hyperalgesia)</td>
</tr>
</tbody>
</table>

Opioid not effective
- Opioid effectiveness = improved function or at least 30% reduction in pain intensity
- Opioid being used to regulate mood rather than pain control
- Pain and function remains unresponsive
- Periodic dose tapering or cessation of opioid therapy should be considered to confirm opioid therapy effectiveness
- Consider that tapering can result in withdrawal mediated pain that can present as increased pain for the patient; this should not be taken as evidence confirming opioid effectiveness for pain

≥ 90 Morphine equivalent dose
- For patients with chronic non-cancer pain who are currently using 290 mg morphine equivalents daily or more, tapering opioid to the lowest effective dose with potential discontinuation is suggested
- For patients with chronic non-cancer pain who are using opioids and experiencing serious challenges in tapering, referral to a formal multidisciplinary program or interprofessional coordinated multidisciplinary collaboration is strongly recommended

How to taper - the essentials

**How do I stop?** The opioid should be gradually tapered rather than abruptly discontinued. Patients should be actively engaged in a discussion about the merits of gradual dose reduction, including the potential for better pain control and quality of life. See [Opioid Tapering - Information for Patients](https://www.iwth.org/resources/opioid-tapering-information-for-patients) [v]

**How long will it take to taper the opioid?** Tapers can usually be completed between 2 weeks to 4 months. For some patients on very long-term, high dose opioid therapy, it may take longer.

**When do I need to be more cautious when tapering?** In patients who are pregnant; severe acute opioid withdrawal has been associated with premature labour and spontaneous abortion. Also in patients with acute coronary disease, or severe/unstable psychiatric disorder(s) or mental illness.

**How do I taper the dose?** Example tapering approaches are presented below. There is no evidence that favours one approach over another.

- For additional details and a template please see the RxFiles Opioid Tapering Template [vi]
- For patients with chronic non-cancer pain who are currently using ≥90 mg morphine equivalents daily or more, tapering opioid to the lowest effective dose with potential discontinuation is suggested
- For patients with chronic non-cancer pain who are using opioids and experiencing serious challenges in tapering, referral to a formal multidisciplinary program or interprofessional coordinated multidisciplinary collaboration is strongly recommended

Tips for tapering fentanyl transdermal patch

- Converting fentanyl to other opioids is not recommended as conversions are unreliable, and doing so may result in overdose and toxicity
- Consider reducing fentanyl by 12–25 μg/h patches every 2–4 weeks
- Consider adding immediate release oral opioid for pain relief (e.g. morphine IR 5 mg q 4–6 h prn)
- Once fentanyl is at the lowest available dose (e.g. 12 μg/h every 72 hours), stop the fentanyl transdermal patch and only use the immediate release oral opioid for pain relief

**Note:** It takes 17 hours or more for the fentanyl serum concentration to decrease by 50% after patch is removed

Clinical features of opioid use disorder

- Altering the route of delivery
- Accessing opioids from other sources
- Unsanctioned use
- Drug seeking
- Repeated withdrawal symptoms
- Accompanying conditions
- Social features
- Views on the opioid medication

*Behaviours more indicative of addiction than the others.

**Recommended**

SUGGESTED INITIAL DOSE AND TITRATION FOR BUPRENORPHINE/NALOXONE SUBLINGUAL TABLETS

Buprenorphine/naloxone sublingual tablets are indicated for substitution treatment in patients with problematic opioid drug dependence. It is also used to taper opioids.

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Dosage forms</th>
<th>Initial dose</th>
<th>Minimum time interval for increase</th>
<th>Suggested dose increase</th>
<th>Maximum dose/day</th>
<th>50 MED</th>
<th>90 MED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine/ naloxone SL*</td>
<td>SL: 2/0.5, 8/2 mg</td>
<td>4–12 mg on day 1, maintenance dose of 12–16 mg</td>
<td>Daily</td>
<td>Guided by clinical and psychological status of the patient</td>
<td>24 mg/d</td>
<td>9 mg SL</td>
<td>16 mg SL</td>
</tr>
</tbody>
</table>

**Legend:**
- **d** = day
- **MED** = morphine equivalent dose, **mg** = milligram, **SL** = sublingual
- *Buprenorphine/naloxone tablets should only be prescribed by health care providers who meet the following requirements: a) Experience in substitution treatment in opioid drug dependence, and b) Completion of a recognized buprenorphine/naloxone education program. [iv]*

November 2017

[thewellhealth.ca/pain](https://www.theswellhealth.ca/pain) [nationalpaincentre.mcmaster.ca/opoid/](https://nationalpaincentre.mcmaster.ca/opoid/) [opioidmanager.com](https://opioidmanager.com)
Supporting Material

[i] Management of Chronic Non Cancer Pain - Appendices
https://thewellhealth.ca/cncp

[ii] Management of Chronic Non Cancer Pain
https://thewellhealth.ca/cncp

[iii] Opioid Medication Treatment Agreement
http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b05.html

[iv] Brief Pain Inventory (BPI)
http://nationalpaincentre.mcmaster.ca/documents/brief_pain_inventory.pdf

[v] Opioid Tapering - Information for Patients

[vi] Opioid Tapering Template

[vii] FAQ About Prescribing Buprenorphine
https://www.cpso.on.ca/CPSO/media/documents/Methadone/FAQs-Prescribing-Buprenorphine.pdf

References


The Opioid Manager was developed by the Centre for Effective Practice (“CEP”) with clinical leadership from Drs. Andrea Furlan, Arun Radhakrishnan and Jose Silveira. In addition, the Opioid Manager was informed by advice from target end-users engaged throughout the development process. The Opioid Manager was updated with funding from the University Health Network (“UHN”).

Developed by: In collaboration with: