*Opioid dosing threshold policy template*

Purpose:

To detail safe limitations for prescribing opioid medication in this practice. The policy relates to indications other than malignant pain.

For more information, please refer to the RACGPs [Prescribing drugs of dependence in general practice – Part A – Clinical Governance Framework](https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/prescribing-drugs-of-dependence/prescribing-drugs-of-dependence-part-a).

[Insert practice name] opioid dosing threshold policy

*Current as of: [insert date of last revision]*

*Version no: [insert version number]*

*Review date: [insert date]*

To detail safe limitations for prescribing opioid medication in this practice. The policy relates to

indications other than malignant pain.

**SAFE LIMITS FOR OPIOID PRESCRIBING**

The practice policy is to not prescribe more than an average daily morphine equivalent dose (MED) of 80–100 mg without further validation. Most patient’s pain will be controlled on MEDs far less than this. Prescribed opioids have accepted individual and a combined morphine equivalent threshold, after which the risk of adverse events significantly rises.

Opioids should be reserved for patients who have not responded to non-opioid treatments and who have defined somatic or neuropathic pain conditions for which opioids have been shown to be effective.

Before prescribing an opioid:

* A diagnosis of the source of the pain must be made.
* Simple analgesia and other appropriate treatments should have been trialled.
* An opioid-risk tool should be used to determine if the patient is at risk of opioid misuse.
* A contract defining treatment goals, length of treatment and an exit strategy should be signed with the patient.
* There should be regular assessment of the patient using the 5As.

**Dosing thresholds**

* The prescriber should routinely evaluate the safety and effectiveness of opioid therapy for chronic non-cancer pain.
* Assessing the effectiveness of opioid therapy should include tracking and documenting both functional improvement and pain relief.
* Compared with patients receiving 1–20 mg per day of opioids, patients receiving 50–99 mg per day had a 3.7-fold increase in overdose risk. Patients receiving 100 mg per day or more had an 8.9-fold increase in overdose risk. Most overdoses were medically serious, and 12% were fatal.

1. If <100 mg MED:

* No assistance from a senior general practitioner or a pain management consultant needed if the prescriber is documenting sustained improvement in both function and pain.
* Consider getting assistance if frequent adverse effects or lack of response is evident in order to address:
* evidence of undiagnosed conditions
* presence of significant psychological condition affecting treatment
* potential alternative treatments to reduce or discontinue use of opioids.

2. ***Before***exceeding 100 mg MED per day threshold:

* Seek assistance from a senior general practitioner or pain management consultant to address:
* potential alternative treatments to opioids
* the risks and benefits of a possible trial with opioid dose above 100 mg MED/d
* the most appropriate way to document improvement in function and pain
* a possible need for consultation from other specialists.

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