RACGP
Royal Australian College *of* General Practitioners

Reducing Opioid Prescribing in General Practice

12 Point Challenge to GPs

For acute pain

- Know when non-opioid analgesics are preferred for acute pain in General Practice - eg headache, dysmenorrhoea, dental pains, minor musculoskeletal strains/sprains
- Engage a physiotherapist early in more severe acute musculoskeletal injuries
- Prioritise non-opioid options for people who have been on long term low-dose codeine preparations
- If opioids are necessary for severe acute pain, limit prescription to 3 days supply
- On discharge from hospital, discuss early tapering of opioids as part of recovery process

For chronic non-cancer pain

- Maximise non-opioid therapies, and multidisciplinary care in chronic pain
- Avoid opioids for CNCP in patients with an active or past substance use disorder or unstable psychiatric disorder.
- Where opioid therapy is necessary, ascertain responsiveness below 50mg morphine-equivalent dose per day and seek assistance well before 100mg morphine-equivalent dose per day is reached
- Reassess opioid-responsiveness regularly and often; have an agreed practice system for the 12 month structured review of opioid therapy
- Undertake intermittent planned reductions of opioid dosage in CNCP management
- Avoid fentanyl patches for non-cancer pain
- Where existing patients are on >100mg morphine equivalents dose per day for chronic non-cancer pain – trial tapering this dose to more appropriate levels