*One-year review of opioid prescribing template*

Purpose:

If opioid therapy is required for longer than 12 months, the Pharmaceutical Benefits Scheme (PBS) requires clinical review of the case and support by a second medical practitioner. The standards required for evaluation for the PBS review have not been documented.

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] one-year review of opioid prescribing protocol

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

*Version no: [insert version number]*

*Review date: [insert date]*

If opioid therapy is required for longer than 12 months, the Pharmaceutical Benefits Scheme (PBS)

requires clinical review of the case and support by a second medical practitioner. The standards required for evaluation for the PBS review have not been documented. This policy details a protocol that [*Insert* *practice name*] feels is appropriate to make an informed evaluation of long-term opioid therapy.

[*Insert practice name*] believe this protocol should be considered for peer clinical review on a regular basis (eg every 2 years).

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| --- | --- | --- |
| Evaluation criteria | Yes | No |
| 1. Clinical diagnosis | | |
| a) Is there a comprehensive documentation of the patient’s pain condition, general medical condition, psychosocial history, psychiatric status and substance use history? |  |  |
| b) Is the indication/diagnosis for prescribing opioids clearly supported and documented? |  |  |
| c) Is opioid medication clinically appropriate in this condition? |  |  |
| 2. Opioid treatment | | |
| a) Has opioid therapy produced and maintained a measurable improvement in the patient’s functional capacity? |  |  |
| b) Are the total doses of all opioids below ‘ceiling’ dose levels? (ie for [*Insert practice name*] 80 mg morphine equivalent a day) |  |  |
| c) Is the patient substantially free from adverse side effects of opioid therapy? |  |  |
| d) Is there continued absence of inappropriate dose escalation, aberrant behaviour, misuse or abuse of opioids? |  |  |
| e) Has a reduction in opioid therapy been trialled? |  |  |
| f) Have urine drug screens been used to investigate possible diversion, compliance, or other illicit drug use? |  |  |
| 3. Additional treatment | | |
| a) Are non-drug therapies maximised? |  |  |
| b) Given the clinical complexity and risk, is the current level of specialist care and  multidisciplinary intervention adequate and appropriate?  In general the following scenarios are considered as complex and high risk by [*Insert*  *practice name*], and indicated for specialist and multidisciplinary review:   * those who use two or more psychoactive drugs in combination (polydrug use) (eg opioid, * benzodiazepines, antipsychotic, anti-epileptics, and depressants) * patients with serious mental illness comorbidities, or antipsychotic medication * mixed use of opioids and illicit drugs * mixed use of opioids and benzodiazepines * recent discharge from a correctional services facility * patients discharged from other general practices due to problematic behaviour * signs of potential high-risk behaviours. |  |  |
| 4. Compliance | | |
| a) Is current opioid prescribing compliant with relevant state and territory laws and  regulations for controlled substances? |  |  |

Answering ‘no’ to any of the above options should prompt a consideration to alter the management plan.

**Recommendations**

* Continue therapy
* Reduce opioid dose
* Reduce and cease opioids
* Pursue alternate therapies
* Suggest specialist review

Disclaimer

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