*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).

|  |  |  |
| --- | --- | --- |
| 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 andmultidisciplinary 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 andregulations 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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