Alberta Health Services

Chronic Pain Centre

Patient Label

Chronic Pain Centre Opioid Guidelines

BEFORE PRESCRIBING

- ☐ Confirm the patient's family physician is willing to prescribe opioids
- ☐ Conduct a complete history and physical exam
  - Assess mental health comorbidities as these may increase risk of addiction / opioid use disorder and overdose
  - Document efficacy of other pharmacological and non-pharmacological treatment options
- ☐ Complete the Opioid Risk Tool
- ☐ Use the Opioid Information, Functional Goals, and Treatment Agreement to:
  - Discuss the probability the medication will improve the patient's health and function; establish functional goals
  - Discuss side effects and risks of opioids
  - Discuss the use of urine drug tests – baseline, and at least once per year
  - Offer a Take Home Naloxone kit when factors that increase risk for opioid overdose are present, including:
    - History of overdose, history of substance use disorder, higher opioid doses, i.e. ≥ 50 mg morphine equivalent daily dose (MEDD), concurrent benzodiazepine use
  - Sign and provide a copy to the patient
- ☐ Search NetCare to confirm the patient's current medications
  - If NetCare is incomplete, obtain triplicate records from CPSA (1-800-561-3899 ext 4939)
- ☐ Call the patient's pharmacy to cancel any remaining opioid refills
- ☐ Discuss tapering off concurrent benzodiazepines (see Appendix)

DURING TREATMENT

- ☐ Assess within 1-4 weeks of initiating or increasing dose, and reassess at least every 3 months; document patient's function and pain at each reassessment
- ☐ Review Netcare at least every 3 months
- ☐ Ensure there is only one prescriber for all opioids (exceptions allowed for vacation or sick leave coverage) and send prescriptions by fax to a single pharmacy
- ☐ Write prescriptions with dispensing intervals of ≤ 30 days
  - For high risk patients, start with daily or weekly dispensing using blister packs
- ☐ Update the Opioid Flow Sheet with each prescription
- ☐ Order testosterone levels only if the patient is symptomatic and there is a plan to treat
- ☐ Reassess evidence of individual benefits and risks if considering an increase to ≥ 50 mg MEDD
  - Document a minimum of 30% improvement in function and a minimum of 30% improvement in pain; otherwise, taper and discontinue
- ☐ Avoid increasing dose to ≥ 90 mg MEDD
- ☐ Before rotating opioids, ask another health care professional to double-check doses

APPENDIX: BENZODIAZEPINE TAPERING GUIDELINES

1. Discuss benefits of a benzodiazepine taper, including increased alertness and energy, improved quality of sleep, memory, mental clarity, and mood, etc.
2. Taper with current benzodiazepine (preferred) or switch to an equivalent dose of diazepam using the table below (Note: diazepam tablets are available as 2 mg, 5 mg, and 10 mg tablets; all are scored and can be split).
3. Taper by 10% every 2 weeks or longer (generally up to 5 mg diazepam equivalent per week). Slower tapers are more likely to be successful. Alternatively, decrease by quarter- or half-tablets on select days of the week; see http://www.criugm.qc.ca/fichier/pdf/BENZOeng.pdf (case-sensitive)
4. Use the multidisciplinary team to schedule regular follow-ups and support the taper.
5. Consider referral to psychologist. Cognitive behavioural therapy combined with tapering is more effective than tapering alone.
6. Once the dose has reached 20% of the original dose, consider slowing the taper to 5% every 4 weeks or longer.

Benzodiazepine Equivalence Table

Benzodiazepine	Brand Name	Equivalence to Diazepam (Valium®)10 mg*
Alprazolam	Xanax®	1 mg
Bromazepam	Lectopam®	6 mg
Chlordiazepoxide	Librium®	25 mg
Clobazam	Frisium®	20 mg
Clonazepam	Rivotril®	1 mg
Clorazepate	Tranxene®	15 mg
Flurazepam	Dalmane®	30 mg
Lorazepam	Ativan®	1 mg
Nitrazepam	Mogadon®	10 mg
Oxazepam	Serax®	20 mg
Temazepam	Restoril®	20 mg
Triazolam	Halcion®	0.5 mg
Benzodiazepine-Like Z-Drugs**		
Zolpidem	Sublinox®	20 mg
Zopiclone	Imovane®	15 mg

*Please note this is a guideline only. Wide variation exists between patients.
**Listed to show dose equivalence to benzodiazepines; z-drugs are usually not converted to a benzodiazepine for tapering purposes.

Patient Resources to explain risks of benzodiazepines and sample tapering schedules:
http://www.criugm.qc.ca/fichier/pdf/BENZOeng.pdf (case-sensitive)
www.benzo.org.uk/manual

References:
Ashton CH. Benzodiazepines: how they work and how to withdraw; also known as The Ashton Manual. Available online at: www.benzo.org/uk/manual
Baillargeon L et al. Discontinuation of benzodiazepines among older insomniac adults treated with cognitive-behavioural therapy combined with gradual tapering: a randomized trial. CMAJ 2003;169(10):1015-1020.
Canadian guideline for safe and effective use of opioids for chronic non-cancer pain. 2010 National Opioid Use Guideline Group (NOUGG).
Tannenbaum 2014. Institut universitaire de geriatrie de Montreal. You may be at risk: you are taking one of the following sedative-hypnotic medications. Available online at: http://www.criugm.qc.ca/fichier/pdf/BENZOeng.pdf (case-sensitive)
CDC guideline for prescribing opioids for chronic pain – March 2016. US Centers for Disease Control and Prevention.