

GUIDELINES FOR PRESCRIBING OPIOIDS FOR HOSPICE AND PALLIATIVE CARE PATIENTS

1. Always calculate the MEDD (morphine equivalent daily dose) prior to any titration
2. For opioid naïve patients, start with a short acting narcotic then switch to a long-acting medication when needed
3. Starting dose for opioid naïve patients:
 - a. For mild pain use 2-5mg oral morphine, or equivalent, q4h
 - b. For moderate to severe pain, use 5-10mg morphine, or equivalent, q4h
4. When only one drug is used, conversion to a long acting opioid is done by summing all of the doses and dividing by 2 for bid dosing or by 3 for tid dosing
5. Avoid using more than one long-acting opioid at a time. This allows for easier medication adjustment and control of side effects
6. The breakthrough dose for a patient on a single long acting opioid is 10-15% of the 24 hour dose, given q1-2 hrs
7. Titration of a single long-acting opioid is usually needed when a patient requires more than 3 breakthrough doses. Add all of the short-acting doses and long-acting doses and divide by 2 for bid dose. Remember to order a new breakthrough dose.
8. For titration of a single long-acting opioid when pain is not controlled with breakthrough doses, sum the short and long acting medications and adjust the dose based on pain.
 - a. For severe pain (score >7), increase the new total dose by 50-100%
 - b. For moderate pain (score 4-7), increase the new total dose by 25-50%
 - c. For mild pain (score <4), increase the new total dose by 25%

9. Patients with addiction problems also need pain control and should not be denied adequate pain medication for their end of life comfort. They may require higher doses of opioids to relieve their pain. Pseudo-addiction is behavior seen in patients that have inadequate pain control
10. Incomplete cross tolerance occurs because of different opioid receptor affinity from one opioid to another. Therefore, tolerance to one opioid does not imply tolerance to another. When a patient is converted from one opioid to another, the new dose is decreased to 50-75% of projected dose (25-50% reduction in MEDD). Generally if pain is uncontrolled, the new opioid dose is not reduced.
11. Equianalgesic opioid conversions:
 - a. Look up the equianalgesic dose
 - b. Calculate the MEDD
 - c. Calculate the dose of new opioid
 - d. Adjust for incomplete cross tolerance
 - e. Calculate the breakthrough dose
 - f. Re-check calculations
12. When calculating continuous IV/SQ opioids:
 - a. Start with MEDD and refer to the equianalgesic table with adjustment for incomplete cross tolerance (50-75% of projected dose). Divide by 24 for hourly rate.
 - b. IV/SQ breakthrough dosing is usually 50% of the hourly dose.
 - c. This is a guideline only and may vary considerably. For severe pain, the breakthrough dose may be 100% of the hourly rate given q10 minutes and for mild pain, the breakthrough dose may be only 25% of the hourly rate given q20 minutes.
 - d. The hourly dose is often adjusted daily to decrease the patient's breakthrough pain. Add the total hourly dose and breakthrough doses to determine the new total 24 hour dose.
13. Methadone has a long half life varying from 15 hours to 6 days. This makes the drug more difficult to use. Equianalgesic conversion varies with dose, lower doses having one conversion and higher doses having another. There are also several proposed methods for methadone conversion. Rotating to

methadone from high dose opioids requires consultation with someone who has experience using this drug.

14. Titrating down opioids due to sedation or confusion
 - a. If the patient is mildly sedated or mildly confused, hold the prn/breakthrough doses and if there is no change decrease the basal or long acting opioid by 25%
 - b. If the patient is moderately sedated or moderately confused, hold the prn/breakthrough doses, and if there is no change, decrease the basal or long acting opioid by 50%
 - c. If the patient is very sedated or very confused, hold the prn/breakthrough doses and the basal or long acting medication, reassessing frequently. If the patient complains of or appears in pain with the above medication adjustments, a patient and family discuss re-affirming or reviewing goals of care is needed

15. Pinpoint pupil size and respiratory rate 6 or less are concerns for possible overdose. Decrease opioids and stimulate the patient. Avoid Narcan if at all possible. Some patients will need sedating doses of opioids to achieve comfort. Clarify goals of care.