**Appendix A: Non-pharmacological treatments**

### A) Physical activity/exercise therapies\(^{1,2,3}\)

<table>
<thead>
<tr>
<th>Type of activity/exercise</th>
<th>Benefits/role</th>
<th>Level of evidence</th>
<th>Type of pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aerobic exercise (e.g. walking)</td>
<td>Improved global well being and physical function, reduced pain (fibromyalgia(^1))</td>
<td>••</td>
<td>Fibromyalgia</td>
</tr>
<tr>
<td>Strengthening exercise (e.g. lifting weights)</td>
<td>Global well being, pain and physical function (fibromyalgia(^1))</td>
<td>•</td>
<td>Fibromyalgia, non-specific low back pain</td>
</tr>
<tr>
<td>Core stabilising exercises (e.g. pilates)</td>
<td>Reducing pain (non-specific low back pain(^2), fibromyalgia(^1))</td>
<td>Not reported in guideline</td>
<td>Non-specific low back pain, fibromyalgia</td>
</tr>
<tr>
<td>Tai Chi</td>
<td>Reducing pain, improving disability (arthritis(^1)), quality of life (fibromyalgia(^1))</td>
<td>Not reported in guideline</td>
<td>Chronic arthritis, fibromyalgia</td>
</tr>
<tr>
<td>Yoga (any type)</td>
<td>Reducing pain and disability (headache, back pain, rheumatoid arthritis(^1)). Improved quality of life, pain and function (fibromyalgia(^1))</td>
<td>••</td>
<td>Fibromyalgia, headache, low back pain, rheumatoid arthritis</td>
</tr>
<tr>
<td>Therapeutic aquatic exercise</td>
<td>Improved pain, quality of life, physical function, muscle strength (fibromyalgia(^1), low back pain(^2))</td>
<td>Not reported in guideline</td>
<td>Fibromyalgia, low back pain</td>
</tr>
</tbody>
</table>

### B) Self-management programs\(^2,4\)

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Level of evidence</th>
<th>Type of pain</th>
<th>Benefits/role</th>
<th>Harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-management resources should be considered to compliment other therapies of patients with chronic pain</td>
<td>••</td>
<td>Chronic musculoskeletal pain (osteoarthritis, rheumatoid arthritis, fibromyalgia, low back pain, neck pain, shoulder pain)</td>
<td>Reduced pain and disability (arthritis(^1))</td>
<td>Possible increased pain with exercise, resulting in drop out from programs: if this occurs, explore with the patient how best to help them cope.(^3)</td>
</tr>
</tbody>
</table>

**Self-management program characteristics**
- Primarily educational using interactive and collaborative method often run by patients
- Focus on taking an active part in managing their pain
- Delivered as: individuals, face-to-face or electronically
- Content may include: education around goal setting, self-monitoring, psychological and rehabilitation interventions (e.g. exercise therapies)

### C) Psychological therapies

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Recommendations</th>
<th>Level of evidence</th>
<th>Type of pain</th>
<th>Benefits/role</th>
<th>Harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Behavioural Therapy</td>
<td>Cognitive behavioural therapy should be considered for the treatment of patients with chronic pain</td>
<td>••</td>
<td>Orofacial pain, low back pain, neck pain, rheumatoid arthritis, fibromyalgia</td>
<td>Reduced pain (orofacial, low back pain, fibromyalgia(^1)); Reduced use of analgesics (low back pain); Reduced disability (low back pain(^2), fibromyalgia(^1)); Improved quality of life (low back pain); Improved coping (low back pain, fibromyalgia); Reduced depression (low back pain(^2), fibromyalgia(^1)); Reduced physician visits (low back pain(^2)); Improved sleep(^2)</td>
<td>Rarely may include worsening of co-existing mental disorders</td>
</tr>
<tr>
<td>Mindfulness based interventions</td>
<td>No recommendations given in guidelines</td>
<td>••</td>
<td>Fibromyalgia, low back pain, rheumatoid arthritis, musculoskeletal pain</td>
<td>Reduced pain, reduced depression and anxiety, improved quality of life</td>
<td>Not reported in guideline</td>
</tr>
<tr>
<td>Acceptance and Commitment Therapy</td>
<td>No recommendations given in guidelines</td>
<td>•••</td>
<td>Osteoarthritis, neuropathic pain, low back pain</td>
<td>Improved depression and anxiety</td>
<td>Not reported in guideline</td>
</tr>
<tr>
<td>Respondent behavioural therapies</td>
<td>Progressive relaxation or EMG biofeedback should be considered for the treatment of patients with chronic pain</td>
<td>••</td>
<td>Low back pain</td>
<td>Short term pain reduction, reduction in disability. No better than Cognitive Behavioural Therapy</td>
<td>Not reported in guideline</td>
</tr>
</tbody>
</table>

### D) Physical therapies

<table>
<thead>
<tr>
<th>Therapy type</th>
<th>Type of pain</th>
<th>Level of evidence</th>
<th>Recommendations</th>
<th>Benefits/role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual therapy</td>
<td>Low back pain, neck pain</td>
<td>•••</td>
<td>Manual therapy should be considered for short term pain relief of patients with chronic low back pain</td>
<td>Short term: pain relief, functional improvement and cervicogenic headache(^2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Manual therapy in combination with exercise should be considered for the treatment of patients with chronic neck pain</td>
<td></td>
</tr>
<tr>
<td>TENS</td>
<td>Neuropathic pain, low back pain</td>
<td>•••</td>
<td>TENS should be considered for the relief of chronic pain; either low or high frequency can be used</td>
<td>Pain (neuropathic pain(^2)), improved function (low back pain(^2))</td>
</tr>
<tr>
<td>Low level laser therapy</td>
<td>Low back pain</td>
<td>•••</td>
<td>Low level laser therapy should be considered as a treatment option for patients with chronic low back pain</td>
<td>Reduced pain(^2)</td>
</tr>
<tr>
<td>Drug/drug class</td>
<td>Pain type</td>
<td>Level of evidence</td>
<td>Role in therapy</td>
<td>Potential harms</td>
</tr>
<tr>
<td>-----------------</td>
<td>-----------</td>
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<td>-----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Acetaminophen</td>
<td>Osteoarthritis (hip or knee), in addition to non-pharmacological treatment</td>
<td>⋆⋆⋆</td>
<td>Should be considered for hip or knee osteoarthritis (alone or in combination with NSAIDs), in addition to non-pharmacological treatments</td>
<td>Can be hepatotoxic at doses greater than 3-4 grams/day and at lower dosages in patients with chronic alcohol use or liver disease</td>
</tr>
<tr>
<td>Nonsteroidal anti-inflammatory drugs (NSAIDs):</td>
<td>Non-opioid medications: general</td>
<td>⋆⋆⋆</td>
<td>Should be considered for chronic non-specific low back pain</td>
<td>Risk of gastrointestinal bleeding/perforation, gastritis, and peptic ulcer disease</td>
</tr>
<tr>
<td>Meloxicam</td>
<td>Low back pain, osteoarthritis</td>
<td>⋆⋆⋆</td>
<td>May have synergistic, dose-sparing effect when added to opioids</td>
<td>Avoid in severe renal dysfunction (CrCl &lt; 30 mL/min) or deteriorating renal disease; use caution if CrCl = 30-59 mL/min</td>
</tr>
<tr>
<td>Ibuprofen</td>
<td>Low back pain, osteoarthritis</td>
<td>⋆⋆⋆</td>
<td>Avoid during pregnancy (3rd trimester) or breastfeeding, severe uncontrolled heart failure, severe allergy to acetylsalicylic acid or NSAIDs, active peptic ulcer disease, cerebrovascular disease, inflammatory bowel disease, or known hyperkalemia</td>
<td>Monitors blood pressure and signs of heart failure</td>
</tr>
<tr>
<td>Naproxen</td>
<td>Low back pain, osteoarthritis</td>
<td>⋆⋆⋆</td>
<td>Avoid in elderly (consider topical instead)</td>
<td>Cardiovascular risks (heart attack and stroke)</td>
</tr>
<tr>
<td>Naproxen sustained release</td>
<td>Low back pain, osteoarthritis</td>
<td>⋆⋆⋆</td>
<td>Avoid in the elderly (consider topical instead)</td>
<td>Cardiovascular risks (heart attack and stroke)</td>
</tr>
<tr>
<td>Naproxen (220 mg strength)</td>
<td>Low back pain, osteoarthritis</td>
<td>⋆⋆⋆</td>
<td>Avoid in the elderly (consider topical instead)</td>
<td>Cardiovascular risks (heart attack and stroke)</td>
</tr>
</tbody>
</table>

**LEGEND: CATEGORIES FOR LEVELS OF EVIDENCE** (according to original guidelines' taxonomy)
- ⋆ Highest level of evidence (meta-analyses; systematic reviews of RCTs; RCTs with varying levels of bias)
- ⋆⋆ Mid-level evidence (systematic reviews of case studies; high quality case control or cohort studies; experimental studies w/o randomization; case reports or studies)
- ⋆⋆⋆ Low-level evidence (expert opinion and/or clinical experiences of respected authorities/guideline development group)
### Appendix B: Non-opioid medications

#### Non-opioid medications: anticonvulsants

<table>
<thead>
<tr>
<th>Drug/drug class</th>
<th>Pain type</th>
<th>Level of evidence</th>
<th>Role in therapy</th>
<th>Potential harms</th>
<th>Dosage*</th>
<th>Tapering**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Carbamazepine</strong></td>
<td>Trigeminal neuralgia (may also be used for general neuropathic pain)</td>
<td>•••</td>
<td>• Should be considered for neuropathic pain</td>
<td>• May cause blood dyscrasias and liver toxicity&lt;sup&gt;10&lt;/sup&gt;</td>
<td>• Starting dose: 100 mg – 200 mg daily</td>
<td>• Every 3 months, consider discontinuing or reducing the dose&lt;sup&gt;21&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Monitor blood counts and liver function tests&lt;sup&gt;11&lt;/sup&gt;</td>
<td>• Titratin: increase biweekly by 100-200 mg/day</td>
<td>• Requires tapering: reduce dose by approximately 20% each week (faster if patient has reduced liver function)&lt;sup&gt;22&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Enzyme inducer – may interfere with other drugs such as warfarin&lt;sup&gt;21&lt;/sup&gt;</td>
<td>• Usual maintenance dose: 200-800 mg per day (in 2 to 4 divided doses). Doses of up to 1200-1600 mg/day have been used&lt;sup&gt;2,21&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td><strong>Gabapentin</strong></td>
<td>Neuropathic pain</td>
<td>•••</td>
<td>• Should be considered (at doses titrated up to at least 1,200 mg/day) for neuropathic pain</td>
<td>• May cause dizziness, drowsiness, or confusion&lt;sup&gt;10&lt;/sup&gt;</td>
<td>• Starting dose: 300 mg once daily at night</td>
<td>• Requires tapering: reduce dose gradually over at least 1 week&lt;sup&gt;23,24&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Potential for abuse - could lead to drug misuse or make the patient a target for drug abusers&lt;sup&gt;14&lt;/sup&gt;</td>
<td>• Titratin: Increase weekly by 300 mg/day</td>
<td></td>
</tr>
<tr>
<td><strong>Pregabalin</strong></td>
<td>Neuropathic pain</td>
<td>•••</td>
<td>• Should be considered (at doses titrated up to at least 300 mg/day) for neuropathic pain if other 1st and 2nd line pharmacological treatments have failed</td>
<td>• May cause sedation or dizziness&lt;sup&gt;10&lt;/sup&gt;</td>
<td>• Starting dose: 75 mg twice daily</td>
<td>• Reduce dose gradually over at least 1 week&lt;sup&gt;25&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Usual maintenance dose: 300 mg/day (150 mg bid)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Maximum: 600 mg/day (300 mg bid)&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td><strong>Fibromyalgia</strong></td>
<td></td>
<td>•••</td>
<td>• Is recommended (at doses titrated up to at least 300 mg/day) for fibromyalgia</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Anticonvulsants with insufficient evidence to support use in chronic pain:**

- Sodium valproate, lacosamide, lamotrigine, phenytoin, clonazepam, levetiracetam, topiramate

---

**LEGEND: CATEGORIES FOR LEVELS OF EVIDENCE** (according to original guidelines’ taxonomy)

- ••• Highest level of evidence (meta-analyses; systematic reviews of RCTs; RCTs with varying levels of bias)
- •• Mid-level evidence (systematic reviews of case studies; high quality case control or cohort studies; experimental studies w/o randomization; case reports or studies)
- • Low-level evidence (expert opinion and/or clinical experiences of respected authorities/guideline development group)
### Non-opioid medications: antidepressants

<table>
<thead>
<tr>
<th>Drug/drug class</th>
<th>Pain type</th>
<th>Level of evidence</th>
<th>Role in therapy</th>
<th>Potential harms</th>
<th>Dosage*</th>
<th>Tapering**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tricyclic Antidepressants (TCAs); amitriptyline, nortriptyline, imipramine</strong></td>
<td>Neuropathic pain</td>
<td>3 3 3</td>
<td>Should be considered for neuropathic pain, except HIV-related neuropathic pain (imipramine or nortriptyline may be used if amitriptyline is ineffective)</td>
<td>• May cause sedation, dry mouth, confusion, constipation, urinary retention, prolonged QT interval, weight gain 1 1 10</td>
<td>Amitriptyline: • Starting dose: 10-25 mg/day</td>
<td>Requires tapering: • Taper gradually over 4 weeks to 3 months or more (e.g. reduce dose by 25% every 4 weeks) particularly if patient has been on the drug for 6 weeks or more • Doses should be decreased more slowly towards the end of the taper 21 23</td>
</tr>
<tr>
<td>Fibromyalgia</td>
<td>3 3 3</td>
<td>Should be considered for fibromyalgia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Duloxetine (a selective serotonin norepinephrine reuptake inhibitor; SNRI)</td>
<td>Neuropathic pain due to diabetes</td>
<td>3 3 3</td>
<td>Should be considered for diabetic neuropathic pain if other 1st or 2nd line pharmacological therapies have failed</td>
<td>• May cause headache, gastrointestinal upset, insomnia, drowsiness, constipation, fatigue, dizziness 10 10 10</td>
<td>Starting dose: 60 mg once daily (30 mg starting dose may be used for tolerability reasons in some patients, with a goal of reaching 60 mg once daily within 1-2 weeks)</td>
<td>Requires tapering if patient has been taking for more than 1 week 20 • Taper by switching to 30 mg strength or taking 60 mg on alternate days for at least 2 weeks 21</td>
</tr>
<tr>
<td>Fibromyalgia</td>
<td>3 3 3</td>
<td>Should be considered for fibromyalgia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>3 3 3</td>
<td>Should be considered for osteoarthritis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Fluoxetine (serotonin reuptake inhibitor; SSRI)</td>
<td>Fibromyalgia</td>
<td>3 3 3</td>
<td>Should be considered for fibromyalgia</td>
<td>• May cause nausea, dizziness, headache, anxiety, nervousness, drowsiness, weakness, diarrhea, upset stomach, dry mouth, loss of appetite, excessive sweating, sexual dysfunction • May cause aggression or suicidal ideation/behaviour • May prolong QT 12</td>
<td>20 mg/day (up to 80 mg/day)!</td>
<td></td>
</tr>
</tbody>
</table>

### Non-opioid medications: topical

<table>
<thead>
<tr>
<th>Drug/drug class</th>
<th>Pain type</th>
<th>Level of evidence</th>
<th>Role in therapy* (unless otherwise specified)</th>
<th>Potential harms</th>
<th>Dosage*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General</strong></td>
<td>Musculoskeletal pain and osteoarthritis</td>
<td>3 3 3</td>
<td>Should be considered for musculoskeletal pain or osteoarthritis, in patients who cannot tolerate oral NSAIDs • Manufactured and compounded NSAID products may vary in potency</td>
<td>• Do not apply to skin with cuts or rashes • May cause skin blistering • Increases sun sensitivity (rare) 34</td>
<td>Solution: 50 drops per knee 3 times a day, or 40 drops per knee 4 times a day 7 Gel: Apply 3-4 times daily (for lower strengths) or twice daily (for higher strengths) 14 Allow 1 week to reach full effects 7</td>
</tr>
<tr>
<td>Topical NSAIDs: diclofenac solution or gel</td>
<td>Musculoskeletal pain and osteoarthritis</td>
<td>3 3 3</td>
<td>Should be considered for musculoskeletal pain or osteoarthritis, in patients who cannot tolerate oral NSAIDs • Manufactured and compounded NSAID products may vary in potency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Topical rubifenacients (salicylate-containing; e.g. triethanolamine salicylate)</td>
<td>Musculoskeletal pain (if other drug treatments are not effective)</td>
<td>3 3 3</td>
<td>Should be considered for musculoskeletal pain if other pharmacological therapies have been ineffective</td>
<td>• Skin reddening and irritation at application site</td>
<td>1 to 3 plasters (12 hours on, 12 hours off). Try for up to 4 weeks, then discontinue if no improvement.</td>
</tr>
</tbody>
</table>

---

*Titrate until efficacy or intolerance. 8 10 Counsel that side effects often diminish after 1-2 weeks. 7 Tapering is not required for topical medications. **Tapering recommendations are intended as general guidelines only. Monitor the patient’s response to dosage changes and use clinical judgment to base the pace of the taper on the patient’s response to prior dosage reductions. 14
## Non-opioid medications: medical cannabinoids

<table>
<thead>
<tr>
<th>Drug/drug class</th>
<th>Pain type</th>
<th>Level of evidence</th>
<th>Role in therapy</th>
<th>Potential harms</th>
<th>Dosage</th>
<th>Tapering</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cannabinoids:</td>
<td>Neuropathic pain</td>
<td>High**</td>
<td>Oral/buccal cannabinoids: Evidence is weaker than for other drug treatments</td>
<td>May cause drowsiness, euphoria, dry mouth, hallucinations</td>
<td>These substances are not covered by Ontario Drug Benefit (except for nabilone).</td>
<td>Nabilone: 1 or 2 mg bid; max 6 mg/day</td>
</tr>
<tr>
<td>Synthetic tetrahydrocannabinol (nabilone-oral)</td>
<td>Neuropathic pain</td>
<td>High**</td>
<td>Oral/buccal cannabinoids: In general, other pharmacological and non-pharmacological neuropathic pain therapies should be tried first</td>
<td>Even low doses of cannabis can cause cognitive impairment lasting up to 24 hours</td>
<td>Nabilone: 1 or 2 mg bid; max 6 mg/day</td>
<td>If patients using cannabinoids are also on high doses of benzodiazepines or opioids, consider lowering the dose of these medications</td>
</tr>
<tr>
<td>Nabiximols (buccal cannabinoids)</td>
<td>Neuropathic pain</td>
<td>High**</td>
<td>Nabiximols are indicated as adjunctive treatment for neuropathic pain in patients with multiple sclerosis</td>
<td>May cause physical or psychological dependence</td>
<td>Nabiximols: 4 to 8 sprays/day (divided bid); max 12 sprays/day</td>
<td>Dried cannabis: Dose is difficult to standardize due to limited dosing studies, differences in administration and cannabinoid content of different strains of cannabis, as well as interpatient variability. One study of vaporized cannabis used 800 mg placed in the vaporizer, with 8 to 12 inhalations taken over 2 hours. Inhale slowly over 5 seconds, hold breath for 10 seconds, then gently exhale.</td>
</tr>
<tr>
<td>Dried cannabis (taken by vaporizer or as an edible product)</td>
<td>Neuropathic pain</td>
<td>High**</td>
<td>Dried cannabis is not appropriate for people: under 25 years of age with personal or strong family history of psychosis</td>
<td>May cause physical or psychological dependence</td>
<td>Dried cannabis: Do not use for neuropathic pain unless other pharmacologic therapies, non-pharmacologic therapies, and oral cannabinoids have failed</td>
<td>For smoked cannabis (note: vaporization is generally preferred to smoking for safety reasons), the dose may range from 100-700 mg of no more than 9% THC cannabis daily. The upper safe level is approximately 3.0 g of dried cannabis per day (this upper limit would only be used for experienced cannabis users, not naïve patients, and would be gradually reached).</td>
</tr>
<tr>
<td>General</td>
<td>Neuropathic pain</td>
<td>High**</td>
<td>Oral/buccal cannabinoids: No research evidence to support use in other types of chronic pain (fibromyalgia, low back pain, osteoarthritis); only for neuropathic pain that has failed to respond to standard treatments</td>
<td>Dried cannabis: Not recommended for use in other types of chronic pain (fibromyalgia, low back pain, osteoarthritis); only for neuropathic pain that has failed to respond to standard treatments</td>
<td>Oral/buccal cannabinoids: No research evidence to support use in other types of chronic pain (fibromyalgia, low back pain, osteoarthritis); only for neuropathic pain that has failed to respond to standard treatments</td>
<td>Very little evidence exists in edible products. The upper safe limit is 3.0 g (this would only be used for experienced cannabis users).</td>
</tr>
</tbody>
</table>

### General Information
- **Cannabinoids**: Synthetic tetrahydrocannabinol (nabilone-oral), Nabiximols (buccal cannabinoids), Dried cannabis (taken by vaporizer or as an edible product).
- **Neuropathic pain medications**: Oral/buccal cannabinoids, Dried cannabis.
- **Neuropathic pain medications (oral/buccal cannabinoids)**: Evidence is weaker than for other drug treatments.
- **Neuropathic pain medications (dried cannabis)**: No research evidence to support use in other types of chronic pain (fibromyalgia, low back pain, osteoarthritis); only for neuropathic pain that has failed to respond to standard treatments.
- **Neuropathic pain medications (oral/buccal cannabinoids)**: In general, other pharmacological and non-pharmacological neuropathic pain therapies should be tried first.
- **Neuropathic pain medications (dried cannabis)**: May cause physical or psychological dependence.

### Dosage
- **Nabilone**: 1 or 2 mg bid; max 6 mg/day.
- **Nabiximols**: 4 to 8 sprays/day (divided bid); max 12 sprays/day.
- **Dried cannabis**: The dose is difficult to standardize due to limited dosing studies, differences in administration and cannabinoid content of different strains of cannabis, as well as interpatient variability. One study of vaporized cannabis used 800 mg, with 8 to 12 inhalations taken over 2 hours. Inhale slowly over 5 seconds, hold breath for 10 seconds, then gently exhale.

### Potential Harms
- May cause drowsiness, euphoria, dry mouth, hallucinations.
- Even low doses of cannabis can cause cognitive impairment lasting up to 24 hours.
- May cause physical or psychological dependence.

### Legend: Categories for Levels of Evidence
- High: Meta-analyses; systematic reviews of RCTs; RCTs with varying levels of bias.
- Mid: Systematic reviews of case studies; high quality case control or cohort studies; experimental studies with no randomization; case reports or studies.
- Low: Expert opinion and/or clinical experiences of respected authorities/guideline development group.
### Key points to discuss prior to an opioid trial

<table>
<thead>
<tr>
<th>Issue</th>
<th>Talking points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Explaining an opioid trial</strong></td>
<td>“Opioids may or may not help you, and they have some risks. This is why we usually do what is called a ‘trial’. We will start the medication slowly and gradually increase the dose to see if we can find a dose that improves your pain and function without causing side effects that you can’t live with.”</td>
</tr>
</tbody>
</table>
| **Establishing realistic goals of therapy for pain and function** | • “What do you hope that the opioid treatment will do for you? How important is this benefit to you?”
• Goals may include reducing pain, improving function, or improving quality of life. Keep in mind that:
  • Opioids have a medium effect on pain (10-20% difference on pain scale)
  • Opioids have a small effect on function (<10% change on function scale)
  • Function can improve even when pain is still present.
  • However, there is no good evidence that opioids improve pain or function with long-term use.
• “It can also be helpful to think about what coping skills you may use to manage the pain. We can discuss non-drug methods of managing pain in more detail.” |
| **Patient’s concerns about therapy** | • “Is there anything that worries you about starting opioid treatment? What difficulties do you think you might have?”
• See the relevant rows in this table for talking points to address common concerns. |
| **Possible risks of therapy** | • **Common side effects**: nausea, constipation, drowsiness, dizziness, dry skin/itching, vomiting. “The most common side effects are nausea and constipation. These can usually be managed by using anti-nausea drugs and anti-constipation drugs while on an opioid. Anti-nausea drugs are generally used short-term until the nausea side effect wears off. Anti-constipation drugs are generally used long-term while you are on the opioid.”
• **Accidents**: See “Driving/operating machinery” row below in this table
• **Overdose**: Avoid mixing opioids with alcohol or sleeping pills because this increase the risk of overdose. Signs of overdose include slurred or drawling speech, becoming upset or crying easily, poor balance, or “nodding off” during conversation or activity.
• **Addiction**: see “Addiction” row below in this table
• **Long-term risks**: Long-term use of opioids can lead to serious side effects such as sleep disorders, increased sensitivity to pain, and hormonal effects (low testosterone, loss of sex drive, decreased fertility). |
| **Possible benefits of therapy** | • **Reduced pain**: “With treatment, we hope to reduce your pain by a couple of points on the pain scale, for example, from a 7 to a 5 (out of 10).”
• **Improved function**: “With treatment, we hope to improve your ability to do the activities that are important to you. However, the effect of the medication on function may be small. It’s important not to overuse the medication, or function may actually get worse.” |
| **Safety** | “Opioids can help but they do have risks – these can be managed if we work together.”
• **Driving/operating machinery**: “Don’t drive while your dose is being gradually increased or if the medication is making you feel sleepy or confused.”
• **Withdrawal**: “If you stop taking your medication abruptly, you will experience withdrawal symptoms. This may feel like the flu: nausea, diarrhea, and chills. Withdrawal can be uncomfortable but it is not dangerous. It does not mean that you are addicted, just that you stopped the drug too quickly. If you stop your medication for 3 days or more, check with me before restarting it, because restarting opioids at your usual dose can have a significant risk of overdose and even death.”
• **Safe storage**: “Your body will get used to the dose that we set for you, but this same dose can be very dangerous for others. Store your medication safely at home; consider storing it in a lockbox, especially if there are children in the home. Do not store it in the medicine cabinet, as others will know to look for it there. Do not share your medication with others.”
• **Naloxone**: Naloxone is available to all patients prescribed opioids, particularly important for patients on doses of 50 MME/day or greater; those with a history of overdose, or concurrent benzodiazepine use). “We recommend that you keep naloxone on hand in case of an accidental overdose. Naloxone is a medication that can reverse the effects of an opioid. You can get naloxone at your local pharmacy without a prescription. The pharmacist will show you and your family how to safely use and store it.” |
| **Addiction** | “Addiction is a disorder where a person cannot control their use of a drug and continues to use it compulsively even if it leads to negative consequences in their life. Not all those suffering with addiction use the drug to ‘get high’. When people take opioids for pain, there is a risk that some may develop an addiction to it; those at greatest risk have a history of addiction with alcohol or other drugs. However, we will make a plan to watch out for it to help keep you safe.” |
| **Treatment agreement** | “To help us tell whether the opioid trial is working for you, we will make a treatment agreement together. A treatment agreement helps outline our goals and expectations for the trial, and how the trial will work.” |
| **Resources** | • Prescription opioids: What you need to know: [https://link.cep.health/cncp14](https://link.cep.health/cncp14)
• Opioid information for patients: [https://link.cep.health/cncp18](https://link.cep.health/cncp18)
## Opioids

<table>
<thead>
<tr>
<th>Drug/drug class</th>
<th>Pain type</th>
<th>Level of evidence</th>
<th>Role in therapy</th>
<th>Potential harms</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Codeine</strong></td>
<td>Chronic low back pain, Osteoarthritis</td>
<td>2,4</td>
<td>Use only if patient does not respond to non-opioid therapies. Among opioids, this is a 1st-line opioid for mild to moderate pain</td>
<td>Nausea, constipation, drowsiness, dizziness, dry skin/itching, vomiting, Abuse/addiction (risk lower than with stronger opioids)</td>
<td>Immediate release:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Start: 15-30mg q4h prn</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Titration: q7d, increase by 15-30mg/d</td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Max: 600 mg/d or acetaminophen 4g/d</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tramadol</strong></td>
<td>Chronic low back pain, Osteoarthritis</td>
<td>2,4</td>
<td>Use only if patient does not respond to non-opioid therapies. Among opioids, this is a 1st-line opioid for mild to moderate pain</td>
<td>Seizure risk in patients at high risk of seizure or patients on medications that increase serotonin, such as selective serotonin reuptake inhibitors (SSRIs), Nausea, constipation, drowsiness, dizziness, dry skin/itching, vomiting, Abuse/addiction: (risk may be lower than with other opioids)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Tramadol/acetaminophen (37.5/325 mg):</td>
<td>Start: 1 tab q4-6h (max 4 tabs/d)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Titration: q7d, increase by 1 tab q4-6h</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Max: 8 tabs/d</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Tramadol immediate release:</td>
<td>Starting dose (days 1-3): 25 mg qam</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Titration (as tolerated):</td>
<td>Day 4-6: 25 mg bid</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Day 7-9: 25 mg tid</td>
<td>Day 10-12: 25 mg qid</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Day 13-15: 50 mg tid</td>
<td>Day 16 and thereafter: 50 mg qid</td>
<td></td>
</tr>
</tbody>
</table>

**Putting the evidence in perspective:**

While many opioid therapies have 2 or 3 dots under “Evidence level”, denoting a good quality of evidence, this simply means that the studies were well-designed, not that the effect was large. Most of the studies were no more than 3 months long, and the overall effect size of opioids is only moderate for pain (corresponding to a 1 or 2 point decrease on a 10-point pain scale) and low for improved function (corresponding to a 10% or smaller improvement in function). Non-opioid treatments are considered 1st-line in managing chronic non-cancer pain. Opioids should be used only if non-opioid treatments have failed or cannot be used.\(^4\)
## Appendix C: Opioid prescribing and monitoring for chronic non-cancer pain

### Opioids

<table>
<thead>
<tr>
<th>Drug/drug class</th>
<th>Pain type</th>
<th>Level of evidence</th>
<th>Role in therapy</th>
<th>Potential harms</th>
<th>Dosage</th>
</tr>
</thead>
</table>
| **Morphine**    | Chronic low back pain | **II** | Use only if patient does not respond to non-opioid therapies. Among opioids, this is a 2nd-line opioid for mild to moderate pain and a 1st-line opioid for severe pain | Nausea, constipation, drowsiness, dizziness, dry skin/itching, vomiting | **Immediate release:**<br>• Start: 5-10 mg q4-6h (max 30 mg/d)  
• Titrate: q7d, increase by 5-10 mg/d  
• Max: Reassess benefit/risk of doses ≥ 50 MME/day, avoid or justify increasing dosage at doses ≥ 90 MME/day** |
| Osteoarthritis (only continue if there is ongoing pain relief; regular review is required) | **II** | Use only if patient does not respond to non-opioid therapies. Among opioids, this is a 2nd-line opioid for mild to moderate pain and a 1st-line opioid for severe pain | Nausea, constipation, drowsiness, dizziness, dry skin/itching, vomiting | Avoid in renal impairment (toxic metabolite can accumulate) | **Controlled release:**<br>• Start: 10-15 mg q12-24h  
• Titrate: q14d, increase by 5-10 mg/d  
• Max: Reassess benefit/risk of doses ≥ 50 MME/day, avoid or justify increasing dosage at doses ≥ 90 MME/day** |
| **Oxycodone**   | Chronic low back pain | **II** | Use only if patient does not respond to non-opioid therapies. Among opioids, this is a 2nd-line opioid for mild to moderate pain and a 1st-line opioid for severe pain | Nausea, constipation, drowsiness, dizziness, dry skin/itching, vomiting | **Immediate release:**<br>• Start: 5 mg q6h (max 30 mg/d)  
• Titrate: q7d, increase by 5 mg/d  
• Max: Reassess benefit/risk of doses ≥ 50 MME/day, avoid or justify increasing dosage at doses ≥ 90 MME/day** |
| Osteoarthritis (only continue if there is ongoing pain relief; regular review is required) | **II** | Use only if patient does not respond to non-opioid therapies. Among opioids, this is a 2nd-line opioid for mild to moderate pain and a 1st-line opioid for severe pain | Nausea, constipation, drowsiness, dizziness, dry skin/itching, vomiting | Use with caution in patients with high risk of opioid abuse | **Controlled release:**<br>• Start: 10 mg q12h  
• Titrate: q14d, increase by 10 mg/d  
• Max: Reassess benefit/risk of doses ≥ 50 MME/day, avoid or justify increasing dosage at doses ≥ 90 MME/day** |
| **Hydromorphone** | Chronic low back pain | **II** | Use only if patient does not respond to non-opioid therapies. Among opioids, this is a 2nd-line opioid for mild to moderate pain and a 1st-line opioid for severe pain | Nausea, constipation, drowsiness, dizziness, dry skin/itching, vomiting | **Immediate release:**<br>• Start: 1-2 mg q4-6h (max 8 mg/d)  
• Titrate: q7d, increase by 1-2 mg/d  
• Max: Reassess benefit/risk of doses ≥ 50 MME/day, avoid or justify increasing dosage at doses ≥ 90 MME/day** |
| Osteoarthritis (only continue if there is ongoing pain relief; regular review is required) | **II** | Use only if patient does not respond to non-opioid therapies. Among opioids, this is a 2nd-line opioid for mild to moderate pain and a 1st-line opioid for severe pain | Nausea, constipation, drowsiness, dizziness, dry skin/itching, vomiting | Use with caution in patients with high risk of opioid abuse | **Controlled release:**<br>• Start: 3 mg q12h (max 9 mg/d)  
• Titrate: q14d, increase by 3 mg/d  
• Max: Reassess benefit/risk of doses ≥ 50 MME/day, avoid or justify increasing dosage at doses ≥ 90 MME/day** |
| **Fentanyl**     | Chronic low back pain | **II** | Use only if patient does not respond to non-opioid therapies. Among opioids, this is a 2nd-line opioid for mild to moderate pain and a 1st-line opioid for severe pain | Nausea, constipation, drowsiness, dizziness, dry skin/itching, vomiting | Only use fentanyl in patients who have taken a morphine equivalent dose (MED) of at least 60-100 mg/day for at least 2 weeks | Use Opioid Manager to convert from other opioids.  
• Do not switch patients directly from codeine to fentanyl (10% of Caucasian patients lack the enzyme that metabolizes codeine to morphine; these patients may not have developed a tolerance to opioids).  
• In Ontario, fentanyl patches must be prescribed and dispensed in accordance with the Patch For Patch program  
• The Opioid Patch Exchange Disposal Tool can help assist with patch exchange |
| Osteoarthritis (only continue if there is ongoing pain relief; regular review is required) | **II** | Use only if patient does not respond to non-opioid therapies. Among opioids, this is a 2nd-line opioid for mild to moderate pain and a 1st-line opioid for severe pain | Nausea, constipation, drowsiness, dizziness, dry skin/itching, vomiting | Use with caution in patients with high risk of opioid abuse | **Controlled release:**<br>• Start: 3 mg q12h (max 9 mg/d)  
• Titrate: q14d, increase by 3 mg/d  
• Max: Reassess benefit/risk of doses ≥ 50 MME/day, avoid or justify increasing dosage at doses ≥ 90 MME/day** |
| **Methadone**   | Chronic low back pain | **II** | Use only if patient does not respond to non-opioid therapies. Methadone is primarily used for managing addiction but may sometimes be used to manage pain. Health Canada has removed the exemption on prescribing for methadone. For more information on the new requirements visit CPSO - Methadone Program | Nausea, constipation, drowsiness, dizziness, dry skin/itching, vomiting | Methadone is not intended for initial titration in an opioid trial.  
• Consult a specialist with expertise in methadone treatment. |
| Osteoarthritis | **II** | Use only if patient does not respond to non-opioid therapies. Methadone is primarily used for managing addiction but may sometimes be used to manage pain. Health Canada has removed the exemption on prescribing for methadone. For more information on the new requirements visit CPSO - Methadone Program | Nausea, constipation, drowsiness, dizziness, dry skin/itching, vomiting | Use with caution in patients with high risk of opioid abuse | **Controlled release:**<br>• Start: 3 mg q12h (max 9 mg/d)  
• Titrate: q14d, increase by 3 mg/d  
• Max: Reassess benefit/risk of doses ≥ 50 MME/day, avoid or justify increasing dosage at doses ≥ 90 MME/day** |

**Notes:**
- **MME:** Morphine milligram equivalent.
- **Last updated:** May 2018
- **Source:** CPSO - Opioid Manager
- **Disclaimer:** This document is for information purposes only and is not intended to replace professional medical advice. Use with caution when prescribing opioids and always consult with a specialist for any questions or concerns.

### Stronger opioids

- Fentanyl
- Methadone
- Oxycodone
- Hydromorphone
- Morphine

### Potential harms

- **Abuse/addiction:**
- Use with caution in patients with high risk of opioid abuse
- Avoid in renal impairment (toxic metabolite can accumulate)

### Dosage

- **Immediate release:**
  - Start: 5 mg q6h (max 30 mg/d)
  - Titrate: q7d, increase by 5-10 mg/d
  - Max: Reassess benefit/risk of doses ≥ 50 MME/day, avoid or justify increasing dosage at doses ≥ 90 MME/day**

- **Controlled release:**
  - Start: 10-15 mg q12-24h
  - Titrate: q14d, increase by 5-10 mg/d
  - Max: Reassess benefit/risk of doses ≥ 50 MME/day, avoid or justify increasing dosage at doses ≥ 90 MME/day**

### Appendix C: Opioid prescribing and monitoring for chronic non-cancer pain

- **Fentanyl**
- **Methadone**
- **Oxycodone**
- **Hydromorphone**
- **Morphine**

### Pain type

- **Chronic low back pain**
- **Osteoarthritis (only continue if there is ongoing pain relief; regular review is required)**
### Appendix C: Opioid prescribing and monitoring for chronic non-cancer pain

**Part 4 of 6**

<table>
<thead>
<tr>
<th><strong>Drug/drug class</strong></th>
<th><strong>Pain type</strong></th>
<th><strong>Level of evidence</strong></th>
<th><strong>Role in therapy</strong></th>
<th><strong>Potential harms</strong></th>
<th><strong>Dosage</strong></th>
</tr>
</thead>
</table>
| **Tapentadol**      | • Osteoarthritis (studied mainly in knee osteoarthritis)  
• Low back pain | ⬤ ● ● ● | • Should be considered as an option for pain relief in patients with chronic low back pain and osteoarthritis | • Nausea, constipation, drowsiness, dizziness, dry skin/itching, vomiting, hypotension  
• Abuse/addiction | • Immediate release  
• **Start:** 50 mg q 4-6 h prn  
• **Titrate:** 50 mg q 4-6 h  
• **Max:** Not recommended daily doses >700 mg on the first day of therapy and 600 mg on subsequent days. |
| **Buprenorphine (transdermal)** | • Chronic low back pain  
• Osteoarthritis | ● ● | • Useful if problems with oral administration. | • Nausea, constipation, drowsiness, dizziness, dry skin/itching, vomiting.  
• Abuse/addiction  
• **Allow 3 weeks before re-using the same patch site,** and avoid exposing the patch to direct sunlight [increases absorption].  
• **Do not use in people weighing less than 40 kg.**  
• **May accumulate in severe hepatic impairment.** | • May be used in opioid-naïve and opioid-experienced patients (in patients taking up to 80 mg oral MME/day). May cause opioid withdrawal symptoms in patients taking long-term or higher dose opioids before being switched to buprenorphine. |
| **Buprenorphine/naloxone** | NA | NA | • **Should only be prescribed by physician who:**  
• Has experience in substitution treatment of opioid dependence  
• Has completed a recognized education program.  
• Must be dispensed daily under healthcare professional supervision until patient is stable enough to safely store take-home doses.  
• Co-ingestion with alcohol or other CNS depressants could lead to a fatal overdose.  
• Accidental consumption of even one dose by an opioid-naïve person could lead to fatal overdose.  
• **Side effects:**  
• After first dose: withdrawal effects (e.g. shaking, sweating, headache, pain, muscle aches, nausea)  
• Other side effects: constipation, anxiety, tiredness, nausea/vomiting, dizziness, orthostatic hypotension. | • Do not use in opioid-naïve patients.  
• **When to start:**  
• **Patients dependent on heroin or short-acting opioids:** Start when objective signs of withdrawal occur (Clinical Opioid Withdrawal Scale [COWS] score of 13 or greater), but not less than 6 hours after the patient last used opioids.  
• **Patients receiving methadone:** First, reduce methadone to minimum dose tolerated by patient, then start buprenorphine/naloxone only when objective signs of withdrawal appear (COWS score of 13 or greater) and generally not less than 24 hours after the patient last used methadone.  
• **Starting dose:**  
• **Day 1:** 4 mg, then an additional 4 mg dose if needed. Usual dose target for Day 1 is 8-12 mg.  
• **Titration:** Increase by 2-8 mg to a level that holds the patient in treatment and prevents withdrawal effects  
• **Usual maintenance dose:**  
• 12 mg to 16 mg once daily, maximum 24 mg daily  
• Once stable, may give twice the patient’s daily dose every other day (e.g. give 16 mg every other day for a patient stabilized on 8 mg daily) or 3 times a week (with twice the daily dose on Monday and Wednesday and three times the daily dose on Friday); do not exceed 24 mg on any one day. |
**General dosage/administration tips:**

- Titrate oral opioids until efficacy or intolerance\(^\text{10}\)
- Use the lowest effective dose\(^\text{9}\)
- Benzodiazepines can considerably lower the lethal opioid dose; consider tapering off of benzodiazepines or starting with a lower dose of opioid
- Parenteral opioids are not recommended in CNCP (high risk of overdose, addiction, and infection)
- Use caution with controlled-release formulations: they can cause overdose if bitten/crushed (this converts them to immediate-release)\(^\text{41}\)
- Titrate oral opioids until efficacy or intolerance\(^\text{10}\)

Opioids are subject to restrictions around prescribing and dispensing:

- Be aware of the risk of prescription fraud - see the College of Physicians and Surgeons of Ontario (CPSO) resource on Prescribing Drugs\(^\text{49}\)
- Refills are not permitted on opioid prescriptions. For more information, see the regulations summary chart\(^\text{50}\)
- Patients must present valid photo ID (e.g. driver’s license, photo health card, passport) when having an opioid prescription written by their prescriber and may also need to show ID when picking up opioid prescriptions at the pharmacy. To learn more, see this resource on Ontario’s Narcotics Strategy\(^\text{51}\)
- Effective January 1, 2017, Ontario Drug Benefit (ODB) does not cover certain high-dose opioid formulations: see this resource for more details\(^\text{52}\)

WATCHFUL DOSE: Recommend reassessing the benefit/risk of doses ≥50 MME/day and to “avoid or justify increasing dosage” at doses ≥ 90 MME/day.

**LEGEND: CATEGORIES FOR LEVELS OF EVIDENCE** (according to original guidelines’ taxonomy)

- Highest level of evidence (meta-analyses; systematic reviews of RCTs; RCTs with varying levels of bias)
- Mid-level evidence (systematic reviews of case studies; high quality case control or cohort studies; experimental studies w/o randomization; case reports or studies)
- Low-level evidence (expert opinion and/or clinical experiences of respected authorities/guideline development group)
Appendix C: Opioid prescribing and monitoring for chronic non-cancer pain

### Monitoring tips

- Monitor every 2-4 weeks for efficacy and tolerability
- Continue until optimal dose is reached (see definition)\(^40\)
- Do a 3-day “tolerance check” for those at high risk of sedation (elderly, on benzodiazepines, renal or hepatic impairment, COPD, sleep disorders, cognitive impairment)\(^45\)
- Call the patient 3 days after initiation or dose change to ask about signs of sedation\(^40\)

### Optimal dose definition\(^40\)

- Improved function (based on goals agreed upon with patient)* OR
- At least a 30% pain reduction (2 points on a 0-10 scale) without loss of function\(^6\)
- No additional analgesic benefit for 1 or 2 additional dose increases
- No serious side effects or complications

*Can assess pain and function with Brief Pain Inventory scale

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### Process for managing patients coming into your practice on opioids

#### i) Review appropriateness of therapy:

Patients entering your practice on opioids may not have received a proper opioid trial and may have inadvertently ended up on long-term opioid therapy for an acute condition that has since resolved.

#### Review and document\(^40\)

<table>
<thead>
<tr>
<th>Pain condition diagnosis</th>
<th>• Is patient on the opioid for a pain condition for which opioids have been shown to be effective? (See Evidence for opioids in chronic non-cancer pain conditions table on p. 7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk screening</td>
<td>• Assess patient’s risk for abuse (may use Opioid Risk Tool) Opioids are not recommended for patients with an active substance use disorder. Facilitate treatment of the substance use disorder if not already addressed(^49)</td>
</tr>
<tr>
<td>Goal setting</td>
<td>• Ask patient about their goals for therapy (pain reduction, function improvement), and whether they feel the opioid is helping them achieve these goals: “Realistically, what would living well look like for you?”</td>
</tr>
<tr>
<td>Informed consent</td>
<td>• Review risks/benefits/goals of therapy (see Talking Points in the Opioid Trial section p. 6). • Consider using an informed consent/treatment agreement (see sample treatment agreement).</td>
</tr>
<tr>
<td>Appropriateness of opioid and dose</td>
<td>• Ask patient whether their pain and function have improved (can assess pain and function with Brief Pain Inventory scale)</td>
</tr>
<tr>
<td>Adverse events of current opioid treatment</td>
<td>• Ask patient if they are having side effects and if so, the impact on their life.</td>
</tr>
</tbody>
</table>

#### ii) If opioid therapy is inappropriate, consider switching or discontinuing the opioid.

- **Switch:** “Sometimes a medication is appropriate when it is started but becomes less appropriate as time goes on and things change. I usually review my patients’ pain medications regularly to make sure they are still on the best treatment for them. At this point, it seems that you might benefit from switching to a different opioid. How would you feel about that?”

- **Discontinuation:** “Sometimes a medication is appropriate when it is started but becomes less appropriate as time goes on and things change. I usually review my patients’ pain medications regularly to make sure they are still on the best treatment for them. At this point, it seems that your opioid medication is no longer giving you enough benefits to warrant the risks of using it. How would you feel about trying to slowly decrease the dose?”

---

**Talking Points\(^42,55\)**

- **Scenario:** You are concerned that your patient may be showing signs of addiction.

  - Open the discussion in a non-judgmental way: “Is there anything about your use of pain pills that you are concerned about?”

  - Explore ambivalence by asking about pros and cons: **Pros:** “What do you like about your way of using pain pills?” **Cons:** “What do you not like about your way of using pain pills? What makes you think about stopping?”

  - Offer help: “I can give you some information about addiction to pain pills. Would that be OK with you?”

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For support on prescribing and managing opioids for patients with chronic non-cancer pain please see the [Opioid Manager](https://www.cep.health/CNCP).

For support on discussing and executing an opioid taper please see the [Opioid Tapering Template](https://www.cep.health/CNCP).
Appendix references


[53] Ontario Ministry of Health and Long-Term Care. Important notice regarding changes to the Ontario Drug Benefit (ODB) program funding of opioid medications.


Updated May 2018 cep.health/CNCP
This Tool was developed as part of the Knowledge Translation in Primary Care Initiative, led by Centre for Effective Practice with collaboration from the Ontario College of Family Physicians and the Nurse Practitioners' Association of Ontario. Clinical leadership for the development of the tool was provided by Dr. Arun Radhakrishnan, MSc, MD, CM CCFP and was subject to external review by health care providers and other relevant stakeholders. This Tool was funded by the Government of Ontario as part of the Knowledge Translation in Primary Care Initiative.

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