

Appendix A – Checklist

This fillable checklist can be completed and inserted into the patient medical record for patients starting or continuing a trial of opioid therapy.

Patient name	
Pain diagnosis	
Date of pain onset	

Goals decided with patient (SMART goals: Specific, Measurable, Agreed-upon, Realistic, Time-based)

	Y	N	Date	Notes
Has non-pharmacological therapy ^[1] been optimized?				
Has non-opioid pharmacotherapy ^[1] been optimized?				
Stable psychiatric disorder(s) or mental illness?				
Current or past substance use disorder?				
Cannabis use?				
Thorough baseline assessment conducted ^[iii] (as needed)?				
Explained potential benefits ^[1] ?				
Explained adverse effects ^[1] ?				
Explained risks ^[1] ?				
Explained opioid safety ^[1] ?				
Informed consent obtained?				
Signed treatment agreement ^[iii] (as needed)?				
Patient given information handout(s) ^[iii] ?				
Urine drug screening (as needed)?				
Naloxone prescription (as needed)?				

Which non-opioid pharmacotherapies have been optimized?
<input type="checkbox"/> General: acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs)
<input type="checkbox"/> Anticonvulsants: carbamazepine, gabapentin, pregabalin
<input type="checkbox"/> Antidepressants: amitriptyline, duloxetine, fluoxetine
<input type="checkbox"/> Topical: topical NSAIDs, topical rubifacients
<input type="checkbox"/> Other:

Which non-pharmacological therapies have been optimized?
<input type="checkbox"/> Physical activity: aerobic exercise, strengthening exercise, core stabilizing exercise, Tai Chi, yoga, therapeutic aquatic exercise
<input type="checkbox"/> Self-management programs
<input type="checkbox"/> Psychological therapies: cognitive behavioural therapy, mindfulness based interventions, acceptance and commitment therapy, respondent behavioural therapies
<input type="checkbox"/> Physical therapies: manual therapy, transcutaneous electrical nerve stimulation, low level laser therapy
<input type="checkbox"/> Other:

Appendix B – Initiation, Maintenance & Monitoring Chart

This fillable table can be completed and inserted into the patient medical record for patients starting or continuing a trial of opioid therapy.

Patient name	
Pain diagnosis	
Date of pain onset	

Goals decided with patient (SMART goals: Specific, Measurable, Agreed-upon, Realistic, Time-based)

Date (patient seen)					
Opioid prescribed					
Daily dose, frequency and timing					
MED					
<input type="text" value="≥ 90 mg MED/day"/> <input type="text" value="< 90 mg MED/day"/>					
Date of new dose to be administered					
Goals achieved <input type="button" value="Yes"/> <input type="button" value="No"/> <input type="button" value="Partially"/>					
Pain intensity (Brief Pain Inventory ^[iv])					
Functional status <input type="button" value="Improved"/> <input type="button" value="Worsened"/> <input type="button" value="No Change"/>					
Adverse effects <input type="text" value="0 = None"/>					
<input type="text" value="1 = Limits ADLs"/> <input type="text" value="2 = Prevents ADLs"/>					
Fatal overdose					
Non-fatal overdose					
Motor vehicle accident					
Addiction					
Sleep apnea					
Osteoporosis					
Drowsiness					
Constipation					
Dizziness/vertigo					
Hypogonadism/sexual dysfunction					
Vomiting					
Nausea					
Opioid induced hyperalgesia					
Dry skin/pruritis					
Other					
Clinical features of opioid use disorder ^[v] <input type="button" value="Yes"/> <input type="button" value="No"/>					
Urine drug screening <input type="text" value="Date"/> <input type="text" value="Result"/>					
Naloxone prescription <input type="button" value="Yes"/> <input type="button" value="No"/>					
Tapering offered <input type="button" value="Accepted"/> <input type="button" value="Declined"/>					
Non-pharmacological therapies being used for pain <input type="button" value="Yes"/> <input type="button" value="No"/>					
Non-opioid pharmacotherapy being used for pain <input type="button" value="Yes"/> <input type="button" value="No"/>					

Legend: ADLs = activities of daily living, MED = morphine equivalent dose

Appendix C – Switching Opioids

This appendix contains succinct steps and examples on how to switch opioid therapies, and fillable switching templates that can be completed and inserted into the patient medical record. Tables are available for both switching methods.

Patient name	
Pain diagnosis	
Date of pain onset	

Goals decided with patient (SMART goals: Specific, Measurable, Agreed-upon, Realistic, Time-based)

Method 1 examples. Decrease the total daily dose of the current opioid by 25–50% and convert to new opioid equivalent dose.

Steps	Example #1: Morphine and oxycodone/acetaminophen to hydromorphone	Example #2: Hydromorphone to buprenorphine transdermal patch
1. Determine current opioid(s) regimen (e.g. opioid name, dose and frequency)	<ul style="list-style-type: none"> •Morphine SR 90 mg tid •Oxycodone/acetaminophen 5/325 mg q 4 h prn (averages 6 tabs/d, 2 tabs tid) 	<ul style="list-style-type: none"> •Hydromorphone CR 6 mg bid •Hydromorphone IR 2–4 mg q 4 h prn (average 10 mg/d)
2. Calculate total daily dose of opioid(s)	<ul style="list-style-type: none"> •Morphine 180 mg/d •Oxycodone 30 mg/d 	<ul style="list-style-type: none"> •Hydromorphone CR 12 mg/d •Hydromorphone IR 10 mg/d
3. Convert the dose of each current opioid to a MED	<ul style="list-style-type: none"> •Morphine 180 mg/d x 1 = morphine 180 mg/d •Oxycodone 30 mg/d x 1.5 = morphine 45 mg/d 	<ul style="list-style-type: none"> •Hydromorphone 22 mg/d x 5 = morphine 110 mg/d
4. Calculate total MED	<ul style="list-style-type: none"> •Total MED = 225 mg/d 	<ul style="list-style-type: none"> •Total MED = 110 mg/d
5. Determine proportion of the initial daily dose that will be switched to the new opioid Determine total MED that will be switched to the new regimen Note: Reduce the calculated dose by 25–50% to minimize the risk of inadvertent overdose; the amount reduced will depend on the patient’s pain, adverse effects, hyperalgesia, and reason for switching opioid	<ul style="list-style-type: none"> •50% = morphine 112.5 mg/d <input checked="" type="checkbox"/> 60% = morphine 135 mg/d •75% = morphine 169 mg/d •Other: 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> 50% = morphine 55 mg/d •60% = morphine 66 mg/d •75% = morphine 82.5 mg/d •Other:
6. Calculate the daily dose of the new opioid using the daily MED	<ul style="list-style-type: none"> •60% = morphine 135 mg/d •MED to hydromorphone: morphine 135 mg/d x 0.2 = hydromorphone 27 mg/d 	<ul style="list-style-type: none"> •50% = morphine 55 mg/d •MED to buprenorphine transdermal patch: morphine 46 mg/d approximately = buprenorphine transdermal patch 20 µg/h q 7 days
7. Delineate new opioid dosage regimen (e.g. dose, name, frequency and quantity)	<ul style="list-style-type: none"> •Hydromorphone CR 12 mg bid M: 2 weeks •Hydromorphone IR 1 mg tid prn, M: 21 tablets 	<ul style="list-style-type: none"> •1 buprenorphine transdermal patch 20 µg/h every 7 days, M: 2 patches •Note: It takes at least 3 days for buprenorphine transdermal patch to reach steady state
8. Discontinue previous opioid prescriptions Ask patient to give any unused opioid prescriptions to their pharmacy for appropriate disposal	<ul style="list-style-type: none"> •Discontinue morphine SR 90 mg bid •Discontinue oxycodone/acetaminophen q 4 h prn 	<ul style="list-style-type: none"> •Discontinue hydromorphone CR 6 mg bid •Discontinue hydromorphone IR 2–4 mg q 4 h prn
9. Follow up	<ul style="list-style-type: none"> •Consider a 3-day follow-up to assess withdrawal symptoms and pain; contact the patient 3 days after starting the new opioid to check for signs of over-sedation and to ensure that pain relief is at least comparable to the pre-switch treatment •Follow up with patient every 2–4 weeks 	

Legend: bid = twice a day, CR = controlled release, d = day, h = hour, IR = immediate release, M = Mitte (how much to dispense), MED = morphine equivalent dose, mg = milligram, µg = microgram, prn = as needed, q = every, SR = sustained release, tab = tablet, tid = 3 times a day

Note: Doses in the examples in the above tables are approximations due to inter-individual variation.

Steps and examples in the above tables have been developed in part from a consensus of expert opinion.

Method 1 fillable template. Decrease the total daily dose of the current opioid by 25–50% and convert to new opioid equivalent dose.

Steps	
1. Determine current opioid(s) regimen (e.g. opioid name, dose and frequency)	Opioid name:
	Dose:
	Frequency:
2. Calculate total daily dose of opioid(s)	Opioid: mg/day
3. Convert the dose of each current opioid to a MED	_____ x _____ = _____
	_____ x _____ = _____
	_____ x _____ = _____
4. Calculate total MED	MED:
5. Determine proportion of the initial daily dose that will be switched to the new opioid Determine total MED that will be switched to the new regimen Note: Reduce the calculated dose by 25–50% to minimize the risk of inadvertent overdose; the amount reduced will depend on the patient’s pain, adverse effects, hyperalgesia, and reason for switching opioid	<input type="checkbox"/> 50% = morphine: mg/day
	<input type="checkbox"/> 60% = morphine : mg/day
	<input type="checkbox"/> 75% = morphine: mg/day
	Other:
6. Calculate the daily dose of the new opioid using the daily MED	New opioid dose:
7. Delineate new opioid dosage regimen (e.g. dose, name, frequency and quantity)	Opioid name:
	Dose:
	Frequency:
	Quantity:
8. Discontinue previous opioid prescriptions Ask patient to give any unused opioid prescriptions to their pharmacy for appropriate disposal	Discontinue:
	Discontinue:
9. Follow Up	<input type="checkbox"/> 3-day follow-up to assess withdrawal symptoms and pain:
	<input type="checkbox"/> week follow-up:
	<input type="checkbox"/> week follow-up:

Legend: MED = morphine equivalent dose, mg = milligram

Method 2 (Cross Taper Method) example. Decrease the total daily dose of the current opioid by 10–25% per week while titrating up the total daily dose of the new opioid weekly by 10–20% with a goal of switching over 3–4 weeks (also consider dose formulations available).

- Consider more regular (e.g. weekly) follow-ups, weekly dispensing and/or dosette/blisterpack if required.

	Current opioid(s)	New opioid(s)
Example #1	<ul style="list-style-type: none"> • Morphine SR 60 mg tid • Oxycodone/acetaminophen 5/325 mg q 4 h prn (averages 6 tabs/d, 2 tabs tid) 	<ul style="list-style-type: none"> • Hydromorphone 24 mg/d
Week 1	<ul style="list-style-type: none"> • Discontinue oxycodone/acetaminophen 5/325 mg tablets ⊘ • Morphine SR 45 mg tid ↓ 	<ul style="list-style-type: none"> • Add hydromorphone CR 3 mg bid †
Week 2	<ul style="list-style-type: none"> • Morphine SR 30 mg tid ↓ 	<ul style="list-style-type: none"> • Hydromorphone CR 6 mg bid ↑
Week 3	<ul style="list-style-type: none"> • Morphine SR 15 mg tid ↓ 	<ul style="list-style-type: none"> • Hydromorphone CR 9 mg bid ↑
Week 4	<ul style="list-style-type: none"> • Discontinue morphine SR 15 mg tid ⊘ 	<ul style="list-style-type: none"> • Hydromorphone CR 12 mg bid

Legend: bid = twice a day, CR = controlled release, d = day, h = hour, mg = milligram, prn = as needed, q = every, SR = sustained release, tab = tablet, tid = 3 times a day

Note: Doses in the examples in the above table are approximations due to inter-individual variation.

Steps and examples in the above tables have been developed in part from a consensus of expert opinion.

Method 2 fillable template. Decrease the total daily dose of the current opioid by 10–25% per week while titrating up the total daily dose of the new opioid weekly by 10–20% with a goal of switching over 3–4 weeks (also consider dose formulations available).

- Consider more regular (e.g. weekly) follow-ups, weekly dispensing and/or dosette/blisterpack if required.

	Current opioid(s)	New opioid(s)
Week 1	(Titrate down) Opioid name:	(Add) Opioid name:
	Dose:	Dose:
	Frequency:	Frequency:
Week 2	(Titrate down) Opioid name:	(Titrate up) Opioid name:
	Dose:	Dose:
	Frequency:	Frequency:
Week 3	(Titrate down) Opioid name:	(Titrate up/remain the same) Opioid name:
	Dose:	Dose:
	Frequency:	Frequency:
Week 4	(Discontinue) Opioid name:	(Titrate up/remain the same) Opioid name:
	Dose:	Dose:
	Frequency:	Frequency:

 See the [Morphine Equivalence](#) table, [Suggested Initial Dose and Titration for Buprenorphine Transdermal Patch](#) table and [Suggested Initial Dose and Titration for Buprenorphine/Naloxone Sublingual Tablets](#) table from the main Opioid Manager tool for opioid conversions.

Supporting Material

- [i] **Management of Chronic Non Cancer Pain - Appendices**
cep.health/cncp
- [ii] **Management of Chronic Non Cancer Pain**
cep.health/cncp
- [iii] **Opioid Medication Treatment Agreement**
<https://link.cep.health/om5>
- [iv] **Brief Pain Inventory (BPI)**
<https://link.cep.health/om7>

The Opioid Manager was developed by the Centre for Effective Practice ("CEP") with clinical leadership from Drs. Andrea Furlan, Arun Radhakrishnan and Jose Silveira. In addition, the Opioid Manager was informed by advice from target end-users engaged throughout the development process. The Opioid Manager was updated with funding from the University Health Network ("UHN").

The Opioid Manager was developed for licensed health care professionals in Canada as a guide only and does not constitute medical or other professional advice. Primary care providers and other health care professionals are required to exercise their own clinical judgment in using the Opioid Manager. Neither the CEP, UHN, the contributors to the Opioid Manager, nor any of their respective agents, appointees, directors, officers, employees, contractors, members or volunteers: (i) are providing medical, diagnostic or treatment services through the Opioid Manager; (ii) to the extent permitted by applicable law, accept any responsibility for the use or misuse of the Opioid Manager by any individual including, but not limited to, primary care providers or entity, including for any loss, damage or injury (including death) arising from or in connection with the use of the Opioid Manager, in whole or in part; or (iii) give or make any representation, warranty or endorsement of any external sources referenced in the Opioid Manager (whether specifically named or not) that are owned or operated by third parties, including any information or advice contained therein.



The Opioid Manager is a product of the CEP and UHN under copyright protection with all rights reserved to UHN. Permission to use, copy, and distribute printed copies of the Opioid Manager and permission to link to a author webpage for the Opioid Manager, for all non-commercial and research purposes is granted, provided the above disclaimer, this paragraph and appropriate citations appear in all copies, modifications, and distributions. Republishing digital materials via third-party websites or platforms is prohibited. Use of the Opioid Manager for commercial purposes or any modifications of the Opioid Manager are subject to charge and use must be negotiated with the CEP and UHN (Email: info@cep.health).

For statistical and bibliographic purposes, please notify the CEP (info@cep.health) of any use or reprinting of the Opioid Manager. Please use the below citation when referencing the Opioid Manager:

Reprinted with Permission from the Centre for Effective Practice and University Health Network (November 2017). Opioid Manager. Toronto.

Developed by:



Centre
for Effective
Practice

In collaboration with:



Toronto General
Toronto Western
Princess Margaret
Toronto Rehab