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

Which non-opioid pharmacotherapies have been optimized?
☐ General: acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs)
☐ Anticonvulsants: carbamazepine, gabapentin, pregabalin
☐ Antidepressants: amitriptyline, duloxetine, fluoxetine
☐ Topical: topical NSAIDs, topical rubifacients
☐ Other:

Which non-pharmacological therapies have been optimized?
☐ Physical activity: aerobic exercise, strengthening exercise, core stabilizing exercise, Tai Chi, yoga, therapeutic aquatic exercise
☐ Self-management programs
☐ Psychological therapies: cognitive behavioural therapy, mindfulness based interventions, acceptance and commitment therapy, respondent behavioural therapies
☐ Physical therapies: manual therapy, transcutaneous electrical nerve stimulation, low level laser therapy
☐ 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						
≥ 90 mg MED/day / < 90 mg MED/day						
Date of new dose to be administered						
Goals achieved: Yes / No / Partially						
Pain intensity (Brief Pain Inventory[iv])						
Functional status: Improved / Worsened / No Change						
Adverse effects: 0 = None / 1 = Limits ADLs / 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[ii]: Yes / No						
Urine drug screening: Date / Result						
Naloxone prescription: Yes / No						
Tapering offered: Accepted / Declined						
Non-pharmacological therapies being used for pain: Yes / No						
Non-opioid pharmacotherapy being used for pain: Yes / 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)	• Morphine SR 90 mg tid • Oxycodone/acetaminophen 5/325 mg q 4 h prn (averages 6 tabs/d, 2 tabs tid)	• 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)	• Morphine 180 mg/d • Oxycodone 30 mg/d	• Hydromorphone CR 12 mg/d • Hydromorphone IR 10 mg/d
3. Convert the dose of each current opioid to a MED	• Morphine 180 mg/d x 1 = morphine 180 mg/d • Oxycodone 30 mg/d x 1.5 = morphine 45 mg/d	• Hydromorphone 22 mg/d x 5 = morphine 110 mg/d
4. Calculate total MED	• Total MED = 225 mg/d	• 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	• 50% = morphine 112.5 mg/d ☑ 60% = morphine 135 mg/d • 75% = morphine 169 mg/d • Other:	☑ 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	• 60% = morphine 135 mg/d • MED to hydromorphone: morphine 135 mg/d x 0.2 = hydromorphone 27 mg/d	• 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)	• Hydromorphone CR 12 mg bid M: 2 weeks • Hydromorphone IR 1 mg tid prn, M: 21 tablets	• 1 buprenorphine transdermal patch 20 ug/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	• Discontinue morphine SR 90 mg tid • Discontinue oxycodone/acetaminophen q 4 h prn	• Discontinue hydromorphone CR 6 mg bid • Discontinue hydromorphone IR 2–4 mg q 4 h prn
9. Follow up	• 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	☐ 50% = morphine: mg/day ☐ 60% = morphine : mg/day ☐ 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	☐ 3-day follow-up to assess withdrawal symptoms and pain: ☐ week follow-up: ☐ 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	• Morphine SR 60 mg tid • Oxycodone/acetaminophen 5/325 mg q 4 h prn (averages 6 tabs/d, 2 tabs tid)	• Hydromorphone 24 mg/d
Week 1	• Discontinue oxycodone/acetaminophen 5/325 mg tablets ⊘ • Morphine SR 45 mg tid ↓	• Add hydromorphone CR 3 mg bid +
Week 2	• Morphine SR 30 mg tid ↓	• Hydromorphone CR 6 mg bid ↑
Week 3	• Morphine SR 15 mg tid ↓	• Hydromorphone CR 9 mg bid ↑
Week 4	• Discontinue morphine SR 15 mg tid ⊘	• 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 conversations.

Supporting Material

[i] Management of Chronic Non Cancer Pain - Appendices
https://thewellhealth.ca/cncp

[ii] Management of Chronic Non Cancer Pain
https://thewellhealth.ca/cncp

[iii] Opioid Medication Treatment Agreement
http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b05.html

[iv] Brief Pain Inventory (BPI)
http://nationalpaincentre.mcmaster.ca/documents/brief_pain_inventory.pdf

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").

Developed by:

Centre for Effective Practice

In collaboration with:

UHN Toronto General Toronto Western Princess Margaret Toronto Rehab