Opioid Stewardship

Safer prescribing, OME conversion & deprescribing

CLINICAL PATHWAY

Most patients on long-term opioids for chronic non-cancer pain gain no functional benefit. Start low, time-limit every trial, and check SafeScript (or your state's monitoring system) before every script. Consider take-home naloxone with any opioid prescription, and recommend it above an oMEDD of 40mg/day — per the FPM ANZCA 2025 update.

OME CONVERSION FACTORS (APPROX.)

Multiply the daily dose by the factor to estimate oral morphine equivalent (oMEDD): morphine oral ×1 (reference), oxycodone oral ×1.5, hydromorphone oral ×5, tapentadol oral ×0.3, tramadol oral ×0.2, codeine oral ×0.13, fentanyl patch ×3 (mcg/h), buprenorphine patch ×2 (mcg/h). Example: oxycodone 40mg/day = oMEDD 60mg.

OME RISK BANDS (mg/DAY)

- <40mg: lower risk — still consider take-home naloxone and patient education
- 40–100mg: caution — around a fourfold increase in cardiorespiratory event risk; recommend take-home naloxone
- >100mg: high risk — around an elevenfold increase in cardiorespiratory event risk; taper recommended, consider pain-clinic referral

SAFER PRESCRIBING — EVERY TIME

- Start low, short-acting for any new trial; set a review date before starting — a 4–6 week trial
- Document pain history, biopsychosocial assessment, risk screening (e.g. the ROOM tool) and consent
- Check SafeScript or your jurisdiction's real-time monitoring system before every script for a monitored medicine
- Never combine an opioid with a benzodiazepine, Z-drug or gabapentinoid without a specific, time-limited reason — overdose risk rises sharply

WHEN TO CONSIDER DEPRESCRIBING

No functional benefit despite dose escalation; adverse effects (constipation, sedation, falls, cognitive impairment, low testosterone); dose creep beyond around 50mg OME/day (lower, around 30mg, in older or multimorbid patients); or patient preference — many welcome the conversation when it's framed as care, not punishment.

TAPERING PRINCIPLES

- Slow is safer: reduce by 5–10% of the current dose every 2–4 weeks for most patients; slower again with long-duration use or older age
- Pause rather than reverse if withdrawal symptoms are prominent — reassess in 2–4 weeks; this isn't the underlying pain returning
- Counsel on withdrawal before starting: early symptoms (anxiety, yawning, sweating) at 6–24h, peak GI/autonomic symptoms at 48–72h
- Consider buprenorphine for a taper that stalls above around 30mg OME

OME CALCULATOR & MONITORING

Use the FPM ANZCA Opioid Calculator (anzca.edu.au) for an individual oMEDD calculation before any dose change or opioid rotation — conversion factors are approximate and vary between patients. Confirm current SafeScript/monitoring requirements at health.vic.gov.au (or your state's equivalent).

SAFETY

- Take-home naloxone (Nyxoid nasal spray or Prenoxad injection) is free, PBS-listed and needs no prescription — offer to any at-risk patient and train family/household
- Counsel on withdrawal symptoms before starting any taper — withdrawal is not the same as relapse or dependence
- Never start or continue an opioid + benzodiazepine/Z-drug/gabapentinoid combination without a specific, time-limited reason

RED FLAGS / REFER

- Iatrogenic opioid dependence, suspected opioid use disorder, or a taper that repeatedly stalls → addiction medicine or a multidisciplinary pain clinic
- oMEDD persistently >100mg/day, or escalating despite no functional gain → specialist pain or addiction medicine review
- Severe or medically complicated withdrawal, or a patient requesting supervised withdrawal → specialist support

For health-professional use. Framework: RACGP Drugs of Dependence Part C2, FPM ANZCA Opioid Dose Equivalence (Oct 2025).
Companion to PA-01 Chronic Pain Pathway; MJA Deprescribing Opioids 2023. Verify individual oMEDD at anzca.edu.au before any rotation.