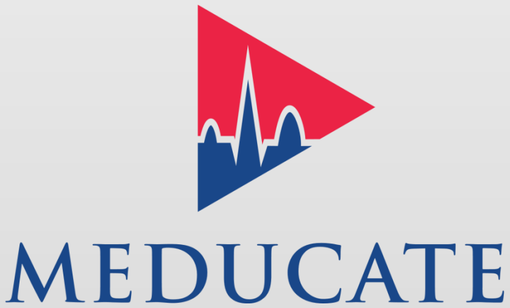
MEDUCATE

# HOW TO MANAGE A RED FLAG WORK BOOK

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# Part 1
## Questions

**Q) How does the pattern of deaths associated with prescription drugs compare with that associated with the road toll in Victoria?**

**Q) When does the use of SafeScript become mandatory**

**Q) What are the exceptions to the mandatory checking of SafeScript?**

**Q) What are the penalties for not checking SafeScript?**

**Q) Is it possible to access SafeScript secretly?**

**Q) Who can legally access SafeScript?**

**Q) What impact does SafeScript have on S8 permits?**

**Q) What are the approved opioids and their OME 100 mg doses?**

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**Q) According to DSM 5 how many criteria are needed to diagnose substance use disorder?**

**Q) How does the diagnosis of prescription opioid use disorder differ from other types of substance use disorder?**

**Q) What mnemonic can help memorize all 11 criteria for substance use disorder?**

**Q) Which three risk tools can help personalize the risks for a patient identified as having a red flag?**

**Q) What factors are identified within the Riosord tool?**

**Q) What would you say to a patient who suggested that “Only opioids help my pain”?**

**Q) What would you say to a patient who states that “I am stable on my opioids”?**

**Q) What would you say to a patient who states that “If I don’t get my opioids, I will get sick”?**

**Q) What would you say to a patient who states that ““I am only asking for what has been given to me before”?**

**Q) What would you say to a patient who states that “I will make a complaint”?**

**Q) What would you say to a patient who states that “The other doctors have prescribed them”**

**Q) What would you say to a patient who refuses other potential therapeutic interventions?**

**Q) What would you say to a patient who states that “I can’t sleep without my opioids / Benzodiazepines”**

**Q) What would you say to a patient who states that “Not prescribing these medications will worsen my mental state”**

**Q) What would you say to a patient who states that “If you don’t prescribe, I will be forced to source these drugs illicitly”**

**Q) What elements would you consider important in the development of a new therapeutic alliance?**

**Q) Why is coercion an important behavior to identify?**

**Q) How might a doctor manage coercion?**

**Q) What does “write or fight” mean?**

**Q) How can one distinguish patient centered care from the need to maintain clinical boundaries?**

**Q) How do professional boundaries impact upon prescribing?**

**Q) Which specific chronic non-cancer pain syndromes should not be treated with opioids?**

**Q) What are the “four Ds” and what do they mean?**

**Q) What are the essential elements of a harm minimization plan?**

**Q) How would you describe the “rule of one”?**

**Q) What are the indications for use of Prenoxad**

**Q) In Victoria for how many patients can a doctor prescribe buprenorphine/naloxone without undergoing specific accreditation training?**

**Q) Why are opioids such as methadone and buprenorphine used to treat opioid dependency.**

**Q) What is “Suboxone”?**

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**Q) What is buprenorphine?**

**Q) Why is buprenorphine used to treat opioid use disorder?**

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**Q) what are the side effects of buprenorphine?**

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**Q) What is the maximum dose of buprenorphine?**

**Q) Why do patients not die of respiratory depression and coma when double or tripled dosed with buprenorphine?**

**Q) Describe the absolute and relative contra-indications to take away doses**

**Q) Regarding Suboxone prescribing in Victoria, what is the permitted take away regime and where can one find more information on this issue?**

**Q) How frequently should one review a patient on suboxone.**

**Q) What is the URL for the online smart form “Application for a permit to treat an opioid dependent person with methadone or buprenorphine”?**

**Q) Are permits required for the first five patients to whom a doctor in Victoria might wish to prescribe Suboxone?**

**Q) How does opioid rotation reduce opioid load?**

**Q) How fast can one taper an opioid?**

**Q) How fast can one taper a benzodiazepine?**

# Part 2

## Questions with answers

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| **Q) How does the pattern of deaths associated with prescription drugs compare with that associated with the road toll in Victoria?** | A) In 2016, 372 Victorians died from overdoses involving prescription medicines, 257 died from overdose deaths involving illicit drugs, and 291 died in road accidents |
| **Q) When does the use of SafeScript become mandatory** | A) April 2020 |
| **Q) What are the exceptions to the mandatory checking of SafeScript?** | A) Prisons, inpatient settings, resident of aged care facilities, in the context of palliative care |
| **Q) What are the penalties for not checking SafeScript?** | A) Penalties are imposed for repeated failure to check SafeScript, or in the case of risk of significant harm to patients. Current penalty is set at 100 penalty points. Current value of a penalty point (as of September 2019) is $165.22. |
| **Q) Is it possible to access SafeScript secretly?** | A) No, all access to SafeScript is audited and the information is available in the audit log. |

**Q) Who can legally access SafeScript?**

A) Only clinicians involved in direct patient care can legally access SafeScript. Examples of direct care include: prescribing or supplying a medicine to the patient; reviewing patient's medication history as part of a patient consultation; discussing the patient's medication history with other registered health practitioners who are involved in that patient's care.

**Q) What impact does SafeScript have on S8 permits?**

A) No permit needed if SafeScript checked and

Patient not notified as drug dependent

OME < 100 mg

Approved list of opioids

Patient is well known to the clinician

**Q) What are the approved opioids and their OME 100 mg doses?**

A) Opioids equivalent to Morphine oral 100mg daily include the following

Hydromorphone oral 20mg daily

Oxycodone oral 60mg daily

Tapentadol oral 250mg daily

Buprenorphine patch 40mcg/hr weekly

Fentanyl patch 25mcg/hr every three days

**Q) What drugs are monitored by SafeScript?**

A) All Schedule 8 medicines, all benzodiazepines, Z-drugs, quetiapine and codeine combination medicines

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| **Q) What factors trigger an amber flag?** | A) OMED > 50 mg < 100 mg, and more than one prescriber or dispenser. |
| **Q) What factors trigger a red flag?** | A) OMED > 100 mg, four or more prescribers or dispensers, dangerous polypharmacy. |
| **Q) What constitutes dangerous polypharmacy?** | A) Fentanyl or methadone and any benzodiazepine; methadone or fentanyl and any other long acting opioid |
| **Q) what is the evidence base for red flag OMED > 100 mg?** | A) patients prescribed more than 100 mg MED/day may have an 11-fold greater risk of opioid overdose death than those prescribed lower doses (1) |
| **Q) What is the evidence base for red flag dangerous co-prescribing?** | A) Methadone co-prescribed with any benzodiazepine doubles risk of death (2). Opioids in general co-prescribed with any benzodiazepine increases risk of death by a factor of 10 (1). Evidence indicates that patients receiving opioids from 4 or more prescribers or 4 or more pharmacies have a 6-fold greater risk of opioid overdose death (1). |

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| **Q) What are the risk factors for aberrancy according to the opioid risk tool?** | A) Pre- adolescent child sexual abuse in females; current history of mental health disorders and substance use disorders; family history of mental health disorders and substance use disorders; age 16-45 (3). |
| **Q) Why is catastrophizing an important factor to identify in patients with chronic pain?** | A) Catastrophizing predicts prescription opioid misuse (4). |
| **Q) According to DSM 5 how many criteria are needed to diagnose substance use disorder?** | A) 2 |
| **Q) how does the diagnosis of prescription opioid use disorder differ from other types of substance use disorder?** | A) The criteria for tolerance and withdrawal cannot be used to diagnose prescription opioid use disorder. At least 2 out of the remaining 9 criteria are needed to make the diagnosis of prescription opioid use disorder. |

**Q) What mnemonic can help memorize all 11 criteria for substance use disorder?**

A) “Chew that cop”

C = unable to cut down

H = health

E = excessive use

W = Withdrawal

T= tolerance

H = hazards

A = activities

T = time

C = craving

O = obligations

P = personal problems

**Q) Which three risk tools can help personalize the risks for a patient identified as having a red flag?**

A) Opioid risk tool (3), Catastrophizing scale (5) and Risosord (6)

**Q) What factors are identified within the Riosord tool?**



A) Patient health factors and patient drug factors

Patient health factors include the following

- Substance use disorder (abuse or dependence)
- Bipolar disorder or schizophrenia
- Stroke or other cerebrovascular disease
- Kidney disease with clinically significant renal impairment
- Heart failure
- Non-malignant pancreatic disease (e.g., acute or chronic pancreatitis)
- Chronic pulmonary disease (e.g., emphysema, chronic bronchitis, asthma, pneumoconiosis and asbestosis)
- Recurrent headache (e.g., migraine)?Patient drug factors include the following
- Fentanyl
- Morphine
- Methadone
- Hydromorphone
- An extended-release or long-acting formulation of any prescription opioid
- A prescription benzodiazepine
- A prescription antidepressant
- OMED > 100 mg

**Q) what would you say to a patient who suggested that “Only opioids help my pain”?**

A) The following serve as useful discussion points.

- Treatment should always be evidence-based
- Pain management is a long-term process and requires more than medicines
- High dose opioids can be associated with hyperalgesia
- Reduction in opioids may improve pain control
- Non-opioid pain interventions are associated with better longer-term outcomes – options include physio massage acupuncture
- Side effects of long-term high dose opioids include fatigue sleep disordered breathing hypogonadism constipation falls

**Q) What would you say to a patient who states that “I am stable on my opioids”?**

A) The following serve as useful discussion points.

- High OMEDs associated with elevated risk of death and other side effects
- Reduction in OMED necessary to mitigate risk of death
- Patient waivers do not mitigate clinician’s medicolegal liability in the case of an adverse event

**Q) What would you say to a patient who states that “If I don’t get my opioids, I will get sick”?**

A) The following serve as useful discussion points.

- Withdrawal symptoms can occur in patients dependent on long term opioids but tend to be transient/limited in duration
- Physiological dependence on opioids may precede prescription opioid use disorder
- I am concerned that you may have an opioid use disorder
- Opioid use disorder should not be managed by mere continued prescribing of current opioid, but rather may be managed by opioid substitution therapy involving methadone or buprenorphine

**Q) What would you say to a patient who states that ““I am only asking for what has been given to me before”?**

A) The following serve as useful discussion points.

- Medical knowledge evolves
- The medical profession has only recently come to realize the harms of high dose long term opioid therapy and its effects on mortality
- Medical research continues to reveal new things that change the way we think and practice medicine.
- The medications that have been prescribed to you are now known to not be in your best interests

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| **Q) What would you say to a patient who states that “I will make a complaint”?** | A) The following serve as useful discussion points.<br>▪ I am sorry, you are asking me to do something which I consider to be inappropriate or unsafe.<br>▪ While I can understand your situation, I cannot prescribe outside legal frameworks or if I consider that the medication will not help. |
| **Q) What would you say to a patient who states that “The other doctors have prescribed them”** | A) The following serve as useful discussion points.<br>▪ That’s Dr X’s decision, but other doctors in this practice insist on continual monitoring of patients for whom they prescribe this medication<br>▪ Other doctors that prescribe to you will also have access to SafeScript alerts<br>▪ I do not believe it is safe or appropriate to prescribe the medication you are asking me to prescribe under these conditions. |
| **Q) What would you say to a patient who refuses other potential therapeutic interventions?** | A) The following serve as useful discussion points.<br>Patients who are able to consent to treatment also have the right to refuse treatment.<br>If a patient refuses your advice, they should be informed of the implications of their decision and given enough time to consider and clarify any information to make an informed decision |

**Q) What would you say to a patient who states that “I can’t sleep without my opioids / Benzodiazepines”**

A) The following serve as useful discussion points.

- Tolerance to these drugs is common
- The soporific effect of these drugs diminishes over time
- Long term use of these drugs is not recommended
- Tapering is an effective intervention which minimizes long term risk of death
- Patients often find that sleep quality improves after cessation of benzodiazepines
- The management of any underlying medical or psychiatric problems that may be contributing to sleep problems needs to be addressed

**Q) What would you say to a patient who states that “Not prescribing these medications will worsen my mental state”**

A) The following serve as useful discussion points.

- There is limited evidence to support long term use of benzodiazepines as a primary treatment for psychiatric disorder
- Persistent use of benzodiazepines for mental health complaints signals likely undiagnosed or undertreated mental illness
- Other treatments need to be considered e.g. antidepressants and psychology

**Q) What would you say to a patient who states that “If you don’t prescribe, I will be forced to source these drugs illicitly”**

A) The following serve as useful discussion points.

- It is your choice to take illicit drugs
- If you use illicit drugs you run the risk of poor health outcomes and forensic complications
- We do not condone the use of illicit drugs
- It is our responsibility to provide medically appropriate care and treatment that is in your best interests

**Q) What elements would you consider important in the development of a new therapeutic alliance?**

A) The following are important elements to consider in a therapeutic alliance

- One doctor and one pharmacy
- Attendance at appointments
- No provision for early scripts
- No replacement of lost scripts
- Engagement with harm minimization plan
- Engagement with other treatment modalities
- No coercion / threat

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| **Q) Why is coercion an important behavior to identify?** | A) An initial “no” (refusal to prescribe by the physician) that eventually is changed to a “yes” (willingness to prescribe) in the face of pressure from the patient is considered by some experts to be pathognomonic of prescription drug abuse.(7) A suggested response might include the following points: “I'm feeling pushed by you to write a prescription today that is not medically indicated and thus I'm concerned about you, and we need to talk about your use of alcohol (or other substances).” |
| **Q) How might a doctor manage coercion?** | A) RACGP (8) has suggested the following.<br><br>“AnThey coercion or threat (physical or verbal) to prescribe is an immediate red flag and a breach of the therapeutic alliance. Where boundaries have been crossed and the GP no longer considers it appropriate to treat a patient who has behaved in a violent or threatening manner, the GP has the right to discontinue the care of that patient. The GP may choose to end the therapeutic relationship during a consultation or, depending on the circumstances, by letter or telephone. Safety should dictate the method chosen. It is advisable for the practice to document a process to be followed by practice staff if the patient makes any subsequent contact.” |

**Q) What does “write or fight” mean?**

A) Clinicians commonly have difficulty in saying “No”. Clinicians may feel uncomfortable setting boundaries for high risk patients. Fear of confrontation plays into the hands of chemically dependent patients. Pressure to see more patients in less time. Clinicians might rather “write than fight” i.e. write the prescription(7).

**Q) How can one distinguish patient centered care from the need to maintain clinical boundaries?**

A) Patient centered care (8) does not mean that...

- Professional boundaries can be transgressed
- Legislative requirements can be ignored
- Therapy continued if detrimental to the patient’s health
- SafeScript red flags can be ignored
- Practices and practitioners are obliged to take full responsibility for high-risk situations e.g.
- Staff safety adversely affected
- Healthcare needs outside the expertise of practitioners

**Q) How do professional boundaries impact upon prescribing?**

A) The following prescribing practices are impacted upon by professional boundaries (8,9)

- > 100 m OMED for CNCP
- High-risk medication combinations e.g. opioids and benzodiazepines
- Quetiapine to treat insomnia and anxiety
- Benzodiazepines first-line treatment for psychiatric disorders
- Benzodiazepines in pain management
- Benzodiazepines in opioid withdrawal management
- Pethidine or fentanyl in the management of chronic non-cancer pain (e.g. migraine)
- Injectable opioids for pain management

**Q) Which specific chronic non-cancer pain syndromes should not be treated with opioids?**

Acute pain conditions where opioid medications are not recommended of the document “Prescribing drugs of dependence in general practice, Part C2: The role of opioids in pain management”(9).

Atraumatic dental pain

Other pain syndromes wherein opioids are not recommended include the following.

- Fibromyalgia
- Low back pain
- Visceral pain including irritable bowel syndrome and dysmenorrhea
- Complex regional pain syndrome

There is no evidence for the use of opioids first line in the management of fibromyalgia (10).

There is no evidence for the use of opioids first line in the management of low back pain (11,12) .

**Q) Which specific chronic non-cancer pain syndromes should not be treated with opioids?**

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There is no evidence for the use of opioids first line in the management of low back pain (11,12) .

There is no evidence for the use of opioids first line in the management of irritable bowel syndrome (13,14).

There is no evidence for the use of opioids first line in the management of complex regional pain syndrome (15,16).

There is no evidence for the use of opioids first line in the management of migraine(17,18).

There is no evidence for the use of opioids in the management of chronic tension headache (19)

**Q) What are the “four Ds” and what do they mean?**

A) The four Ds (7): dated, duped, disabled, dishonest.

**Dated:** reports suggest that physicians are sometimes more out of date in their knowledge and less confident in their skills in the following areas of medical practice.

- Pharmacology
- Differential diagnosis and management
- Chronic pain
- Anxiety
- Insomnia
- Addiction

**Duped:** clinicians are generally caring and trusting. Clinicians want to help their patients. Clinicians generally want to work in an open and honest therapeutic relationship based on mutual respect

Clinicians may be vulnerable to a manipulative patient. Chemically dependent patients may project onto clinicians the message that “my problem is now your problem.”

Clinician co-dependency may involve

1. overstepping one's boundaries and limits
2. fear of patients’ rejection
3. rescuing: clinician may over-identify with the patient, set unrealistic expectations and unwittingly create a ‘self-assigned impossible task’

There is a fine line between empathy and co-dependency.

**Disabled:** clinicians with a medical or psychiatric disability (e.g. chemical dependency / personality disorder) are more likely to be identified as “Loose” prescribers, and are less likely to confront patients who are abusing substances.

**Dishonest:** this is uncommon. There are a few physicians in every jurisdiction who are willing to write prescriptions for controlled substances in exchange for financial gain. Such physicians should be reported to the state medical board or other law enforcement agencies and appropriately investigated.

**Q) What are the essential elements of a harm minimization plan?**

A) OPQRST is a useful mnemonic to conceptualize the elements of a harm minimization plan.

- “One” Rule / Opioid antagonist therapy
- Pharmacotherapy
- Quantities
- Rotate / Refer
- Staged Supply
- Taper

**Q) How would you describe the “rule of one”?**

A) A harm minimization plan needs to incorporate an agreement that the patient will seek medical care from one prescriber, one practice and one pharmacy only.

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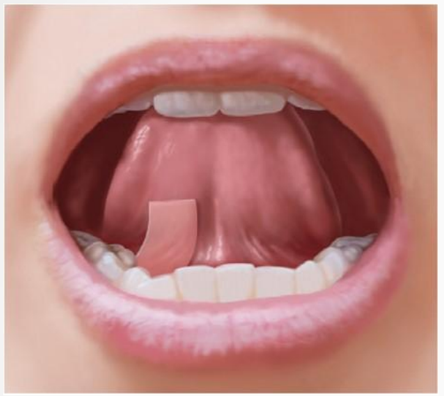
| **Q) What are the indications for use of Prenoxad** | A) High-dose opioids carry a risk of overdose and respiratory depression. The Community Overdose Prevention Education (COPE) program provides training on harm reduction interventions, including the use of naloxone (20). Naloxone, a mu-opioid receptor antagonist, reverses the effects of opioid overdose (21). In Australia it is available as a vial, a prefilled syringe (Prenoxad), or as a nasal spray (Nyxoid). Naloxone, and accompanying training on its administration, should be offered to all patients who are at risk of opioid overdose, including those on high-risk opioid medications (22). Guidance suggests that the threshold for considering naloxone supply should be OMEDD 50 mg (23). Training can be as basic as identification of features of toxicity and the administration of intranasal or intramuscular naloxone (24). |
| **Q) In Victoria for how many patients can a doctor prescribe buprenorphine/naloxone without undergoing specific accreditation training?** | A) Victorian doctors can prescribe suboxone for five patients without undergoing specific MATOD training. All states require accredited training to prescribe methadone opioid agonist therapy. |
| **Q) Why are opioids such as methadone and buprenorphine used to treat opioid dependency.** | A) Methadone and buprenorphine have long terminal half-lives, usually more than 24 hours, which smooth out the pattern of recurrent craving and withdrawal that occurs with dependency on opioids which have a shorter terminal half-life. |

**Q) What is “Suboxone”?**



A) Suboxone is a film medication that contains two medications (buprenorphine and naloxone) in a fixed ratio of 4:1 (25). Refer to full product information “AUSTRALIAN PRODUCT INFORMATION SUBOXONE FILM (BUPRENORPHINE/NALOXONE)” for further information.

Suboxone is available in two strengths.

- Low strength: 2mg buprenorphine / 0.5mg naloxone
- High strength: 8mg buprenorphine / 2mg naloxone

**Q) Why does Suboxone contain naloxone?**

A) The naloxone component of Suboxone is not absorbed when the film is taken sublingually (or buccally). It does however produce an opioid withdrawal effect if Suboxone is injected. Therefore, its function within Suboxone is to act as a deterrent to injecting behavior.

**Q) What is buprenorphine?**

A) Buprenorphine is a synthetic opioid, and a partial agonist at the mu-opioid receptor.

**Q) Why is a mu partial agonist safer than a full mu agonist?**

Buprenorphine is a partial agonist at the mu-opioid receptor. This causes a ceiling effect, whereby after a certain dose further dose increases do not produce any clinical effect. This ceiling level occurs in fit adults at a dose less than that needed to cause respiratory depression, i.e. the ceiling effect is lower than the threshold for respiratory depression (respiratory threshold). Therefore, during buprenorphine use, respiratory depression in a fit adult is highly unlikely, although it can occur in patients with compromised respiratory function and in patients who have co-ingested other respiratory depressant drugs, medication or alcohol.

**Q) What are the side effects of buprenorphine?**

A) The majority of patients experience minimal side effects however some experience the following

- Activation: a “wired” feeling
- Sweating
- hypotension / heart rate reduction (bradycardia)
- Headache
- Insomnia
- Nausea
- Constipation

Refer to full product information for more details.

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| **Q) Which two properties of buprenorphine underpin precipitated withdrawal?** | A) High avidity for the mu-opioid receptor and partial agonism at the mu-opioid receptor.<br><br>Buprenorphine, because of its high avidity for mu-opioid receptor will displace other residual opioids from that receptor. Its partial agonist effect may then precipitate an opioid withdrawal if the patient is opioid dependent. |
| **Q) How is precipitated withdrawal avoided?** | A) To avoid precipitated withdrawal buprenorphine should not be started until a patient is already in withdrawal. This usually occurs after the following intervals: 6-12 hours after last short acting opioid (heroin codeine oxycodone) or 24 hours or longer after last long acting opioid (methadone or long acting opioid preparations). |
| **Q) What are the signs and symptoms of opioid withdrawal?** | A) Opioid withdrawal is associated with the following signs<br><br>▪ Dilated pupils<br>▪ Pulse > 90/min<br>▪ BP > 140/90<br>▪ Sweatiness<br>▪ Sniffing<br>▪ Yawning<br>▪ Watery eyes<br>▪ Anxiety<br>▪ Piloerection (goose bumps) |

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| **Q) How can the assessment of withdrawal be standardized?** | A) A standardized assessment of opioid withdrawal is useful because the individual signs or symptoms of opioid withdrawal are not very specific. For example, a hypertensive patient may already have an elevated blood pressure, and an anxious patient may already have a tachycardia. The COWS (Clinical Opioid Withdrawal Scale) (26) provides one way of standardizing the assessment of opioid withdrawal. |
| **Q) How quickly can the dose of buprenorphine be increased?** | A) The manufacturers of buprenorphine recommend maximum daily dose increments of eight mg. |
| **Q) What is the maximum dose of buprenorphine?** | A) The maximum daily dose of buprenorphine is thirty-two mg. |
| **Q) Why do patients not die of respiratory depression and coma when double or tripled dosed with buprenorphine?** | A) Buprenorphine is a partial agonist of the mu-opioid receptor. Therefore, it has a ceiling effect. This maximum clinical effect occurs at doses which do not typically cause respiratory depression in fit adults. Subject to a daily maximum dose of 32 mg, buprenorphine can be safely double or triple dosed. This is a function of two clinical effects.<br><br>1) Long half life<br><br>2) Partial agonist at mu-opioid receptor |

**Q) Describe the absolute and relative contra-indications to take away doses**

A) The four absolute contra-indications to take away doses are:

1. the absence of secure storage;
2. a history of recent self-harm or suicide;
3. a recent history of overdose;
4. a recent history of diversion.

Relative contra-indications to take away doses include the following.

- Irregular attendance missed  1 in 4 appointments
- Missed doses (confirmed with pharmacist) missed  1 dose per week
- UDS not provided on request or reveals unsanctioned drug use
- Reported misuse of prescription medicines, alcohol or illicit drugs
- Evidence of recent injecting sites
- Intoxicated presentations at medical clinic or pharmacy
- Reported use of take-away doses in advance

- Reported hoarding or ‘stockpiling’ of take-away doses
- Reported lost or stolen take-away doses
- No stable accommodation
- Persons with histories of drug misuse are present or likely to visit the home
- Concerns about other medical condition (e.g. severe liver or respiratory disease)
- Reasonable need also needs to be identified prior to the provision of take away doses.
- Living in a rural or remote area where daily travel to a pharmacy is difficult
- Work, study or family commitments where daily attendance at a pharmacy is not possible
- Significant medical condition restricting ability to attend a pharmacy on a daily basis
- Urgent travel where alternative arrangements for supervised dosing cannot be organized
- Incentive and reward for stability and progress in treatment
- Further information can be found in the Victorian Policy for maintenance pharmacotherapy for opioid dependence (27)

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| **Q) Regarding Suboxone prescribing in Victoria, what is the permitted take away regime and where can one find more information on this issue?** | A) The permitted take away regime is as follows.<br>▪ First two weeks: daily pick up<br>▪ Two weeks to two months: 2 take-aways per week<br>▪ Two months to six months: 5 take-aways per week<br>▪ > six months: 6 take away doses per week<br>Other states in Australia may have different regulations regarding take-away dosing<br>Further information can be found in the Victorian Policy for maintenance pharmacotherapy for opioid dependence (27) |
| **Q) How frequently should one review a patient on suboxone.** | A) Reviews should occur as clinically necessary. The following is a recommendation, but reviews need to be tailored to individual patient circumstances and may occur more (or less) frequently than suggested here.<br>Initial titration phase: day 1 day 3<br>Subsequent titration: weekly –fortnightly<br>Stable: monthly for the first two years of treatment |

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| **Q) What is the URL for the online smart form "Application for a permit to treat an opioid dependent person with methadone or buprenorphine"?** | https://forms.business.gov.au/smartforms/servlet/SmartForm.html?formCode=application-for-ort |
| **Q) Are permits required for the first five patients to whom a doctor in Victoria might wish to prescribe Suboxone?** | A) Even though accredited training is not required for doctors in Victoria to prescribe Suboxone to five patients, permits are required for each and every patient prior to initiating Suboxone treatment. |
| **Q) How does opioid rotation reduce opioid load?** | A) Opioid rotation, whereby a patient is switched from one opioid to another (28,29), may provide a rapid means of reducing OMEDD without loss of analgesic efficacy (30). Canadian guidance on the use of opioids for CNCP validates the use of opioid rotation as a "as a way of facilitating…dose reduction" (31). Reduction in OMEDD during rotation relies on the fact that patients do not usually demonstrate cross-tolerance between opioids (31). Converting from one opioid to another mandates the use of a reduction in calculated equianalgesic dose of the second opioid, firstly to avoid the risks of side effects including respiratory depression and overdose, and secondly to accommodate the variability of dose conversion charts and patient |

factors. The elderly, and those with hepatic or renal impairment, have a higher risk of accidental overdose and may require lower doses of the second opioid in an opioid rotation regimen. Drug-drug interactions also must be considered given the possibility of dramatic fluctuations in serum levels of the second opioid (29). Such cautious prescribing of the second opioid during an opioid rotation could involve switching to approximately 25 – 50%  of the calculated equianalgesic dose (28,31) of the second opioid.

For example, if a patient was using “Ordine” liquid 20 mg t.d.s. and “MS Contin” 60 mg b.d. then the patient’s total OMEDD would be 180 mg. According to the to FFPM ANZCA 180 mg equals 120 mg of oxycodone. If one were to prescribe this then the patient, because of a lack of cross tolerance, would in all likelihood suffer side effects including sedation and respiratory depression. Therefore, it would be prudent to reduce the dose of the second opioid by approximately 25- 50% of the calculated equivalent dose, which in this case would be oxycodone 30 - 45 mg bd (or 60 - 90 mg per day). According to the FFPM ANZCA, 60 mg of oxycodone is equivalent to 90mg of oral morphine and 90 mg of oxycodone is equivalent to approximately 135 mg of morphine. This rotation from morphine to oxycodone has, by using a 50% reduction, reduced the total OMEDD to less than 100 mg OMEDD, and by using a 25% reduction has reduced the OMEDD to approximately 135 mg which, whilst not being less than 100 mg OMEDD, is at least a step in the right direction.

| | |
|---|---|
| **Q) How fast can one taper an opioid?** | A) Most patients tolerate an opioid taper at a rate of reduction of approximately 10% of the starting dose per week or fortnight. |
| **Q) How fast can one taper a benzodiazepine?** | A) Assuming normal phase one liver metabolism and having converted all benzodiazepines to a maximum dose of 40 mg b.d. of diazepam, most patients tolerate a rate of reduction of diazepam of approximately 15% of starting dose per week or fortnight. |

# Resources

DACAS 1800 812 804

GPCAS 1800 812 804 (DACAS line)

Project ECHO. Opioid management (https://echo.pabn.org.au)

**Pharmacotherapy Area Based Networks** (https://www2.health.vic.gov.au/about/publications/factsheets/information-on-victorian-pharmacotherapy-area-based-networks)

**SafeScript Training**

https://www2.health.vic.gov.au/public-health/drugs-and-poisons/safescript/training

**Faculty of Pain Medicine:**

Free Opioid Calculator App for mobile devices

http://fpm.anzca.edu.au/documents/opioid_calculator_app.pdf

Health Pathways

https://melbourne.healthpathways.org.au/

**Turn To Help Website**

www.turntohelp.com.au

Contains advice for healthcare practitioners in video and written format

**Medication Support and Recovery Service**

https://msrs.org.au/about/

Help for patients struggling with medication misuse

**Reconnexion**

http://www.reconnexion.org.au

Service directed at the management of anxiety disorders and benzodiazepine dependence

Direct Line (1800 888 236)

https://www.directline.org.au

Patient referral and matching service

PAMS (1800 443 844)

https://www.hrvic.org.au/pams

**Patient advocacy service**

**Medicines and Poisons regulations (Formerly Drugs and Poisons Regulations): legislative advice**

https://www2.health.vic.gov.au/public-health/drugs-and-poisons

1300 364 545

**Written resources from the RACGP**

Prescribing drugs of dependence in general practice, Part A – Clinical governance framework. Melbourne: The Royal Australian College of General Practitioners, 2015.

Prescribing drugs of dependence in general practice, Part B – Benzodiazepines. Melbourne: The Royal Australian College of General Practitioners, 2015

The Royal Australian College of General Practitioners. Prescribing drugs of dependence in general practice, Part C1: Opioids. East Melbourne, Vic: RACGP, 2017.

The Royal Australian College of General Practitioners. Prescribing drugs of dependence in general practice, Part C2: The role of opioids in pain management. East Melbourne, Vic: RACGP, 2017.

**Written resources from the DHHS**

A brief guide to prescribing buprenorphine/naloxone

https://www2.health.vic.gov.au/about/publications/policiesandguidelines/buprenorphine-naloxone-prescribing-brief-guide

Policy for maintenance pharmacotherapy for opioid dependence

https://www2.health.vic.gov.au/public-health/drugs-and-poisons/pharmacotherapy/pharmacotherapy-policy-in-victoria

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