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NATIONAL PAIN CENTRE

FAQ's

Can you provide guidance on switching my patient from OxyContin to OxyNEO?

Until spring 2013 you will be able to continue your patient on OxyNEO at the same dose as the Oxycontin under the Ontario Drug Benefit (ODB) coverage. In spring 2013 it will become necessary to submit an Exceptional Access Program (EAP) request (formerly section 8) demonstrating that the patient has tried and failed on the alternative OBD covered opioid (usually morphine and hydromorphone). Data from previous patient trials can be assembled for the EAP request. Should you and your patient decide not to pursue the EAP request, you can switch now to another opioid. The *Opioid Manager - Switching Opioids* tool available on the National Pain Centre website can assist you in the conversion process.

What do you consider to be the definition of "high" dose versus "moderate to low" dose?

The dose of 200 mg MEQ daily has been used for this definition.

Why is the recommendation to decrease the dose by 50% or 60-75% not included in the actual conversion table as part of the clinical decision-making process?

The recommendation is to reduce the dose to 60-75% of the *ORIGINAL DOSE*; not reduce by the proportion.

Why is there a more significant decrease recommended for patients on moderate to low dose, as opposed to high dose? Is this due to assumed less tolerability?

The larger proportionate reduction occurs in the higher dose patients. These suggestions have been taken from the experience of clinicians initiating the opioid switch.

Are the conversion guidelines based on switching due to lack of efficacy, intolerance, or both?

The reason for switching can be: inability to tolerate a given opioid, increasing dose without improved effect, lack of adequate effect despite dosing at a level which gives intolerable side effects.

I am uncomfortable prescribing opioids to my patient knowing there is an alcohol abuse problem. What should I do?

This is a difficult problem. It is suggested that you not focus on the opioid issue in isolation, but look at the overall issue of patient care. When seeing a new patient, there is always a period of establishing a relationship, learning about the patient and engaging them in the process of care. This will involve reviewing their medical conditions, inquiring as to the reasons for various medications, letting them know that you need to do this in order to offer effective medical care. This may include pain treatment which could be different than they have had in the past. Patient information about the long-term effects of opioids (hypogonadism, osteoporosis, drug and alcohol interactions, etc.) may help highlight for the patient some of your concerns. There may be issues to do with optimal therapy for arthritis, for example, which can put the use of opioids into perspective for your patient. Outreach programs in your area may be able to offer educational program for physicians and patients which might be useful.

May I have permission to use charts from the *Canadian Opioid Guideline* in my presentation?

You may use charts from the *Canadian Opioid Guideline* in your presentation. When referencing the guideline use the following format: Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain. Canada: National Opioid Use Guideline Group (NOUGG); 2010 [cited year month date].

You may download any of the *Canadian* Op*ioid Guideline* documents. The content in the guideline is licensed under a Creative Commons Attribution-Noncommercial-No Derivative Works 2.5 Canada License. Reproduction is permitted but content must be unaltered from the original.

Address: http://nationalpaincentre.mcmaster.ca/opioid/