NPS MEDICINEWISE

# OPIOIDS
Prescribing in chronic non-cancer pain

**Practice Review**
**PBS data**
November 2019

*For more information about this Practice Review and how to interpret your data, see **nps.org.au/pbs-opioids***


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DHS1
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Your PBS data are provided confidentially to you only and are intended for personal reflection on your practice.
**Data are not used for any regulatory purposes.**
**For queries about your data or any of this information, contact NPS MedicineWise:**
**02 8217 8700 info@nps.org.au**

12 November 2019

Dear Mr Gibbs,

NPS MedicineWise routinely sends Practice Reviews, with a focus on quality use of medicines and medical tests, to support clinicians in professional development and continuing quality improvement. This individualised Practice Review is part of our current national program ***Opioids, chronic pain and the bigger picture***. It has been developed in collaboration with GPs and sent to approximately 30,000 prescribers across Australia, including all GPs. The enclosed PBS data provide you with an opportunity to reflect on your prescribing of opioids for patients with chronic non-cancer pain.

**Harms from prescription opioids are increasing[1]**
Every day in Australia, 3 people die, nearly 150 people are hospitalised and 14 people present to emergency departments because of harm from opioids.[1] GPs see many patients with chronic non-cancer pain[2] and given these harms, it is important for you to communicate the risks and benefits of different pain treatments to patients.[2]

**Most patients with chronic non-cancer pain will not benefit from opioids**
Due to the biopsychosocial nature of chronic non-cancer pain, a multimodal approach is recommended, combining psychological and physical treatments.[2] Recent evidence shows that for most patients, opioids do not provide clinically important improvements in pain or function compared with placebo,[3] but are associated with significant harms, such as risk of dependence, misuse or overdose.[4]

**Balancing the harms of opioids with managing pain is challenging**
For most patients, chronic non-cancer pain can be managed without opioids, and many GPs do this. For patients who are prescribed an opioid, safe and appropriate prescribing combined with a pain management plan, regular reviews and tapering when possible, will optimise outcomes.[2]

**How else can NPS MedicineWise support you?**
Book an **Educational visit**, participate in a **Clinical e-Audit** (which provides guidance on tapering, including a tapering algorithm), or access the **Medicinewise News** and **a fact sheet and tapering plan for consumers** by visiting **nps.org.au/opioids**

Yours sincerely,

Steve Morris
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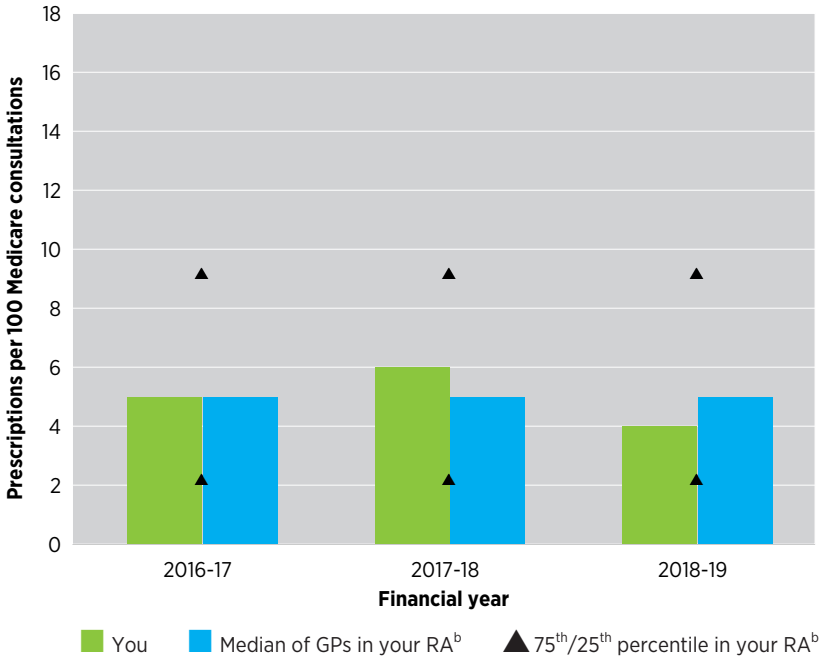
# Your confidential PBS data

NPS MedicineWise provides this information for your reflection only. The data are from the Department of Human Services (DHS) and include PBS prescriptions for oral and transdermal opioids that you prescribed and that were dispensed. **The indication for prescribing (eg, chronic vs acute pain) cannot be determined from PBS data,** however we have excluded PBS item codes listed for palliative care, opiate dependence or dental prescribing. **All practices are different; practices specialising in palliative care, cancer care or acute care may have higher appropriate utilisation rates. Consider the data presented with regard to your patients and their indications for treatment.**

**Opioids included in this report are:**

- buprenorphine
- codeine
- fentanyl
- hydromorphone
- oxycodone
- oxycodone + naloxone
- tapentadol
- tramadol

## How has your prescribing of opioids changed over time?




### Points for reflection

- Optimise non-opioid management for patients with chronic non-cancer pain before trialling an opioid.[4]
- Only consider prescribing an opioid as part of a multimodal pain management plan.[5]
- Any benefits of opioid treatment can usually be determined within 2–4 weeks of starting treatment.[2]

## How many of your patients were prescribed an opioid in 2018–19?

In 2018-19, you prescribed an opioid for 26 (4%) of your patients, and of these, 21 were started[c] on an opioid.

*Note: Indication for prescribing (eg, chronic vs acute pain) cannot be determined from PBS data.*

### Points for reflection

- Pain management plans should include goals agreed with the patient, criteria for success and when the opioid will be tapered.[2]
- Pain management should focus on an increase in function, rather than on the removal of pain.[6]
- Recognise that any pain-relieving effects of an opioid may wane over time because of tolerance and/or opioid-induced hyperalgesia.[7]

**MedicineInsight**

**MedicineInsight data show that of patients aged ≥ 18 years with chronic non-cancer pain who are currently prescribed an opioid, around 40% have been prescribed an opioid for more than 12 months.[d]**

*Note: For MedicineInsight data, among patients currently prescribed an opioid, chronic non-cancer pain is inferred by excluding patients whose medical records have a reference to acute pain in the last 3 months, or a diagnosis of cancer or opioid use disorder in the last 24 months, or any reference to palliative care ever.*

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Choosing Wisely Australia
An initiative of NPS MedicineWise

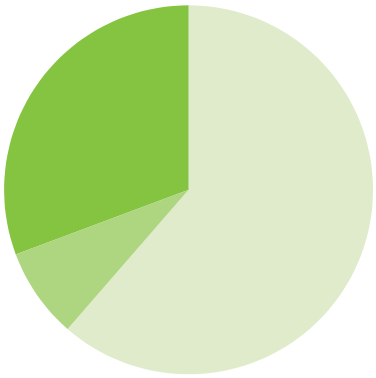
RACGP, through Choosing Wisely Australia, recommends:
**Do not continue opioid prescribing for chronic non-cancer pain without ongoing demonstration of functional benefit, periodic attempts at dose reduction and screening for long-term harms**
choosingwisely.org.au/recommendations/racgp

### Points for reflection

- Opioid-related harms are dose-dependent and risk of harms is more likely to outweigh benefits at higher doses.[7,8]
- Any beneficial response to an opioid should be evident at an oral morphine equivalent daily dose (OMEDD) ≤ 60 mg.[9]
- Consider specialist advice for patients prescribed an OMEDD > 60 mg.

Use the ANZCA Faculty of Pain Medicine opioid dose-equivalence table to calculate the OMEDD **https://fpm.anzca.edu.au/documents/opioid-dose-equivalence.pdf**,
(eg, tramadol SR 50 mg capsule twice a day is equivalent to 20 mg OMEDD; tapentadol 100 mg twice a day is equivalent to 60 mg OMEDD).

## How many patients had ≥ 7 opioid prescriptions from you in 2018–19?




*Note: This chart only includes patients prescribed opioids by you that were dispensed in 2018–19. Due to rounding, percentages may not total 100%. n = number of patients in 2018–19.*

### Points for reflection

- Review patients within 1–4 weeks of starting an opioid and then at least every 3 months to assess the risk of harms against any benefits of ongoing opioid treatment.[2]
- **Tapering opioids for patients with chronic non-cancer pain can improve pain, function and quality of life.[10]**
- Taper opioid treatment with the aim of stopping when:[2]
  - there is no improvement in pain and/or function
  - the cause of pain has resolved
  - the patient shows aberrant behaviour or signs of misuse
  - the adverse effects of the opioid are intolerable
  - the risk of harms outweighs the potential benefits.

## What does this mean for me?

- How do I assess the potential harms and benefits before prescribing an opioid?
- Do I monitor the change in the patient's function rather than in pain intensity as the most important measure of response to opioid treatment?
- Do I involve multidisciplinary services where appropriate?
- Does my practice have policies and systems to ensure safe and effective opioid prescribing?

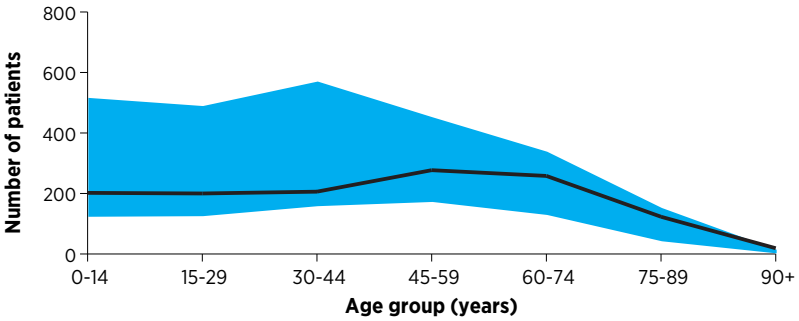
## Practice profile

This practice profile is provided to help you interpret your prescribing data.

**Your RA[b] peer group is Major City**

### Age profile of your patients

1 July 2018 to 30 June 2019




The black line represents the age profile of your patients. The shaded area lies between the 25th and 75th percentile for GPs in your RA.[b]
*Data values are outside the range of the graph

### Your Medicare patients and concession card holders

1 July 2018 to 30 June 2019

| Patients | You | Median of GPs in your RA[b] |
|---|---|---|
| Total Medicare | 1,243 | 1,558 |
| Concession card holders<br>Includes those reaching Safety Net | 220 | 302 |

Department of Veterans' Affairs health card holders are not included.

### Notes

a. Data shown are an aggregate of all your provider locations.

b. The comparator group 'RA' includes all general practitioners currently located in a similar geographical location.

c. Patients prescribed an opioid by you that was dispensed in financial year 2018–19, and had not had an opioid prescribed by you that was dispensed in the previous 3 months.

d. MedicineInsight data as at 1 July 2019. Opioid-containing products solely indicated for unrelated conditions such as cancer, opioid use disorder, acute pain, palliative care or cold and flu are not included.

### References


1. Australian Institute of Health and Welfare. Opioid harm in Australia and comparisons between Australia and Canada. Canberra: AIHW, 2018.
2. Royal Australian College of General Practitioners. Prescribing drugs of dependence in general practice, Part C2: The role of opioids in pain management. 2017. https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/prescribing-drugs-of-dependence/prescribing-drugs-of-dependence-part-c2 (accessed 19 September 2019).
3. Busse JW, et al. JAMA 2018;320:2448-60.
4. Busse JW, et al. CMAJ 2017;189:E659-E66.
5. Faculty of Pain Medicine. Australian and New Zealand College of Anaesthetists. Recommendations regarding the use of opioid analgesics in patients with chronic non-cancer pain. PM01 2015. http://fpm.anzca.edu.au/documents/pm1-2010 (accessed 16 September 2019).
6. Hall T. JPPR 2019;49:3-8.
7. Juurlink DN. CMAJ 2017;189:E1222-E3.
8. Royal Australian College of General Practitioners. Prescribing drugs of dependence in general practice, Part C1: Opioids. 2017. https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/prescribing-drugs-of-dependence/prescribing-drugs-of-dependence-part-c1 (accessed 19 September 2019).
9. NSW Therapeutic Advisory Group Inc. Preventing and managing problems with opioid prescribing for chronic non-cancer pain. Sydney: NSWTAG, 2015.
10. Frank JW, et al. Ann Intern Med 2017;167:181-91.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Log in to your Health Professional Online Services (HPOS) account
https://www.humanservices.gov.au/organisations/health-professionals/services/medicare/hpos

Send your full name, provider number and new preferred mailing address to provider.registration@humanservices.gov.au from a personal email address that clearly identifies you, or is the email address stored on the Medicare Provider Directory.

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