FPM

Faculty of Pain Medicine
ANZCA

Drug and therapeutics committee submission guidelines

Requesting endorsement of atypical opioid prescribing for clinicians other than the pain service

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Introduction

Not all states or institutions endorse widespread prescribing of atypical opioid medications, with many restricting prescribing to acute pain services or palliative care teams.

Increasing evidence for patient safety demonstrates that the use of atypical opioids may be preferable when compared to a full mu agonist in some patients populations.

Local drug and therapeutic committees (DTC) will have a process for applying to expand local prescribing rights and the use of atypical opioids as first-line treatment when simple analgesics are insufficient.

When completing any application, advice should be sought from the local DTC pharmacist or committee.

Example submission medication extension - tapentadol (example only)

Australian approved (generic) name	tapentadol IR
Trade name	Palexia IR
Dosage form(s) – provide full details	50 mg
Manufacturer/supplier	CSL Seqirus
Pharmacological class and action (summary)	Atypical Opioid

Indication(s) for use

Is the drug approved by the Therapeutic Goods Administration (TGA) for marketing in Australia?

☑ Yes ○ No

What is the proposed indication(s) for use in the hospital?

- **Short-term management of acute pain.**
- **Extension of prescribing rights to include all medical officers not limited to acute pain service.**

Is this a TGA approved indication?

☑ Yes ○ No

Is the drug already listed on the hospital formulary for other indications?

☑ Yes ○ No

If **YES**, list current formulary approval (including restrictions):

For short-term management of pain, restricted to acute pain service.

PBS listing and continuity of supply

Has the drug been considered by the Pharmaceutical Benefits Advisory Committee (PBAC) for the proposed indication for use?

○ Yes ☑ No

Explain implications for supply.

Opioids are indicated for short-term use only in acute pain or for short-term management of a flare in acute or chronic pain.

There is no indication for ongoing use in either acute or chronic non-cancer pain.[1]

There is no requirement for ongoing supply, and this is discouraged.

Medication supply on discharge will most commonly be 10 tablets or less.

A maximum of 20 tablets would be supplied for any discharge script.

Reasons for request

Change in formulary approved use.

Explain your reasons for wanting to use this drug.

Tapentadol IR will be prescribed as the first line opioid within the hospital for new acute severe pain in younger patients (age < 70).

Tapentadol IR is an atypical opioid with analgesic activity via synergism between the mu-opioid activation in ascending pain pathways and the noradrenergic reuptake inhibition in descending pain pathways. The mu load is responsible for tapentadol's most common side effects, with the noradrenergic component contributing little to the side effect burden.

The relative mu load of tapentadol compared with oxycodone is 30-40%, meaning that for an equianalgesic dose, tapentadol has only 30-40% of the opioid side effects like constipation and respiratory depression when compared to oxycodone.

Tapentadol has been demonstrated to have lower rates of persistent use in the community when compared to oxycodone.[1]

Provide the following details:

Treatment details: Age and co-morbidity-based dosing.	
Recommended dosage, administration details, duration of treatment, etc	For patients ages >70: 50mg q3-4hrly PRN. Max 250mg/24 hrs. For younger patients: 50-100mg q3hrly PRN. Max 600mg/24 hrs.
List drugs recommended for co-administration or used in combination.	To be prescribed when non-opioid analgesia, e.g. paracetamol, NSAIDs are insufficient to manage acute pain.

Provide recommendations for order sentences, care sets

Recommend inclusion and or development of a prescribing protocol for acute pain.

This drug will be used in preference to oxycodone IR and Panadeine Forte.

Oxycodone should remain available on imprest when low-dose opioid analgesics are required, e.g. in advanced age when 2.5mg oxycodone tablet should be prescribed and a 5mg tablet is divided.

Monitoring requirements:

Describe the objective criteria that will be used to monitor effectiveness.

No monitoring required. Available evidence exists to demonstrate reduced side effects.

Proposed place in therapy:

Describe investigations necessary for patient selection and treatment.

Tapentadol IR will be the first-line opioid for severe acute/ acute on chronic pain in patients aged <70.

Which patient groups are most likely to benefit?

Will this drug be used as first, second or third-line therapy?

What prescribing restrictions should be in place (e.g. medical officers authorised to prescribe)?

This submission is designed to broaden the prescribing from acute pain service to all medical officers in recognition of the reduced side effect profile associated with this drug as evidenced by:

Respiratory depression is a rare but potentially catastrophic opioid-related event more likely when a full mu agonist is prescribed.

Opioid-induced gastrointestinal side effects in particular constipation are distressing for patients.

Unintended transition to long-term opioid use has been associated with increases in community opioid-related morbidity and mortality in Australia.

Each of these effects is reduced when tapentadol is compared to oxycodone.

Cost offsets if the new drug were introduced:

Decreased cost associated with reduction in anti-nausea agents and aperient use.

Reduction in potential patient harm and consequent reduction in community health care burden when consideration is given to risk for unintentional respiratory depression and persistence opioid use.

Evidence

Significant adverse effects	New drug: Current formulary alternative(s):
Common: *(i.e. incidence of 1% or more)* **Infrequent:** *(i.e. incidence between 0.1% and 1%)* **Rare:** *(i.e. incidence less than 0.1%)*	tapentadol 50mg vs oxycodone 10mg (equipotent)[2] **Vomiting:** **10% v 29%** 0.37 CI [0.24, 0.56] p<0.00001[2] **Nausea:** **30% v 50%** 0.64 CI [0.48, 0.85] p<0.002[2] **Constipation:** **7% v 17%** 0.44 CI [0.21, 0.93] p<0.03[2] Discontinuation due to adverse events: 0.52 CI [0.52, 0.77] p<0.001[2]

Level 1 evidence:
Jing-Ping Xiao, et al. Efficacy and Safety of tapentadol Immediate Release Assessment in Treatment of Moderate to Severe Pain: A Systematic Review and Meta-Analysis. Pain Medicine. 2017;18(1):14–24.

Main benefit in safety	New drug: Current formulary alternative(s):
Incidence of main effectiveness outcome measure expressed as a percentage. Specify outcome measure (eg cure rate, relapse rate) and whether measure represents a surrogate marker or an actual health outcome. Level of evidence.	For patients who underwent orthopaedic surgery, tapentadol IR had a lower rate of unintended persistence at 3 months post-surgery than oxycodone IR **(OR=0.52-0.63)**, n=19,970.[1]

Level 3 evidence:
Unintended persistent opioid use at 3 months:
Lam T, et al, Effect of discharge opioid on persistent postoperative opioid use: a retrospective cohort study comparing tapentadol with oxycodone. Anaesthesia. 2023;78(4):420-431.

Main benefit in safety	New drug: Current formulary alternative(s):
Incidence of main adverse event expressed as a percentage. Specify (eg stroke, mortality, allergic reaction, etc). Level of evidence.	tapentadol 100mg vs oxycodone 20mg (equipotent doses for analgesia) Oxycodone 20 mg had a significantly larger respiratory depressant effect than tapentadol 100 mg (mean difference -5.0 L min-1, 95% confidence interval: -7.1 to -2.9 L min-1, P<0.01) as measured by the effect of treatment on the ventilatory response to hypercapnia and ventilation at an extrapolated end-tidal PCO2 of 7.3 kPa (55 mmHg, VE55).[3]

Level 3 evidence:
Respiratory depression:
van der Schrier R, et al. An experimental study comparing the respiratory effects of tapentadol and oxycodone in healthy volunteers. Br J Anaesth. 2017 Dec 1;119(6):1169-1177.

References:

1. Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine. Position statement on acute pain management 2023. From https://www.anzca.edu.au/getattachment/558316c5-ea93-457c-b51f-d57556b0ffa7/PS41-Guideline-on-acute-pain-management Published 2023. Accessed January 2024.
2. Lam T, et al, Effect of discharge opioid on persistent postoperative opioid use: a retrospective cohort study comparing tapentadol with oxycodone. Anaesthesia. 2023;78(4):420-431.
3. Jing-Ping Xiao, et al. Efficacy and Safety of tapentadol Immediate Release Assessment in Treatment of Moderate to Severe Pain: A Systematic Review and Meta-Analysis. Pain Medicine. 2017;18(1):14–24.
4. van der Schrier R, et al. An experimental study comparing the respiratory effects of tapentadol and oxycodone in healthy volunteers. Br J Anaesth. 2017 Dec 1;119(6):1169-1177.

The Resources for Opioid Stewardship Implementation (ROSI) have been developed by Ms. Bernadette Findlay, Clinical Nurse Consultant, and Associate Professor Jennifer Stevens, Anaesthetist and Pain Medicine Specialist at St. Vincent's Hospital, Sydney, in conjunction with the Faculty of Pain Medicine. Thanks to Peter Samios, Director of Pharmacy at St. Vincent's Hospital, Sydney for his assistance with creation of this guide. Development of the ROSI has been supported by an unrestricted educational grant from CSL Seqirus. CSL Seqirus were not involved in the creation of intellectual property or any other content contained within the ROSI.

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