

Properties of Opioid Analgesics and Approximate Equianalgesic Doses*

Medication	Route	Equianalgesic Dose (mg)	Duration (hr)	Comments						
Morphine	IV	10	3-4	(IR: immediate release, ER: extended release, OME: oral morphine equivalent, SSRI: selective serotonin reuptake inhibitor, TD: transdermal, TDD: total daily dose) Renally eliminated metabolites, prolonged effect with renal impairment; pruritus common.						
	PO	30	3-4 (IR) 8-12 (ER)							
HYDROMorphine	IV	1.5	2-4							
	PO	7.5	2-4							
OxyCODONE	PO	20	3-6 (IR) 8-12 (ER)	Caution for Acetaminophen Dosing when prescribing combination medications						
HYDROcodone	PO	30	4-8	Caution for Acetaminophen Dosing when prescribing combination medications						
FentaNYL	IV	0.1	1-2	To convert to patch , calculate OME first, then use chart below (DO NOT use this chart to convert from TD fentaNYL to another opioid). Patch onset = 12-24 hours , ensure adequate analgesia during this time.						
	TD	See comment	72							
Multiple other products available										
		OME (mg)	60-134	135-224	225-314	315-404	405-494	495-584	585-674	675-764
		TD FentaNYL Dose (mcg/hr)	25	50	75	100	125	150	175	200
Warnings: heat (fever, heat pad) will increase rate and extent of patch absorption										
Methadone	IV	Long, variable duration, delayed onset (hours, days) IV:PO 1:2	4-6	USE CAUTIOUSLY! Consider expert consultation due to complexity of dosing. Warnings: QTc prolongation; drug-drug interactions.						
	PO									
Buprenorphine	PO	0.75-1.5	4-6	Butrans Transdermal 5, 7.5, 10, 15, 20 mcg 7-day patches - Pain Management Buprenorphine/Naloxone (mg) - Opioid Use Disorder						
Tapentadol	PO	See comment	4-6	Max 600 mg/d, 100 mg/dose Tapentadol 75 mg PO = oxyCODONE 20 mg PO. Warnings: seizures, serotonin syndrome						
TraMADol	PO	200 (max 100 mg/dose)	4-6	Max 400 mg/d; 200 mg/d if CrCl < 30 mL/min Warnings: seizures, serotonin syndrome. Avoid in geriatrics						

Opioids slow gastric transit time, recommend initiating a STIMULANT bowel regimen

Medication	Route	Initial Dose	Frequency	Time of Onset	Comments
Sennoside	PO	8.6mg	Daily	6-10 hr	May increase to 8 tablets Daily
Polyethylene Glycol	PO	17g packet	Daily	24-96 hr	
Bisacodyl	PO	5mg	Daily	6-10 hr	May increase to 15mg Daily
Lactulose	PO	10g	Daily	24-48 hr	May increase up to 40g Daily
Lubiprostone	PO	24mcg	Twice Daily	1 hr	\$\$\$ Dose Adjustments for Liver Disease.
Methylnaltrexone	SC	12mg	Every Other Day	30 min	\$\$\$ Dose Adjustment in Liver and Renal Disease

DISCLAIMER: This information is to be used as a guideline and is not a substitute for clinical judgement.

This reference is specific to products supplied by and doses approved by St. Luke's University Health Network and should NOT be used for patients outside of the network

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References: Lexicomp®; McPherson, ML. *Demystifying Opioid Conversion Calculations: A Guide for Effective Dosing.*

Non-Opioid Adjuncts for Pain Control

Unless modulating within neuropathic classes, it is recommended to use only ONE medication from each adjunct class

		Medication	Route	Initial Dosages	Frequency	Comments	
		Acetaminophen	PO	650-1000mg	q6-8hours	Max: 4000mg/day Liver Disease recommendation for no more than 2g/day	
Anti-Inflammatory		Ibuprofen	PO	400-800mg	q6-8hours	Max: 3200mg/day CAUTION in Liver and Kidney Disease	
		Ketorolac	PO	10mg	q6hours	Recommended to not exceed 5 days of dosing. No added benefit from increased doses CAUTION in Liver and Kidney Disease. PO and IV dosing is equivalent	
			IV	15mg			
		Prednisone	PO	20mg	Daily	Poor data supporting use of prophylactic PPIs	
		Dexamethasone	PO	2mg	Daily		
Neuropathic		Gabapentin	PO	300mg	qHS	Max: 3600mg TOTAL Daily dose. Renally Adjusted Medication – check CrCl prior to determining dose ceiling. Minimal Therapeutic benefit from total daily doses above 1800mg/day Typically do not titrate more than 300mg every 3-5 days Start with 100mg qHS for geriatric patients	
		Pregabalin	PO	50mg	TID	Max: 600mg TOTAL Daily dose. Only if patient had intolerable side effects of Gabapentin	
	SNRI		Duloxetine	PO	30mg	Daily	Adjunct AFTER therapeutic trial of gabapentin. CAUTION in Liver Disease. Max: 60mg Daily. Titrate to 60mg dose after at least 1 week
			Venlafaxine ER	PO	37.5mg	Daily	Adjunct AFTER therapeutic trial of gabapentin. Use IR formulation in renal disease/dialysis Max: 225mg Daily. Increase to 75mg after one week trial
	TCA		Amitriptyline	PO	25mg	Daily	Start with 10mg dose in geriatric patients. Requires minimum of 3-12 weeks for maximal effect Max: 150mg Daily. Monitor for Anticholinergic effects.
			Nortriptyline	PO	25mg	Daily	Start with 10mg dose in geriatric patients. Requires minimum of 3-12 weeks for maximal effect Max: 150mg Daily. Monitor for Anticholinergic effects.
Muscle Relaxer		Baclofen	PO	5mg	TID	Max: 80mg TOTAL Daily dose. Therapeutic Effect noticed in 3-4 days.	
		Tizanidine	PO	2mg	TID	Max: 24mg TOTAL Daily dose. CAUTION in Renal Disease	
		Diazepam	PO	2-5mg	TID	Max: 30mg TOTAL Daily dose. CAUTION respiratory depression with concomitant use of opioids	
		Methocarbamol	PO	500mg	TID	<i>Dosing by age: 59 years and younger: 750 mg every 6 hours; 60 to 69 years: 500 mg every 6 hours</i>	
		Cyclobenzaprine	PO	5mg	TID	Max: 30mg TOTAL Daily dose Monitor for anticholinergic effects. Do not combine with TCA or Tramadol	
Topical		Lidocaine		5% patch	Daily	Do not wear for greater than 12 hour period. Maximum 3 patches Minimal systemic absorption. Approved for topical neuropathic pain	
		Diclofenac sodium		1% gel	QID	2g dosing for upper extremity, 4g dosing for lower extremity Minimal systemic absorption	

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