FENTANYL PATCH

Prescribed Safer Supply Protocol

CLINICAL SUMMARY

1. Evidence Supporting Intervention (pg.5)

Currently, there is no evidence or established best practices supporting fentanyl patches for mitigating risk from the toxic drug supply. There is, however, limited clinical experience demonstrating benefits for those with an opioid use disorder (OUD) that want to reduce their use of illicit opioids.

2. Eligibility

It is strongly recommended that fentanyl patches be trialed only in situations where established, evidence-based opioid agonist treatment (oral or injectable) has not been successful in achieving the patient's goal of reducing their reliance on the illicit drug supply.

The following considerations for eligibility should be assessed and documented in the patient's health record:

- Opioid use disorder diagnosis **AND**
- Ongoing active illicit fentanyl use **AND**
- A high risk of overdose or other harms related to illicit opioid use

3. Drug-Drug Interactions (pg. 14)

There are many drugs that interact with fentanyl, such as CYP inhibitors and inducers (commonly prescribed—ritonavir, fluoxetine, paroxetine, trimethoprim/sulfamethoxazole, ciprofloxacin, fluconazole, cimetidine). A detailed list can be found in the practice resource.

Special Caution: Antiretroviral Medication

There is a strong interaction between fentanyl and some antiretroviral (ARV) drugs used to treat HIV. Antiretroviral medications containing the "boosters" cobiscisat or ritonavir inhibit CYP3A4, which can lead to significant increases in fentanyl levels. Individuals who are stable on potentially-interacting ARV treatment may be started on fentanyl and should be monitored closely for sedation. Initiating fentanyl patches for individuals who might stop and restart potentially-interacting ARVs is not recommended. A clinician who specializes in HIV care should be consulted prior to initiating or changing ARVs.

4. Patient Education Checklist

This checklist ([available here](#)) can be used to ensure key points have been discussed with the patient prior to implementation of the program.

✓	Key points
	Individuals with OUD, engage in illicit fentanyl use, and are at a high risk of overdose or harms are eligible for this program
	Due to the potency and long-acting nature of the patches, it is not appropriate for those without opioid tolerance
	The patch needs to be worn continuously on the skin and changed at a pharmacy or clinic every 2–3 days
	Sweating may cause the patch to fall off. Tape or a clear occlusive dressing may be used to reinforce the patch
	Old patches should be returned intact before new ones are given
	If the patch falls off, fold the patch so adhesive side sticks together to avoid sticking to other individuals, children, or pets, place it in a container and bring it into the pharmacy as soon as possible
	If a patch change is missed, visit the clinic or pharmacy as soon as possible. The dose may need to be adjusted
	Drug–drug interaction exists with HIV medications and may increase risk of overdose
	Excessive heat (e.g., fever, hot bath) and intense physical activity may increase the absorption of the drug and increase your risk of an overdose
	Avoid using other downers such as alcohol or benzodiazepines as it may increase risk of overdose
	Let your provider know if you experience an overdose
	Do not cut or tamper with the patch, as it can affect how well the patch works and increase risk of overdose
	Side effects: slowed breathing, nausea, vomiting, constipation, overdose or death
	Adhesive may cause skin irritation. Encourage patch rotation

5. Patch Visit Assessment ([pg. 19](#)) & Assessment of Benefit ([pg. 37](#))

- A patch visit assessment should be conducted at the initial visit and with every patch change
- Can be performed by a pharmacist, nurse, nurse practitioner or doctor
- Assessment of benefit should be conducted monthly by the prescriber

Titration Methods (pg. 24)

Option 1: Slow-release Oral Morphine (SROM) to Fentanyl Patch

Patients can undergo a SROM titration, as per the SROM titration schedule outlined in the BCCSU's *Opioid Use Disorder Practice Update*. When the patient reaches an SROM dose where they are comfortable (e.g., managing withdrawal symptoms or cravings), their SROM dose can be converted to the fentanyl patch, with a maximum starting dose of 300mcg/hr.

If a patient is on multiple oral OAT medications, they should be transitioned to SROM alone prior to initiating a fentanyl patch.

Typically, a 25% dose reduction is required when converting between opioids to account for incomplete cross tolerance. However, the conversion charts in fentanyl patch product monographs are more conservative than conversion charts for other opioids. **Therefore, a dose reduction is not usually required when switching from SROM to a fentanyl patch.** A 25% dose reduction from SROM may result in significant under-dosing upon transitioning to the fentanyl patch, unless the reason for dose reduction is not related to the issue of cross tolerance.

Morphine Milligram Equivalents (MME) Table

Calculating Morphine Milligram Equivalents (MME)		
Opioid (Oral Dose)	**Dose Equivalent to oral Morphine Sulfate (30mg) as example**	**Conversion Factor (convert to MME)**
Morphine	30	1
Codeine	200	0.15
Oxycodone	20	1.5
Hydromorphone	6	5
Meperidine	300	0.1
Methadone & Tramadol	Dose equivalents unreliable	
Transdermal fentanyl	60 to 134mg oral morphine = 25mcg/hr 135 to 179mg oral morphine = 37mcg/hr 180 to 224mg oral morphine = 50mcg/hr 225 to 269mg oral morphine = 62mcg/hr 270 to 314mg oral morphine = 75mcg/hr 315 to 359mg oral morphine = 87mcg/hr	

	360 to 404mg oral morphine = 100mcg/hr

To calculate the total daily MME dose to start Transdermal Fentanyl:

1. Determine the total daily doses of current opioid medication
2. Convert each dose into MMEs by **multiplying** the dose by the conversion factor.
3. If more than one opioid medication, add together THEN
4. Refer to the chart above for fentanyl patch dose
5. If fentanyl patch dose is higher than 100mcg/hr consult another experienced prescriber

Option 2: Fentanyl Patch Only Titration (pg. 25)

For those who are not currently on OAT, there are 2 titration options depending on an individual's known tolerance. For those who may have low or unknown tolerance, after 3 consecutive doses (or 2 patch changes at the same dose), the dose can be increased by 25–50mcg (i.e., approximately once weekly). For those with a known high tolerance, the dose may be increased after 2 consecutive doses.

Unknown tolerance

Starting Dose	Weekly Increase
25 mcg/hr	25–50 mcg/hr
Day	Dose
1	25 mcg/hr
2	-
3	25 mcg/hr
4	-
5	25 mcg/hr
6	-
7	50 mcg/hr
8	-
9	50 mcg/hr
10	-
11	50 mcg/hr
12	-
13	75 mcg/hr

Known High Tolerance

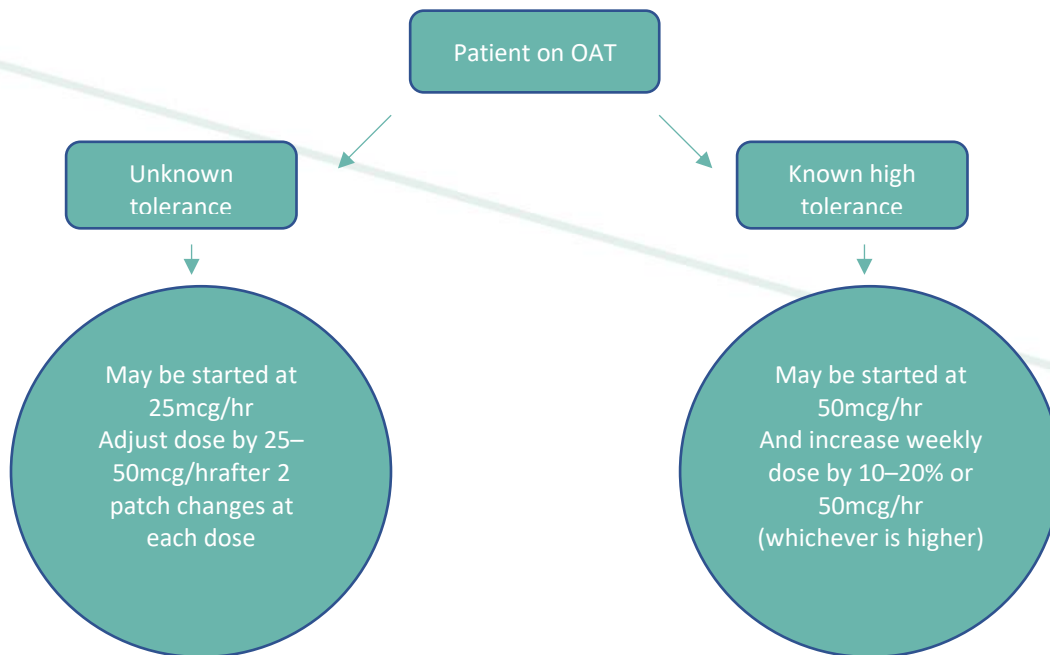| Day	Dose
1	50 mcg/hr
2	-
3	50 mcg/hr
4	-
5	100 mcg/hr
6	-
7	100 mcg/hr
8	-
9	150mcg/hr
10	-
11	150 mcg/hr
12	-
13	175 mcg/hr

Bridging Opioids During Titration

When following a SROM to fentanyl patch titration or a fentanyl-only titration, most patients will require some PRN short-acting opioids to alleviate discomfort during the titration. The prescribing protocol in the BCCSU's *Opioid Use Disorder Practice Update* may be used to support decision making.

Fentanyl Patch Titration for Individuals on OAT

Individuals on OAT who continue to use illicit opioids may be prescribed a fentanyl patch to reduce their reliance on the illicit drug supply. Once a fentanyl patch titration has been initiated, the patient's OAT dose should not be increased until they are stabilized on a fentanyl patch dose for a least 1 week. The OAT dose can be decreased at any time during titration.

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                          ┌─────────────────┐
                          │  Patient on OAT  │
                          └─────────────────┘
                    ↙                           ↘
        ┌──────────────────┐           ┌──────────────────┐
        │    Unknown        │          │   Known high      │
        │    tolerance      │          │   tolerance       │
        └──────────────────┘           └──────────────────┘
                 ↓                              ↓
    ┌────────────────────────┐     ┌────────────────────────┐
    │   May be started at     │    │   May be started at     │
    │       25mcg/hr          │    │       50mcg/hr          │
    │   Adjust dose by 25–     │   │  And increase weekly    │
    │   50mcg/hrafter 2        │   │   dose by 10–20% or     │
    │   patch changes at       │   │       50mcg/hr          │
    │     each dose            │    │ (whichever is higher)   │
    └────────────────────────┘     └────────────────────────┘
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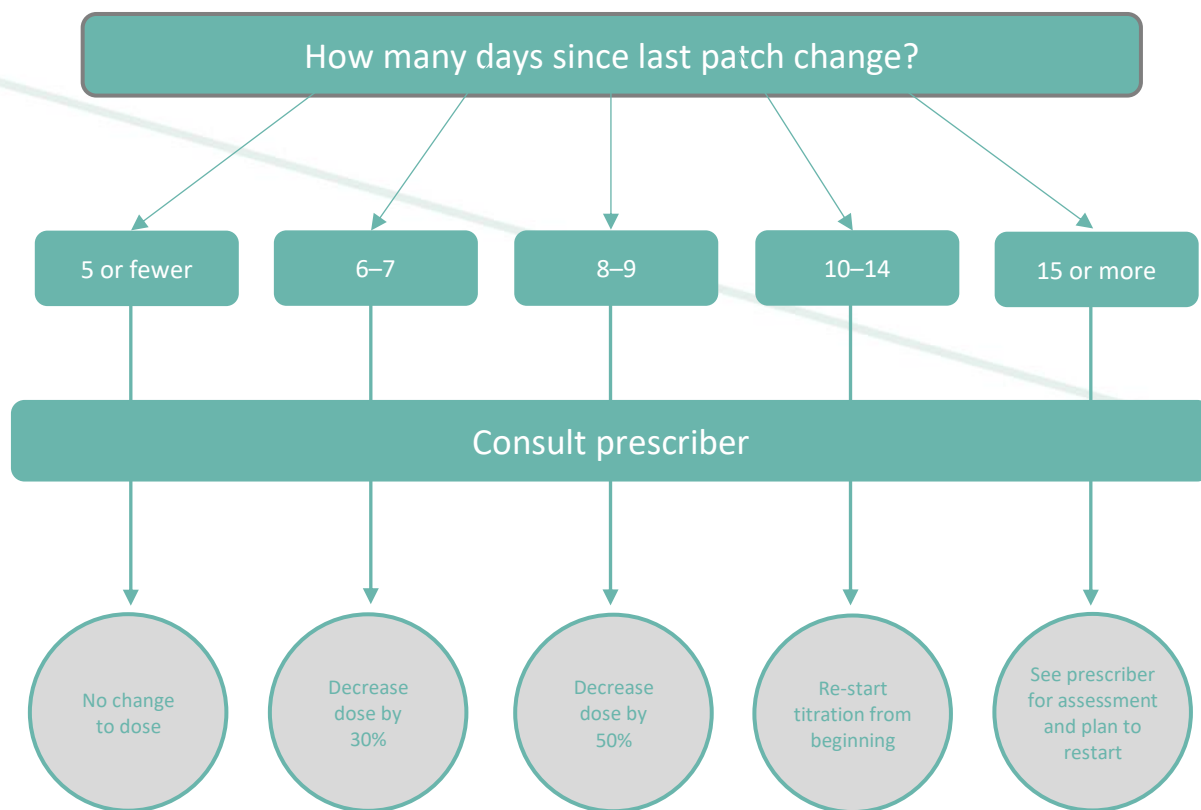## Fentanyl Patch and OAT Co-Prescribing

To avoid mixing long-acting opioids, the goal should generally be to taper the OAT dosage and to stabilize the patient on the fentanyl patch alone. However, in some cases the patient may remain on both the patch and low oral OAT dose.

Writing Prescriptions

Prescribers should clearly include "SA" in the Directions for Use section of the form, below the information for dispensing schedule, delivery site, and date range.

Missed Doses (pg. 33)
Missed Patch Change for Patients on Stable Dose

How many days since last patch change?

- 5 or fewer
- 6–7
- 8–9
- 10–14
- 15 or more

Consult prescriber

- No change to dose
- Decrease dose by 30%
- Decrease dose by 50%
- Re-start titration from beginning
- See prescriber for assessment and plan to restart

Count the days beginning with the first day after a patch change as Day 1. For dose decreases, round up to the nearest 25mcg/hr (e.g., if dose is 175mcg/hr and a 50% dose reduction is required, the patient would receive 100mcg/hr).

For restarts, patients should generally be restarted at 50mcg/hr. However, prescribers may decide on a case-by-case basis to restart at 100 mcg/hr.

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Missed Patch Change During Planned Dose Increase

Days Missed Since Last Patch Change	Action
Less than or equal to 3	Increase dose as planned
4–5	Maintain previous stable dose
6–7	Decrease dose by 30%
8–9	Decrease dose by 50%
10–14	Re-start titration from beginning
Greater than 15	See prescriber for assessment and to discuss plan to restart

Those who have been on a stable dose of the fentanyl patch for at least 4 weeks and have had a dose reduction due to missed doses could be considered for a rapid re-titration. The patient may be restarted at 100mcg/hr, and can be increased by 50 mcg/hr or 10–20% (whichever is greater) at every patch change.

Clinical Considerations Regarding Dosing

The following considerations should be made when adjusting fentanyl patch dosing:

- Client's body composition: those with low body fat may require more frequent patch changes
- Heat: high heat (such as having a fever or hot bath/shower) can affect absorption of drug from patch
- Physical activity: intense physical activity can increase absorption

6. Feedback and support

As the use of the fentanyl patch is not an evidence-based approach, the BCCSU welcomes clinicians to share observations, comments, or issues based on clinical experience. Please email BCCSU Education: bccsu_education@bccsu.ubc.ca.

Clinicians can also call the 24/7 Addiction Medicine Clinician Support Line at **(778) 945-7619** for clinical advice around substance use care and treatment.

For more information on the fentanyl patch program, please click here: https://www.bccsu.ca/clinical-care-guidance/prescribed-safer-supply/fentanyl-patch/