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Slow-release Oral Morphine Guidance

This document provides a high-level overview on the guidance of slow-release oral morphine (SROM) for the treatment of opioid use disorder (OUD). For full guidance please refer to the BC Centre on Substance Use's A Guideline for the Management of Opioid Use Disorder.

ADMINISTRATION

Generally, slow-release oral morphine capsules will be provided whole to be swallowed. If clinically indicated or preferred by the person receiving care, capsules may be opened and the pellets may be sprinkled for immediate ingestion.

INITIATION AND DOSING

Starting dose.

Table 1. Starting doses for SROM based on individuals' opioid tolerance.

Level of tolerance	Suggested starting dose
No/low tolerance | opioid-naïve High risk of toxicity Includes people who have completed withdrawal management, those not currently using opioids but at risk of return to use, individuals with heavy use of other sedating agents, and people with severe comorbidities that affect toxicity risks	50mg/day
Unknown/moderate tolerance Moderate risk of toxicity Includes people who use benzodiazepines or other sedatives (prescribed or unprescribed), people with alcohol use disorder	100–150mg/day
Known high tolerance Lower risk of toxicity Includes Individuals actively using opioids	200mg/day
Known very high tolerance Very low risk of toxicity Characterized specifically by previous SROM experience and current fentanyl use	300mg/day*
*Higher doses may be considered with caution on a case-by-case assessment of risks and benefits; rationale for higher doses should be documented and individual's informed consent should be obtained.	

TITRATION

Dosage increases of up to 100mg should generally be separated by at least 24 hours.

Table 2. Sample SROM titration schedule

Day	SROM dose (moderate tolerance)
1	200mg
2	300mg
3	400mg
4	500mg
5	600mg
6	700mg
7	800mg

There is no defined maximum dose for SROM

- The highest dose described in the literature to date is 1200mg
- However, clinical experience indicates that doses above 1200mg are often required to address the high opioid tolerance of people who use fentanyl
- Use caution with respect to side effects when prescribing higher doses (e.g., above 1200mg) and clearly document the rationale
- Assess for sedation with dose increases

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MISSED DOSES

The dispensing pharmacy is required to cancel the prescription if the individual misses 4 consecutive doses, and notify the prescribing clinician.

Table 3. Suggested protocol for managing missed SROM doses

Consecutive missed once-daily doses	Suggested dose adjustment
1–3	Same dose (no change). Resume without dose reduction
4	Cancel prescription. Assess. Resume at 50% of previous dose or initiation dose (whichever is higher).
5 or more	Cancel prescription. Assess. Restart at initiation dose

Consider a smaller reduction if risk of tolerance loss is low (e.g., those who have continued using other opioids since last SROM dose). Consider a more conservative dose adjustment schedule for individuals who have not used unregulated opioids since their last SROM dose.

TAKE-HOME DOSING

- Consider take-home dosing collaboratively with the person receiving care in consideration of risks and benefits
- Take-home SROM doses should start as individual non-consecutive doses for individuals who meet the take-home dosing criteria
- Additional take-home doses can be offered gradually (e.g., every 2 weeks) to individuals who:
  - Consistently manage previous take-home doses
  - Sustain medication adherence
  - Experience improving clinical and psychosocial stability
- Exercise caution when considering take-home doses for people who are still in the titration phase
- Confirmation that criteria listed below have been met should be clearly documented

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TAKE-HOME DOSING (CONTINUED FROM PREVIOUS PAGE)

Individual criteria for SROM take-home doses

Table 4: Criteria and protocol for SROM take-home doses

Number of take-home doses per week	Minimum time on SROM	Conditions/Criteria
0 (Not a candidate for take-home doses)	-	**Any** of: • Inability to safely store medication • Unstable psychiatric illness or other acute mental health crisis • Frequent missed doses and appointments • Ongoing high-risk or uncontrolled substance use patterns (e.g., causing frequent overdoses, blackouts, or hospitalizations)

1–3
 	
(non-consecutive take-home doses)
	4 weeks	**All** of:
		• Ability to safely store medication
		• Evidence of medication adherence
		• Clinical and psychosocial stability, including:
		  ◦ Ability to keep appointments and manage medication
		  ◦ No acute behavioral or psychiatric issues at point of assessment
		  ◦ No high-risk or uncontrolled substance use patterns that cause frequent overdoses, blackouts, or other severe safety risks

4–6
 	
(consecutive take-home doses)
	12 weeks	**All** of:
		• Consistent medication adherence with rare missed doses and appropriate management of non-consecutive take-home doses
		• Improved clinical and psychosocial stability, including:
		  ◦ Rare missed appointments
		  ◦ Minimal unprescribed unprescribed substance use, in alignment with treatment plan and indivdual goals, with no recent overdoses or blackouts

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TAKE-HOME DOSING (CONTINUED FROM PREVIOUS PAGE)

Monitoring of take-home dosing for slow-release oral morphine

People receiving take-home SROM dosing should be seen at least monthly to assess progress and stability. The following are considerations for follow-up and reassessment:

- Indication of increased use of unregulated opioids and other CNS depressants
- Missed appointments or doses, or repeated reports of lost, spilled, stolen, or vomited doses
- Requests to increase a previously stable dose
- Unable to attend the clinic or lab for UDTs

Signs of instability

- Assess and potentially reduce take-home dosing days or return to daily witnessed ingestion, if appropriate
- Increase clinical appointment frequency and refer to psychosocial treatment and community supports
- If instability persists, explore alternative agonist treatment after discussing with the individual

Evidence of diversion

- Prescribe witnessed doses following a discussion with the person to ensure that the medication is appropriately meeting their needs
- Consider transitioning to another medication in collaboration with the person, if appropriate
- In the case of negative UDT results for OAT, assess loss of tolerance and consider restarting or resuming OAT at a lower dose, as needed, to minimize risk of drug poisoning

URINE DRUG TESTING

Table 5: Suggested urine drug testing frequency

Treatment stage	UDT schedule
Initial confirmatory testing	Performed to confirm unregulated opioid use prior to initiating OAT
SROM	
Initiation, titration, and stabilization	**Monthly** or more or less frequently as required and when clinically indicated. In circumstances where UDT is occurring less than monthly, safety can be increased with daily witnessed ingestion.
Maintenance	When clinically indicated
Take-home doses	**6–8 tests per year** or when there are any safety concerns Frequency of UDT is as required when clinically indicated

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