Oxycodone/naloxone (Targinact®)

The NHS England guidance on items which should not routinely be prescribed in primary care lists products that are regarded as low priority for funding, poor value for money or for which there are safer alternatives (https://www.england.nhs.uk/publication/items-which-should-not-be-routinely-prescribed-in-primary-care-guidance-for-ccgs/). This briefing focuses on oxycodone/naloxone prolonged release (PR) (Targinact®) tablets and provides the rationale for therapy to be stopped, for patients to be switched to alternative agents and for new patients not to be started on Targinact® tablets.

Key recommendations

- Commence new patients requiring strong opioid therapy on morphine sulfate.[1]
- Review all patients on Targinact® for suitability for switching to morphine sulfate modified release (MR). Prescribers should be aware of the difference in potency of oxycodone compared to morphine (morphine dose is 1.5 to 2 times oxycodone dose).[2,3]
- Review all patients that need to be switched to an equivalent daily dose of 120mg oral morphine equivalent. Increasing opioid load above this dose is unlikely to yield further benefits but exposes the patient to increased harm. Consider specialist review.[2]
- For patients on Targinact® who are switched to morphine sulfate MR, prescribe additional concomitant regular laxative therapy, for example a combination of stool-softening and stimulant laxatives (e.g. docusate plus senna or bisacodyl; or co-danthramer in the terminally ill) or lactulose plus bisacodyl or senna in those not terminally ill. Please note it may not be appropriate to switch terminally ill patients.
- Patients on Targinact® unsuitable for a switch to morphine sulfate should be switched to an equivalent dose of oxycodone prolonged release (PR), prescribed as a cost-effective brand, e.g. Longtec®.[4] CCGs should take into account the strengths and manufacturer availability.
- Patients on long term opioid therapy for non-cancer pain should be reviewed regularly to assess whether there is a continued need for treatment with an opioid.[5]
- Prescribers should be aware of the abuse potential of all opioids and give careful consideration when prescribing opioids for non-cancer pain to patients with a history of substance misuse or where abuse is a concern.[5]

Supporting evidence

Targinact® tablets (oxycodone/naloxone prolonged release (PR) tablets) are licensed for severe pain which can be adequately managed only with opioid analgesics. The naloxone component in oxycodone/naloxone PR tablets is intended to counteract opioid-induced constipation. Trials conducted in patients with moderate to severe non-cancer pain have shown no difference in pain control against oxycodone. Targinact® tablets reduced but did not eliminate the need for laxatives. There are no published trials comparing oxycodone/naloxone PR tablets with other oral strong opioids given with regular stool-softening and stimulant laxatives, the recommended laxative regimen.[6,7]

Prescribers should be aware of the differences and dosing requirements of opioid products they are prescribing.

Savings

In England and Wales, almost £45 million pounds is spent annually on oxycodone/naloxone prolonged release products.

Switching Targinact® to morphine sulphate MR (Zomorph® is the least costly product) at an equivalent dose with additional laxatives **could save approximately £3.5 million annually. This is equivalent to £6,058 per year per 100,000 patients**.

Switching to Longtec® at an equivalent dose with additional laxatives **could save £2.8 million annually. This is equivalent to £4,971 per 100,000 patients.**

References

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Additional resources	Bulletin	Implementation resources	https://www.prescqipp.info/our-resources/bulletins/oxycodonenaloxone-targinact/

Contact help@prescqipp.info **with any queries or comments related to the content of this document.**

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