Opioid patches

This project should be used in line with 149 Non-neuropathic pain: https://www.prescqipp.info/our-resources/bulletins/bulletin-149-non-neuropathic-pain/

Recommendations

- Ensure correct prescribing, use and disposal of opioid patches due to the potential for serious adverse events, e.g. respiratory depression in opioid-naïve patients. Only prescribe opioid patches for patients who have previously tolerated opioids.[1] Opioid patches must not be used for acute pain.[2]
- NICE Clinical Guideline (CG) 140 states first-line choice of strong opioid is sustained release (SR) oral morphine, with immediate release oral morphine for breakthrough pain.[3]
- Consider specifying criteria for patients to use opioid patches for pain, e.g. those:
  - Unable to tolerate tablets due to side-effects, or have difficulty swallowing (although oral liquids and subcutaneous morphine may be suitable alternatives instead of a patch).[4]
  - With compliance issues such as mental health problems, or who are socially isolated with limited access to care.[4]
- NICE CG 140 recommends initiating transdermal patches with the lowest acquisition cost for patients in whom oral opioids are not suitable and analgesic requirements are stable, specialist advice should be sought when needed.[3] Ensure stock availability of the branded preparation.
- Prescribe opioid patches by brand name for continuity of supply and to avoid confusion for patients and carers. Fentanyl patches are available as matrix and reservoir formulations. Although neither should be cut, cutting reservoir patches can lead to leaking and overdose. The matrix patch is thinner and smaller than the reservoir patch. Patient familiarity with one brand is important.[2,6]

Supporting evidence

A Midlands Therapeutic Review and Advisory Committee (MTRAC) Commissioning Support bulletin found that evidence for the efficacy of fentanyl transdermal patches in cancer and non-cancer pain was relatively weak. Overall transdermal fentanyl was shown to be as effective as SR morphine and more effective than placebo (although the trial designs made them prone to bias). The cost of transdermal fentanyl compared with oral morphine gives it a low place in therapy.[4]

Another MTRAC Commissioning Support bulletin found that evidence for the efficacy of buprenorphine transdermal patches was also relatively weak. The results showed a considerable placebo effect. The cost of buprenorphine patches compared with oral morphine SR gives it a low place in therapy.[7]

Savings available in suitable patients

Reviewing the appropriateness of all opioid patch therapy, reducing and eventually stopping prescribing of the patches **could save approximately £41.7 million per year in England and Wales (assuming a 50% reduction in prescribing). This equates to over £69,178 per 100,000 patients.**

The additional costs of alternative analgesia for individual patients would vary depending on what treatment the patient was switched to and would be offset by the savings made.

For fentanyl, a switch to patches of lowest acquisition costs **could release savings of up to £8.2 million annually, which equates to £13,546 per 100,000 patients.**

Use of branded patches for buprenorphine **would result in potential savings of £23.3 million annually, which equates to £37,453 per 100,000 patients.**

References

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Additional resources		Bulletin	https://www.prescqipp.info/our-resources/bulletins/bulletin-215-opioid-patches/
		Audit, PIL	
		Data pack	https://pdata.uk/#/views/B215_Opioidpatchesupdate/FrontPage?:iid=1

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