Managing Patients with Over-The-Counter (OTC) Codeine Dependence
Advice for GPs

From February 2018, OTC codeine products will be prescription only. There may be an increase in patients presenting to GPs for treatment of opioid dependence.

Treatment options include GP based slow reductions or acute withdrawals with symptomatic management (see Table 2). Other treatments include psychosocial supports including residential rehabilitation, and opioid pharmacotherapy for acute withdrawal or long term maintenance (buprenorphine and methadone preparations). Patients should not be converted to other opiates.

Some clients with mild opioid use disorder (using less than 300mg total daily dose of codeine phosphate), good social support and no medical or psychiatric comorbidity may be able to reduce their opioid use with GP support, for this group see Option 1 or 2.

Option 1 - Codeine Reduction:

- Undertake initial assessment (see ‘Initial Assessment Includes’ below)
- Calculate total daily dose of codeine consumed, see Table 1
  Note that currently in the NT, codeine phosphate (on prescription) is classified as an unrestricted S8 medication, as such, daily doses of above 240mg or, if prescribing for longer than 8 weeks, must be notified to the CHO (Chief Health Officer) or his or her delegate and cannot be prescribed purely for addiction, they may however be used as a part of a pain management plan.
- Prescribe codeine phosphate tablets commencing at approximately 75% of total daily dose
- Negotiate slow reduction at rate of 10%-25% per week over approximately one to two months
- Scripts should be faxed/emailed directly to pharmacy with client attending for daily pickups – you may need to call your pharmacy to clarify if they accept this arrangement
- Many clients need review to manage emergent anxiety, depression and pain – avoid benzodiazepine use

**DO NOT CONVERT PATIENT TO OTHER OPIATES** – the metabolism of codeine is extremely variable among individuals and conversion to other opiates may result in overdose and will exacerbate any opiate dependency.

Option 2 - Abrupt Withdrawal:

Consider abrupt withdrawal with pharmacological support with symptomatic medications (see Table 2).

*See below for patient groups where this option would not be the recommended pathway in a General Practice setting without specialist advice.

Note: Opioid use disorder is often a chronic relapsing condition requiring the patient engage in long term treatment with the support of specialty services regardless of the type of opioid used.

Option 3: Referral to Addiction Services

See below under ‘Who to Refer’ for patients that should be referred to an addiction service for management of their codeine dependence.
Initial Assessment Includes:

Substance use history and guided examination. Excess consumption of combination OTC products containing paracetamol or nonsteroidal anti-inflammatories may have placed the client at risk of liver disease, gastric bleeding and renal failure. Consider urgent assessment of FBC, UECs, LFTs and screening for blood borne viruses if there is history of IVDU.

Who to refer:

Abrupt withdrawal from opioids is generally uncomplicated in young healthy individuals, and a list of symptomatic medications to support patients wishing to withdraw in a general practice setting is below (see Table 2). In some individuals, detoxification and withdrawal may be medically dangerous and such patients will need management support from specialty services.\(^1\)

AVOID rapid opioid withdrawal and seek specialist advice for the following clients:\(^2\)
- Pregnant women
- Significant medical comorbidity including heart disease, renal impairment, liver disease
- Frail/elderly
- Polysubstance users
- Significant mental illness such as severe depression or psychosis.
- Those using >300mg total daily dose of codeine phosphate.

Other patients who may benefit from being managed by addiction services include patients with:
- High risk behaviors (IVDU, dose diversion, medications not taken as prescribed, dose escalation)
- Chronic pain
- Severe psychiatric illness
- Those with complications from excess paracetamol or ibuprofen intake
- All clients who cannot be withdrawn from codeine over an eight week period
- All clients where dependence is the primary problem

In such clients, a high level of support, supervised dosing and pharmacotherapy (buprenorphine or methadone) may be needed for management of withdrawal and/or as ongoing treatment.\(^3\)

Stabilization and long term maintenance treatment on opioid substitution in those with opioid dependence is effective for reducing opioid use, decreasing mortality \(^3\) and improving quality of life.

Referrals can be made to:
- Darwin- Alcohol and Other Drugs Service (AODS) on 8922 8399
- Alice Springs- Alcohol and other Drugs Services Central Australia (ADSCA) on 8951 7580
- For 24 hour clinical advise phone DACAS on 1800 111 092

Legislative requirements for prescribing opioid pharmacotherapy for the treatment of addiction in the NT

Buprenorphine/naloxone (Suboxone and Subutex) and methadone (Biodone) are indicated for the treatment of opioid dependence. In the NT, GPs may become authorized prescribers once they have completed a credentialing training package, currently provided through TEHS Alcohol and Other Drugs Services, and must then apply to the Chief Health Officer for authorization to supply.

Legislative advice, contract templates, and notifications to the CHO can be sought from the Department of Health Medicines and Poisons Control on 8922 7341 or by visiting their website at https://health.nt.gov.au/professionals/environmental-health/medical-practitioners-schedule-8-medicines.
Common Names of OTC Preparations | Codeine Phosphate Dose Per Tablet/Capsule
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Mersyndol® | 9.75mg
Nurofen plus® | 12.8mg
Panadeine Extra® | 15mg
Panadeine® | 8mg

Table 1. Codeine content of common OTC preparations

Possible Symptomatic Medications for Opioid Withdrawal

Please consider your individual patient needs

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Drug Name</th>
<th>Dosage</th>
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<tbody>
<tr>
<td>Diarrhoea</td>
<td>Loperamide (e.g. Imodium)</td>
<td>4mg stat, then 2mg PRN after each loose bowel motion (maximum 16mg in 24hrs)</td>
</tr>
<tr>
<td>Joint Pain, Cramps</td>
<td>Ibuprofen (e.g Nurofen)</td>
<td>200-400mg PRN with Food (maximum 1200mg in 24hrs)</td>
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</tbody>
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| Pain, Cramps           | Paracetamol (e.g. Panadol) | 1000mg every 6-8hrs PRN (maximum 4000mg in 24hrs)
Dependent upon liver function |
| Stomach Cramps         | Hyoscine butylbromide (e.g Buscopan) | 10-20mg 3-4 times daily PRN (maximum 80mg in 24 hrs)          |
| Insomnia, Agitation    | Temazepam (e.g Temaze) or other benzodiazepine | Low dose short term (ie. Temazepam 10mg at night for three to five nights) |
| Nausea, Vomiting       | Metoclopramide (e.g. Maxolon) | 10mg TDS PRN                                                  |

Table 2. Symptomatic medications for opioid withdrawal

References and Further Information

