MONOGRAPH

Oxycodone

Scope (Staff):	Medical, Pharmacy, Nursing
Scope (Area):	All Clinical Areas

Child Safe Organisation Statement of Commitment

CAHS commits to being a child safe organisation by applying the National Principles for Child Safe Organisations. This is a commitment to a strong culture supported by robust policies and procedures to reduce the likelihood of harm to children and young people.

This document should be read in conjunction with this DISCLAIMER

⚠ HIGH RISK MEDICINE ⚠

QUICKLINKS

Dosage/Dosage Adjustments	Administration	Compatibility	Monitoring

DRUG CLASS

Opioid analgesic[1]

Oxycodone is a High Risk Medicine.

INDICATIONS AND RESTRICTIONS

- Acute and chronic pain[1]

Oxycodone is restricted to children aged 6 months and above, unless used in the Paediatric Critical Care (PCC) unit or in consultation with the Acute Pain Service (APS) or an Oncologist (for oncology/haematology patients).

Refer to Formulary One for more information.

CONTRAINDICATIONS

- Hypersensitivity to oxycodone or any component of the formulation.[2]
- Acute or severe asthma in an unmonitored setting[2]
- Hypercarbia[2]
- GI obstruction[2]

PRECAUTIONS

- May cause respiratory and central nervous system (CNS) depression and sedation. Monitor closely initially[1]
- Obstructive sleep apnoea – can potentiate respiratory depression effect. Titrate if needed and monitor closely[2]
- Biliary tract disease (including pancreatitis) – may cause spasm of sphincter of Oddi. Use with caution[1]
- Endocrine disorders (such as adrenal insufficiency and hypothyroidism) – dose titration required[1]
- Opioid induced constipation may occur[3]
    - Chart regular prophylactic oral aperients for all patients receiving regular opioids (unless contraindicated)[3] and monitor bowel function.
    - Consider osmotic laxatives as first line treatment[3]
    - If ineffective/unsuitable consider stool softeners and/or stimulant laxatives[3]

FORMULATIONS

Listed below are products available at PCH, other formulations may be available, check with pharmacy if required:

Immediate release products:

- Liquid: 1 mg/mL
    - 5 mL pods are used in inpatient areas.
    - Prescribe 10 mL, 20 mL or 50 mL repacks for discharge scripts where possible.
- Tablets: 5 mg
- Capsules: 5 mg and 10 mg

Controlled release products:

- Tablets: 5 mg, 10 mg, 20 mg and 40 mg
- Targin® (oxycodone/naloxone): 2.5 mg/1.25 mg, 5 mg/2.5 mg, 10 mg/5 mg, 20 mg/10 mg and 40 mg/20 mg

Imprest location: Formulary One

DOSAGE & DOSAGE ADJUSTMENTS

Neonates: Refer to Neonatal Medication Protocols

Dosing in Overweight and Obese Children: Calculate dose based on Adjusted Body Weight

Renal impairment:

- eGFR calculator
- Oxycodone clearance may be reduced in renal impairment. Consider dose reduction.[2, 4]

Hepatic impairment:

- Avoid or reduce dose in severe impairment.[1, 2, 4]

The below doses are for opioid naïve patients.[5] Oxycodone should be titrated according to the patient's clinical response.[5]

Oral:

Immediate Release:

- Moderate to severe pain:
  - < 6 months: Contact the Acute Pain Service or a Consultant Oncologist for dosing advice.
  - 6 – 12 months: 0.05 – 0.1 mg/kg every 4 hours
  - > 1 year: 0.1 – 0.2 mg/kg every 4 hours[5]
    - Initial dose range is 5 – 10 mg per dose[4]
    - More frequent dosing than 4 hourly must be written under the direction of APS, Palliative Care or an Oncology Consultant only. A clear escalation plan is also required and must be documented on the medication chart.
- Severe pain post tonsillectomy for obstructive sleep apnoea:
  - 1 – 18 years: 0.05 – 0.1 mg/kg (maximum 5 mg) **every 6 hours** when required[6]
    - An appropriate dose must be determined by a consultant anaesthetist based on a patient's individual clinical assessment.[6]
    - Further oxycodone doses and discharge supply are contingent on the patient safely tolerating a "test dose" in hospital (see monitoring).[6]
    - Discharge prescriptions are restricted to a supply of 10 – 15 doses (or close to) only, based on the available 10 mL, 20 mL and 50 mL liquid repacks required.
      - Tonsillotomy patients have a shorter pain course and 6 – 10 doses are recommended.[6]

Controlled Release:

- Contact the Acute Pain Service, the Complex Pain Service or a Consultant Oncologist to facilitate the conversion from oral or parenteral opioids to controlled release products.

ADMINISTRATION

- Immediate release: Tablets can be crushed.[1]
- Controlled release: Tablets must be swallowed whole with water – do not break, crush or chew.[1]
    - OxyContin® tablets swell and become highly viscous when wet; they are not suitable for children who are unable to swallow tablets quickly with adequate water (risk of choking)[5]
    - Oxycodone controlled release tablets reach a peak plasma level 4 – 5 hours post administration[7]
    - Targin® tablets reach a peak plasma level 3 – 4 hours post administration.[8]

MONITORING

- Sedation scores (UMSS – University of Michigan Sedation Scale)[2]
- Respiratory rate and effort[2]
- Oxygen saturation[2]
- Heart rate[2]
- Pain intensity scores[2]

Record baseline vital signs pre-administration and hourly for two hours post first dose.

- Following the initial dose, patients should be regularly monitored and assessed for maintenance of pain control and development of adverse reactions.[2]

Pre-discharge dose:

- Although all patients receiving oxycodone for discharge are encouraged to receive a test dose in hospital, exclusion may apply to certain children who are comfortable post-surgery where opioid pain relief is not required because of an ongoing effective regional analgesia (e.g. caudal or penile nerve block for circumcision or hypospadias repair).[6] For these patients, it is at the discretion of the prescriber as to whether they can have their 1st dose of oxycodone at home.[6] These patients should be generally healthy, without significant cardio-respiratory disease, serious co-morbidities or oxygen requirement.[6]
- Emergency Department patients receiving oxycodone on discharge should receive a test dose 1 – 2 hours before discharging from ED unless approved by an ED consultant as per the PCH Analgesia Emergency Department guideline.

Post Tonsillectomy/ Adenotonsillectomy Patients:

Refer to Clinical Practice Manual: Tonsillectomy and Adeno-tonsillectomy: Postoperative Management

ADVERSE EFFECTS

Common: Nausea, vomiting, constipation, drowsiness, dizziness, headache, orthostatic hypotension, itch, dry mouth, miosis, urinary retention[1]

Infrequent: Bronchospasm, confusion, hallucinations, delirium, agitation, mood changes, tremor, visual disturbances, urticaria, hypothermia, bradycardia or tachycardia, hypertension, biliary spasm, ileus, raised liver enzymes, muscle rigidity, flushing[1]

Rare: Syndrome of inappropriate antidiuretic hormone secretion (SIADH), anaphylaxis, seizure[1]

Management of Opioid Induced Itch/Pruritis or Reversal of an Opioid Overdose:

Refer to Opioid Infusion Management in General Wards

STORAGE

Oxycodone is a Schedule 8 medication and must be stored securely in automated dispensing machines (ADMs).

- Tablets, capsules, liquid: Store below 25°C. Protect from light and moisture.[9]

INTERACTIONS

This medication may interact with other medications; consult PCH approved references (e.g. Clinical Pharmacology), a clinical pharmacist or PCH Medicines Information Service on extension 63546 for more information.

Please note: The information contained in this guideline is to assist with the preparation and administration of **Oxycodone**. Any variations to the doses recommended should be clarified with the prescriber prior to administration

Related CAHS internal policies, procedures and guidelines
High Risk Medicines
Opioid Infusion Management in General Wards
Schedule 8 and Restricted Schedule 4 Medication
Tonsillectomy and Adeno-tonsillectomy: Postoperative Management

References

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