Suggestions for how to time the switch between opioid formulations and/or routes of administration in palliative care

Note: The advice in this table is guidance only—individuals vary markedly in their response to different opioids, and different routes of administration have different bioavailability; frequent review is necessary. Seek expert advice when switching opioids in patients taking more than 100 mg oral morphine (or equivalent) in 24 hours.

Ensure all patients have adequate immediate-release opioids available as required for breakthrough symptoms.

CHANGING TO: / CHANGING FROM:	transdermal buprenorphine	transdermal fentanyl	twice-daily modified-release opioid	once-daily modified-release opioid	continuous subcutaneous opioid infusion
transdermal buprenorphine	—	Apply fentanyl patch 24 hours after removing buprenorphine patch	Give first dose 24 hours after removing patch	Give first dose 24 hours after removing patch	Start infusion 12 to 18 hours after removing patch [NB1]
transdermal fentanyl	[NB2]	—	Give first dose 8 to 12 hours after removing patch	Give first dose 4 to 8 hours after removing patch	Start infusion 6 to 8 hours after removing patch [NB1]
twice-daily modified-release opioid	[NB2]	Apply patch at the same time as last dose	Give first dose 12 hours after last dose [NB3]	Give first dose 12 hours after last dose	If pain is well controlled, start infusion 2 to 4 hours before the next opioid dose would have been given If pain is not controlled, infusion may need to be started earlier; seek specialist palliative care advice
once-daily modified-release opioid	[NB2]	Apply patch 18 hours after last dose	Give first dose 24 hours after last dose	Give first dose 24 hours after last dose [NB3]	
continuous subcutaneous opioid infusion	Apply patch and stop infusion 12 to 18 hours later [NB4]	Apply patch and stop infusion 6 to 8 hours later	Give first oral dose and stop infusion 2 to 4 hours later	Give first oral dose and stop infusion 4 to 6 hours later	—

NB1: In the last days of life, to avoid potentially inaccurate dose conversion, continue transdermal patches; additional analgesic therapy can be administered subcutaneously, as required.

NB2: Advice not given because in practice this change is unlikely. Seek specialist palliative care advice.

NB3: This advice is for changing to a different opioid or a different brand of the same opioid.

NB4: It takes up to 3 days for buprenorphine to reach steady-state concentration.