NARCOTIC SUMMARY TABLE

Drug	Common Doses	Notes
Immediate-Release	Start low in opiate-naïve patients.	
Codeine	15-60 mg PO Q 4-6 hrs PRN.	Acetaminophen is often the limiting dosing factor. Low potency. Relatively high incidence of itching and nausea. Up to 10% of Caucasians lack the enzyme to activate.
Fentanyl IR (ABSTRAL, ACTIQ, FENTORA, LAZANDA, ONSOLIS, SUBSYS, GENERIC)	Oral or nasal transmucosal: Start with lowest dose, titrating up as needed. 50-100 mcg IV/IM Q 1-2 hrs PRN.	Multiple transmucosal forms (SL/buccal strip, tab, lozenge, oral spray, nasal spray). Even generics are expensive. Various formulations are not directly interchangeable. Do not cut/chew/crush/swallow. High equianalgesic potency; do not use in opiate-naïve patients.
Hydrocodone (LORTAB, VICODIN)	5-10 mg PO Q 4 hrs PRN.	A good first choice for breakthrough pain, if the acetaminophen or ibuprofen components are not limiting.
Hydromorphone (DILAUDID, GENERIC)	2-8 mg PO Q 3-4 hrs PRN. 3 mg rectally Q 6-8 hrs PRN. 1-4 mg SC/IV/IM Q 4-6 hrs PRN.	Sometimes effective when analgesia from other narcotics has waned. Acceptable with renal disease, but reduce dose 50-75% in moderate-severe CRF. High equianalgesic potency.
Levorphanol (LEVO-DROMORAN, GENERIC)	2-4 mg PO Q 6-8 hrs PRN. Parenteral form available in some countries.	Very long half-life of 16-18 hrs, despite the need for dosing Q 6-8 hrs. Incomplete cross-tolerance with other opiates; use a very conservative interpretation of equianalgesic tables. Risk of accumulation; wait 72 hrs between dosage increases.
Methadone	2.5-10 mg PO Q 8-12 hrs PRN. 2.5-5 mg SC/IV Q 8-12 hrs PRN.	Very long, variable half-life; better used as maintenance drug rather than a breakthrough med. See discussion under ER meds below.
Morphine IR (GENERIC)	10-30 mg PO/SL Q 3-4 hrs PRN. 10-20 mg Q 4 hr rectally PRN. 2.5-10 mg SC/IV Q 2-6 hrs PRN.	Be careful not to confuse with the extended-release formulation when prescribing. Caution in severe renal failure; accumulation of metabolites can cause agitation, delirium.
Oxycodone IR (ROXICODONE, GENERIC) Oxycodone IR tamper-resistant (Oxecta)	5-30 mg PO Q 4 hrs PRN.	A good choice for breakthrough pain, particularly when there is a need to avoid acetaminophen. Be careful not to confuse with the extended-release formulation when prescribing.
Oxycodone IR/acetaminophen or NSAID or ASA combinations (TYLOX, PERCOCET, others, GENERIC)	5-30 mg hydrocodone PO Q 4 hrs PRN.	Acetaminophen/NSAID often becomes the dose-limiting factor. Be careful not to confuse with extended-release formulations when prescribing.
Oxymorphone IR (OPANA, GENERIC)	10-20 mg PO Q 4-6 hrs PRN. 1-1.5 mg SC/IM Q 4-6 hrs PRN. 0.5 mg IV Q 4-6 hrs PRN.	Expensive, even as generic—though may be Alabama Medicaid-covered. Give PO doses 1 hr before or 2 hours after meals. High equianalgesic potency.
Tapentadol (NUCYNTA)	50-100 mg PO Q 4-6 hrs PRN.	Weak mu agonist/norepinephrine reuptake inhibitor. Weaker than morphine, perhaps fewer GI effects, same CNS effects.
Tramadol (ULTRAM)	50-100 mg PO QID PRN.	Central opioid agonist/SNRI. A good initial choice for mild pain. Lowers seizure threshold.

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Extended-Release	Base initial dosing on equianalgesic conversion table.	
Fentanyl Transdermal (DURAGESIC, GENERIC)	Individualize dosage, based on equianalgesic conversion table. Replace patch Q 72 hrs.	Titrate slowly. Analgesia reaches peak 12 hrs after application; may persist 12-24 hrs after removal. High equianalgesic potency; do not use in opiate-naïve patients.
Hydromorphone ER (EXALGO)	8-64 mg PO Q 24 hrs, based on equianalgesic conversion table.	Very expensive. Sometimes effective when analgesia from other narcotics has waned. Acceptable with renal disease, but reduce dose 50-75% in moderate-severe CRF. High equianalgesic potency; do not use in opiate-naïve patients.
Levorphanol (LEVO-DROMORAN, GENERIC ER)	2-4 mg PO Q 6-8 hrs PRN. Parenteral form available in some countries.	Very long half-life of 16-18 hrs, despite the need for dosing Q 6-8 hrs. Incomplete cross-tolerance with other opiates; use a very conservative interpretation of equianalgesic tables. Risk of accumulation; wait 72 hrs between dosage increases. Q 6-8 hr dosing makes it most commonly used as a breakthrough med, though may be useful as maintenance drug in some patients.
Methadone	2.5-10 mg PO Q 8-12 hrs. 2.5-5 mg SC/IV Q 8-12 hrs.	Very long, variable half-life. Titrate very slowly to effect; it may take 3-5 days to achieve full analgesic effect. Peak sedation and respiratory depressant effects may occur later than peak pain effect; always write "hold for sedation." Incomplete cross-tolerance with other opiates; use a very conservative interpretation of equianalgesic tables. Relatively safe with renal disease.
Morphine ER Twice-Daily (MS CONTIN, GENERIC ER)	15-30 mg PO Q 12 hrs.	There are once-daily and sprinkle versions, but they are branded, more expensive. Caution in severe renal failure; accumulation of metabolites can cause agitation, delirium.
Morphine ER Once-Daily (KADIAN, AVINZA)	See brands for cap sizes/dosing. Can try once-daily dosing, though still may need twice daily. Unlike regular morphine, there are brand-specific maximal doses. May open cap & sprinkle, but do not crush/chew/dissolve.	Combination of immediate & delayed-release. Very expensive. Caution in severe renal failure; accumulation of metabolites can cause agitation, delirium.
Morphine ER/Naltrexone tamper-resistant (EMBEDA)	Individualize based on equianalgesic conversion table. Q 24 hrs, to Q 12 hrs if necessary. May open cap & sprinkle, but do not crush/chew/dissolve.	Naltrexone passes through gut unabsorbed if taken correctly; if abuse attempted by crushing/dissolving, it at least partially blocks euphoria from morphine. Expensive.
Oxycodone ER (OXYCONTIN)	10-80 mg PO Q 12 hrs.	A commonly used, first-choice maintenance medicine.
Oxymorphone ER (OPANA ER, GENERIC ER)	5-40 mg PO Q 12 hrs.	Expensive, even as generic. Give PO doses 1 hr before or 2 hours after meals. High equianalgesic potency.
Tapentadol ER (NUCYNTA ER)	Start at 50 mg PO Q 12 hrs; may increase by 50 mg every 3 days, up to 500 mg/day. Do not crush/chew/dissolve.	Weak mu agonist/norepinephrine reuptake inhibitor. Weaker than morphine, perhaps fewer GI effects, same CNS effects.
Tramadol ER (ULTRAM ER, GENERIC ER)	100-300 mg/day.	Expensive, even as generic. Low potency, so probably not a practical maintenance choice in most chronic pain settings.