

# Clinical Resource Guide: Morphine Shortage Guidance

## INTRODUCTION

The United States is currently experiencing a national shortage of both immediate-release and sustained-release morphine formulations, as reported by the American Society of Health-System Pharmacists (ASHP). According to the ASHP Drug Shortages List, these shortages are due primarily to manufacturing delays and increased demand, with backorders for morphine sustained-release and immediate-release products **projected to persist through at least the third quarter of 2025**. This situation is consistent with prior analyses showing that opioid shortages, particularly for generic and injectable formulations, are often prolonged and can significantly disrupt patient care.

Given these constraints, clinicians are advised to consider alternative opioids for pain management in hospice and palliative care settings. The United States Centers for Disease Control and Prevention (CDC) and the American Academy of Pain Medicine recommend the following principles for opioid rotation and dose conversion:

1. Equianalgesic conversions are estimates and do not account for individual variability in genetics, pharmacokinetics, or incomplete cross-tolerance. When switching opioids, always reduce the calculated equianalgesic dose by 25–50% to minimize overdose risk, especially in frail or elderly patients, or those with organ dysfunction.
2. The CDC provides the following conversion factors to morphine milligram equivalents (MME): hydromorphone (4;1), oxycodone (1.5:1), hydrocodone (1:1). Please see the Transdermal Fentanyl and Methadone Clinical Resource Guides for additional guidance on transitioning from morphine to these agents.

Below is a table summarizing commonly prescribed bulk medications in hospice, their typical use, and the most common commercially available quantity:

MORPHINE SR THERAPEUTIC INTERCHANGE CONSIDERATIONS				
	Morphine SR 15mg q24h (15mg/day)	Morphine SR 15mg q12h (30mg/day)	Morphine SR 15mg q8h (45mg/day)	Morphine SR 15mg q6h (60mg/day)
Methadone	2.5mg po/SL q8-12h (AAHPM 2019 Guidance)			
Fentanyl Patch	Not appropriate*			25mcg/hr
Oxycodone SR	N/A	10mg q12h	15mg q12h	20mg q12h

#- from American Association of Hospice and Palliative Medicine (AAHPM) 2019 Expert Consensus Guidance

\*- Contraindicated in patients with morphine equivalent daily dose less of 60mg or less

§- Oxycodone SR cost is often > 10x more than morphine or methadone equivalent

### THE FIVE-STEP APPROACH TO OPIOID CONVERSION

<b>Step 1</b>	Complete a comprehensive pain assessment to determine status of pain, and to review proposed pathophysiology of pain to help guide opioid rotation selection
<b>Step 2</b>	Calculate the total daily usage of the current opioid. This should include all long-acting and breakthrough opioid doses.
<b>Step 3</b>	Decide which opioid analgesic to transition to and refer to the opioid conversion table adopted by agency to determine dose of new opioid to initiate
<b>Step 4</b>	Individualize dose based on assessment information gathered in Step 1 and ensure adequate access to breakthrough medication
<b>Step 5</b>	Determine monitoring plan to assess safety, efficacy and tolerability of newly initiated opioid regimen and make adjustment to therapy as appropriate.

### Additional Opioid Resources from BetterRX:

1. [Methadone Clinical Guide](#)
2. [Methadone Patient Information Guide](#)
3. [Fentanyl Patch Clinical Resource Guide](#)
4. [Oxycontin Clinical Guide](#)
5. [Opioid Conversion Consideration Guide](#)

## REFERENCES

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