Issue date
29 November 2022

Distributed to:
Chief Executives
Directors of Clinical Governance
Director, Regulation and Compliance Unit

Action required by:
Chief Executives
Directors of Clinical Governance

We recommend you also inform:
Directors, Managers and Staff of:

- Palliative Care
- Pain Services
- Renal & Dialysis
- Oncology
- Emergency
- Alcohol and Other Drugs Services

Drug and Therapeutics Committees
Other relevant clinicians, departments and committees.

Expert Reference Group

Content reviewed by:
Medication Safety Expert Advisory Committee

Representatives from:
ACI Palliative Care and End of Life Network
ACI Renal Network
ACI Pain Management Network

Clinical Excellence Commission
Tel: 02 9269 5500
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Intranet

Review date
November 2023

Discontinuation of Jurnista® (HYDROmorphone hydrochloride) modified release tablets in Australia

Situation

All strengths of Jurnista (HYDROmorphone hydrochloride) modified release tablets will be discontinued from **30 April 2023**. Currently there are no other brands of modified release HYDROmorphone tablets listed on the Australian Register of Therapeutic Goods (ARTG). HYDROmorphone immediate-release oral liquid (Dilaudid) was discontinued in April 2021. Immediate release tablet and injectable formulations continue to be available.

Background

HYDROmorphone is a potent opioid (**5 to 7 times more potent than morphine**) used to treat severe, acute or chronic pain in patients for whom other treatment options have failed, are contraindicated, not tolerated or otherwise inappropriate to provide sufficient management of pain.

Assessment

As direct alternatives to Jurnista are not available, patients currently prescribed Jurnista will need to be switched to an alternative medicine(s). Switching patients between opioids can be complex, and care must be taken to avoid patient harm (overdose) or inadequate pain control (underdose).

Recommendations

- Avoid initiating any further patients on Jurnista.
- Clinicians and governance committees should review local protocols and guidelines, and remove reference to the availability of modified release HYDROmorphone tablets.
- Clinicians should review all patients currently being treated with Jurnista as soon as possible, and begin discussions with patients/carers about the need to switch to alternate medicines for ongoing management of pain. Clinicians should utilise this opportunity to review their patient's ongoing requirements for opioids.
- To ensure the most appropriate alternative is selected, clinicians should carefully consider individual patient factors (e.g., renal function), and seek expert advice if required.
- Opioid conversion tools (e.g., ANZCA Opioid Calculator, eviQ Conversion Calculator) should be used to guide switching and to determine a suitable starting dose. Specialist advice should be sought if there is limited experience with opioid conversions.
    - Alternative opioids should be commenced at a lower dose than the equianalgesic dose and then titrated to effect.
    - Close monitoring is required until the patient is stabilised on their alternative treatment regimen.
    - Resources for chronic pain (for clinicians and consumers) developed by the ACI Pain Management Network can be found here.
- Clearly communicate changes to patient's medications in medical records, and ensure that this is handed over appropriately especially at transitions of care. Provide written information to patients including dosing and advice on management of adverse effects (see CEC factsheet).
- Governance committees should liaise with local eMeds/ICT teams to review and modify available order sentences in eMM systems.

PTO

Required actions for the Local Health Districts/Networks

1. Distribute this Safety Notice to all relevant clinicians and clinical departments where Jurnista is prescribed, stored and administered, and include this Safety Notice in relevant handovers and safety huddles.
2. Undertake a local risk assessment, and develop strategies to manage the discontinuation of Jurnista which integrate the recommendations provided in this Safety Notice.
3. Ensure a system is in place to document actions taken in response to this Safety Notice.
4. Confirm receipt and distribution of this Safety Notice within **72 hours** to:
   CEC-MedicationSafety@health.nsw.gov.au