

**FAST FACTS AND CONCEPTS #70**  
**PRN RANGE ANALGESIC ORDERS**  
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**Introduction** Use of PRN opioid orders with a wide dose range (e.g. ‘morphine 2-8 mg IV q2h PRN’) is a practice designed to provide flexibility in dosing to meet an individual’s unique and changing needs. However, such orders can be a common source of error due to unsafe interpretation. A dose range should be at least 2 times but generally no larger than 4 times, the smallest dose. It is critical that physicians, nurses, and pharmacists share a common understanding of how to properly write, interpret, and carry out PRN range orders.

**Considerations for writing and interpreting PRN range opioid orders:**

- **Avoid therapeutic duplication consisting of more than one type of PRN opioid by the same route.** If PRN opioids from different routes are ordered, give clear indication for use (i.e., use oral route unless patient is NPO or vomiting, use IV route prior to dressing change)
- **Avoid prescribing a dose based on pain ratings.** While severe pain may require more aggressive analgesic treatment a nonlinear relationship has been demonstrated between opioid dose and the visual analog scale. There is high variability in individual responses to opioid doses.
- **Reasonable range.** A range order should be large enough to provide options for dose titration, but small enough to ensure safety. The maximum allowable difference for analgesic dose range orders should be no more than four times the lowest dose (eg. four times 2 mg is 8 mg).
- **Patient’s prior drug exposure.** If the patient is opioid-naïve, the first dose administered should be the lowest dose in the range; if the patient is opioid tolerant or has received a recent dose with inadequate pain relief and tolerable side effects, utilize a dose on the higher end of the range.
- **Prior response.** Inquire about this patient’s response to previous doses. How much relief did prior doses provide, and how long did it last? Did the patient experience side effects?
- **Age.** For very young or elderly patients, *start low and go slow*.
- **Liver and renal function.** If your patient has hepatic or renal insufficiency, anticipate a more pronounced peak effect and a longer duration of action.
- **Pain severity.** As a general rule, for moderate to severe pain increase the dose by 50-100%; do not increase by >100% at any time. To “fine-tune” the dose once pain is at a mild level, increase or decrease by 25%.
- **Anticipated pain duration.** Is the pain acute, chronic, or progressive (likely to worsen)? In other words, is the patient likely to require more or less analgesic over time?
- **Kinetics.** Know the onset, peak, and duration of action for the specific drug ordered. Unlike scheduled long-acting opioid formulations, doses of short-acting opioids can be increased at each specified dosing interval,
- **Co-morbidities.** Debilitated patients, or those with respiratory insufficiency, may be at more risk for hypoxia.
- **Use of other sedating drugs.** When other CNS depressants are administered in combination with opioids, the dose of each medication required to achieve the desired effect may be 30-50% less than if either drug was administered alone.
- **Combination drugs.** Limit doses of combination drugs: opioids with acetaminophen or an NSAID. Average adults should not receive more than 4000 mg of acetaminophen in 24 hours. If substantial upward dose titration is required or anticipated, use opioid-only preparations.
- **Avoid administration of a partial dose.** Partial doses at more frequent intervals may result in ineffective pain relief and create time delays in the ability to administer a full dose within the allowed range (i.e. giving oxycodone 5mg every hour when the order reads 5-15mg every 3 hours).

**Example:** Opioid naïve patient arrives with the order ‘Morphine sulfate 2-6 mg IV every 2h PRN pain.’ Give 2 mg for first dose. Reassess within 30 minutes. If adequate relief, reassess within next 2 hours. If no side effects but inadequate relief – may give 4 mg more in 30 minutes or when time to peak effect has passed from first dose. Total dose therefore is 6 mg in a 2-hour period.

**Document patient response to PRN dosing:**

- Reassess pain relief, side effects and adverse events produced by treatment, and the impact of pain and treatment effects on patient function, once sufficient time has elapsed to reach peak effect: 15-30 minutes after parenteral drug therapy or 1 hour after oral administration of a PRN analgesic or non-pharmacologic intervention.
- Reassessments may be done less frequently for patients with chronic stable pain or for patients who have exhibited good pain control without side effects after 24 hours of stable therapy.

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