



# Shortage of Acetaminophen with Oxycodone or Codeine

For the current status of drug shortages and discontinuations, refer to Drug Shortages Canada at [www.drugshortagescanada.ca](http://www.drugshortagescanada.ca).

This document specifically addresses the shortages of acetaminophen with oxycodone or codeine; we are aware that several opioid products are currently unavailable and that this situation will have a significant impact on patient care. Some guidance is provided here on switching between opioids to help patients who are currently managing their pain with one of the affected products.

## Indications for acetaminophen with oxycodone or codeine:

- Treatment of acute or chronic pain

## Management Options

- Avoid starting patients on acetaminophen with oxycodone or codeine while the shortage persists. For common acute pain conditions, including back and neck pain, sprains, dental extractions, kidney stones, and headaches, nonopioids are at least as effective as opioids.<sup>1,2,3,4</sup>
- Encourage patients to contact their pharmacy or health-care provider in advance of depleting their current supply.
- The information presented here is generalized, and patients should be evaluated on an individual basis with appropriate clinical monitoring and consideration of drug coverage options.

Physical dependence is common with the chronic use of opioids. Do not abruptly discontinue chronic use; taper slowly or switch to another opioid.<sup>5</sup> When switching opioids, morphine equivalents are used for conversion (see Table 1). To reduce the risk of overdose, convert to a lower dose of the new opioid using the following measures:<sup>5</sup>

- If the current dose is high, give 50% or less of the new opioid converted to morphine equivalents. Otherwise, start with 60–75% of the previous dose converted to morphine equivalents.
- For treatment of chronic noncancer pain, maximum doses should be less than 90 mg morphine equivalents daily.
- For conversion to transdermal fentanyl, refer to the product monograph for a conversion table and guidelines.
- Use extreme caution when switching from opioids to methadone due to a high risk of overdose, even in patients who are considered opioid tolerant.
- Partial agonist and agonist-antagonist agents such as pentazocine can induce withdrawal in people who take opioids regularly.

For patients living with chronic noncancer pain without opioid-use disorder, a trial of slow dose reductions, in combination with cognitive behavioural therapy, if possible, could be discussed; however, evidence suggests potential harm in patients who are not interested in reducing or stopping opioids.<sup>6,7</sup>



TABLE 1: **Approximate Analgesic Equivalents**<sup>5,a,b</sup>

Drug	Oral Dosage	Parenteral Dosage
<b>Agonists</b>		
Codeine	200 mg	120 mg
Fentanyl <sup>c</sup>	N/A	0.1 mg
Hydromorphone	6 mg	2 mg
Meperidine	300 mg	75 mg
Morphine	Single or intermittent dosing: 60 mg Around-the-clock dosing: 30 mg	10 mg
Oxycodone	15–20 mg	N/A
Tapentadol	100 mg	N/A <sup>d</sup>
Tramadol	180 mg <sup>e</sup>	N/A <sup>d</sup>
<b>Agonist-Antagonists</b>		
Buprenorphine	N/A <sup>f</sup>	N/A <sup>f</sup>
Butorphanol	N/A	2 mg
Nalbuphine	N/A	10 mg
Pentazocine	180 mg	60 mg

- Compared to morphine 10 mg IM.
- From single-dose studies using immediate-release dosage forms. These approximate analgesic equivalences should be used only as a guide for estimating equivalent doses when switching from one opioid to another. Additional references should be consulted to verify appropriate dosing of individual agents.
- For initial dosing of fentanyl transdermal patches in patients currently receiving other opioids, consult specific dosing conversion tables in the product monograph.
- Analgesic potency relative to morphine is not established. Consult the product monograph for dosing recommendations.
- Maximum tramadol daily dose is 300–400 mg. Conversion ratio may be unreliable due to genetic polymorphisms and drug interactions.
- Consult the product monograph for dosing and other prescribing information. Partial agonists such as buprenorphine cannot be substituted for full agonists, since a withdrawal syndrome may occur.

The information presented here is designed to assist health professionals in managing a drug shortage and in selecting alternative products for patients already receiving a specific treatment. It is not a comprehensive review or a clinical practice guideline for this condition. Patient assessment requires professional knowledge and judgment beyond the scope of this document. Consult CPS Full Access or other references if required.



## References

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7. McMaster University (2024). *2024 Canadian opioid prescribing guideline* [PDF file]. Available from: <https://npc.healthsci.mcmaster.ca/wp-content/uploads/2024/06/2024-Opioid-Prescribing-Guideline-Web.pdf>.