General Guidance Document for Prescribing, Dosing, and Titration of Medicinal Cannabis for Health Care Professionals (HCPs)

By The Australian and New Zealand College of Cannabinoid Practitioners (ANZCCP)

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Introduction

The Australian and New Zealand College of Cannabinoid Practitioners (ANZCCP) is committed to providing healthcare professionals with the necessary tools and knowledge to prescribe medicinal cannabis safely and effectively. As the therapeutic use of cannabinoids becomes more prevalent, it is essential for practitioners to be equipped with evidence-based guidance that prioritize patient safety and clinical efficacy.

This document outlines the key principles and practices for the assessment, prescribing, and monitoring of medicinal cannabis therapy. It emphasizes a thorough patient evaluation, including assessing for potential benefits and risks, and recognizing the importance of identifying and managing Cannabis Use Disorder (CUD) when present.

By standardizing approaches to cannabinoid-based treatments, we aim to enhance patient care, support informed decision-making, and ensure that practitioners are well-equipped to navigate the complexities of this emerging field.

The ANZCCP recognizes the unique challenges and opportunities that cannabinoid medicine presents. This guidance is intended not only to support clinicians currently prescribing medicinal cannabis but also to provide a foundation for those new to the field. Our goal is to foster a community of practice that upholds the highest standards of care, ensuring that patients receive the most appropriate, safe, and effective cannabinoid treatments available.

We encourage all practitioners to engage with this document as a dynamic resource, reflective of ongoing developments in the field. Together, we can contribute to the responsible integration of medicinal cannabis into mainstream medical practice, ultimately improving the health and well-being of our communities.

Main Principles

1. **Assessment and Eligibility**: Before prescribing cannabinoids, conduct a comprehensive assessment to evaluate the patient's condition, history of substance use, potential for benefit, and risk of adverse effects. If they have been using cannabis previously (either prescribed medicinally, or illegally, assess for Cannabis Use Disorder (CUD) (see AMCA's Interim Guidance_medical cannabis treatment for patients with SUD_Draft.pdf).
   Ensure the patient's condition is one that may benefit from cannabinoid therapy based on current evidence. If the patient is assessed as having CUD- follow CUD pathway as detailed in AMCA'S guidance document.
2. **Start Low and Go Slow**: Begin with the lowest possible dose, especially with THC-containing products, to minimise psychoactive effects and other side effects. For CBD-dominant treatments, starting doses can be slightly higher due to its lower side effect profile.
3. **Mode of Administration**: Consider the patient's preferences, the onset of action required, and the duration of effect needed. Oral formulations are preferred for chronic conditions due to their longer duration of action, while inhalation can be considered for acute symptom relief due to its rapid onset.
4. **Monitoring and Titration**: Regularly monitor the patient's response to treatment and side effects at follow-up visits. First follow up is recommended two weeks after treatment initiation in most cases, however up to 4 weeks may be appropriate for less complex patients. Adjust the dose gradually until therapeutic effects are achieved without unacceptable side effects. Review every 4 weeks while titrating and every 3 months after stable dose has been achieved. Educate patients about the potential delayed onset of effects, especially with oral formulations.
5. **Safety Considerations**: Medicinal cannabis is generally well-tolerated when appropriately dosed. Practitioners should carefully consider the THC and/or CBD content of products, starting with low doses and gradually increasing to minimise potential toxicities and drug-drug interactions. THC may impair cognitive function acutely and is advised against in children or adolescents and individuals with cardiovascular or psychosis histories. CBD is non-intoxicating and has fewer safety concerns [1] Advise patients against driving or operating heavy machinery if using formulations that contain THC. Advise patients that it is illegal to drive with any detectable level of THC in saliva urine and blood. Understanding the pharmacokinetics and pharmacodynamics of cannabinoids is crucial for effective dosing. Both THC and CBD are metabolised in the liver, presenting the potential for drug interactions. Their effects depend on the administration method, which should be tailored to individual needs. Practitioners are advised to adopt a "start low, go slow" approach to dosing, observing for desired and adverse effects [2]

Maximal doses:

- Oral formulations should always be used as the foundation of treatment, unless not tolerated or contraindicated. THC should always be at least balanced with CBD (THC has a higher affinity to CB1 and CB2 receptors than CBD).
- For most patients, maximal daily dose of oral THC would be 40mg, however some may require higher doses after careful titration, in which case the prescriber may need to consult an experienced practitioner for second opinion. Many patients would require lower doses than 40mg THC daily and THC dose should be titrated to the minimal effective dose.
- For most patients, a maximal dose of 250mg THC daily inhaled cannabis would be advisable (e.g. no more than 1g daily of 25% THC flower), however some with high tolerance (even without CUD history) may require up to 500mg THC daily (e.g. 2g of 25% THC flower daily). Many patients would require lower doses than 250mg inhaled THC daily and THC dose should be titrated to the minimal effective dose
- CBD can be used up to a maximal dose of 1000mg daily for adults and 20mg/kg for children with severe epilepsy. Cost can be prohibitive in these cases. Many patients would require lower doses than 1000mg CBD daily and CBD dose should be titrated to the minimal effective dose
- For patients with CUD- follow CUD pathway for harm minimisation, as per AMCA's guidance document..
- It is acknowledged that there may be unusual circumstances in which using an inhalation method only may be appropriate, however, this is the exception rather than the rule and all attempts should be made to introduce long-acting oral or sublingual formulations.

Guidance for Chronic Pain

Dosing and Administration Protocols: [3]

1. **Routine Protocol** [3]: For most patients with chronic pain, start with a CBD-predominant product at 5 mg twice daily, titrating by 10 mg every 2-3 days until reaching 40 mg/day. If goals are not met, consider introducing THC at 2.5 mg, titrating by 2.5 mg every 2-7 days up to a maximum of 40 mg/day of THC.
    - Many patients would require lower doses than 40mg THC daily and THC dose should be titrated to the minimal effective dose.
2. **Conservative Protocol** [3]: For patients who may be more sensitive to drug effects, initiate with 5 mg of a CBD-predominant product once daily, increasing by 5-10 mg every 2-3 days up to 40 mg/day. If necessary, start THC at 1 mg/day, titrating by 1 mg every 7 days up to a maximum of 40 mg/day of THC.
    - Many patients would require lower doses than 40mg THC daily and THC dose should be titrated to the minimal effective dose.
3. **Rapid Protocol** [3]: For patients requiring urgent management of severe pain or those with significant prior cannabis use, initiate with a balanced THC:CBD product at 2.5-5 mg of each cannabinoid once or twice daily, titrating by 2.5-5 mg of each cannabinoid every 2-3 days until patient goals are met, or to a maximum THC dose of 40 mg/day.
    - Many patients would require lower doses than 40mg THC daily and THC dose should be titrated to the minimal effective dose.

Topical Formulations: Topical formulations can be helpful for more localised pain and very well tolerated.

Inhaled Medicinal Cannabis: Can be used for the management of breakthrough pain. See Vaporisation, page 8.

Monitoring and Safety:

- Schedule follow-up every 2-4 weeks initially, extending to every 3 months or as dictated by clinical judgment once the patient is stabilized.
- Discontinue treatment if the patient experiences intolerable side effects, reaches the maximum dose without benefit, or exhibits misuse or diversion of cannabis.

- The management of medicinal cannabis patients needs to be individualized according to the patient's needs and progress.

Guidance for Insomnia

- **Initial Dosing**: Balanced formulations containing equal amount of THC and CBD show promise in the management of insomnia. [4] Start with a low-dose of 2.5mg THC and CBD each, two hours before bed time with food. [5]
- **Titration**: Increase THC slowly, by 2.5 mg increments every 3-5 days until sleep is improved without next-day impairment. If sleep initiation does not improve, consider adding dry flower for inhalation at bedtime, starting with 0.1g, increasing by 0.1g every 3-5 days to a maximum of 1g at bedtime.
- **Precautions**: Sensitive or elderly patients could be started on a CBD-predominant formulation, starting with 1mg THC nocte and at least 20mg CBD. Titrate up by 1mg THC and at least 2 mg CBD every 5 days.[5]

Guidance for Anxiety

- **Initial Dosing** Start with a CBD-predominant product at 5 mg twice daily
- **Titration**: Titrate CBD by 10 mg every 3-5 days until reaching 200 mg/day (?). If goals are not met, consider introducing THC at 1 mg, titrating by 1 mg every 5-7 days up to a maximum of 40 mg/day of THC with careful monitoring. For severe cases, CBD doses can be increased to 300-800 mg/day [6]
- **Precautions**: THC can have a biphasic effect and can be anxiogenic in high doses.

Guidance for Epilepsy:

1. **Initial Dosing** For Dravet, Lennox-Gastaut and Tuberous Sclerosis complex, start with High-CBD formulations at 5mg/kg per day in two divided doses.[7,8,9] Other forms of epilepsy may respond to significantly lower doses. Start at 10mg CBD BD.

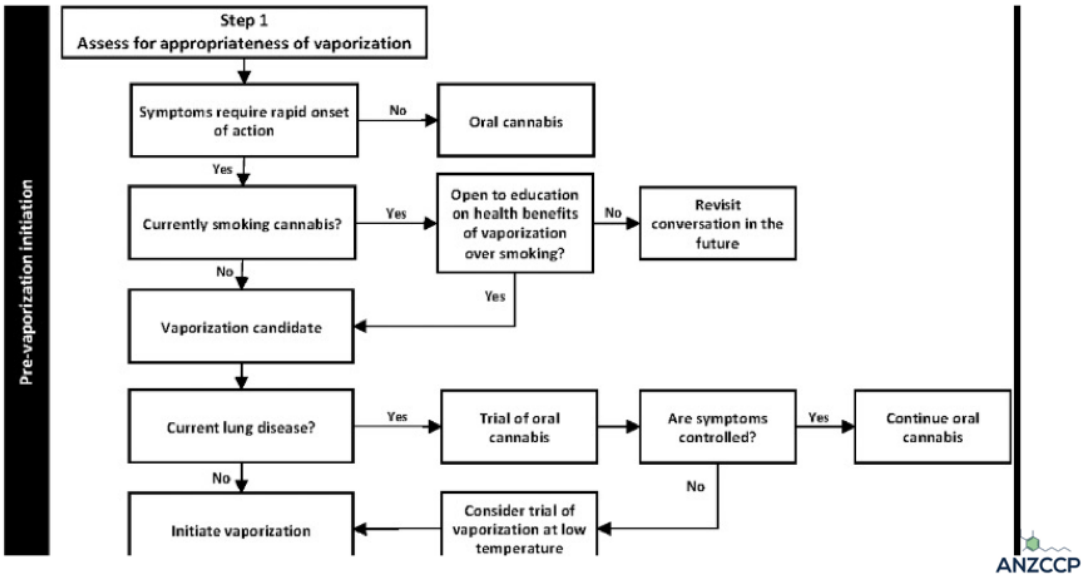
    - Titration: Titrate CBD by 5 mg/kg daily divided every 7 days (for DS, LG and TSC) or by 20mg daily every 7 days for less severe epilepsy until reaching 20mg/kg/day. If goals are not met, consider introducing THC at 0.05mg/kg, titrating by 0.05mg/kg-0.1mg/kg every 7 days up to a maximum of 0.4mg/kg daily [10] .

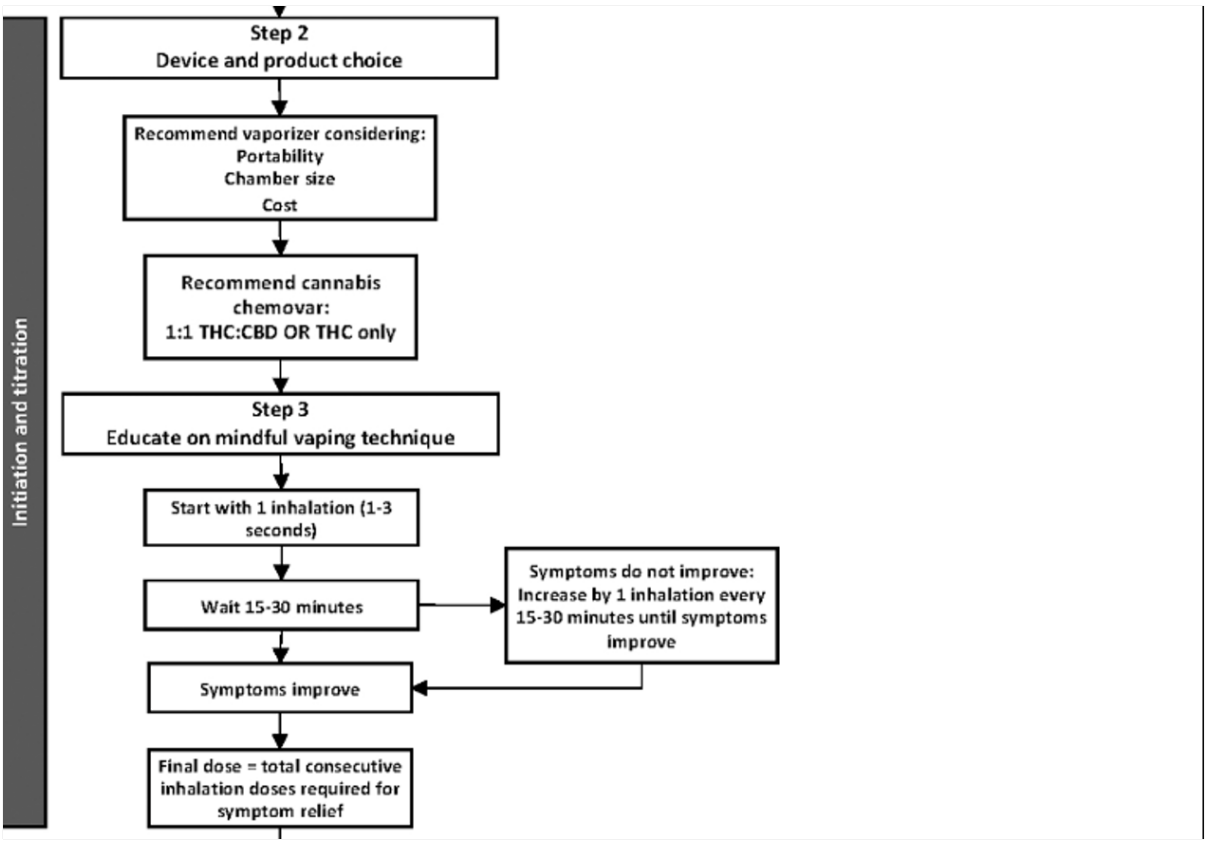
Vaporisation

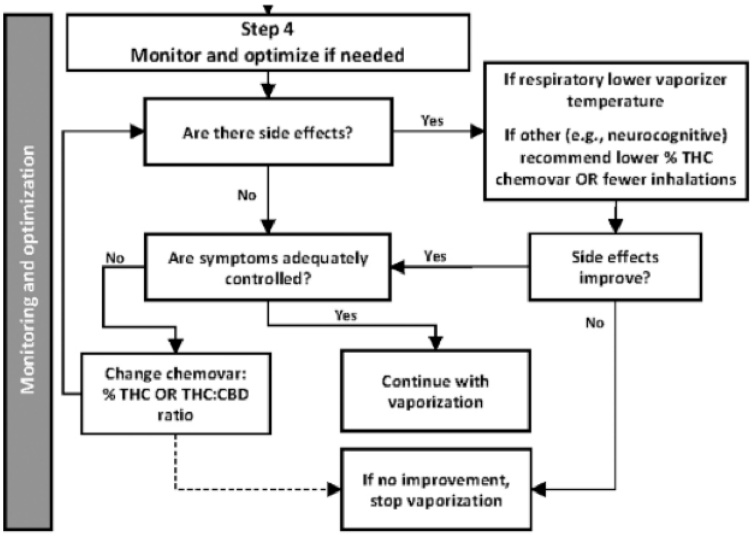
- Medicinal cannabis vaporisation can useful for patients requiring fast-acting method of medicinal cannabis administration for the management of breakthrough symptoms and for patients using smoked cannabis as a harm reduction tool. [11]
- On initiation of medicinal cannabis treatment, "a common approach is for patients to be started on oral CBD-dominant cannabis oils first, in line with a lower risk approach". [11]
- When considering adding on vaporisation for treatment with inhaled MC, follow these steps (see figure X- adapted from McCallum et al, 2024 [11]):
    1. Assess patient for appropriateness of vaporization
    2. Device and product choice
    3. Educate on mindful vaping technique
    4. Monitor and optimise

- When adding vaporisation into the treatment regimen, it is usually at a point where THC may be beneficial. [11]
- "For vaporization, consider selecting cannabis with a low to mid-range (e.g., 1:1) THC:CBD ratio when initiating, or THC< 20%." [9] For naive patients, high CBD chemovar can be utilised as well.
- In patients who are struggling to afford product, cannabis with a higher concentration of THC (>20% but less than 25%) can be used as a cost-saving tactic as less product need to be used. [11]
- Each patient is unique and should be considered on an individual basis when choosing a chemovar and treatment regimen. [11]
- On average, most individuals are suited to around 250mg inhaled THC daily max (e.g. 1g of 25% THC flower daily), but approximately 10% may require up to 500mg inhaled THC daily (e.g. 2g of 25% THC flower daily). "A very small minority of patients may require even higher amounts, especially for severe pain. This can be a sensitive issue, as some experienced patients may request a high daily volume of flower, not solely for medical reasons. Prescribing cannabis should always be a collaborative discussion between the patient and the clinician. However, the clinician ultimately bears the responsibility for the prescription and must feel justified and comfortable with the prescribed dosage. Pressure from the patient to exceed appropriate dosages should be resisted." [12]
- For patients diagnosed with CUD- follow CUD pathway for harm minimisation, as per AMCA's guidance document.
- Dried cannabis vaporisers and metered-dose inhalers over other vaporisation devices [11,13]

- Dried flower, not concentrates or liquids are recommended for vaporisation for the medical use of cannabis, due to the high concentration of THC and unknown risks of concentrates and liquids.
- Employ mindful vaping techniques (see figure X- adapted from McCallum et al, 2024 [11]):






Monitoring and optimization
Step 4
Monitor and optimize if needed
Are there side effects?
Yes
If respiratory lower vaporizer temperature
If other (e.g., neurocognitive) recommend lower % THC chemovar OR fewer inhalations
No
Are symptoms adequately controlled?
No
Yes
Side effects improve?
Yes
No
Change chemovar: % THC OR THC:CBD ratio
Continue with vaporization
If no improvement, stop vaporization

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