

Morphine Intravenous - Standard Concentration

Newborn use only

2025

Alert	S8 - High risk medication- may cause significant patient harm when used in error.																
Indication	Analgesia Sedation Neonatal abstinence syndrome secondary to opioid withdrawal																
Action	mu-opioid analgesic – stimulates brain opioid receptors.																
Drug Type	mu-opioid analgesic.																
Trade Name	DBL Morphine Sulfate Morphine Juno Hydrochloride Morphine Sulfate Medsurge																
Presentation	5 mg/mL (5,000 microgram/mL) ampoule, 10 mg/mL (10,000 microgram/mL) ampoule NOTE: Higher strength products available on the market, however these are not appropriate for use in neonates																
Dosage	<p>ANALGESIA</p> <p>CONTINUOUS IV INFUSION Range: 5–40 microgram/kg/hour: Ventilated infants or after surgery*^{1,2,3}</p> <table border="1"> <thead> <tr> <th>Postnatal age[#]</th> <th>Starting dose</th> <th>Range</th> </tr> </thead> <tbody> <tr> <td>0-7 days</td> <td>10 microgram/kg/hour</td> <td>5-40 microgram/kg/hour</td> </tr> <tr> <td>8-30 days</td> <td>15 microgram/kg/hour</td> <td>5-40 microgram/kg/hour</td> </tr> <tr> <td>31-90 days</td> <td>20 microgram/kg/hour</td> <td>5-40 microgram/kg/hour</td> </tr> </tbody> </table> <p>*Infants after cardiovascular surgery may need lower starting dose and titrated to clinical response²</p> <p>IV BOLUS FOR ANALGESIA 50 microgram/kg (maximum recommended 100 microgram/kg) every 4 hours.⁴</p> <p>PRE-MEDICATION FOR INTUBATION 100 microgram/kg/dose (up to 200 microgram/kg) ⁵</p> <p>NEONATAL ABSTINENCE SYNDROME –INITIAL TREATMENT 10 microgram/kg/hour titrated to Neonatal Abstinence Syndrome scores.</p>	Postnatal age [#]	Starting dose	Range	0-7 days	10 microgram/kg/hour	5-40 microgram/kg/hour	8-30 days	15 microgram/kg/hour	5-40 microgram/kg/hour	31-90 days	20 microgram/kg/hour	5-40 microgram/kg/hour				
Postnatal age [#]	Starting dose	Range															
0-7 days	10 microgram/kg/hour	5-40 microgram/kg/hour															
8-30 days	15 microgram/kg/hour	5-40 microgram/kg/hour															
31-90 days	20 microgram/kg/hour	5-40 microgram/kg/hour															
Maximum Daily Dose	Doses up to 100 microgram/kg/hour have been used in newborns; however, this was associated with an increase in the duration of mechanical ventilation.																
Route	IV																
Preparation	<p>Note: Refer to Appendix for tables to assist with concentration selection.</p> <p>NOTE: Use the smallest volume syringe available/suitable for drawing up the drug for the preparation. (e.g. for <1 mL draw up – use 1 mL syringe). For 10 mL syringe - Recommend using syringe that has markings at 0.2mL increments.</p> <p>Weight suggestions for infusion concentrations below are a guide only. Clinicians may choose infusion concentration different to the suggested based on expected dose and the corresponding 24-hour fluid volumes</p> <table border="1"> <thead> <tr> <th>Infant weight</th> <th><1 kg</th> <th>1 to <3 kg</th> <th>≥3 kg</th> </tr> </thead> <tbody> <tr> <td>Suggested morphine concentration</td> <td>20 microgram/mL</td> <td>60 microgram/mL</td> <td>120 microgram/mL</td> </tr> <tr> <td>10 microgram/kg/hour is equal to</td> <td>0.5 mL/kg/hour</td> <td>0.167 mL/kg/hour</td> <td>0.083 mL/kg/hour</td> </tr> <tr> <td>IV bolus of 50 microgram/kg is equal to</td> <td>2.5 mL/kg</td> <td>0.833 mL/kg</td> <td>0.417 mL/kg</td> </tr> </tbody> </table>	Infant weight	<1 kg	1 to <3 kg	≥3 kg	Suggested morphine concentration	20 microgram/mL	60 microgram/mL	120 microgram/mL	10 microgram/kg/hour is equal to	0.5 mL/kg/hour	0.167 mL/kg/hour	0.083 mL/kg/hour	IV bolus of 50 microgram/kg is equal to	2.5 mL/kg	0.833 mL/kg	0.417 mL/kg
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Using 5mg/mL ampoule

20mL Syringe

It is a 2 step dilution.

Step 1: Draw up morphine and add compatible fluid* to make a diluted solution as per table below:

Morphine concentration	20 microgram/mL	60 microgram/mL	120 microgram/mL
Volume of morphine (5mg/mL)	1 mL (5 mg)	1 mL (5 mg)	1 mL (5 mg)
Volume of compatible fluid*	9 mL	9 mL	9 mL
Total volume	10 mL (500 microg/mL)	10 mL (500 microg/mL)	10 mL (500 microg/mL)

Step 2: Draw up diluted morphine and add to the same compatible fluid* as per table below to make a final volume of 20 mL

Morphine concentration	20 microgram/mL	60 microgram/mL	120 microgram/mL
Volume of diluted morphine from step 1	0.8 mL (400 microgram)	2.4 mL (1200 microgram)	4.8 mL (2400 microgram)
Volume of compatible fluid*	19.2 mL	17.6 mL	15.2 mL
Total volume	20 mL	20 mL	20 mL

* Compatible fluid: glucose 5% or glucose 10% or sodium chloride 0.9%

50mL Syringe

It is a 2 step dilution.

Step 1: Draw up morphine and add compatible fluid* to make a diluted solution as per table below:

Morphine concentration	20 microgram/mL	60 microgram/mL	120 microgram/mL
Volume of morphine (5mg/mL)	1 mL (5 mg)	1 mL (5 mg)	1.2 mL (6 mg)
Volume of compatible fluid*	9 mL	9 mL	8.8 mL
Total volume	10 mL (500 microg/mL)	10 mL (500 microg/mL)	10 mL (600 microg/mL)

Step 2: Draw up diluted morphine and add to the same compatible fluid* as per table below to make a final volume of 50 mL

Morphine concentration	20 microgram/mL	60 microgram/mL	120 microgram/mL
Volume of diluted morphine from step 1	2 mL (1000 microgram)	6 mL (3000 microgram)	10 mL (6000 microgram)
Volume of compatible fluid*	48 mL	44 mL	40 mL
Total volume	50 mL	50 mL	50 mL

* Compatible fluid: glucose 5% or glucose 10% or sodium chloride 0.9%

Using 10mg/mL ampoule

20mL Syringe

It is a 2 step dilution.

Step 1: Draw up morphine and add compatible fluid* to make a diluted solution as per table below:

Morphine concentration	20 microgram/mL	60 microgram/mL	120 microgram/mL
Volume of morphine (10mg/mL)	0.5 mL (5 mg)	0.5 mL (5 mg)	0.5 mL (5 mg)
Volume of compatible fluid*	9.5 mL	9.5 mL	9.5 mL
Total volume	10 mL (500 microg/mL)	10 mL (500 microg/mL)	10 mL (500 microg/mL)

Step 2: Draw up diluted morphine and add to the same compatible fluid* as per table below to make a final volume of 20 mL

Morphine concentration	20 microgram/mL	60 microgram/mL	120 microgram/mL
Volume of diluted morphine from step 1	0.8 mL (400 microgram)	2.4 mL (1200 microgram)	4.8 mL (2400 microgram)
Volume of compatible fluid*	19.2 mL	17.6 mL	15.2 mL
Total volume	20 mL	20 mL	20 mL

* Compatible fluid: glucose 5% or glucose 10% or sodium chloride 0.9%

50mL Syringe

It is a 2 step dilution.

Step 1: Draw up morphine and add compatible fluid* to make a diluted solution as per table below:

Morphine concentration	20 microgram/mL	60 microgram/mL	120 microgram/mL
Volume of morphine (10mg/mL)	0.5 mL (5 mg)	0.5 mL (5 mg)	0.6 mL (6 mg)
Volume of compatible fluid*	9.5 mL	9.5 mL	9.4 mL
Total volume	10 mL (500 microg/mL)	10 mL (500 microg/mL)	10 mL (600 microg/mL)

Step 2: Draw up diluted morphine and add to the same compatible fluid* as per table below to make a final volume of 50 mL

Morphine concentration	20 microgram/mL	60 microgram/mL	120 microgram/mL
Volume of diluted morphine from step 1	2 mL (1000 microgram)	6 mL (3000 microgram)	10 mL (6000 microgram)
Volume of compatible fluid*	48 mL	44 mL	40 mL
Total volume	50 mL	50 mL	50 mL

* Compatible fluid: glucose 5% or glucose 10% or sodium chloride 0.9%

	<p>IV BOLUS</p> <p><u>Using 5mg/mL ampoule</u></p> <p><u>Bodyweight <1 kg</u> Draw up 1 mL (5 mg) of morphine and add 9 mL of sodium chloride 0.9% to make a 10 mL solution [500 microgram/mL] Further dilute: Draw up 2 mL of this solution (1000 microgram) and add 8 mL of sodium chloride 0.9% to make a final volume of 10 mL with a concentration of 100 microgram/mL.</p> <p><u>Bodyweight ≥1 kg</u> Draw up 1 mL (5 mg) of morphine and add 9 mL of sodium chloride 0.9% to make a 10 mL solution [500 microgram/mL]</p> <p>Note: If a continuous infusion is running, bolus doses/loading dose can be calculated and given from the continuous infusion solution.</p> <p><u>Using 10mg/mL ampoule</u></p> <p><u>Bodyweight <1 kg</u> Draw up 0.5 mL (5 mg) of morphine and add 9.5 mL of sodium chloride 0.9% to make a 10 mL solution [500 microgram/mL] Further dilute: Draw up 2 mL of this solution (1000 microgram) and add 8 mL of sodium chloride 0.9% to make a final volume of 10 mL with a concentration of 100 microgram/mL.</p> <p><u>Bodyweight ≥1 kg</u> Draw up 0.5 mL (5 mg) of morphine and add 9.5 mL of sodium chloride 0.9% to make a 10 mL solution [500 microgram/mL].</p> <p>Note: If a continuous infusion is running, bolus doses/loading dose can be calculated and given from the continuous infusion solution.</p> <p>PRE-MEDICATION FOR INTUBATION As above for IV bolus.</p>
Administration	<p>CONTINUOUS IV INFUSION: Via syringe driver.</p> <p>IV BOLUS: Administer over 5 minutes. Flush with 1 mL sodium chloride 0.9% before and after injection. Rapid IV administration may increase adverse effects.</p> <p>PRE-MEDICATION FOR INTUBATION: As above for IV bolus. Wait a minimum of 5 minutes for onset of action; however, for maximum effect wait 15 minutes after giving the dose.</p>
Monitoring	<p>All patients should have cardiorespiratory monitoring and be carefully observed, particularly if they are breathing spontaneously. Respiratory depression/apnoea can be reversed with naloxone. Naloxone is contraindicated in opioid dependent infants.</p> <p>Observe for urinary retention, abdominal distension or delay in passage of stool.</p> <p>Withdraw slowly following prolonged use.</p>
Contraindications	<p>Hypersensitivity to morphine or any excipients.</p>
Precautions	<p>Potentially toxic serum concentrations of morphine may occur in infants with hypoxic ischaemic encephalopathy with moderate hypothermia and infusion rates >10 microgram/kg per hour.³ Use with caution in patients with hypersensitivity reactions to other opioids.</p> <p>Hypotension and bradycardia. Respiratory depression.</p> <p>Transient hypertonia. Convulsions.</p> <p>Ileus and delayed gastric emptying time. Urinary retention. Renal or hepatic impairment.</p> <p>Tolerance may develop after prolonged use – wean slowly.</p>
Drug Interactions	<p>Concomitant use with other CNS depressants potentiates effects of opioids, increasing risk of respiratory depression, profound sedation or coma.</p>

Overdose	AUSTRALIA: Contact the Poisons Information Centre on 13 11 26 for management NEW ZEALAND: Contact the National Poisons Centre on 0800 764 766 for management
Adverse Reactions	Morphine has been associated with respiratory depression (levels above 20 ng/mL); decreased gastrointestinal motility, hypotension at higher doses, and urinary retention. ⁴
Compatibility	Compatibility is likely to be similar for morphine hydrochloride and sulfate. Fluids: Morphine hydrochloride – glucose 5%, sodium chloride 0.9% Morphine sulfate – glucose 2.5%, 5% and 10%, glucose in sodium chloride solutions, Hartmann's, sodium chloride 0.45% and 0.9% Y-site: Morphine hydrochloride – some information is available. Consult the pharmacist, pharmacy department or medicines information service for more advice. Morphine sulfate – adrenaline (epinephrine) hydrochloride, amifostine, amikacin, amiODAROne, ampicillin, anidulafungin, atracurium, atropine, aztreonam, bivalirudin, caspofungin, cefaZOLin, cefOTAXIME, cefOXITIN, ceftAZIDIME, ceftRIAXONE, cisatracurium, clindamycin, dexAMETHASOne, digoxin, dopamine, eptifibatide, ERYthromycin, esmolol, filgrastim, flucONAZOLe, foscarnet, gentamicin, granisetron, haloperidol lactate (in glucose), heparin sodium, hyoscine hydrobromide, insulin (short-acting), ketOROLAC, labetalol, lidocaine, linEZOLID, magnesium sulfate, methylprednisolone sodium succinate, metoclopramide, metoprolol, metronidazole, midazolam, milrinone, noradrenaline (norepinephrine), palonosetron, paracetamol (acetaminophen), piperacillin-tazobactam (EDTA-free), posaconazole, potassium chloride, remifentanil, sodium nitroprusside, TACrolimus, tigecycline, tirofiban, tobramycin, trimETHOPRIM-sulfamethoxazole, vancomycin, vecuronium, zidovudine.
Incompatibility	Fluids: Morphine may precipitate out of solution when the final pH is greater than 6.4. Y-site: Morphine hydrochloride – esomeprazole Morphine sulfate – amiNOPHYLLine, azATHIOPRINE, aziTHROMYCIN, flucLOXACILLIN, folic acid, ganciclovir, indometacin, pentamidine, pethidine, proMETHazine, sodium nitrite, thiopental sodium.
Stability	Continuous IV infusion should be used within 24 hours.
Storage	Ampoule: Store below 25°C. Protect from light. Discard remainder after use (in line with schedule 8 drug legislation). Store in Dangerous Drug (DD) safe and record use in DD register.
Excipients	DBL Morphine Sulfate – sodium chloride, water for injections, hydrochloric acid Morphine Juno Hydrochloride – water for injections, hydrochloric acid Morphine Sulfate Medsurge – sodium chloride, water for injections, hydrochloric acid
Special Comments	Prolonged use (> 5–7 days) may be associated with dependence. Morphine hydrochloride and sulfate contain approximately equivalent amounts of morphine base per milligram.

<p>Evidence</p>	<p>Efficacy:</p> <p>Premedication: Morphine 0.2 mg/kg bolus did not reduce the occurrence of severe hypoxia with bradycardia during intubation, in comparison with placebo.[5] [LOE II] Morphine 0.1 mg/kg – atropine 10 microgram/kg and suxamethonium 1 mg/kg premedication reduced the total time and number of attempts taken to achieve successful nasotracheal intubation of neonates compared to awake intubation;[6] [LOE II] Morphine 0.1 mg/kg – atropine 10 microgram/kg and suxamethonium 2 mg/kg was less effective than propofol with longer time to intubation, increased oxygen desaturations and nasal trauma and increased time to recovery [7]. (LOE II) No difference in time, number of attempts and duration of intubation has been reported in trials comparing morphine-midazolam versus remifentanyl with or without midazolam combination [8, 9]. (LOE II) Conclusion: Morphine appears not to reduce the occurrence of severe hypoxia with bradycardia during intubation, in comparison with placebo, probably because of the delayed onset of action. It is likely that fentanyl is more effective because of the more rapid onset of action [10].</p> <p>Infants on mechanical ventilation: A systematic review of 13 RCTs, 1505 infants, found infants given opioids showed reduced Premature Infant Pain Profile scores (MD -1.71, 95% CI -3.18 to -0.24); had no difference in mortality, incidence of hypotension, duration of mechanical ventilation and long-term and short-term neurodevelopmental outcomes; but a longer duration to reach full enteral feeding [11]. One RCT reported an increased incidence of hypotension in ventilated very preterm infants after morphine 100-300 micrograms/kg loading dose and with 10-30 microgram/kg/hour infusion for 24 hours [12]. Two other RCTs using morphine 50-100 micrograms/kg loading dose and with or without 10 microgram/kg/hour infusion reported no effect on blood pressure [13, 14]. One study that compared morphine with midazolam showed similar pain scores, but fewer adverse effects with morphine [15]. Conclusion: There is insufficient evidence to recommend routine use of opioids in mechanically ventilated newborns. Opioids should be used selectively, when indicated by clinical judgment and evaluation of pain indicators. If sedation is required, morphine is safer than midazolam [11]. (LOE I GOR B)</p> <p>Analgesia: Recommended procedural analgesic doses for neonates are: Intermittent Dose - Morphine sulfate 0.05-0.1 mg/kg intravenously; Infusion Dose - 0.01-0.03 mg/kg per hour. It is advised that neonatal intensive care units use only 1 opioid analgesic agent to ensure familiarity with its use. The opioid doses are only applicable for opioid-naïve patients. All patients should be monitored and carefully observed, particularly if they are breathing spontaneously. Consider slow intravenous opioid infusion (morphine sulfate or fentanyl citrate) for: central venous line placement, endotracheal intubation and suction; chest tube insertion and for ventilated infants. [Consensus statement for the International Evidence-Based Group for Neonatal Pain] [4].</p> <p>Postoperative pain relief: Continuous and intermittent morphine infusions have been trialled in postoperative patients. A continuous morphine 10 microgram/kg per hour or intermittent morphine 30 microgram/kg per 3 hours were equally effective and safe in neonates. (LOE II) A morphine continuous infusion to a targeted morphine concentration of 20 ng/ml provided more reliable analgesia than an intermittent bolus doses as needed. The average infusion rate was 20.6 ± 8.7 microgram/kg/hour. [16]. [LOE II] Postoperative morphine use can be reduced by paracetamol infusion [17]. [LOE II]</p> <p>Neonatal abstinence syndrome secondary to opioids: There are no trials of intravenous morphine for NAS secondary to opioids although its use has been reported including for seizure control [18, 19]. [LOE IV] Recommended oral dose for initial treatment of NAS in opioid dependent infants 0.5 mg/kg/day [20]. Estimated oral morphine bioavailability 48.5% in neonates [21]. (LOE IV GOR C)</p> <p>Pharmacodynamics / Pharmacokinetics:</p> <p>Effective morphine concentrations in the range of 10–20 ng/L have been reported [1, 22]. Concentrations above 20 ng/L have been associated with respiratory depression [2]. The mean morphine half-life is age related, reported as around 9 hours in ventilated preterm infants [23, 24], 6 hours in term infants [24, 25] and 2 hours for infants beyond 11 days age [24]. Pharmacodynamic assessment found median (IQR) average morphine infusion rate for pain relief in was 4.4 (4.0-4.8) microgram/kg/hour in postoperative term neonates <10 days versus 14.4 (11.3-23.4) microgram/kg/hour in older infants (p < 0.001) [26]. Also in postoperative term infants, morphine concentrations suggested neonates <7 days require significantly less morphine</p>
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	<p>postoperatively than older neonates. The recommended dosage for continuous morphine infusions was 7 microgram/kg/h in full-term neonates and 10 microgram/kg/hour in infants >4 weeks of age [27]. (LOE II GOR B)</p> <p>Lynn et al estimated morphine infusion rates to achieve a steady-state concentration ≤ 20 ng/mL for non-cardiovascular surgery are: 0-7 days: 10 microgram/kg/hour; 8-30 days: 15 microgram/kg/hour; 31-90 days: 20 microgram/kg/hour [1]. For infants after cardiovascular surgery clearance was reduced with the following modelled rates: 0-7 days: 5 microgram/kg/hour; 8-30 days: 5 microgram/kg/hour; 31-90 days: 10 microgram/kg/hour [2]. [LOE II GOR B]</p> <p>More restricted dosing recommendations have been suggested in neonates targeting morphine concentrations of ≤ 10 microgram/L [26, 27].</p> <p>Infants with hypoxic ischemic encephalopathy have reduced morphine clearance and elevated serum morphine concentrations when morphine infusion rates are based on clinical state. Potentially toxic serum concentrations of morphine may occur with moderate hypothermia and infusion rates >10 microgram/kg per hour [3].</p> <p>Safety</p> <p>There is no compelling evidence to support severe long-term harm, but subtler behavioural changes have been noted. Morphine use should continue to be based on clinical judgment, carefully weighing the benefits of acute interventions against the potential for long-term harm. [28]</p>
<p>References</p>	<ol style="list-style-type: none"> Lynn A, Nespeca MK, Bratton SL, Strauss SG, Shen DD. Clearance of morphine in postoperative infants during intravenous infusion: the influence of age and surgery. <i>Anesth Analg.</i> 1998;86:958-63. Lynn AM, Nespeca MK, Opheim KE, Slattery JT. Respiratory effects of intravenous morphine infusions in neonates, infants, and children after cardiac surgery. <i>Anesth Analg.</i> 1993;77:695-701. Roka A, Melinda KT, Vasarhelyi B, Machay T, Azzopardi D, Szabo M. Elevated morphine concentrations in neonates treated with morphine and prolonged hypothermia for hypoxic ischemic encephalopathy. <i>Pediatrics.</i> 2008;121:e844-9. Anand KJ, International Evidence-Based Group for Neonatal P. Consensus statement for the prevention and management of pain in the newborn. <i>Arch Pediatr Adolesc Med.</i> 2001;155:173-80. Lemyre B, Doucette J, Kalyn A, Gray S, Marrin ML. Morphine for elective endotracheal intubation in neonates: a randomized trial [ISRCTN43546373]. <i>BMC Pediatr.</i> 2004;4:20. Oei J, Hari R, Butha T, Lui K. Facilitation of neonatal nasotracheal intubation with premedication: a randomized controlled trial. <i>J Paediatr Child Health.</i> 2002;38:146-50. Ghanta S, Abdel-Latif ME, Lui K, Ravindranathan H, Awad J, Oei J. Propofol compared with the morphine, atropine, and suxamethonium regimen as induction agents for neonatal endotracheal intubation: a randomized, controlled trial. <i>Pediatrics.</i> 2007;119:e1248-55. Avino D, Zhang WH, De Ville A, Johansson AB. Remifentanyl versus morphine-midazolam premedication on the quality of endotracheal intubation in neonates: a noninferiority randomized trial. <i>J Pediatr.</i> 2014;164:1032-7. Pereira e Silva Y, Gomez RS, Marcatto Jde O, Maximo TA, Barbosa RF, Simoes e Silva AC. Morphine versus remifentanyl for intubating preterm neonates. <i>Arch Dis Child Fetal Neonatal Ed.</i> 2007;92:F293-4. Barrington K. Premedication for endotracheal intubation in the newborn infant. <i>Paediatr Child Health.</i> 2011;16:159-71. Bellu R, de Waal K, Zanini R. Opioids for neonates receiving mechanical ventilation: a systematic review and meta-analysis. <i>Arch Dis Child Fetal Neonatal Ed.</i> 2010;95:F241-51. Anand KJ, Hall RW, Desai N, Shephard B, Bergqvist LL, Young TE, Boyle EM, Carbajal R, Bhutani VK, Moore MB, Kronsberg SS, Barton BA, Group NTI. Effects of morphine analgesia in ventilated preterm neonates: primary outcomes from the NEOPAIN randomised trial. <i>Lancet.</i> 2004;363:1673-82. Quinn MW, Otoo F, Rushforth JA, Dean HG, Puntis JW, Wild J, Levene MI. Effect of morphine and pancuronium on the stress response in ventilated preterm infants. <i>Early Hum Dev.</i> 1992;30:241-8. Simons SH, Roofthoof DW, van Dijk M, van Lingen RA, Duivenvoorden HJ, van den Anker JN, Tibboel D. Morphine in ventilated neonates: its effects on arterial blood pressure. <i>Arch Dis Child Fetal Neonatal Ed.</i> 2006;91:F46-51.

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Appendix

Infusion tables to assist with concentration selection

Table 1: Infusion rates when using morphine concentration **20 microgram/mL** (suggested weight <1 kg)

Rate (mL/hr)	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	1
Weight (kg)	Approximate microgram/kg/hour									
0.5	4	8	12	16	20	24	28	32	36	40
1	2	4	6	8	10	12	14	16	18	20
1.5	1.3	2.7	4	5.3	6.7	8	9.3	10.7	12	13.3
2	1	2	3	4	5	6	7	8	9	10
2.5	0.8	1.6	2.4	3.2	4	4.8	5.6	6.4	7.2	8
3	0.7	1.3	2	2.7	3.3	4	4.7	5.3	6	6.7

3.5	0.6	1.1	1.7	2.3	2.9	3.4	4	4.6	5.1	5.7
4	0.5	1	1.5	2	2.5	3	3.5	4	4.5	5
4.5	0.4	0.9	1.3	1.8	2.2	2.7	3.1	3.6	4	4.4
5	0.4	0.8	1.2	1.6	2	2.4	2.8	3.2	3.6	4

Table 2: Infusion rates when using morphine concentration **60 microgram/mL**
(suggested weight 1 to <3 kg)

Rate (mL/hr)	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	1
Weight (kg)	Approximate microgram/kg/hour									
0.5	12	24	36	48	60	72	84	96	108	120
1	6	12	18	24	30	36	42	48	54	60
1.5	4	8	12	16	20	24	28	32	36	40
2	3	6	9	12	15	18	21	24	27	30
2.5	2	5	7	10	12	14	17	19	22	24
3	2	4	6	8	10	12	14	16	18	20
3.5	2	3	5	7	9	10	12	14	15	17
4	2	3	5	6	8	9	11	12	14	15
4.5	1	3	4	5	7	8	9	11	12	13
5	1	2	4	5	6	7	8	10	11	12

Table 3: Infusion rates when using morphine concentration **120 microgram/mL**
(suggested weight ≥3 kg)

Rate (mL/hr)	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9	1
Weight (kg)	Approximate microgram/kg/hour									
0.5	24	48	72	96	120	144	168	192	216	240
1	12	24	36	48	60	72	84	96	108	120
1.5	8	16	24	32	40	48	56	64	72	80
2	6	12	18	24	30	36	42	48	54	60
2.5	5	10	14	19	24	29	34	38	43	48
3	4	8	12	16	20	24	28	32	36	40
3.5	3	7	10	14	17	21	24	27	31	34
4	3	6	9	12	15	18	21	24	27	30
4.5	3	5	8	11	13	16	19	21	24	27
5	2	5	7	10	12	14	17	19	22	24

$$\text{Dose (microgram/kg/hour)} = \frac{\text{Rate (mL/hr)} \times \text{Concentration (microgram/mL)}}{\text{Weight (kg)}}$$

$$\text{Rate (mL/hr)} = \frac{\text{Dose (microgram/kg/hour)} \times \text{Weight (kg)}}{\text{Concentration (microgram/mL)}}$$

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Morphine Intravenous - Standard Concentration

Newborn use only

2025

Current 1.3	23/04/2026
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This standard concentration formulary has been developed by the ANMF standard concentration working group. The working group (in alphabetical order): Mohammad Irfan Azeem, Susanah Brew, Cindy Chen, Michelle Jenkins, Kerrie Knox, Rebecca O'Grady

Authors Contribution

Original author/s	Himanshu Popat
Review author/s	Himanshu Popat, Srinivas Bolisetty
Evidence Review	David Osborn
Nursing Review	Celia Cunha da Silva
Pharmacy Review	Michelle Jenkins, Susannah Brew, Kerrie Knox
ANMF Group contributors	Nilkant Phad, Mohammed Irfan Azeem, Michelle Jenkins, Kerrie Knox, Cindy Chen, Thao Tran, Charles Tian, Benjamin Emerson-Parker, Bhavesh Mehta, Amber Seigel, Rebecca Barzegar, Jutta van den Boom, Renae Gengaroli, Bryony Malloy, Simarjit Kaur, Dianne Lee, Gloria Yoo
Final editing	Rebecca O'Grady
Facilitator	Srinivas Bolisetty

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