Opioid Taper Decision Tool

VA
U.S. Department of Veterans Affairs
Veterans Health Administration
PBM Academic Detailing Service

Pages 3, 7, and 11 republished by NEJM Knowledge+ with permission from the U.S. Department of Veterans Affairs. Original can be found at https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf

Possible reasons to re-evaluate the risks and benefits of continuing opioid therapy:

Opioids are associated with many risks and it may be determined that they are not indicated for pain management for a particular patient.[1]

- No pain reduction, no improvement in function or patient requests to discontinue therapy
- Severe unmanageable adverse effects (e.g., drowsiness, constipation, cognitive impairment)
- Dosage indicates high risk of adverse events (e.g., doses of 90 MEDD* and higher)

- Non-adherence to the treatment plan or unsafe behaviors** (e.g., early refills, lost/stolen prescription, buying or borrowing opioids, failure to obtain or aberrant UDT***)
- Concerns related to an increased risk of SUD**** (e.g., behaviors, age <30, family history, personal history of SUD†)
- Overdose event involving opioids

- Medical comorbidities that can increase risk (e.g., lung disease, sleep apnea, liver disease, renal disease, fall risk, advanced age)
- Concomitant use of medications that increase risk (e.g., benzodiazepines)
- Mental health comorbidities that can worsen with opioid therapy (e.g., PTSD, depression, anxiety)

Consider Tapering Opioid

Prior to any changes in therapy, discuss the risks of continued use, along with possible benefits, with the patient. Establish a plan to consider dose reduction, consultation with specialists, or consider alternative pain management strategies.

*Morphine equivalent daily dose
**Consider assessment for opioid use disorder (OUD)
*** Urine drug test
****Substance use disorder
†Personal history of SUD includes alcohol use disorder (AUD), opioid use disorder (OUD), and/or a use disorder involving other substances

Example Tapers for Opioids[5-9]			
Slowest Taper (over years) Reduce by 2 to 10% every 4 to 8 weeks with pauses in taper as needed *Consider for patients taking high doses of long-acting opioids for many years*	**Slower Taper (over months or years)** Reduce by 5 to 20% every 4 weeks with pauses in taper as needed **MOST COMMON TAPER**	**Faster Taper (over weeks)****** Reduce by 10 to 20% every week	**Rapid Taper (over days)****** Reduce by 20 to 50% of first dose if needed, then reduce by 10 to 20% every day
Ex: morphine SR 90 mg Q8h = 270 MEDD **Month 1:** 90 mg SR qam, 75 mg noon, 90 mg qpm [5% reduction]* **Month 2:** 75 mg SR qam, 75 mg noon, 90 mg qpm **Month 3:** 75 mg SR (60 mg+15 mg) Q8h **Month 4:** 75 mg SR qam, 60 mg noon, 75 mg qpm **Month 5:** 60 mg SR qam, 60 mg noon, 75 mg qpm **Month 6:** 60 mg SR Q8h **Month 7:** 60 mg SR qam, 45 mg noon, 60 mg qpm **Month 8:** 45 mg SR qam, 45 mg noon, 60 mg qpm **Month 9:** 45 mg SR Q8h**	Ex: morphine SR 90 mg Q8h = 270 MEDD **Month 1:** 75 mg (60 mg+15 mg)SR Q8h [16% reduction] **Month 2:** 60 mg SR Q8h **Month 3:** 45 mg SR Q8h **Month 4:** 30 mg SR Q8h **Month 5:** 15 mg SR Q8h **Month 6:** 15 mg SR Q12h **Month 7:** 15mg SR QHS, then stop***	Ex: morphine SR 90 mg Q8h = 270 MEDD **Week 1:** 75 mg SR Q8h [16% reduction] **Week 2:** 60 mg SR (15 mg x 4) Q8h **Week 3:** 45 mg SR (15 mg x 3) Q8h **Week 4:** 30 mg SR (15 mg x 2) Q8h **Week 5:** 15 mg SR Q8h **Week 6:** 15 mg SR Q12h **Week 7:** 15 mg SR QHS x 7 days, then stop***	Ex: morphine SR 90 mg Q8h = 270 MEDD **Day 1:** 60 mg SR (15 mg x 4) Q8h [33% reduction] **Day 2:** 45 mg SR (15 mg x 3) Q8h **Day 3:** 30 mg SR (15 mg x 2) Q8h **Day 4:** 15 mg SR Q8h **Days 5-7:** 15 mg SR Q12h **Days 8-11:** 15 mg SR QHS, then stop***

*Continue the taper based on patient response. Pauses in the taper may allow the patient time to acquire new skills for management of pain and emotional distress while allowing for neurobiological equilibration.

**Continue following this rate of taper until off the morphine or the desired dose of opioid is reached.

***May consider morphine IR 15 mg ½ tablet (7.5 mg) twice daily.

****Rapid tapers can cause withdrawal effects and patients should be treated with adjunctive medications to minimize these effects; may need to consider admitting the patient for inpatient care. If patients are prescribed both long-acting and short-acting opioids, the decision about which formulation to be tapered first should be individualized based on medical history, mental health diagnoses, and patient preference. Data shows that overdose risk is greater with long-acting preparations.

Consider use of adjuvant medications during the taper to reduce withdrawal symptoms:[6-9, 11-19]

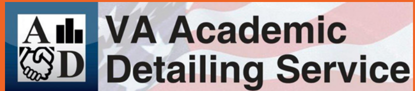
Short-term oral medications can be utilized to assist with managing the withdrawal symptoms, especially during fast tapers.

Indication	Treatment Options
Autonomic symptoms (sweating, tachycardia, myoclonus)	**First line** • Clonidine 0.1 to 0.2 mg oral every 6 to 8 hours; hold dose if blood pressure <90/60 mmHg (0.1 to 0.2 mg 2 to 4 times daily is commonly used in the outpatient setting) – Recommend test dose (0.1 mg oral) with blood pressure check 1 hour post dose; obtain daily blood pressure checks; increasing dose requires additional blood pressure checks – Re-evaluate in 3 to 7 days; taper to stop; average duration 15 days **Alternatives** • Baclofen 5 mg 3 times daily may increase to 40 mg total daily dose – Re-evaluate in 3 to 7 days; average duration 15 days – May continue after acute withdrawal to help decrease cravings – Should be tapered when it is discontinued • Gabapentin start at 100 to 300 mg and titrate to 1800 to 2100 mg divided in 2 to 3 daily doses[*] – Can help reduce withdrawal symptoms and help with pain, anxiety, and sleep • Tizanidine 4 mg three times daily, can increase to 8 mg three times daily
Anxiety, dysphoria, lacrimation, rhinorrhea	• Hydroxyzine 25 to 50 mg three times a day as needed • Diphenhydramine 25 mg every 6 hours as needed[**]
Myalgias	• NSAIDs (e.g., naproxen 375 to 500 mg twice daily or ibuprofen 400 to 600 mg four times daily)[***] • Acetaminophen 650 mg every 6 hours as needed • Topical medications like menthol/methylsalicylate cream, lidocaine cream/ointment
Sleep disturbance	• Trazodone 25 to 300 mg orally at bedtime
Nausea	• Prochlorperazine 5 to 10 mg every 4 hours as needed • Promethazine 25 mg orally or rectally every 6 hours as needed • Ondansetron 4 mg every 6 hours as needed
Abdominal cramping	• Dicyclomine 20 mg every 6 to 8 hours as needed
Diarrhea	• Loperamide 4 mg orally initially, then 2 mg with each loose stool, not to exceed 16 mg daily • Bismuth subsalicylate 524 mg every 0.5 to 1 hour orally, not to exceed 4192 mg/day

[*]adjust dose if renal impairment; [**] avoid in patients > 65 years old; [***]caution in patients with risk GI bleed, renal compromise, cardiac disease

References:

1. Dowell D, Haegerich TM, Chou R; CDC guideline for prescribing opioids for chronic pain – United States, 2016. MMWR 2016;65(1-49).
2. Atlas SJ, Deyo RA; Evaluating and managing acute low back pain in the primary care setting. J Gen Intern Med. 2001 Feb; 16(2): 120–131. doi: 0.1111/j.1525-1497.2001.91141.x
3. DSM-5 Criteria for Opioid Use Disorder: American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders Fifth Edition. 2013.
4. J. A. Boscarino, S. N. Hoffman, and J. J. Han, "Opioid-use disorder among patients on long-term opioid therapy: impact of final DSM-5 diagnostic criteria on prevalence and correlates.," Subst. Abuse Rehabil., vol. 6, pp. 83–91, Jan. 2015.
5. Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain — Part B: Recommendations for Practice, Version 5.5. April 30, 2010. [NOUGG] Accessed at: http://nationalpaincentre.mcmaster.ca/documents/opioid_guideline_part_b_v5_6.pdf
6. Berna C, Kulich RJ, Rathmell JP. Tapering Long-term Opioid Therapy in Chronic Noncancer Pain: Evidence and Recommendations for Everyday Practice. Mayo Clin Proc. 2015:90(6):828-842.
7. Kral, LA; Jackson K, Uritsky TJ. A practical guide to tapering opioids. Ment Health Clin (internet). 2015;5(3):102-108. DOI: 10.9740/mhc.2015.05.102.
8. Chou R, Fanciullo GJ, Fine PG, Adler JA, et al. Clinical guidelines for the use of chronic opioid therapy in chronic non-cancer pain. J Pain. 2009;10(2):113-30. DOI: 10.1016/j.jpain.2008.10.008.
9. Kahan M, Wilson L, Mailis-Gagnon A, Srivastava A, National Opioid Use Guideline G. Canadian guideline for safe and effective use of opioids for chronic non-cancer pain: clinical summary for family physicians. Part 2: special populations. Can Fam Physician. 2011;57(11):1269-76, e419-28.
10. American Society of Addiction Medicine (ASAM) National practice guideline for the use of medications in the treatment of addiction involving opioid use. 2015. Available from: http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24
11. Micromedex Drugdex Evaluations. Thomson Micromedex. Greenwood Village, CO. Available at: http://www.thomsonhc.com. Accessed March 19, 2012.
12. Charney DS, Sternberg DE, Kleber HD, et. al. The clinical use of clonidine in abrupt withdrawal from methadone. Effects on blood pressure and specific signs and symptoms. Arch Gen Psychiatry. 1981 Nov;38(11):1273-7.
13. Mattick RP, Hall W. Are detoxification programmes effective? Lancet. 1996 Jan 13;347(8994):97-100.
14. Boscarino JA, Hoffman SN, Han JJ. Opioid-use disorder among patients on long-term opioid therapy: impact of final DSM-5 diagnostic criteria on prevalence and correlates. Substance Abuse and Rehabilitation 2015:6 83–91
15. Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain Part B: Recommendations for Practice, Version 5.5 April 30, 2010. [NOUGG] Accessed at: http://nationalpaincentre.mcmaster.ca/documents/opioid_guideline_part_b_v5_6.pdf
16. Ahmadi-Abhari SA, Akhondzadeh S, Assadi SM, Shabestari OL, Farzanehan SM, Kamlipour A. Baclofen versus clonidine in the treatment of opiates withdrawal, side-effects aspect: a double-blind randomized controlled trial. Journal of Clinical Pharmacy and Therapeutics 2001;26:67-71
17. Akhondzadeh S, Ahmadi-Abhari SA, Assadi SM, Shabestari OL, Kashani AR, Farzanehgan SM. Double-blind randomized controlled trial of baclofen in the treatment of opiates wit Journal of Clinical Pharmacy and Therapeutics 2000; 25:347-353.
18. Assadi SM, Radgoodarzi R, Ahmadi-Abhari SA. BMC Psychi atry. Baclofen for maintenance treatment of opioid dependence: A randomized double-blind placebo-controlled clinical trial. 2003;3:16-26.
19. de Beaurepaire, R. Suppression of alcohol dependence using baclofen: a 2 year observational study of 100 patients. Frontiers in Psychiatry. 2012;103: 1-7.



Real Provider Resources
Real Patient Results

U.S. Department of Veterans Affairs

This reference guide was created to be used as a tool for VA providers and is available to use from the Academic Detailing SharePoint.

These are general recommendations only; specific clinical decisions should be made by the treating provider based on an individual patient's clinical condition.

VA PBM Academic Detailing Service Email Group:
PharmacyAcademicDetailingProgram@va.gov

VA PBM Academic Detailing Service SharePoint Site:
https://vaww.portal2.va.gov/sites/ad/SitePages/Home.aspx

VA PBM Academic Detailing Public Website:
http://www.pbm.va.gov/PBM/academicdetailingservicehome.asp

October 2016

IB 10-939 P96820