Provider Considerations for Tapering of Opioids

Opioids play an important role in managing chronic pain, however, regular monitoring is essential to minimize the inherent risks of long-term opioid use including death, accidents, and increasing disability. The Centers for Disease Control and Prevention described prescription pain medication overdose as a growing and deadly epidemic. Consider tapering to a reduced opioid dosage or tapering and discontinuing opioid therapy when your patient **(This guideline does not apply to patients with cancer pain or those receiving end-of-life care. No single approach to tapering is appropriate for all patients):**

- requests dosage reduction
- does not have clinically meaningful improvement in pain and function (e.g., at least 30% improvement on the 3-item PEG scale); pain perception can be altered by opioids, resulting in hyperalgesia-long-term effectiveness of opioid pain medication is not clear and many patients report less pain when they discontinue opioids.
- is on dosages ≥ 50 MME/day (morphine milligram equivalents) without benefit or opioids are combined with benzodiazepines
- shows signs of substance use disorder (e.g. work or family problems related to opioid use, difficulty controlling use)
- experiences overdose or other serious adverse event
- shows early warning signs for overdose risk such as confusion, sedation, or slurred speech

Follow up regularly

Have patients return frequently to determine whether opioids are meeting treatment goals and whether opioids can or should be reduced to lower dosage or discontinued. Consider use of urine drug screens, pill counts, and use of CSRS to aid in determining determine adherence.

How to taper:

Tapering plans should be individualized and should minimize symptoms of opioid withdrawal while maximizing pain treatment with non-pharmacologic therapies and non-opioid medications. If multiple drugs are involved, taper one at a time (e.g., start with opioids, follow with benzodiazepines). In general:

Go Slow

- A decrease of 10% of the original dose per week is a reasonable starting point. Some patients who have taken opioids for a long time might find even slower tapers (e.g., 10% per month) easier.
- Determine rate of taper based upon clinical assessment of degree of risk.
- Discuss the increased risk for overdose if patients quickly return to a previously prescribed higher dose.
- Consider adjuvant medications: antidepressants, gabapentin, NSAIDs, clonidine, anti-nausea, anti-diarrhea during the taper period as needed.
- Consult/coordinate with specialists and treatment experts as needed—especially for patients at high risk of harm such as pregnant women or patients with an opioid use disorder.

- The American Congress of Obstetricians/Gynecologists position regarding pregnant women with an opioid use disorder is that opioid agonist pharmacotherapy is the recommended therapy and is preferable to medically supervised withdrawal because withdrawal is associated with high relapse rates, which lead to worse outcomes.*

Support

- Make sure patients receive appropriate psychosocial support. If needed, work with mental health providers, arrange for treatment of opioid use disorder, and offer naloxone for overdose prevention.
- Set a date to begin and set a reasonable date for completion. Provide information to the patient and establish behavioral supports prior to instituting the taper.
- Watch for signs of anxiety, depression, and opioid use disorder during the taper and offer support or referral as needed.

Encourage

Let patients know that most people have improved function without worse pain after tapering opioids. Some patients even have improved pain after a taper, even though pain might briefly get worse at first.

Tell patients "I know you can do this" or "I'll stick by you through this."

Additional Considerations:

1. Adjust the rate and duration of the taper according to the patient's response.
2. Don't reverse the taper; however, the rate may be slowed or paused while monitoring and managing withdrawal symptoms.
3. Once the smallest available dose is reached, the interval between doses can be extended and opioids may be stopped when taken less than once a day

Additional Resources:

Oregon Pain Guidance:
http://www.oregonpainguidance.org/app/content/uploads/2016/05/Opioid-and-Benzodiazepine-Tapering-flow-sheets.pdf

CDC Pocket Guide to Tapering Opioids:
https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf

Intermountain Physicians Healthcare:
https://intermountainphysician.org/Documents/Opioid%20Tapering.pdf

CDC Guideline for Prescribing Opioids for Chronic Pain:
https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

* American Congress of Obstetricians and Gynecologists- Opioid Use and Opioid Use Disorder in Pregnancy
https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy

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