The Functional Restoration/Chronic Pain Development Team developed these guidelines to assist providers with tapering patients’ opioid pain medications. The Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain, Utah Clinical Guidelines on Opioid Dosing for Chronic Non-cancer Pain, and other peer-reviewed clinical guidelines were used to develop the guidelines.

 WHY FOCUS ON OPIOID TAPERING?

Opioids play an important role in managing chronic pain; however, regular monitoring is essential to minimize these inherent risks:

- **Serious consequences** of long-term opioid use include death, accidents, and increasing disability. The Centers for Disease Control and Prevention described prescription pain medication overdose as a growing and deadly epidemic.
- **Adverse effects** associated with opioid use include functional limitations, apnea, anxiety, and depression.
- **Pain perception** can be altered by opioids, resulting in hyperalgesia. The long-term effectiveness of opioid pain medication is not clear. Many patients report less pain when they discontinue opioids.
- **Abuse, addiction, and diversion** are all significant risks of opioids.

 KEY POINTS

- 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.
- If overdose or aberrant behavior is detected or suspected, consider consulting with or referring patient to an addiction specialist.
- If pain is uncontrolled and patient requires a high dose of opioids (e.g., morphine equivalent > 120 mg/day), consider referral to a pain specialist.
- Tapering can be a slow process and requires preparation, planning, monitoring, and follow-up.
- Although potentially unpleasant, withdrawal symptoms associated with tapering generally are not dangerous.

 KEY RECOMMENDATIONS

Assess these factors:
- Patient’s desire to discontinue opioids
- Pain and function
- Adverse effects
- Reasons for continuing use
- Abuse, addiction, or diversion

Consider these guidelines:
- Most patients tolerate a 10% dose reduction per week. Faster or slower tapering may be indicated.
- Abstinence syndrome may be treated with medications such as oral or transdermal clonidine.
- Patients should be regularly monitored and referred to specialists as needed.

MEASUREMENT & GOALS

- Improve the quality of life for patients with chronic pain in terms of overall function, work status, sleep, and activity levels.
- Reduce admissions for opioid overdose.
- Reduce the number of patients taking 2 or more long-acting opioids.
- Reduce the number of patients taking a morphine equivalent dose of more than 120 mg/day.

These guidelines apply to common clinical circumstances, and may not be appropriate for certain patients and situations. The treating clinician must use judgment in applying guidelines to the care of individual patients.
Opioid Tapering Assessment

ASSESS for abuse, addiction, and diversion
Consider the following red flags and evaluate using the COMM assessment tool, if needed (a):
- Aberrant results on a urine drug test (b) or refusal to participate in screening
- Aggressively demanding opioids
- Escalating dose without consulting a provider
- Presenting to the ED repeatedly for pain management
- Motor vehicle accident due to drug or alcohol impairment or DUI charge
- Hospital admission for overdose or drug abuse
- Positive report in the State of Utah Controlled Substance Database
- Obtaining opioid medication from multiple providers
- Frequently losing prescriptions
- Serious nonadherence to the Pain Management Plan

Are there concerns regarding abuse, addiction or diversion?

no

ASSESS further; TREAT or REFER
- Discuss your concerns with the patient
- If you suspect diversion, contact your facility’s risk management or legal department (c)
- Complete a mental health assessment
- Perform urine drug screening
- See the Substance Use Disorder CPM
- Consult with or refer patient to an addiction specialist, if needed
- See page 4 for discussion of the role of methadone and buprenorphine

yes to any

EVALUATE for risk of adverse events
Does the patient demonstrate any of the following?:
- History of significant adverse events (eg, falls, accidents)
- Contraindications to continued opioid use (d)
- Currently taking >1 long-acting opioid
- Dose exceeds morphine equivalent of 120 mg/day (e)
- Concurrent use of benzodiazepines and opioids

no to all

CONSIDER other reasons to taper
- Patient prefers to discontinue opioids
- Pain improved (f)
- Medical condition improved

no to all

CONTINUE opioid treatment; RE-EVALUATE regularly
- Update the Controlled Substance Agreement annually and provide the Opioid Medication for Chronic Pain fact sheet
- Discuss alternative pain treatments (h)
- Update pain diagnosis on Problem List
- Monitor compliance with the Pain Management Plan
- Reassess the risk of abuse: perform unannounced urine drug screening (twice annually for medium-risk patients; annually for low-risk patients)
- Reassess appropriateness of tapering using this algorithm

EDUCATE patient about opioid risks (g), PROCEED with tapering

REFER to next page for tapering process

Source: agencymeddirectors.wa.gov/mobile.html

Published equianalgesic ratios are considered estimates and depend on age (use caution with elderly patients) and coexisting conditions, especially liver, renal, or pulmonary disease. When converting to a new opioid, start with a 25–50% lower equianalgesic dose because of incomplete cross-tolerance. When converting from a fentanyl patch, allow 12–24 hours for absorption of residual drug before starting a new opioid. Conversion tables may overestimate the morphine equivalent potency; therefore, reduce the dose of the new drug at least 50%.

(f) Use the Brief Pain Inventory to determine severity of pain and interference with function.

(g) Provide the fact sheet on Cutting Back on Opioid Pain Medication.

(h) Refer to the Management of Chronic Non-cancer Pain CPM.

(a) The Current Opioid Misuse Measure (COMM) has been shown to be effective in identifying whether a patient may be exhibiting aberrant behaviors associated with opioid medication misuse.

(b) Positive screening results should be confirmed with testing that uses gas or liquid chromatography/mass spectrometry (GC/MS) to ensure accuracy. All results should be interpreted in the context of the clinical setting and discussed with patients to improve patient care.

(c) For guidance on handling suspected diversion, refer to pages 25–26 of the Management of Chronic Non-cancer Pain Care Process Model.

(d) Possible contraindications to continuing opioid therapy include COPD, congestive heart failure, obstructive/central sleep apnea, abnormal breathing/snoring, substance abuse or history of substance abuse, mental health disorders, advanced age, and renal or hepatic dysfunction.

(e) ORAL DOSE EQUIVALENTS of 120 mg/day morphine

<table>
<thead>
<tr>
<th>Drug</th>
<th>Equivalency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>800 mg/day</td>
</tr>
<tr>
<td>Fentanyl (transdermal)</td>
<td>25–50 mcg/hr</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>120 mg/day</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>30 mg/day</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>80 mg/day</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>40 mg/day</td>
</tr>
</tbody>
</table>

Source: agencymeddirectors.wa.gov/mobile.html

(e) Published equianalgesic ratios are considered estimates and depend on age (use caution with elderly patients) and coexisting conditions, especially liver, renal, or pulmonary disease. When converting to a new opioid, start with a 25–50% lower equianalgesic dose because of incomplete cross-tolerance. When converting from a fentanyl patch, allow 12–24 hours for absorption of residual drug before starting a new opioid. Conversion tables may overestimate the morphine equivalent potency; therefore, reduce the dose of the new drug at least 50%.

CLINICAL GUIDELINE – TAPERING OPIOID PAIN MEDICATION

AUGUST 2015

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(Patient and Provider Publications 801-442-2963)
Providers should be careful to maintain the therapeutic relationship during tapering. Some patients may resort to risky behaviors such as doctor-shopping or illicit drug use. Patients may also challenge providers or exaggerate their pain to avoid tapering. See page 4 for tips on talking with patients.

Fast tapering may be considered for patients who have been on lower doses of opioids and/or taking opioids for a shorter time (e.g., <1 month). Generally, these patients can be tapered more rapidly during the first 50% of dose reduction. The final 25% may be more challenging and require slower tapering.

Slower tapering is suggested for patients who:
- Are psychologically dependent on opioids or anxious about tapering
- Have been on high doses and/or taking opioids for a longer time
- Have unstable cardiac disease

Withdrawal symptoms can persist for up to 6 months after opioids are discontinued and may include the following:
- abdominal cramping
- nausea
- vomiting
- diarrhea
- muscle and joint pain
- myoclonus
- tachycardia
- fever
- elevated blood pressure
- anorexia
- insomnia
- rhinorrhea
- anxiety
- irritability
- dysphoria

Pregnant patients: Acute withdrawal symptoms can trigger premature labor and spontaneous abortion in pregnant patients and can exacerbate some medical and psychiatric conditions.

Re-initiating opioid therapy: Be extremely cautious about restarting opioid therapy after discontinuation. Patients may redevelop tolerance quickly.
REFERENCES AND RESOURCES


DISCUSSION WITH PATIENTS

While some patients choose to discontinue opioids, others may be anxious about the process or prefer not to taper. The following approaches can be helpful when patients are resistant, hesitant or anxious about opioid tapering:

- Summarize the risks and benefits of opioids, focusing on the patient’s particular situation. Explain that tapering is necessary in his or her case because long-term use could do more harm than good.
- Emphasize the likely benefits of tapering, such as improved day-to-day functioning, greater energy, and clearer thinking. Ask the patient about his or her personal goals and discuss how tapering opioids could help achieve them.
- Remind the patient that people taking opioids are at risk for addiction, even if they have not had problems with drugs or alcohol in the past.
- Discuss nonopioid pain treatments, including alternative therapies that appeal to the patient. Explain that although you are recommending tapering, you are committed to caring for the patient and treating his or her pain.
- Reassure the patient that the tapering protocol will be tailored to his or her needs and can be modified if necessary. Encourage regular follow-up.
- Inform the patient that while discontinuing opioid pain medications might be uncomfortable, it is generally not dangerous.
- Set realistic expectations for tapering. Tell the patient that pain might increase temporarily when the dose is reduced. Discuss common withdrawal symptoms and possible treatments. Encourage patients to call if withdrawal symptoms are bothersome.
- Acknowledge the patient’s emotional distress, if appropriate. Discuss coping strategies and offer referral to a behavioral health specialist.
- Respectfully “agree to disagree” with the patient’s perspective on the situation, if necessary.

NOTES ON METHADONE & BUPRENORPHINE

Methadone: Patients who are already on a stable dose of methadone can be tapered according to this guideline. Although methadone can be used to taper off other opioids, it should only be used this way by clinicians who are familiar with its risks and use and are prepared to conduct the necessary careful monitoring. Its use in the setting of opioid addiction requires special licensure.

Suboxone (buprenorphine/naloxone): This drug is approved for the treatment of opioid addiction and also requires special licensure. It is a partial agonist at the mu opioid receptor and therefore does have analgesic properties. This makes it particularly useful in treating chronic pain complicated by comorbid opioid abuse, misuse, or addiction. While it may be used as a means of tapering off opioids, addicted patients should consider staying on it longer term due to the high recidivism rates in these patients.

Topical and sublingual buprenorphine: These can be used in chronic pain disorders and can be prescribed by primary care physicians.