

Oregon Health Authority
Oregon Opioid Taper Guidelines Task Force
AGENDA



Oregon Opioid Taper Guidelines Task Force

June 14, 2019

9:00-12:00

Portland State Office Building

800 NE Oregon, Room 1A

Conference Line: 1-888-278-0296

Public Meeting ID: 843163

Goals

- Review and continue discussion of guidelines

Agenda

- **Welcome, goals, agenda review, introductions** - Dana Hargunani, Chief Medical Officer, Oregon Health Authority; Diana Bianco, Principal, Artemis Consulting
- **Updates** – Dana
- **Workplan review** - Diana
- **Guideline content**
 - Update
 - Patient Assessment/Evaluation
 - Continue topic review and discussion
 - Approach to Tapering (cont'd)
 - Setting goals and defining success
 - Taper plans
 - Role of MAT
 - Special populations
 - Multidisciplinary supports
 - Social and cultural supports
 - Monitoring and reassessment
 - Managing withdrawal
- **Public comment** (approx. 11:45)
- **Next steps and summary**
 - July and August meetings

Oregon Health Authority

Oregon Opioid Taper Guidelines Task Force

WORKPLAN



This workplan is to manage the Oregon Opioid Taper Guidelines Task Force in developing guidelines in an efficient and organized manner. Topics intended to be discussed at each meeting are reflected below.

March

Principles, Guidelines Framework

April

Principles, Guidelines Outline, Definitions, Patient Assessment and Evaluation

May

Definitions, When to consider Tapering, Approach to Tapering

June

Approach to Tapering

July

Long-term Support and Follow Up, When to Refer, Provider Education
Begin review of draft guideline document

August

Organizational Supports for Plans and Health Systems, Resources for Providers and Patients, References
Continue review of draft guideline document

September/October (as needed)

Final review of complete draft guideline
Endorsement of guideline document

Last update June 11, 2019

Oregon Health Authority
Oregon Opioid Taper Guidelines Task Force
MEETING NOTES



Oregon Opioid Taper Guidelines Task Force

May 23, 2019

1:30 p.m. - 4:00 p.m.

Portland State Office Building

800 NE Oregon, Room 1A

Conference Line: 1-888-278-0296

Public Meeting ID: 843163

Welcome, goals, agenda review, introductions

Diana Bianco, Principal of Artemis Consulting, welcomed the Task Force and asked Task Force members to introduce themselves. Diana reviewed the agenda.

Updates

Dana Hargunani, Chief Medical Officer of the Oregon Health Authority, announced that the Task Force is looking for additional members with lived experience and will be re-opening the application process to fill that role. Task Force members are encouraged to share the recruitment.

Dana also provided an update on the HERC's recent decisions regarding Oregon Health Plan coverage for five chronic pain conditions. The HERC decided not to cover the five chronic pain conditions due to the limited evidence of effectiveness for the treatments under review. They will continue to review forthcoming evidence to identify when there is an opportunity to revisit this coverage in the future. The HERC also decided, after reviewing evidence and public input over the last year, to remove the requirement for tapering patients already using opioids for the treatment of back and neck pain. Finally, the HERC has also committed to re-opening the back and neck pain guidelines, originally established in 2016, no later than this winter when new evidence is expected to be published. Dana shared with the HERC that this Task Force hopes the forthcoming taper guidelines will inform the HERC's work ahead.

Review: Guideline Principles

The Task Force reviewed the list of principles with the revisions based on discussion at April's meeting:

- We changed "medically realistic" to "data driven"
- We changed "practical" to "applicable to different practice settings"

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→ The Task Force also wants to add “patient safety” to the list of principles. With that addition, the Task Force approved the principles.

Review: Definitions

The Task Force reviewed the definitions section of the working document. They adopted the definitions with the following specific edit recommended: update the patient abandonment to remove “Doctor/patient relationship” should be changed to “*Provider*/patient relationship”. The Task Force accepted the definitions section with this change.

For the remainder of the meeting, the Task Force reviewed content from the discussion guide to inform remaining sections of the taper guidelines not yet discussed as follows:

Guideline Section: Patient assessment/evaluation to determine whether to taper

We continued our discussion on the Patient Assessment/Evaluation section.

- Members agreed that we should draft an algorithm for this section. A small group will work on this, building on existing tools and resources. Members who volunteered for this group are Kim Mauer, Kim Swanson, Helen Turner, and Meenakshi Dogra.
 - Task Force members suggested the following resources to inform the algorithm: Providence flowchart, PEG tool, DVPRS pain rating scale from VA/DoD, the Joint Commission new pain assessment standards.
 - The Task Force discussed whether they should be recommending specific tools (i.e., PEG tool, DVPRS pain scale) due to risk that they may become replaced/outdated; the workgroup agreed that the guideline should offer examples and should state that any tool used should be up-to-date, evidence-based, validated and used with fidelity.
 - OHA will reach out to small group members with doodle poll for scheduling.

Guideline Section: When to Consider Tapering

The Task Force decided to adapt the VA/DoD example language as listed in the Discussion Guide with some editing. Specifically, the Task Force recommended making the following edits to the VA/DoD tool for inclusion in the taper guideline:

- Add “develop or” to this statement as follows: Mental health comorbidities that can **develop or** worsen with opioid therapy (e.g., PTSD, depression, anxiety)

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- Add a clarifying statement that these opioid tapering guidelines apply to when opioids (agonists or partial agonists) are used in the context of pain management, not when used for opioid use disorder.
- Change “comorbidities” to “risk factors” across all bullet points
- Add hyperalgesia as an adverse effect and remove “severe” from the statement as follows: ~~Severe~~ unmanageable adverse effects (e.g., drowsiness, constipation, cognitive impairment, **hyperalgesia**)
- Consider adding additional adverse effects from the literature; a specific resource will be shared with the group by Jonathan Robbins.
- Change “advanced age” to medical frailty as follows: Medical comorbidities that can increase risk (e.g., lung disease, sleep apnea, liver disease, renal disease, fall risk, ~~advanced age~~ **medical frailty**)
- Add poly-pharmacy and other sedating medications to the list as follows: Concomitant use of medication can increase risk (e.g., benzodiazepines, **other sedative-hypnotics, and poly-pharmacy**)

In addition to the above recommended changes, the Task Force had a long discussion about what MED # to include in this section. The workgroup discussed the following considerations:

- Align with what the evidence shows (i.e., is there an inflexion point whereby risks become markedly greater)? At least one member feels the evidence would support a focus on 50 MED or greater.
- Consider referring to clinical judgment, not just a number. However, other members voiced their opinion that it is important to reference a number.
- The MED # needs to indicate “when to consider” tapering, but it should be noted that risks can occur at lower doses as well.
- Consider the evidence not only pertaining to high risk doses for OUD but also for overdose, which may be different in different populations.
- Meenakshi Dogra noted that the VA is going to focus on 50 MED within forthcoming guidelines; the guidelines will result in community-based providers caring for veterans getting a letter telling them to be aware of the risks associated with > 50 MED and the need to do a risk assessment. There will be no mandate, but rather just trying to assess for and mitigate any risk that might be present.

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- Ultimately the group agreed upon referencing a range of MED to 50-90 for the purposes of this section as follows: Dosage indicates high risk of adverse events (e.g., doses between **50-90 MED** and higher)

“Parking Lot” discussion items from this section:

- Katrina Hedberg noted that mental health evaluation should be included in the assessment/evaluation section.
- Need to cross reference all elements with other sections of the guidelines (when applicable) and with similar topics as listed in the existing Chronic Pain Guidelines.
- Will need to make sure the guidelines indicate that patients on opioids should be repeatedly assessed for risk vs. benefits.

Guideline Section: When to Consider Tapering

The Task Force agrees with the existing headers in this section. The group added the following subsections: Buprenorphine, OUD/MAT, Team-based Care (including organizational supports), Harm Reduction. Some specific discussions on these topics included:

- Buprenorphine: At least one Task Force member perspective feels that discussion of buprenorphine in the guideline should be focused on OUD: when OUD is uncovered, or there is a concern for OUD, then buprenorphine would be preferred over tapering. Other Task Force members indicated they would use buprenorphine as a safer option for people on opioids, not only with OUD (i.e., with opioid dependence). It was noted that there is a separate need for a “Buprenorphine 101” resource.
- Patient education & setting goals subsections: these subsections should be rewritten and possibly combined, to include: risk benefit discussion (i.e., difficult conversations), motivational interviewing, education about withdrawal and what to expect, communication (i.e., written taper plan). These subsections should be focused on shared decision making, should include language around patient-centered engagement, and should include information about common beliefs and perspectives. Consider referencing or framing with the BRAVO approach. Consider adding the safekeeping of medications into this section (as included in WA language).

Resources

Task Force members were reminded that if they have additional resources (i.e., sources of content for the guidelines), they should be sent to Lisa Bui.

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Two documents have been added to the resource list and are included in the meeting documents for today's meeting.

- April 9, 2019 FDA statement - new opioid analgesic labeling changes:
<https://www.fda.gov/news-events/press-announcements/statement-douglasthrockmorton-md-deputy-center-director-regulatory-programs-fdas-center-drug-0>
- No Shortcuts to Safer Opioid Prescribing by Dowell, Haegerich, Chou (New England Journal of Medicine, 2019: <https://www.nejm.org/doi/full/10.1056/NEJMp1904190>)

Public comment (approximately 3:45)

A letter to HERC was submitted for public comment and distributed to Task Force members. Two persons in attendance provided comment.

Meeting Evaluation

Diana asked for feedback regarding what worked and what didn't work in terms of the structure of the meeting and meeting materials. Task Force members provided the following comments:

- Scribing requested via whiteboard or flip chart as might be helpful.
- Offering ways to contribute/volunteer if attendance at meetings isn't possible.

Next steps and summary

The next meeting will include the following:

- Review summary of May meeting
- Continued discussion of content in "approach to tapering" section

June 14th meeting will be extended by 30 minutes. July and August meetings to be re-scheduled pending results of polling for group availability.

Next meeting: June 14, 2019 from 9:00 a.m. - 12:00 p.m.

Oregon Opioid Taper Prescribing Guidelines WORKING DOCUMENT

Acknowledgements

Task Force membership

Background

Principles

The Oregon Opioid Taper Prescribing Guideline Task Force adopted the following principles that should underlie these guidelines for opioid tapering, including:

- Compassionate
- Patient-centered
- Flexible
- Trauma-informed
- Promote patient engagement and shared decision-making
- Support informed consent
- Focus on harm reduction
- Data driven
- Evidence-based
- Focus on pain science
- Promote an integrated approach
- Applicable to different practice settings
- Accessible/clear
- Focus on patient safety

Definitions

The following are definitions adopted by the Oregon Opioid Taper Prescribing Guidelines Task Force to inform their work:

Tapering: Collaborating with a patient to achieve a a reduced opioid dosage or reducing dosage and discontinuing opioid therapy. (CDC)

Opioid Tolerance: Defined by either of the following: a) need for markedly increased amounts of opioids to achieve desired effect whether therapeutic or recreational, b) markedly diminished effect with continued use of the same amount of opioid. (DSM-5)

Opioid Withdrawal syndrome: Defined by Criteria A and B, including:

A) Either of the following: 1) cessation of (or reduction in) opioid use that has been heavy and prolonged (several weeks or longer), or 2) administration of an opioid antagonist after a period of opioid use;

B) Three (or more) of the following, developing within minutes to several days after Criterion A: dysphoric mood; nausea or vomiting; muscle aches; lacrimation or rhinorrhea; pupillary dilation, piloerection, or sweating; diarrhea; yawning; fever; or insomnia. (DSM-5)

Opioid Withdrawal: Defined by either of the following: a) Characteristic opioid withdrawal syndrome, or b) same (or closely related) substance is taken to relieve or avoid withdrawal symptoms. (DSM-5)

Opioid Use Disorder: A problematic pattern of opioid use leading to clinically significant impairment or distress. To confirm a diagnosis of OUD, at least two of the following should be observed within a 12-month period (the last two diagnostic criteria, related to tolerance and withdrawal, are not considered to meet OUD for individuals taking opioids solely under appropriate medical supervision):

- a. Opioids are often taken in larger amounts or over a longer period than was intended.
- b. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- c. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- d. Craving, or a strong desire or urge to use opioids.
- e. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
- f. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- g. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
- h. Recurrent opioid use in situations in which it is physically hazardous.
- i. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- j. Exhibits tolerance (discussed in the next section).
- k. Exhibits withdrawal (discussed in the next section).

Severity of OUD is specified as: Mild (2-3 criteria), Moderate (4-5 criteria), or Severe (6 or more criteria). (DSM-5)

Medical Abandonment: a medical professional's discontinuation of an established ~~doctor~~provider-patient relationship before the patient's necessary treatment has ended and without arranging for continuing treatment or care. It is a form of medical malpractice. (Black's Law Dictionary 10th Edition, 2015).

Patient Assessment/Evaluation (tbd)

When to Consider Tapering

Consider tapering opioids (either full or partial opioid agonists) for individuals being treated for pain when:

- No pain reduction, no improvement in function or patient requests to discontinue therapy

- ~~Severe u~~Unmanageable adverse effects (e.g., drowsiness, constipation, cognitive impairment, hyperalgesia)
- Dosage indicates high risk of adverse events (e.g., doses of ~~90-50-90~~ MED 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~~ factors that can increase risk (e.g., lung disease, sleep apnea, liver disease, renal disease, fall risk, ~~advanced age~~ medical frailty)
- Concomitant use of medications can increase risk (e.g., benzodiazepines, other sedative-hypnotics, and poly-pharmacy)
- Mental health ~~comorbidities~~ risk factors that can develop or worsen with opioid therapy (e.g., PTSD, depression, anxiety)

(adapted from VA/DoD language)

Approach to Tapering

Subsections:

Patient Education, Setting Goals, and Defining Success

Team-based Care and Organizational Supports

Taper Plans

Opioid Use Disorder and Role of Medication-Assisted Therapy

Buprenorphine

Harm Reduction

Multidisciplinary Supports

Social and Cultural Supports

Monitoring and Reassessment

Managing Withdrawal

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Reference documents

- **Centers for Disease Control & Prevention (CDC):** [Pocket Guide: Tapering; Training Module 5: Assessing and Addressing Opioid Use Disorder](#); [Guideline for Prescribing Opioids for Chronic Pain](#)
- **Oregon Pain Guidance (OPG):** [Tapering Guidance & Tools](#); [Pain Treatment Guidelines](#)
- **Veteran's Health Administration/Dept. of Defense (VA/DoD):** [Opioid Taper Decision Tool](#); [Transforming the Treatment of Chronic Pain: Moving Beyond Opioids](#)
- **Washington Agency Medical Director's Group (WA):** [AMDG 2015 Interagency Guideline on Prescribing Opioids for Pain](#)
- **Diagnostic and Statistical Manual of Mental Disorders (DSM-5)**
- **FDA statement** - new opioid analgesic labeling changes: <https://www.fda.gov/news-events/press-announcements/statement-douglas-throckmorton-md-deputy-center-director-regulatory-programs-fdas-center-drug-0>
- **No Shortcuts to Safer Opioid Prescribing** by Dowell, Haegerich, Chou (New England Journal of Medicine, 2019): <https://www.nejm.org/doi/full/10.1056/NEJMp1904190>

Definitions

Tapering definition

1. **CDC:** Tapering to a reduced opioid dosage or tapering and discontinuing opioid therapy
2. **OPG:** Opioid dose reduction
3. **VA/DoD:** Determine if the initial goal is a dose reduction or complete discontinuation. If initial goal is determined to be a dose reduction, subsequent regular reassessment may indicate that complete discontinuation is more suitable.
4. **WA:** Reducing or discontinuing chronic opioid analgesic therapy

Opioid tolerance definition

1. **DSM-5:** Defined by either of the following:
 - a. Need for markedly increased amounts of opioids to achieve intoxication or desired effect
 - b. Markedly diminished effect with continued use of the same amount of opioid

Opioid withdrawal definition

1. **DSM-5:** Defined by either of the following:

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- a. Characteristic opioid withdrawal syndrome
- b. Same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

Opioid withdrawal syndrome definition

- 1. **DSM-5:** Defined by Criteria A and B:
 - a. Either of the following: 1) Cessation of (or reduction in) opioid use that has been heavy and prolonged (several weeks or longer), or 2) administration of an opioid antagonist after a period of opioid use.
 - b. Three (or more) of the following, developing within minutes to several days after Criterion A: dysphoric mood; nausea or vomiting; muscle aches; lacrimation or rhinorrhea; pupillary dilation, piloerection, or sweating; diarrhea; yawning; fever; or insomnia.

Opioid Use Disorder/Addiction definition

- 1. **DSM-5:** Opioid Use Disorder (OUD) is defined as a problematic pattern of opioid use leading to clinically significant impairment or distress. To confirm a diagnosis of OUD, at least two of the following should be observed within a 12-month period (the last two diagnostic criteria, related to tolerance and withdrawal, are not considered to meet OUD for individuals taking opioids solely under appropriate medical supervision):
 - a. Opioids are often taken in larger amounts or over a longer period than was intended.
 - b. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
 - c. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
 - d. Craving, or a strong desire or urge to use opioids.
 - e. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
 - f. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
 - g. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
 - h. Recurrent opioid use in situations in which it is physically hazardous.
 - i. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
 - j. Exhibits tolerance (discussed in the next section).
 - k. Exhibits withdrawal (discussed in the next section).

Severity of OUD is specified as: Mild (2-3 symptoms), Moderate (4-5 symptoms), or Severe (6 or more symptoms).

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Opioid dependence definition

1. **DSM-5:** term no longer utilized
2. **OPG:** Complex Persistent Opioid Dependence (CPOD)
 - o **Complex:** Dependence is complicated by desire to continue taking opioid for the treatment of pain. Withdrawal is complicated by anhedonia and hyperalgesia which, unlike classic 'physical' symptoms, may not reverse within days.
 - o **Persistent:** Tapering is poorly tolerated. Tapering, therefore, may fail, or is highly protracted (takes months or years).
 - **What distinguishes CPOD from OUD:**
 - No craving
 - No compulsive use
 - No harmful use that is not medically directed (patient takes opioid exactly as prescribed)
 - Social disruption is attributed to pain and not to OUD
3. **WA:** The term "opioid dependence," while often acceptable to patients, is best avoided due to possible confusion with its outdated formal definition in DSM-IV.

Patient Abandonment language (use to develop definition?)

1. **CDC:** Let patients know that most people have improved function without worse pain after tapering opioids. Some patients even have improved pain after a taper. Tell patients "I know you can do this" or "I'll stick by you through this"
2. **OPG:** The prescriber's job is to remain empathic, yet resolute, and communicate to patients that a careful risk-benefit assessment informed by experience and compassion has led to this treatment plan and that to continue opioids under these circumstances would be to cause the patient further harm. Tapering down the opioid dose or not prescribing opioids doesn't mean you aren't taking care of the patient. Reassure each patient that supportive adjunctive treatment of withdrawal will be provided as needed, and may be quite helpful, but set expectations that this will not include dangerous replacement medications.
3. **VA/DoD:** When a decision is made to taper, special attention must be given to ensure that the Veteran does not feel abandoned. Prior to any changes being made in opioid prescribing, a discussion should occur between the Veteran, family members/caregivers, and the provider either during a face-to-face appointment or on the telephone. Listen to the Veteran's story; let the Veteran know that you believe their pain is real; include family members or other supporters in the discussion; acknowledge the Veteran's fears about tapering.

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4. **WA:** Patients on COAT can be reluctant to change, and many who agree to try will have difficulty as the dose is reduced. Such reluctance and difficulty in tapering often reflect anxiety. There may be apprehension about worsening of pain and withdrawal symptoms or, if there is opioid use disorder, about reduced access to the drug. Exploring each of these possibilities in a non-judgmental manner helps the provider understand the patient's perspective and helps the patient have realistic expectations. This, in turn, strengthens the therapeutic relationship and supports future strategies.

Patient assessment/evaluation to determine whether to taper

(example components to include but not limited to):

▪ **Pain assessment/evaluation**

1. **CDC:** Focus on functional goals and improvement, engaging patients actively in their pain management. Assess pain using validated instruments such as the 3-item (PEG) Assessment Scale.
Determining When to Initiate or Continue Opioids for Chronic Pain
(CDC Guideline)
Recommendation 1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
Recommendation 2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
2. **OPG:** Specific review of symptoms related to Central Sensitization spectrum, physical exam, past medical and psychiatric history, pain and, most important, functional assessment to evaluate progress with treatment over time: Oswestry, Low Back Pain Intensity, Visual Analog Scale, PEG 3-item scale for pain tracking.
3. **VA/DoD:** Assess pain and functional treatment goals and adherence to treatment plan (no specific assessment)
4. **WA:** Perform a thorough history and physical examination at initial visit for pain management. Do not pursue diagnostic tests unless risk factors or "red flags" indicate the need for further evaluation. Assess and document function and pain using validated tools at each visit where opioids are prescribed (3-item PEG, 2-item Graded Chronic Pain Scale to assess pain intensity and pain interference, STarT Back to assess risk of transitioning to chronic pain)

Commented [DB1]: Relying on existing content, we should consider developing an algorithm/visual.

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▪ **Assessing and addressing opioid/other substance use and opioid use disorder/substance use disorder**

1. **CDC: *Assessing Risk and Addressing Harms of Opioid Use* (CDC Guideline)**

Recommendation 8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present.

Recommendation 9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

Recommendation 10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

2. **OPG:** Query the PDMP, UDS POC in-office will provide results at the time of the visit, substance-abuse risk screening. If patient has OUD, transition to MAT; if patient has Complex Persistent Opioid Dependence, transition to Buprenorphine off-label for pain, or slow down taper and re-assess quarterly.

3. **VA/DoD:** If patient has OUD, use a shared decision-making approach to discuss options for OUD treatment. First-line is MAT, preferred buprenorphine/naloxone; alternative is injectable naltrexone. Ensure screening and treatment is offered for conditions that can complicate pain management before initiating opioid taper. The lifetime prevalence for OUD among patients receiving long-term opioid therapy is estimated to be about 41%: approximately 28% for mild symptoms, 10% for moderate symptoms and 3.5% for severe symptoms of OUD.

l. Patients with chronic pain who develop OUD from opioid analgesic therapy need to have BOTH pain and OUD addressed. Either tapering the opioid analgesic or continuing to prescribe the opioid without providing OUD treatment may increase the risk of overdose and other adverse events. Refer to DSM 5 criteria for OUD.3

m. Use a shared decision-making approach to discuss options for OUD treatment: First-line: Medication Assisted Therapy (MAT)

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- i. **PREFERRED:** Opioid Agonist Therapy (OAT)— buprenorphine/naloxone (Suboxone®) or methadone maintenance*
 - ii. **ALTERNATIVE:** Extended Release (ER) Injectable Naltrexone (Vivitrol®)
 - n. MAT can be provided in a variety of treatment settings including: residential SUD treatment, intensive outpatient SUD treatment, regular SUD specialty care clinic, primary care or general mental health clinic, or federally regulated opioid treatment program.
 - 4. **WA:** Assess the patient behaviors that may be suggestive of SUD; address increased pain with use of non-opioid options; evaluate patient for mental health disorders. Opioid Risk Tool (ORT), CAGE Adapted to Include Drugs (CAGE-AID), Screener and Opioid Assessment for Patients with Pain – Revised (SOAPP-R), Current Opioid Misuse Measure (COMM), DIRE, Alcohol Use Disorders Identification Test (AUDIT).
- **Psychosocial environment**
 - 1. **CDC:** Because psychological distress frequently interferes with improvement of pain and function in patients with chronic pain, use validated instruments such as the Generalized Anxiety Disorder (GAD)-7 and the Patient Health Questionnaire (PHQ)-9 or the PHQ-4 to assess for anxiety, post-traumatic stress disorder, and/or depression.
 - 2. **OPG:** Mental health screening, for co-occurring mental health disorders related to trauma, depression, anxiety, depression, ACES, and PTSD.
 - 3. **VA/DoD:** Ensure screening and treatment is offered for conditions that can complicate pain management before initiating opioid taper:
 - a. Mental health disorders (PTSD, anxiety disorders, depressive disorders)
 - i. If suicidal, then activate suicide prevention plan
 - ii. If high suicide risk or actively suicidal, consult with mental health provider before beginning taper
 - 4. **WA:** Use validated instruments to assess predictors of suboptimal recovery such as depression, fear avoidance, and catastrophizing, which can lead to persistent pain and functional limitation (PHQ-9, GAD-7, PC-PTSD).
- **Co-occurring conditions**
 - 1. **CDC:** Certain risk factors are likely to increase susceptibility to opioid-associated harms and warrant incorporation of additional strategies into the management plan to mitigate risk, such as sleep-disordered breathing, pregnant women, renal or hepatic insufficiency, patients aged 65 and older, mental health conditions, substance use disorder, and prior nonfatal overdose.

Commented [DB2]: This section should be divided into two sections: Protective and risk factors (social determinants of health such as homelessness, family support, social supports and environmental factors) and Co-occurring conditions (including mental health and physical health).

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2. **OPG:** Co-morbid conditions can increase the risks from opioids: respiratory disease (COPD, sleep apnea, etc.), abnormalities in the endocrine system (depressed testosterone, hypoxemia), cardiac arrhythmias, obesity, dementia, fibromyalgia, depression, anxiety, substance use disorder, history of drug overdoses.
3. **VA/DoD:** Screening for conditions that complicate pain management before initiating opioid taper. Mental health disorders, OUD, SUD, “Moral Injury”, Central sensitization, Medical Complications (lung disease, heart disease, renal disease, fall risk), Sleep Disorders. Assess for medical comorbidities that increase risk (for opioid use): lung disease, sleep apnea, liver disease, renal disease, fall risk, advanced age;
4. **WA:** Screen for medical conditions that could increase sensitivity to opioid-related side effects such as comorbid mental health disorders (especially PTSD and major depressive disorder), and COPD, CHF, sleep apnea, advanced age, or renal or hepatic dysfunction.

When to Consider Tapering

Various elements can be included (none specifically identified by the TF yet)

Example with broad set of elements to consider:

- **VA/DoD:** Consider tapering opioids when:
 - 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 medication can increase risk (e.g., benzodiazepines)
 - Mental health comorbidities that can worsen with opioid therapy (e.g., PTSD, depression, anxiety)

By various components:

- **Patient request**

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1. **CDC:** Patient requests dose reduction
2. **OPG:** *none*
3. **VA/DoD:** Patient requests to discontinue therapy
4. **WA:** Patient requests opioid taper

▪ **Treatment progress**

1. **CDC:** Patient does not have clinically meaningful improvement in pain and function
2. **OPG:** Thorough and systematic risk benefit assessment reveals that benefits outweigh risks, e.g., continued pain and dysfunction
3. **VA/DoD:** No pain reduction, no improvement in function. Consider tapering opioids in Veterans where the risk of continuing the opioid outweighs the benefit of continuing the opioid.
4. **WA:** Patient is maintained on opioids for at least 3 months, and there is no sustained clinically meaningful improvement in function, as measured by validated instruments

2. High dose/ co-prescribing

1. **CDC:** Patient is on dosages ≥ 50 MME/day without benefit or opioids are combined with benzodiazepines
2. **OPG:** Dose over 90 MED; co-prescribed sedative hypnotics
3. **VA/DoD:** Dosage indicates high risk of adverse events (e.g., doses of 90 MEDD* and higher); Concomitant use of medications that increase risk (e.g., benzodiazepines)
4. **WA:** At increased risk for opioid-related toxicity from concurrent drug therapy or comorbid medical conditions

3. Substance use disorder

1. **CDC:** Patient shows signs of SUD
2. **OPG:** Patient meets criteria for Opioid Use Disorder or Complex Persistent Opioid Dependence
3. **VA/DoD:** Concerns related to an increased risk of SUD**** (e.g., behaviors, age < 30, family history, personal history of SUD†)
4. **WA:** Patient has a SUD (except tobacco) or exhibits aberrant behaviors

4. Adverse events or warning signs

1. **CDC:** Patient experiences overdose or other serious adverse event; or patient shows early warning signs for overdose risk such as confusion, sedation, or slurred speech
2. **OPG:** Risk assessment reveals mental health disorder, co-morbid conditions, opioid adverse effects, diversion, or other aberrant behavior
3. **VA/DoD:** Severe unmanageable adverse effects (e.g., drowsiness, constipation, cognitive impairment); Non-adherence to the treatment plan or unsafe behaviors** (e.g., early refills, lost/stolen prescription, buying or

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borrowing opioids, failure to obtain or aberrant UDT***); Overdose event involving opioids

4. **WA:** Patient's risk from continued treatment outweighs the benefit; patient has experienced a severe adverse outcome or overdose event

Approach to Tapering

▪ Patient education

1. **CDC:** Make sure patients receive appropriate psychosocial support. 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.
2. **OPG:** none
3. **VA/DoD:** Use Bio-Psycho-Social Model. Offer Veterans pain education groups. [especially Cognitive Behavioral Therapy (CBT) or Acceptance and Commitment Therapy (ACT) for Pain, if available]. Offer physical therapy and Complementary and Integrative Health (CIH) interventions such as: acupuncture, meditation, yoga. Slowly tapering opioids to reduce opioid risks while not "cutting off" the Veteran. Commit to working with the Veteran on other options for improved function and some decrease in pain.
4. **WA:** Promote patient efforts aimed at increased functional capabilities. Prescribing in acute and subacute phase: Provide patient education on safekeeping of opioids, benzodiazepines, and other controlled substances. Additionally, several resources provided areas: Chronic Pain, Fibromyalgia, Headaches, Medications, Stress and Mental Health, Sleep, Setting Patient Health Goals, Opioid Safety

▪ Setting goals and defining success

1. **CDC:** Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Experts thought that goals should include improvement in both pain relief and function (and therefore in quality of life). Experts noted that function can include emotional and social as well as physical dimensions.
2. **OPG:** For tapering to be successful, clinicians must approach the taper as an alliance with the patient with the goal of improving their safety and quality of life.
3. **VA/DoD:** Draw out their goals for life (not just being pain-free). Determine if the initial goal is a dose reduction or complete discontinuation. If initial goal is determined to be a dose reduction, subsequent regular

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reassessment may indicate that complete discontinuation is more suitable. The goal of opioid tapering is to improve the balance of risks and clinically meaningful benefits for patients on LOT. (main goals of these focus group participants included returning to work, minimizing pain, maintaining a functional life, avoiding invasive medical procedures, and getting off opioids). Maintain focus on patient goals throughout treatment, including any changes in those goals over time. Uses SMART goals method for patient goal setting. The goals of the Stepped Care Model for Pain Management include functional rehabilitation, improvement in quality of life, and prevention of the pain becoming chronic and associated deterioration in function

- 4. WA:** Clinically meaningful improvement is defined as an improvement in pain AND function of at least 30% as compared to the start of treatment or in response to a dose change. A decrease in pain intensity in the absence of improved function is not considered meaningful improvement except in very limited circumstances such as catastrophic injuries (e.g. multiple trauma, spinal cord injury, etc.). perioperative pain plan: Set expectations with them about realistic pain management goals, including functional recovery activities, need for multimodal treatment, limits of therapy, timely return to preoperative baseline opioid dose (if any) or lower, and the analgesic tapering timeline. Resource: Swedish STOMP Brochure is designed to help patient set health goals to alleviate pain and improve quality of life. It includes general information about pain, goal-setting ideas and steps to take to achieve those goals.

- **Taper plans**

- General Approach

- 1. CDC:** If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids. Tapering plans should be individualized and should minimize symptoms of opioid withdrawal while maximizing pain treatment with nonpharmacologic therapies and nonopioid medications.
- 2. OPG:** All legacy patients have a systematic assessment of the risk and benefits of continued opioid therapy. In some cases, where the risks are minimal, and the patient appears to be doing well, continued opioid therapy may be justified. In many cases though a thorough and systematic risk benefit assessment (RBA) will reveal continued pain and dysfunction that indicate that a taper should be initiated, in conjunction with increased use of non-opioid therapies and possible referral to behavioral health or other specialists.
- 3. VA/DoD:** Prior to any changes in therapy, discuss the risks of continued use, along with possible benefits, with the Veteran. Establish a plan to

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consider dose reduction, consultation with specialists, or consider alternative pain management strategies.

4. **WA:** Help the patient understand that chronic pain is a complex disease, and opioids alone cannot adequately address all of the patient's pain-related needs. Exploring the patient's resistance to discontinuing opioids will guide taper strategy. Refer patients with aberrant behaviors for evaluation and treatment. Establish the rate of taper based on safety considerations:

- a. Immediate discontinuation if there is diversion or non-medical use,
- b. Rapid taper (over a 2 to 3 week period) if the patient has had a severe adverse outcome such as overdose or substance use disorder, or
- c. Slow taper for patients with no acute safety concerns. Start with a taper of $\leq 10\%$ of the original dose per week and assess the patient's functional and pain status at each visit.

- o Taper Examples: See examples document

▪ **Role of medication-assisted therapy (MAT)**

1. **CDC:** For patients meeting criteria for opioid use disorder, clinicians should offer or arrange for patients to receive evidence-based treatment, usually medication-assisted treatment with buprenorphine or methadone maintenance therapy in combination with behavioral therapies.
2. **OPG:** strongly recommended that all providers prescribing opioids for chronic pain obtain an X-Waiver. Many providers have found that buprenorphine is an effective tool to assist with tapering high dose COT patient and for some patients
3. **VA/DoD:** MAT can be provided in a variety of treatment settings including: residential SUD treatment, intensive outpatient SUD treatment, regular SUD specialty care clinic, primary care or general mental health clinic, or federally regulated opioid treatment program. Use a shared decision-making approach to discuss options for OUD treatment: First-line: Medication Assisted Therapy (MAT) PREFERRED: Opioid Agonist Therapy (OAT)—buprenorphine/naloxone (Suboxone®) or methadone maintenance* ALTERNATIVE: Extended Release (ER) Injectable Naltrexone (Vivitrol®)
4. **WA:** Patients diagnosed with opioid use disorder should receive a combination of medication-assisted treatment and behavioral therapies. Do not prescribe methadone for chronic pain unless you are knowledgeable of methadone's non-linear pharmacokinetics, unpredictable clearance, multiple drug-to-drug interactions and additional monitoring requirements. Consider prescribing naloxone as a preventive rescue medication for patients with opioid use disorder, especially if heroin use is suspected.

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▪ **Multidisciplinary supports**

1. **CDC:** Some studies suggest that using behavioral therapies in combination with these treatments can reduce opioid misuse and increase retention during maintenance therapy and improve compliance after detoxification.
2. **OPG:** none
3. **VA/DoD:** Complementary and Integrative Health (CIH) interventions such as: acupuncture, meditation, yoga.
4. **WA:** In addition to medication, therapies should include physical activation and behavioral health interventions (such as cognitive behavioral therapy, mindfulness, coaching, patient education, and self-management). Consider spinal manipulation in patients with low back pain. Encourage and facilitate those who have work-related injuries to participate in programs that coordinate efforts to help them get back to work. Do this early in their recovery. Refer patient to a multidisciplinary rehabilitation program if s/he has significant, persistent functional impairment due to complex chronic pain. Seek consultation from a pain management specialist or Structured Intensive Multidisciplinary Pain Program (SIMP; described in Non-opioid Options) for patients who have failed taper in an outpatient setting or who are at greater risk for failure due to high dose opioids, concurrent benzodiazepine use, comorbid substance use disorder or any active mental health disorder.

Table 1. Cognitive Behavioral and Non-pharmacological Therapies for Chronic Pain

Cognitive	Address distressing negative cognitions and beliefs, catastrophizing (pain coping characterized by excessively negative thoughts and statements about the future)
Behavioral approaches	Mindfulness, meditation, yoga, relaxation, biofeedback
Physical	Activity coaching, graded exercise
Spiritual	Identify existential distress, seek meaning and purpose in life
Education (patient and caregivers):	Promote patient efforts aimed at increased functional capabilities

Adapted from Argoff, 2009 & Tauben, 2015

▪ **Social and cultural supports**

1. **CDC:** Although findings are mixed, some studies suggest that effectiveness is enhanced when psychosocial treatments (e.g., contingency management, community reinforcement, psychotherapeutic counseling, and family therapy) are used in conjunction with medication-assisted therapy
2. **OPG:** none

Commented [LTB3]: Limited to no details on cultural supports for the patient on tapering. Family supports listed.

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- 3. **VA/DoD:** Include family members or other supporters in the discussion. Acknowledge the Veteran’s fears about tapering; use motivational interviewing (MI) techniques,
 - 4. **WA:** Group support activities: These evidence based programs teach strategies for understanding chronic pain and provide a support network with both clinician and lay led (by fellow chronic pain sufferers) workshops, 2.5 hours once a week for 6 weeks. These offer a free or low-cost community based model that has demonstrated short term improvements in pain and multiple quality of life variables.
- **Monitoring and reassessment**
 - 1. **CDC:** Adjust the rate and duration of the taper according to the patient’s response. Don’t reverse the taper; however, the rate may be slowed or paused while monitoring and managing withdrawal symptoms. 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. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently.
 - 2. **OPG:** On a quarterly basis, we recommend that you review the patient’s case and confirm that they continue to benefit from opioid treatment.
 - 3. **VA/DoD:** Review PDMP* data at least every 3 months and perform UDT** at least annually***

Follow up with the Veteran during the taper:

Follow Up	Slowest Taper (over years)	Slower Taper (over months)	Faster Taper (over weeks)	Rapid Taper (over days)
When	1 to 4 weeks after starting taper then monthly before each reduction	1 to 4 weeks after starting taper then monthly before each reduction	Weekly before each dose reduction	Daily before each dose reduction or if available offer inpatient admission
Who	PACT Team*			
How	Clinic and/or telephone**	Clinic and/or telephone**	Clinic and/or telephone**	Hospital, clinic or telephone**
What	Patient function,*** pain intensity, sleep, physical activity, personal goals, and stress level			

- 4. **WA:** Evaluate function and pain using brief validated instruments at these critical decision-making phases: a. At the end of the acute phase (6 weeks

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following an episode of pain or surgery), to determine whether continued opioid therapy is warranted. b. At the end of the subacute or perioperative phase (12 weeks following an episode of pain or surgery), to determine whether non-opioid treatment will help or if prescribing COAT is warranted. c. During chronic use with regular assessment and documentation of function and pain.

Table 6. How Often to Monitor Patients on COAT

Level of Risk	Recommended Frequency
Low risk (no risk factors)	Every 6 months
Moderate risk	Every 3 months
High risk or opioid doses >120 mg/day MED	Every month

- **Managing Withdrawal**
 1. **CDC:** none
 2. **OPG:** none
 3. **VA/DoD:** Manage withdrawal symptoms. Autonomic symptoms, anxiety, dysphoria, myalgias, sleep disturbance, nausea, abdominal cramping, diarrhea. Short-term oral medications can be utilized to assist with managing the withdrawal symptoms, especially during fast tapers. not treat withdrawal symptoms with an opioid or benzodiazepine.
 4. **WA:** Treat withdrawal symptoms: restlessness, sweating or tremors, nausea, diarrhea, muscle pain, neuropathic pain or myoclonus, insomnia

Example Tapers for Opioids⁵⁻⁹

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

*Continue the taper based on Veteran 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.

Communicate the opioid taper plan to the Veteran

Example: Veteran is currently taking morphine SR 60 mg, 1 tablet every 8 hours. Goal is to reduce dose of morphine to SR 30 mg every 8 hours using a slow taper. Dose will be reduced by 15 mg every 10 days.

Using **morphine SR 15 mg tablets**, follow the schedule below:

	Morning	Afternoon	Evening
Days 1 to 10	4 tablets = 60 mg	3 tablets = 45 mg	4 tablets = 60 mg
Days 11 to 20	3 tablets = 45 mg	3 tablets = 45 mg	4 tablets = 60 mg
Days 21 to 30	3 tablets = 45 mg	3 tablets = 45 mg	3 tablets = 45 mg

Scenario 1: Veteran is tolerating the taper



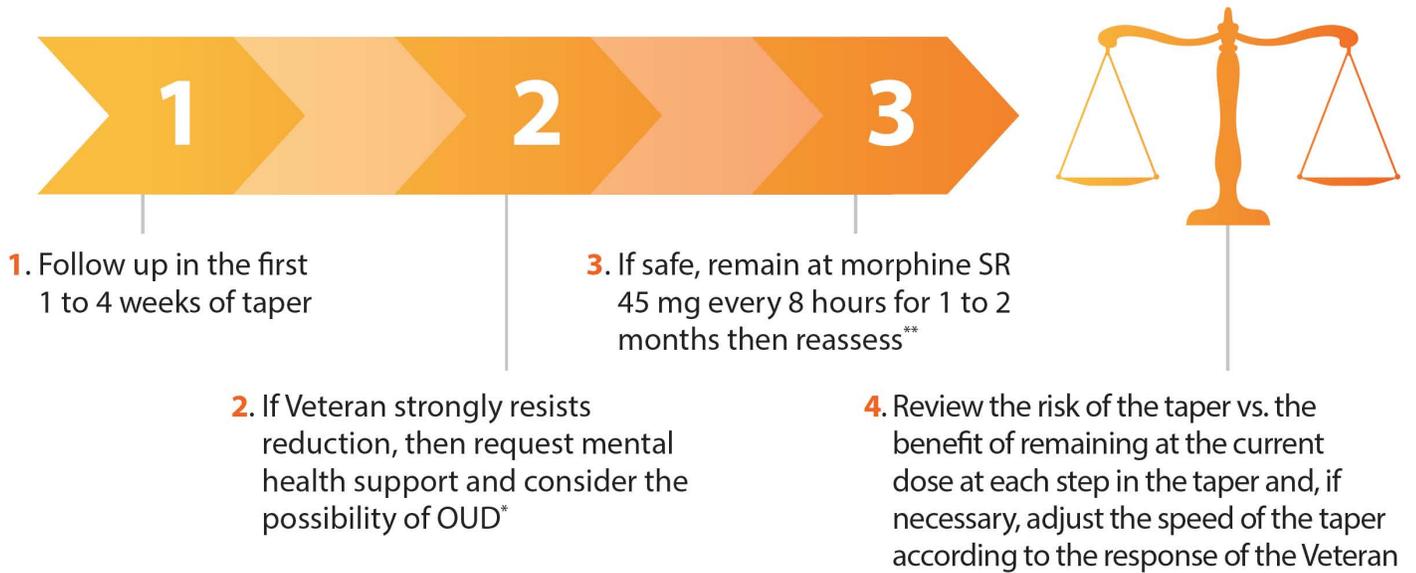
1. Follow up in the first 1 to 4 weeks of taper

2. If Veteran feels supported and is adjusting to the dose reduction

3. Continue strategy of reducing to morphine SR 30 mg every 8 hours

4. Follow up in 1 to 4 weeks to determine the next step in the taper

Scenario 2: Veteran is resisting further reduction



*If the Veteran is resisting further dose reductions, explore the reason for the reluctance: medical (increased pain), mental health (worsening depression, anxiety, etc.), and substance use disorder (SUD)/opioid use disorder (OUD). Refer to OUD Provider Education Guide on VA PBM Academic Detailing SharePoint for more information. <https://vawww.portal2.va.gov/sites/ad/SitePages/OUD.aspx>

**If possible, the Veteran should be actively involved in skills training and/or have a comprehensive pain care plan.

Follow up with the Veteran during the taper:

Follow Up	Slowest Taper (over years)	Slower Taper (over months)	Faster Taper (over weeks)	Rapid Taper (over days)
When	1 to 4 weeks after starting taper then monthly before each reduction	1 to 4 weeks after starting taper then monthly before each reduction	Weekly before each dose reduction	Daily before each dose reduction or if available offer inpatient admission
Who	PACT Team*			
How	Clinic and/or telephone**	Clinic and/or telephone**	Clinic and/or telephone**	Hospital, clinic or telephone**
What	Patient function,*** pain intensity, sleep, physical activity, personal goals, and stress level			

*Follow-up for tapering is recommended to be a team function with various team members taking on roles in which they have demonstrated specific competencies. Mental health practitioners may need to be included in the follow-up plan.

**Providers will need to determine whether a telephone or in-clinic appointment is appropriate based on the risk category of the Veteran. A Veteran with high risk due to a medical condition may have decompensation during the taper and may require a clinic visit over telephone follow-up. If there are issues with the Veteran obtaining outside prescriptions or they are displaying other aberrant behaviors during the taper, providing follow-up in a clinic visit may be more optimal than a telephone visit.

***Quality of Life Scale for patients with pain: https://www.theacpa.org/uploads/documents/Quality_of_Life_Scale.pdf

Tapering Dose Example

Ruben Halperin – September 2018

Consider the following patient:

- 48 year old male on Oxycodone for 16 years since a motor vehicle crash
 - Dose: Oxycodone 30 mg four times daily = 120 mg of oxycodone = 180 mg MED
 - Pain: Still rates his pain as a 10, wants to increase to 40 mg four times daily
 - Function: Hasn't worked since crash. Divorced 9 years ago. Lives alone. On bed or couch 20 hours daily
 - Co-morbid conditions: sleep apnea, diabetes 2, hypertension, depression, osteoarthritis of knees
- After a long discussion he admits that the oxycodone doesn't help him much, but he's afraid of how bad his pain will be on less of it or without it. He reluctantly agrees to the taper when you explain that his dose is unsafe and you don't feel comfortable continuing to prescribe it.

How to taper? Make sure other **ongoing** strategies are in place before you begin. He goes to a pain education class, watches several videos and meets with the behaviorist in clinic. The behaviorist encourages him to join a pain group where he will have a chance to learn and share experiences with other patients in a similar situation.

Week	Dose 1	Dose 2	Dose 3	Dose 4	Total daily dose	MED
0	30 mg	30 mg	30 mg	30 mg	120 mg	180 mg
1	30 mg	25 mg	30 mg	30 mg	115 mg	172.5 mg
2	same					
3	30 mg	25 mg	25 mg	30 mg	110 mg	165 mg
4	same					
5	30 mg	25 mg	25 mg	25 mg	105 mg	157.5 mg
6	same					
7	25 mg	25 mg	25 mg	25 mg	100 mg	150 mg
8	same					
At the end of 8 weeks you have decreased the oxycodone by about 16%. He's had mild withdrawal symptoms, but nothing intolerable						
Week	Dose 1	Dose 2	Dose 3	Dose 4	Total daily dose	MED
9	25 mg	20 mg	25 mg	25 mg	95 mg	142.5 mg
10	same					
11	25 mg	20 mg	20 mg	25 mg	90 mg	135 mg
12	same					
13	25 mg	20 mg	20 mg	20 mg	85 mg	127.5 mg
14	same					
15	20 mg	20 mg	20 mg	20 mg	80 mg	120 mg
16	same					
At the end of 16 weeks you have decreased the oxycodone by about 33%. Withdrawal symptoms mild. He has noticed that his pain isn't any worse. Even so, he tells you he is afraid to keep going, but agrees that everything you told him has been correct.						
Week	Dose 1	Dose 2	Dose 3	Dose 4	Total daily dose	MED
17	20 mg	20 mg	15mg	20 mg	75 mg	112.5 mg
18	same					
19	20 mg	15 mg	15 MG	20 MG	70 MG	105 MG
20	same					

21	20 mg	15 mg	15 mg	15 mg	65 MG	97.5 90
22	same					
23	15 mg	15 mg	15 mg	15 mg	60 MG	90 MG
24	same					
At 24 weeks he is on 50% of his starting opioid dosing. He admits that his pain is no worse. He also tells you his mind feels less foggy and he's been using some of the relaxation techniques when he does feel pain. He began physical therapy a few weeks back and is now walking 15 – 20 minutes daily						
Week	Dose 1	Dose 2	Dose 3	Dose 4	Total daily dose	MED
25	15 mg	15 mg	10 mg	15 mg	55 mg	82.5
26						
27	15 mg	10 mg	10 mg	15 mg	50 mg	75 mg
28						
29	15 mg	10 mg	10 mg	10 mg	45 mg	67.5 mg
30						
31	10 mg	10 mg	10 mg	10 mg	40 mg	60 mg
32	same					
At 32 weeks he is on 30% of his starting opioid dosing. Pain is not worse, in fact he thinks it might be a little better. He's now walking up to an hour daily. He says, I think I want to go to 10 mg 3 times daily and then cut down from there.						
Week	Dose 1	Dose 2	Dose 3		Total daily dose	MED
33	10 mg	10 mg	10 mg		30 mg	45 mg
34	Same: he has a little more withdrawal and asks to stay on 10 mg TID for another 2 weeks					
35	10 mg	10 mg	10 mg		30 mg	45 mg
36	same					
37	10 mg	5 mg	10 mg		25 mg	37.5 mg
38	Same: he wants to cut the morning dose before evening dose because he is worried he won't sleep well					
39	5 mg	5 mg	10 mg		20 mg	30 mg
40	5 mg	5 mg	5 mg		15 mg	22.5 mg
At 40 weeks he is on 12.5% of his starting opioid dosing. He cut down a little faster in last 2 weeks. He is excited by the prospect of getting off completely but still feels like he needs to keep tapering and can't just stop at this dose						
Week	Dose 1	Dose 2	Dose 3		Total daily dose	MED
41	5 mg	2.5 mg	5 mg		12.5 mg	18.25 mg
42						
43	5 mg	5 mg			10 mg	15 mg
44						
45	2.5 mg	5 mg			7.5 mg	11.25 mg
46						
47	X	5 mg			5 mg	7.5mg
48	0				0 mg	0 mg
It took 48 weeks – almost a year, but he successfully came off of a high dose opioid he had been on for 16 years. He admits that his pain is minimal. He is more active than he has been in years, has lost 18 lbs. and he is contemplating going back to work.						