Oregon Health Authority

Oregon Opioid Taper Guidelines Task Force AGENDA

Oregon Opioid Taper Guidelines Task Force

October 25, 2019
9:00-12:00
Portland State Office Building
800 NE Oregon, Room 177
Conference Line: 1-888-278-0296
Public Meeting ID: 843163

Goals

- Finalize guidelines
- Obtain Task Force support for final version

Agenda

- **Welcome, goals, agenda review, introductions** - Dana Hargunani, Chief Medical Officer, Oregon Health Authority; Diana Bianco, Principal, Artemis Consulting

- **Public comment – 9:05 AM** (approximately)

- **Updates** – Dana
  - HHS Guidelines

- **Final review of Guidelines**
  - Specific focus areas
    - Buprenophrine; risks of tapering; rate of taper; MED reference
  - Other discussion per Task Force

- **Check for Task Force support**

- **Next steps and summary**
  - Process for publication

Oregon Opioid Taper Guidelines Task Force
Meeting Summary- September 23, 2019

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, shared that at the final Task Force meeting we'll be asking the Task Force whether they support the final recommendations – we're hoping for consensus.

Working draft guideline review

Introduction, Background, Principles
At the last Task Force meeting, there was a suggestion to change the name of the guidelines and avoid referencing the word "taper." The planning team tried other names, but it was challenging so we ultimately kept the current name. Task Force members didn't object to the name remaining the same.

In background section, we removed "chronic" from the first sentence.

Definitions
We re-titled this section "Terms." Additionally, the Task Force agreed to add a definition for substance use disorder (SUD) and add the Trauma Informed Oregon web link to the Trauma Informed definition.

Assessing the Patient
The Task Force affirmed including the 5 As in the guideline as an approach to pain assessment.

Determining When to Taper Opioids
The Task Force reviewed this section and discussed whether to group and/or re-order the bullets to reflect the domains and severity of risk factors and circumstances. We decided to ask OHA to reformat the section based on the discussion. In addition, the Task Force changed the name of this section to "When to Consider Tapering," and decided to add a "black box" warning stating "there is no one number that applies to all patients."

The Task Force also asked to include generic name of drugs throughout the guidelines and list brand name as examples.

Shared Decision Making
The Task Force reviewed this section and didn't have any edits.

Patient Engagement and Education
The planning team edited this section for brevity. The Task Force suggested changing the name of this section and agreed to change the last bullet to include safekeeping, storage and disposal of medications.

Tapering Plan
Section content reviewed by the Task Force with no recommended edits.

Multidisciplinary Supports
Section content reviewed by the Task Force. The Task Force agreed to remove the table and add the information as domains with a list of examples, including tribal based practices.

Patient Monitoring and Reassessment
The Task Force reviewed this section and recommended removing the last sentence, that begins with "once the smallest" in the second bullet.

Managing Withdrawal
Section content reviewed by the Task Force with no recommended edits.

Handling Complicated Tapers
Section content reviewed by the Task Force with no recommended edits.

Managing Opioid Use Disorder
Section content reviewed by the Task Force with no recommended edits.

Addressing Special Populations
Section content reviewed by the Task Force with no recommended edits.

When to Refer
Section content reviewed by the Task Force with agreement to change "provider" to "prescribing provider," change "social worker" to "integrated behavioral health provider," and add telemedicine and consult lines for resources, including OPAL-A line.

Long-term Support

The Task Force reviewed this section with agreement to change “developed” to “maintained” in the first sentence.

Organizational Supports

The Task Force reviewed this section and changed “supporting” to “developing” in the last bullet regarding medication assisted treatment (MAT). Additionally, Task Force agreed to remove reference to MAT and use evidence-based treatment language.

Community-level Interventions

Section content reviewed by the Task Force with no recommended edits.

Patient, Provider and Community Resources

Task Force members agreed to include a short list of resources in the guidelines and have a more comprehensive list on the OHA Opioid website. The Task Force also agreed to place Oregon resources first.

Public comment

Six individuals provided in-person public comment. In addition, we received six written public comments prior to the meeting and shared those with Task Force members. We also received written public comment after the deadline for this meeting. These comments will be collated and shared with Task Force members prior to the next meeting.

Next steps and summary

The final Task Force meeting is:

- October 25, 9:00-12:00

2019

>> Oregon Opioid Tapering Guidelines

Recommendations for Patient-centered Care to Reduce Harms Associated with Opioid Use

DRAFT

Contents

Oregon Opioid Tapering Guidelines

<<Working Draft: October 18, 2019>>

Background

From 1999 to 2006, Oregon experienced a sharp increase in prescription opioid overdose and death, attributed largely to increased opioid prescribing to treat pain. While the rate of prescription opioid overdose deaths has been declining since 2006, the rate is still three times higher than in 1999. Over-prescribing of opioid medications adversely impacts patients, their families, household members, and the larger community through potential diversion and misuse.

Existing Oregon opioid prescribing guidelines

In order to improve patient safety, disseminate best practices, and address the need for compassionate care, the Oregon Health Authority convened experts from across the state to develop clinical guidelines for opioid prescribing. In 2016, Oregon's Opioid Prescribing Guidelines Task Force approved adoption of Oregon-specific opioid prescribing guidelines based on the *CDC Guideline for Prescribing Opioids for Chronic Pain*. Through similar collaborations, Oregon developed guidelines to address opioid prescribing for acute pain; in dental settings; and to assist clinicians in addressing opioid use in pregnant women. In September 2019, the U.S. Department of Health and Human Services released the *HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics*. The Oregon Opioid Tapering Guidelines complement the new HHS Guide as well as Oregon's previously established prescribing guidelines.

Opioid tapering guidelines overview

The goal of the Oregon Opioid Tapering Guidelines is to reduce harms to patients associated with opioid use and promote patient-centered care. The guidelines lay out general principles and best practices for opioid tapering, potential indications for and approaches to tapering, reasons for referral, and important long-term supports.

There is no one approach to tapering. Tapering requires individualized assessment and treatment. These guidelines are meant to provide guidance; they should not be determinative of how a provider and patient work together when considering opioid tapering.

It is important to note that ***not all patients on opioids need to be tapered***. For example, a patient on a stable opioid dose with minimal side effects who is experiencing good pain control, function, and quality of life may not require tapering.

These guidelines stress the need to provide patient-centered and trauma-informed care, as well as collaborative pain management. In addition, the guidelines emphasize the importance of avoiding inappropriate treatment of chronic pain. As noted by the Washington Medical Commission, this includes "non-treatment, under-treatment, over-treatment, and the continued use of ineffective treatments" (2018).

Principles

The principles that underlie these guidelines are the following:

- Pain management, with or without opioids, should be patient-centered, trauma-informed and based on current pain science.
- The overarching goals for opioid tapering are to improve patient safety, to maintain or improve functional status, and to improve quality of life through provision of compassionate care.
- The tapering guidelines are intended to encourage conversations between clinicians and patients; promote patient engagement and shared decision-making; support informed consent; and apply easily to different practice settings.
- Tapering plans should be individualized, clear, flexible, and include realistic goals.
- Health systems and payers must support a team-based, integrated approach to the tapering process and ensure access to non-opioid and non-pharmacologic pain therapies, including broad multidisciplinary supports as needed.

Terms

Providers and patients should understand the following relevant terms when approaching these guidelines:

Tapering: Collaborating with a patient to achieve a reduced opioid dose or to discontinue opioid therapy using an individualized approach.

Patient-centered Care: Patient-centered care consists of a collaborative therapeutic relationship between provider and patient that is respectful of, and responsive to, individual

patient preferences, needs and values, and ensuring that patient values guide clinical decisions.

Trauma Informed Care: Trauma informed care recognizes the widespread and potentially negative health impact of trauma. Trauma informed care requires an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma informed care emphasizes physical, psychological, and emotional safety for both patients and providers, and helps survivors rebuild a sense of control and empowerment. Trauma is common in society as well as among individuals with substance use disorder. Find more information at Trauma Informed Oregon.

Opioid Tolerance: The Diagnostic and Statistical Manual of Mental Disorders- Fifth Edition (DSM-5) defines tolerance by either of the following: need for markedly increased amounts of opioids to achieve desired effect whether therapeutic or recreational; markedly diminished effect with continued use of the same amount of opioid.

Physiologic Opioid Dependence: Dependence on opioids can occur when an individual's physiology adapts to repeated drug exposure and only functions normally in the presence of the opioid. When the drug is withdrawn, several physiologic reactions occur that can produce both physical and psychological symptoms.

Opioid Withdrawal Syndrome: The DSM-5 defines opioid withdrawal syndrome by Criteria A and B. Patients must have:

A. Either of the following: cessation of (or reduction in) opioid use that has been heavy and prolonged (i.e., several weeks or longer), or administration of an opioid antagonist after a period of opioid use, in addition to:
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.

In addition, the signs or symptoms in Criterion B must cause clinically significant distress or impairment (i.e., in social, occupational, or other important areas of functioning) and not be attributable to another condition or mental disorder.

Opioid Withdrawal: The DSM-5 defines opioid withdrawal by either of the following:

1. Characteristic opioid withdrawal syndrome (see above);
2. Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.

Opioid Use Disorder (OUD): A problematic pattern of opioid use leading to clinically significant impairment or distress. To confirm a diagnosis of OUD according to the DSM-V, at least two of the following criteria should be observed within a 12-month period:

- Opioids are often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- Craving, or a strong desire or urge to use opioids.
- Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
- Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- Important social, occupational, or recreational activities are given up or reduced because of opioid use.
- Recurrent opioid use in situations in which it is physically hazardous.
- 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.
- *The patient exhibits tolerance.
- *The patient exhibits withdrawal.

*__Note__: These criteria for OUD are not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Severity of OUD is specified as: Mild (2-3 criteria), Moderate (4-5 criteria), or Severe (6 or more criteria). ***Note***: Opioid Dependence is no longer a separate category from Opioid Use Disorder within the DSM-5.

Substance Use Disorder (SUD): According to the DSM-V, the diagnosis of SUD is made based on a pattern of behaviors related to use of a specific substance (i.e., Alcohol Use Disorder, Cannabis-Related Disorder, Opioid Use Disorder, etc.). A critical feature of a substance use disorder includes a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. Criteria for each substance use disorder are grouped according to the following: impaired control, social impairment, risky use, and pharmacological criteria.

Guidelines

I. Assessing the Patient

A comprehensive evaluation, including an assessment of pain, function and adverse consequences, is recommended for every patient to determine if they are appropriate for either tapering or continuation of their long-term opioid therapy. As with chronic pain management,

a multidisciplinary, team-based approach to assessment is recommended when available. The comprehensive assessment can occur in one or sequential visits, which should be determined by the urgency and complexity of the patient's needs. Ongoing reassessment and evaluation of progress are critical to ensure the efficacy of the chosen approach.

One framework to assist in the completion of a patient assessment is the "5 As" which includes the following components: activities, adverse effects, aberrancy, affect and analgesia. In addition, a comprehensive assessment should include a complete biopsychosocial assessment, physical exam, and an assessment of risks versus benefits. Appendix A includes a description of the "5 As" framework plus a list of essential comprehensive assessment components.

II. When to Consider Opioid Tapering

As illustrated below, a variety of circumstances should prompt consideration for opioid tapering[1]. The decision of whether and how to proceed with opioid tapering should be determined on an individualized basis through shared decision making between the patient and provider, balancing the risks and benefits of opioid therapy.

This list below provides examples of potential circumstances and risk factors that should prompt consideration for tapering. Whether to proceed with tapering must be an individualized decision based on the patient's unique context, an assessment of risks versus benefits, and the latest emerging science in order to ensure safety and health for the individual.

Opioid tapering should be considered in circumstances when opioids are no longer indicated or there is imminent danger of harm:

- The underlying condition for which opioids were prescribed (e.g., injury, surgical pain) has resolved and opioids are no longer indicated.
- The patient experiences no reduction in pain, no improvement in function, or requests to discontinue or reduce opioid therapy.
- The patient experiences unmanageable adverse effects (e.g., drowsiness, constipation, cognitive impairment, worsening pain despite increasing doses).
- The patient develops suicidality or worsening mood associated with opioid therapy.
- The patient has experienced a previous/recent overdose event involving opioids.
- The patient does not adhere to their treatment plan or exhibits unsafe behaviors (e.g., early refills, lost/stolen prescription, buying or borrowing opioids, failure to obtain or aberrant urine drug test).

[1] Tapering may be applicable to partial opioid agonists (in addition to full opioid agonists) when used for the treatment of chronic pain.

The presence of other risk factors should also warrant consideration of opioid tapering:

- The patient is on a high daily opioid dose (e.g., 50-90 MED or higher) and the individual risks outweigh the benefits. ***Note:*** There is no number that applies to all patients and these dosage examples should not serve as a mandate for dose reduction.
- The patient has medical risk factors that can increase risk of adverse outcomes including overdose (e.g., lung disease, sleep apnea, liver disease, renal disease, fall risk, medical frailty).
- The patient is taking other medications that increase the risk of drug-drug interactions or the risk of overdose, such as benzodiazepines or other sedating medications (e.g., diphenhydramine [Benadryl®], gabapentin [Neurontin®]). Prescribers should be mindful of an individual patient's hepatic and renal function that may impact drug metabolism.
- The patient's history indicates an increased risk for substance use disorder (SUD) (e.g., past diagnosis of SUD, SUD-related behaviors, family history of SUD). If the patient meets diagnostic criteria for SUD/OUD, clinicians should arrange for the appropriate evidence-based treatment (see page 13).

III. Approaches to Opioid Tapering

Shared decision making

Shared decision making between the provider and patient is fundamental when considering opioid tapering. Clinicians must approach the decision to taper as an alliance with the patient focused on the goal of improving safety and quality of life. Key principles that underlie and support shared decision making include: establishing trust; allowing pauses in tapering; ensuring patients direct the focus of tapering; and understanding and incorporating patient values and belief systems.

While shared decision making is critical, providers also must determine whether there is an imminent threat to patient safety that may necessitate tapering opioids to safer levels. If the provider determines that an imminent threat to patient safety exists, providers should convey their concern to the patient, ensure the patient understands the risks, and consider referral to a specialist as needed and available.

Examples of exceptional cases where there are significant risks to patient safety that might limit the appropriateness of shared decision making include: evidence that opioids are being diverted to other users; history of overdose; known active illicit drug use; signs of sedation or intoxication during office visit; and bowel obstruction or other emergent and significant side effects. Providers should rely on objective data assessing patient safety, including: checking the Prescription Drug Monitoring Program; urine drug screens; drug reconciliation; and patient history. Providers should consider risk-mitigating strategies in consultation with the patient, including but not limited to naloxone prescribing.

Setting expectations and goals through patient and provider collaboration

Discussions about tapering can be difficult for both patients and providers. This is especially true when patients are anxious or fearful of withdrawal symptoms or worsening pain, or when providers have had limited experience with opioid tapering. For a taper to be successful, it is important to acknowledge and validate these experiences, to seek additional resources when needed, and to develop a shared understanding of what constitutes success. Key practices to foster patient/provider collaboration include, but are not limited to:

- Explore patient concerns in a non-judgmental fashion.
- Address common beliefs and learn about the patient's perspectives.
- Educate patients about how opioids work, opioid risks, and best practices for safekeeping, storage and disposal.
- Utilize motivational interviewing techniques to determine patient goals.
- Set patient-centered and realistic expectations for the treatment plan together, informed by a thorough assessment of the patient's individual risks and benefits related to opioid therapy.
- Reassure the patient that they will receive continuity of care throughout the tapering process. Avoid dismissing patients from care and patient abandonment.[2]
- Inform patients about what to expect during the taper and the potential for opioid withdrawal. Reassure patients that withdrawal symptoms will be monitored for and addressed.

Tapering plan

When the harms of continued opioid therapy outweigh the benefits, the taper plan should be approached as an alliance between the provider and patient to ensure its success. While there are general approaches to tapering, patients and providers should be aware that this is a rapidly evolving field.

It is essential that each taper plan is individualized based on the patient's history, goals and objective assessment. On a population basis, a range of 5% to 20% taper per month can be a helpful guide.[3] Patients on higher doses of opioids may tolerate a more rapid taper, while those on a lower dose or those who have been on opioids for a long period of time may need

[2] According to Black's Law Dictionary 10th edition (2015), the legal definition of abandonment is "a medical professional's discontinuation of an established 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.
[3] U.S. Department of Veterans Affairs. Opioid Taper Decision Tool. (2016) https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf

a slower taper. The most common cause of failed tapers is attempting to taper too rapidly.

Risks of Rapid Opioid Tapers

The rate of opioid tapers should be carefully considered and tailored to meet individual needs. The risks of rapid opioid tapering may include but are not limited to:

- Acute opioid withdrawal symptoms
- Worsening pain
- Psychological stress or suicide thoughts
- Seeking of other sources of opioids, including possible illicit opioids
- Unsuccessful fulfillment of taper goals

The following principles should be applied during opioid tapering:

- The patient and provider should determine whether the goal is a dose reduction or complete discontinuation of opioids.
- Tapering plans should minimize symptoms of opioid withdrawal, while maximizing pain treatment with nonpharmacologic therapies and nonopioid medications.
- Interdisciplinary, team-based care should be utilized when available to facilitate tapering, and referral to behavioral health or other specialists should be considered as needed.
- A written taper plan should be established that is clearly understood. The plan should be flexible and re-evaluated on a routine basis.
- The rate of taper should be established based on individual factors and safety considerations. There is no evidence basis to recommend a particular taper rate or length.
- Situations when more rapid tapering is indicated based on safety concerns may include but are not limited to patients with a history of recent overdose, evidence of diversion, or those who are actively using illicit drugs. It is important to co-prescribe naloxone in these circumstances.
- It is important to coordinate taper plans with any other providers who have prescribed a controlled substance (e.g., opioids, benzodiazepines) for the patient to ensure that all are aware and supportive of the plan.

Example taper plans have been created by various health organizations but should always be approached with flexibility.[4,5] It is the responsibility of the provider to ensure that any example

[4] Oregon Health & Science University. Adult Safe Opioid Prescribing Guideline for Chronic, Non-End-Of-Life Pain and Practice Resources for Clinical Implementation. (2017) https://www.ohsu.edu/sites/default/files/2018-12/Safe-Opioid-Prescribing-Guideline_FINAL_12-6-18.pdf

[5] U.S. Department of Veterans Affairs. Opioid Taper Decision Tool. (2016) https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf

taper plan is up to date and tailored to each individual patient's needs before use.

Multidisciplinary supports

Multidisciplinary supports should be offered to patients throughout opioid tapering in alignment with the biopsychosocial model of addressing pain. Recommendations for ensuring that these supports are in place include:

- Approach chronic pain and opioid use disorders as chronic conditions using a trauma-informed approach.
- Optimize the use of team-based care including integrated behavioral health in addition to complementary and integrative health services when possible.
- Include treatment approaches that focus on behavioral activation and behavioral therapy.
- Engage mental health providers to assist with treatment of co-occurring conditions when needed, such as depression, anxiety and post-traumatic stress disorder.
- Offer patients referral to peer-delivered services when available.
- Recognize that long-term, stable recovery depends on one's social environment: "treatment happens in the medical system; recovery happens in the community."

Non-pharmacological therapies for chronic pain should be considered for chronic pain patients, including cognitive, behavioral, physical, spiritual and integrative health approaches. Examples include but are not limited to: patient education regarding current pain science, mindfulness, cognitive behavioral therapy, biofeedback, yoga, acupuncture, chiropractic care, occupational therapy, physical therapy and tribal-based or other cultural practices. Providers should consider the underlying diagnosis, patient preferences and existing evidence to determine appropriate therapies for individual patients.

Patient monitoring and reassessment

The tapering plan should include frequent follow-up and assessment of progress, which may vary (i.e., daily, weekly or monthly) based on the rate of the taper and patient response. During follow-up and reassessment, providers should address or consider the following:

- Regularly assess patient function including pain intensity, sleep, physical activity, personal goals, and stress levels.
- Based on the patient's response to the taper, the provider should adjust the rate and duration of the taper. Do not reverse the taper. However, the rate may be slowed or paused while monitoring and managing withdrawal symptoms.
- The provider should remain alert to signs of anxiety, depression, and opioid use disorder that might be unmasked or precipitated by an opioid taper and arrange for prompt management of these co-morbidities.

- Throughout reassessment, providers should assess for the need to shift to safer medications based on the ongoing risk/benefit reassessment.

IV. Managing withdrawal and complicated tapers

Managing withdrawal

Withdrawal can cause significant distress and can undermine the success of opioid tapering. Providers should regularly assess for withdrawal symptoms during an opioid taper and consider the following:

- Withdrawal symptoms may be an indication that the taper is going too quickly. This is an opportunity to pause, rethink, and slow down.
- For individuals for whom a faster taper is indicated (e.g., diversion, use of illicit substance, recent overdose), active management of withdrawal symptoms may need to take precedent instead of slowing the taper rate. In this situation, prioritize appropriate medications to address withdrawal symptoms as well as incorporate multidisciplinary approaches.
- Providers should not use benzodiazepines or other high-risk medications to treat withdrawal.

Handling complicated tapers

While some patients experience minimal or manageable symptoms during opioid tapering, other patients experience more difficulty even despite attempts to slow the taper rate. For these patients, it is important to assess for opioid use disorder using DSM-5 criteria; if criteria are met, providers should arrange for evidence-based OUD treatment (see page 13).

As highlighted in the HHS Guide[6], these individuals may benefit from transitioning to buprenorphine, a partial opioid agonist, either as maintenance therapy or for eventual, continued tapering. Buprenorphine is indicated for the treatment of pain as well as OUD; in addition, there is supporting evidence that it can be helpful to attenuate withdrawal symptoms.[7] Furthermore, buprenorphine has less risk for respiratory depression than full opioid agonists. When considering the use of buprenorphine, providers must be aware that:

- This is an evolving research area and providers should stay up to date related to the newest evidence on buprenorphine, opioid dependence and opioid tapering.
- Caution must be taken when transitioning patients from full opioid agonists to

[6] U.S. Department of Health and Human Services. *HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics*. https://www.hhs.gov/opioids/sites/default/files/2019-10/8-Page%20version__HHS%20Guidance%20for%20Dosage%20Reduction%20or%20Discontinuation%20of%20Opioids.pdf

[7] Gowing et. al. Bupernorphine for managing opioid withdrawal. *Cochrane Database of Systematic Reviews*. (2017)

buprenorphine. For further information, review the *HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics*, and consult additional expertise as needed.

- Use of buprenorphine for opioid dependence requires that the provider obtain a practitioner or "X" waiver. Visit https://www.samhsa.gov/medication-assisted-treatment/training-materials-resources/apply-for-practitioner-waiver for more information.
- Complete prescribing information and medication guides for buprenorphine containing products can be found here: https://www.btodrems.com/SitePages/MedicationGuides.aspx.

Managing opioid use disorder

Patients should be evaluated for opioid use disorder or other substance use disorders prior to initiating a taper. For patients meeting criteria for opioid use disorder, clinicians should offer or arrange for patients to receive evidence-based treatments for opioid use disorder such as buprenorphine or methadone maintenance therapy in combination with behavioral therapies. Providers should care for their patients experiencing opioid use disorder with compassion and be aware of and address any stigma that their patients may face with this diagnosis.

Addressing special populations

These taper guidelines do not address important considerations for all populations. There are special patient populations for whom opioid tapering may be more complex, including but not limited to: cancer patients, those receiving palliative or hospice care, pregnant women, and children. In addition, patients with another substance use disorder (SUD) and/or dual diagnoses of mental illness and SUD will have unique needs that must be considered individually. Patients in these populations may require consultation or referral to a clinician with specific expertise these areas.

When to refer

To facilitate a taper plan, prescribing providers may consider referring patients to other providers with expertise in specific areas. In a team-based model of care, a prescribing provider may engage with another member of the team (when the need is outside provider's scope of practice), such as a pharmacist or integrated behavioral health provider to facilitate the taper plan.

When the need is outside the clinic's scope of practice (i.e., patients with significant mental illness, challenging tapers, or critical social needs), a prescribing provider may want to consider referring to an outside entity/provider. Such specialist referrals might

include addiction medicine, behavioral health, peer support, support groups, and/or pain specialists. When a referral is not available, additional guidance can be received via phone consultation services (e.g. the Oregon Psychiatric Access Line [OPAL] call center). Links to OPAL and additional provider resources are listed in guideline section VIII.

V. Long-term support and follow up

Even after completion of a safe and effective taper, a longitudinal care plan should be maintained. Long-term support beyond the tapering period for individuals with chronic pain should include the following:

- Continual assessment of pain, function and functional goals (i.e., using the PEG scale).
- Mental health assessments.
- Assessment of need for additional therapy or social supports.
- Ongoing assessment and education on opioid use disorder/substance use disorder and discussing patient interest level in addiction treatment, if relevant.

VI. Organizational supports

Health systems and payers share responsibility for ensuring the success of opioid tapering. These organizational responsibilities include but are not limited to:

- Endorse the Oregon Opioid Tapering Guidelines.
- Provide expert consultation to assist with implementation of these guidelines as the standard of care across practice settings.
- Assist in the development of team-based care, including providers of behavioral health, integrative health, peer delivered services and beyond, and ensure referral resources as needed.
- Sponsor provider/practice training in patient-centered and trauma informed care.
- Adopt electronic medical record changes that support best practices and clear documentation for opioid tapering.
- Perform quality review of guideline implementation and monitor results.
- Support schedule changes, such as extended clinic visits for opioid tapering, to allow for high quality and patient-centered care.
- Develop an evidence-based treatment program for opioid used disorder, while also ensuring appropriate referral resources and processes.

VII. Community-level interventions

Outside the medical setting, patients live in community environments that can be supportive or can hinder their success with tapering. In addition, inappropriate prescribing, storage and/or

disposal of opioids can impose risks to the community, such as increasing rates of opioid misuse, opioid use disorder, and overdose. Community-level interventions aimed at improving community safety and ensuring patient support for opioid tapers include: safe handling, storage, and disposal of unused medications; increased availability of naloxone; community education, and beyond. See guideline section VIII for community-level resources.

VIII. Patient, Provider and Community Resources

The goal of these guidelines is to promote patient-centered care and reduce harms associated with opioid use. While these guidelines are intended to assist in this effort, they are not exhaustive. Listed below are supplemental resources to aid in the implementation of the tapering guidelines. Additional resources are available on the OHA opioid website.

Patient resources

- Oregon Pain Guidance (OPG). Patient and family resources regarding tapering.
- Center for Disease Control (CDC). CDC Helpful Materials for Patients – Resources for chronic and acute pain.
- Veteran's Administration (VA). VA Veteran / Patient Education – Links to VA and other government resources (FDA, SAMHSA, etc.) on opioids, pain and its treatment. Updated regularly and available in multiple languages.
- American Society of Regional Anesthesia and Pain Medicine website – Safe opioid storage, tapering, and disposal.
- American Chronic Pain Association – Pain Management Tools. "Living with a chronic condition requires changing the way you think about your health care and your life."
- Substance Abuse Mental Health Services Administration (SAMHSA). Opioid Overdose Prevention TOOLKIT: Safety Advice for Patients & Family Members
- The Swedish Medical Center, STOMP (Structuring Your Own Management of Pain). STOMP Pain Management Guide.
- National Center for Complementary and Integrative Health.

Provider/Practice resources

- Oregon Pain Management Commission. Changing the Conversation about Pain. Education module for providers.
- Oregon Pain Guidance (OPG). Provider resources on tapering.
- BRAVO Tapering Protocol. Free CME.
- Oregon State University College of Pharmacy. Naloxone training for pharmacists – Accredited naloxone education.
- Oregon Health Authority (OHA). Naloxone toolkit for Oregon pharmacists – Information on naloxone rescue for opioid overdose, including FAQ section.

- Substance Abuse Mental Health Services Administration (SAMHSA). Opioid Treatment Program Directory – List of opioid treatment programs (OTP) by state, including contact information.
- Center for Disease Control (CDC). Opioid Overdose: Information for Providers – Multiple resources include: guideline overview, training materials, PDMP overview, FAQs.
- Oregon Addictions and Mental Health Services – Information specific to Oregon for Addictions and Mental Health.
- Veteran's Administration (VA). Provider Education – Tools for providers in the following areas: pain and opioid safety, opioid use disorder, benzodiazepines, and opioid overdose and naloxone distribution tools.
- Oregon Health and Science University Comprehensive Pain Center: consultation services.
- Oregon Psychiatric Access Line (OPAL): consultation/call center.
- University of California, San Francisco, Clinician Consultation Center (free and confidential clinician-to-clinician consultation focusing on substance use evaluation and management for primary care clinicians; sponsored by the Health and Resources Services Administration/HRSA).
- University of Washington Pain Medicine- TelePain (free, weekly service for community providers intended to increase knowledge and confidence in chronic pain management).
- U.S. Department of Health and Human Services. *HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics*.

Community resources

- Heal Safely Campaign – Heal Safely is a campaign to empower people to heal safely after injury or surgery.
- Trauma Informed Oregon including resources for providers, organizations, individuals and families.
- Oregon Health Authority (OHA). Safe Disposal of Medications in Oregon – Information on safe disposal and drug take back; includes collection boxes across Oregon.
- Oregon Health Authority (OHA). Oregon peer delivered services for behavioral health conditions – Information on peer support specialists and peer wellness specialists, including substance use disorder peer delivered services curriculum.

Appendix A

Patient assessment

It is important to perform an initial and thorough patient assessment using a combination of tools. Critical components of a global assessment should include, but may not be limited to the following:

Assess and document efficacy of current chronic opioid therapy using the 5As:

- ***Activities***: this includes activities of daily living and functional activities
- ***Adverse effects***: this represents side effects from medications including but not limited to: sedation, respiratory depression, constipation
- ***Aberrance***: this must be assessed and documented in a consistent manner
- ***Affect***: this assesses the impact of opioid therapy on mood and sleep
- ***Analgesia***: this refers to effectiveness of pain control

Complete a biopsychosocial assessment (including clinical interview and patient self-report)

- Patient-centered interview and exploration of goals, questions, concerns, beliefs, expectations, and fears related to opioid therapy and tapers
- History of pain and duration of symptoms, including: onset, location(s), radiation, previous episodes, and intensity
- Patient perception of symptoms; example tools to document patient reported symptoms include, but are not limited to: Pain, Enjoyment of Life and General Activity (PEG) tool, Defense and Veterans Pain Rating Scale (DVPRS) scale, Brief Pain Inventory (BPI), Pain Numeric Rating Scale, and Pain Catastrophizing Scale
- Coexisting conditions, treatments (e.g., use of benzodiazepines or other sedating medications), and the effect on pain
- Patient general medical history, including but not limited to: physical comorbidities (e.g., sleep apnea, diabetes); chronic pain related treatments and outcomes (surgery and procedures); pharmacology; non-pharmacological treatments (e.g., physical therapy)
- Patient substance use/mental health history, including but not limited to: mood disorders, suicidality/prior suicide attempts; history of self-injurious behavior; history of medications for psychiatric conditions and outcomes; trauma history; psychosis; attention deficit hyperactivity disorder (ADHD); substance use history, including tobacco, and associated prescription medication use; the presence of a specific substance use disorder (using standardized screening measures e.g. the cannabis use disorder identification test- revised [CUDIT-R]); history of overdose
- Lifestyle/behavioral history, including but not limited to: exercise, nutrition, leisure time, time in nature, sleep hygiene practices
- Social history, including: social support, family factors e.g., family solicitousness

(unintentional reinforcement of illness behaviors) versus positive support (reinforcement of wellness behaviors); employment or disability status; living conditions; economic status and finances; legal issues
- Family history, including but not limited to: history of chronic pain conditions, psychological/psychiatric history, history of substance use disorders, or history of suicide

Conduct a physical exam

- A thorough physical exam should be completed, with particular attention to areas of chronic pain, in addition to neurologic and psychiatric system examination
- Can include diagnostic studies as appropriate

Conduct a risk assessment

The following tools can help assess the risk of opioid use among patients:

- Urine drug screen
- Prescription Drug Monitoring Program
- Self-reported Measures, including:
    - Opioid Risk Tool (ORT)
    - Screener & Opioid Assessment for Patients with Pain- Revised (SOAPP-R)

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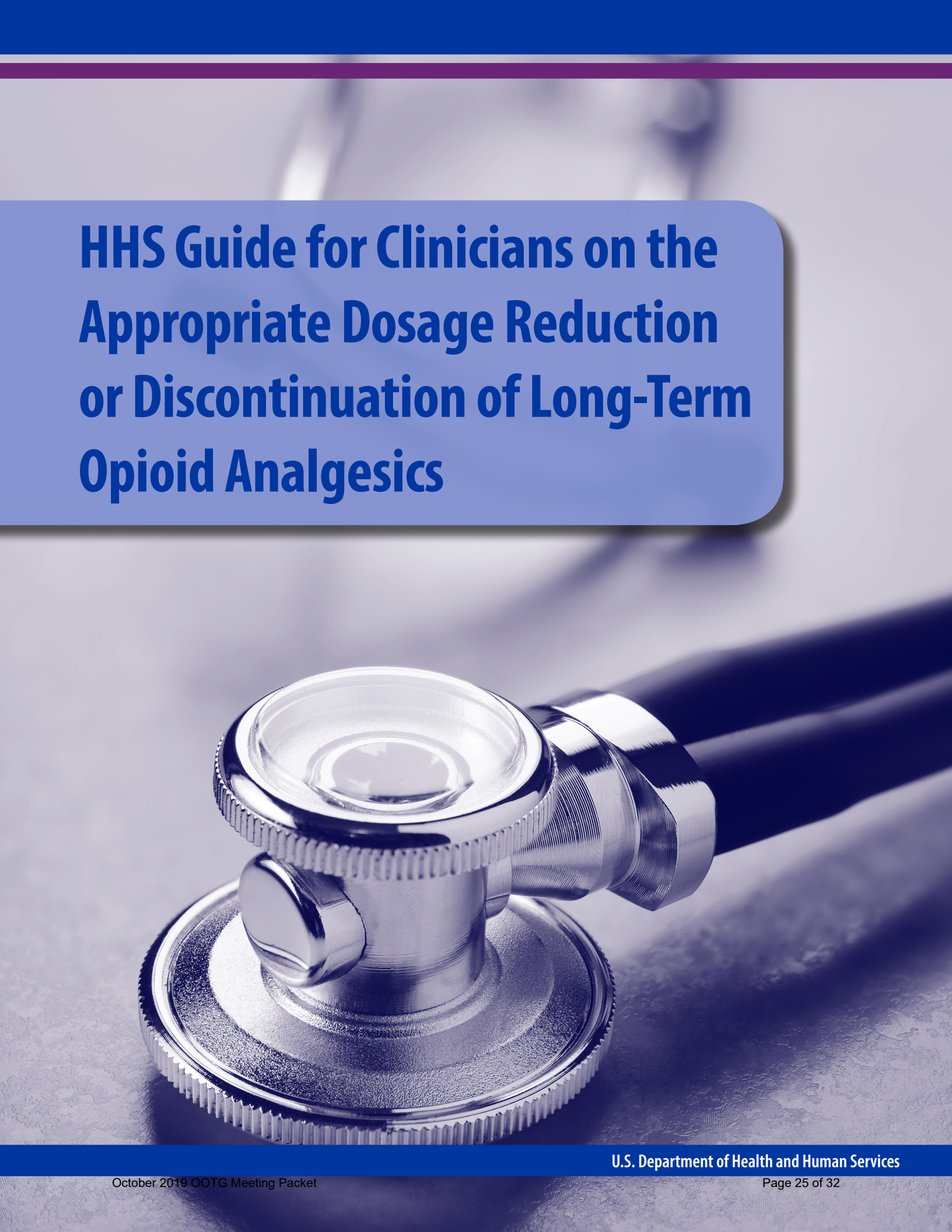
HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics



U.S. Department of Health and Human Services

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U.S. Department of Health and Human Services

HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics

This *HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics* provides advice to clinicians who are contemplating or initiating a reduction in opioid dosage or discontinuation of long-term opioid therapy for chronic pain. In each case the clinician should review the risks and benefits of the current therapy with the patient, and decide if tapering is appropriate based on individual circumstances.

After increasing every year for more than a decade, annual opioid prescriptions in the United States peaked at 255 million in 2012 and then decreased to 191 million in 2017.[i] More judicious opioid analgesic prescribing can benefit individual patients as well as public health when opioid analgesic use is limited to situations where benefits of opioids are likely to outweigh risks. At the same time opioid analgesic prescribing changes, such as dose escalation, dose reduction or discontinuation of long-term opioid analgesics, have potential to harm or put patients at risk if not made in a thoughtful, deliberative, collaborative, and measured manner.

Risks of rapid opioid taper

- Opioids should not be tapered rapidly or discontinued suddenly due to the risks of significant opioid withdrawal.
- Risks of rapid tapering or sudden discontinuation of opioids in physically dependent[ii] patients include acute withdrawal symptoms, exacerbation of pain, serious psychological distress, and thoughts of suicide.[1] Patients may seek other sources of opioids, potentially including illicit opioids, as a way to treat their pain or withdrawal symptoms.[1]
- Unless there are indications of a life-threatening issue, such as warning signs of impending overdose, HHS does not recommend abrupt opioid dose reduction or discontinuation.

Whether or not opioids are tapered, safe and effective nonopioid treatments should be integrated into patients' pain management plans based on an individualized assessment of benefits and risks considering the patient's diagnosis, circumstances, and unique needs.[2,3] Coordination across the health care team is critical. Clinicians have a responsibility to provide or arrange for coordinated management of patients' pain and opioid-related problems, and they should never abandon patients.[2] More specific guidance follows, compiled from published guidelines (the *CDC Guideline for Prescribing Opioids for Chronic Pain*[2] and the *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*[3]) and from practices endorsed in the peer-reviewed literature.

Consider[iii] tapering to a reduced opioid dosage, or tapering and discontinuing opioid therapy, when

- Pain improves[3,4]
- The patient receives treatment expected to improve pain[3]
- The patient requests dosage reduction or discontinuation[2,3,5]
- Pain and function are not meaningfully improved[2,3,5]
- The patient is receiving higher opioid doses without evidence of benefit from the higher dose[2,3]
- The patient has current evidence of opioid misuse[3,4,5]
- The patient experiences side effects[iv] that diminish quality of life or impair function[3,4,6]
- The patient experiences an overdose or other serious event (e.g., hospitalization, injury),[2,5] or has warning signs for an impending event such as confusion, sedation, or slurred speech[2,6]
- The patient is receiving medications (e.g., benzodiazepines) or has medical conditions (e.g., lung disease, sleep apnea, liver disease, kidney disease, fall risk, advanced age) that increase risk for adverse outcomes[3,5]
- The patient has been treated with opioids for a prolonged period (e.g., years), and current benefit-harm balance is unclear

[i] https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html

[ii] Physical dependence occurs with daily, around-the-clock use of opioids for more than a few days and means that the body has adapted to the drug, requiring more of it to achieve a certain effect (tolerance). Patients with physical dependence will experience physical and/or psychological symptoms if drug use is abruptly ceased (withdrawal).

[iii] Additional tools to help weigh decisions about continuing opioid therapy are available: Assessing Benefits and Harms of Opioid Therapy, Pain Management Opioid Taper Decision Tool, and Tapering Opioids for Chronic Pain.

[iv] e.g., drowsiness, constipation, depressed cognition

Important considerations prior to deciding to taper

Overall, following voluntary reduction of long-term opioid dosages, many patients report improvements in function, sleep, anxiety, and mood without worsening pain or even with decreased pain levels.[4,7,8,9,10,11] Other patients report increased pain, insomnia, anxiety, and depression.[4,7,9,12] The duration of increased pain related to hyperalgesia or opioid withdrawal is unpredictable and may be prolonged in some patients.[7,12] Decisions to continue or reduce opioids for pain should be based on individual patient needs.[2,13] Consider whether opioids continue to meet treatment goals, whether opioids are exposing the patient to an increased risk for serious adverse events or opioid use disorder, and whether benefits continue to outweigh risks of opioids.[2,13]

- Avoid insisting on opioid tapering or discontinuation when opioid use may be warranted (e.g., treatment of cancer pain, pain at the end of life, or other circumstances in which benefits outweigh risks of opioid therapy). ***The CDC Guideline for Prescribing Opioids for Chronic Pain does not recommend opioid discontinuation when benefits of opioids outweigh risks.***[2,4,13]
- Avoid misinterpreting cautionary dosage thresholds as mandates for dose reduction.[4] While, for example, the CDC Guideline recommends avoiding or carefully justifying *increasing* dosages above 90 MME/day, it does not recommend abruptly reducing opioids from higher dosages.[2,4] Consider individual patient situations.
- Some patients using both benzodiazepines and opioids may require tapering one or both medications to reduce risk for respiratory depression. Tapering decisions and plans need to be coordinated with prescribers of both medications.[2] If benzodiazepines are tapered, they should be tapered gradually[v] due to risks of benzodiazepine withdrawal (anxiety, hallucinations, seizures, delirium tremens, and, in rare cases, death).[2]
- Avoid dismissing patients from care. This practice puts patients at high risk and misses opportunities to provide life-saving interventions, such as medication-assisted treatment for opioid use disorder.[2,4,13] Ensure that patients continue to receive coordinated care.
- There are serious risks to noncollaborative tapering in physically dependent patients, including acute withdrawal, pain exacerbation, anxiety, depression, suicidal ideation, self-harm, ruptured trust, and patients seeking opioids from high-risk sources.[1,14]

Important steps prior to initiating a taper

- Commit to working with your patient to improve function and decrease pain.[2,7] Use accessible, affordable nonpharmacologic and nonopioid pharmacologic treatments.[2,5,7] Integrating behavioral and nonopioid pain therapies before and during a taper can help manage pain[10] and strengthen the therapeutic relationship.
- Depression, anxiety, and post-traumatic stress disorder (PTSD) can be common in patients with painful conditions, especially in patients receiving long-term opioid therapy.[15] Depressive symptoms predict taper dropout.[7,8] Treating comorbid mental disorders can improve the likelihood of opioid tapering success.
- If your patient has serious mental illness, is at high suicide risk, or has suicidal ideation, offer or arrange for consultation with a behavioral health provider before initiating a taper.[3,5]
- If a patient exhibits opioid misuse behavior or other signs of opioid use disorder, assess for opioid use disorder using DSM-5 criteria.[2,3] If criteria for opioid use disorder are met (especially if moderate or severe), offer or arrange for medication-assisted[vi] treatment.[2,3]
- Access appropriate expertise if considering opioid tapering or managing opioid use disorder during pregnancy. Opioid withdrawal risks include spontaneous abortion and premature labor. For pregnant women with opioid use disorder, medication-assisted treatment is preferred over detoxification.[2]
- ***Advise patients that there is an increased risk for overdose on abrupt return to a previously prescribed higher dose.***[2] Strongly caution that it takes as little as a week to lose tolerance and that there is a risk of overdose if they return to their original dose.[2,5,6] Provide opioid overdose education and consider offering naloxone.[2]

Share decision making with patients

- Discuss with patients their perceptions of risks, benefits, and adverse effects of continued opioid therapy, and include patient concerns in taper planning. For patients at higher risk of overdose based on opioid dosages, review benefits and risks of continued high-dose opioid therapy.[2,5]
- If the current opioid regimen does not put the patient at imminent risk, tapering does not need to occur immediately.[4] Take time to obtain patient buy-in.[14]
- For patients who agree to reduce opioid dosages, collaborate with the patient on a tapering plan.[2] Tapering is more likely to be successful when patients collaborate in the taper.[vii] Include patients in decisions, such as which medication will be decreased first and how quickly tapering will occur.

[v] Example benzodiazepine tapers and clinician guidance are available at https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Benzodiazepine_Provider_AD_%20Risk_Discussion_Guide.pdf

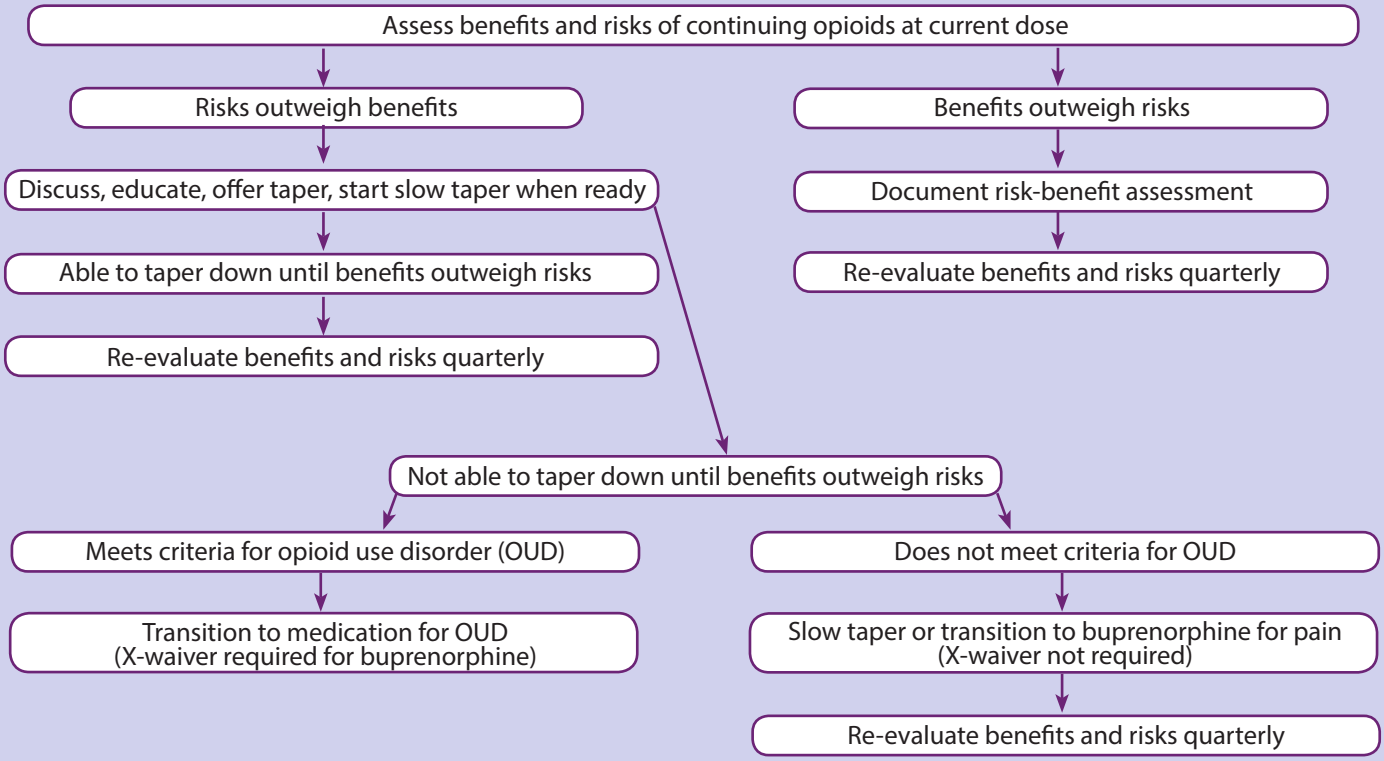
[vi] See SAMHSA's TIP 63: Medications for Opioid Use Disorder, SAMHSA's Buprenorphine Practitioner Locator, and SAMHSA's Opioid Treatment Program Directory

[vii] A recent systematic review found that when opioids were tapered with buy-in from patients who agreed to decrease dosage or discontinue therapy, pain, function, and quality of life improved after opioid dose reduction.[10]

Individualize the taper rate

- When opioid dosage is reduced, a taper slow enough to minimize opioid withdrawal symptoms and signs[viii] should be used.[2,3] Tapering plans should be individualized based on patient goals and concerns.[2,3,5,6]
- The longer the duration of previous opioid therapy, the longer the taper may take. Common tapers involve dose reduction of 5% to 20% every 4 weeks.[3,5]
  - **Slower tapers** (e.g., 10% per month or slower) are often better tolerated than more rapid tapers, especially following opioid use for more than a year.[2] Longer intervals between dose reductions allow patients to adjust to a new dose before the next reduction.[5] Tapers can be completed over several months to years depending on the opioid dose.[2,5] See "slower taper" example here.
  - **Faster tapers** can be appropriate for some patients. A decrease of 10% of the original dose per week or slower (until 30% of the original dose is reached, followed by a weekly decrease of 10% of the remaining dose) is less likely to trigger withdrawal[7] and can be successful for some patients, particularly after opioid use for weeks to months rather than years. See "faster taper" example here.
- At times, tapers might have to be paused and restarted again when the patient is ready.[2] Pauses may allow the patient time to acquire new skills for management of pain and emotional distress, introduction of new medications, or initiation of other treatments, while allowing for physical adjustment to a new dosage.[3,5]
- Tapers may be considered successful as long as the patient is making progress, however slowly, towards a goal of reaching a safer dose,[2] or if the dose is reduced to the minimal dose needed.
- Once the smallest available dose is reached, the interval between doses can be extended.[2,5,7] Opioids may be stopped, if appropriate, when taken less often than once a day.[2,7] See "example tapers for opioids" here.
- More rapid tapers (e.g., over 2-3 weeks[16]) might be needed for patient safety when the risks of continuing the opioid outweigh the risks of a rapid taper (e.g., in the case of a severe adverse event such as overdose).
- Ultrarapid detoxification under anesthesia is associated with substantial risks and ***should not be used***.[2]

Opioid Tapering Flowchart



Adapted from Oregon Pain Guidance. Tapering – Guidance & Tools. Available at https://www.oregonpainguidance.org/guideline/tapering/.

DSM-5 Opioid Use Disorder

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least 2 of the following, occurring within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain, use, or recover from the effects of opioids.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect, or
    b. Markedly diminished effect with continued use of the same amount of an opioid.

    Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.
11. Withdrawal, as manifested by either of the following:
    a. The characteristic opioid withdrawal syndrome, or
    b. Opioids (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.

    Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.

Mild: Presence of 2-3 symptoms
Moderate: Presence of 4-5 symptoms
Severe: Presence of 6 or more symptoms

Treat symptoms of opioid withdrawal

- If tapering is done gradually, withdrawal symptoms should be minimized and manageable.
- Expectation management is an important aspect of counseling patients through withdrawal.
- Significant opioid withdrawal symptoms may indicate a need to pause or slow the taper rate.
- Onset of withdrawal symptoms depends on the duration of action of the opioid medication used by the patient. Symptoms can begin as early as a few hours after the last medication dose or as long as a few days, depending on the duration of action.[7] Early withdrawal symptoms (e.g., anxiety, restlessness, sweating, yawning, muscle aches, diarrhea and cramping[viii]) usually resolve after 5-10 days but can take longer.[5]
- Some symptoms (e.g., dysphoria, insomnia, irritability, increased pain) can take weeks to months to resolve.[5]
- Short-term oral medications can help manage withdrawal symptoms, especially when prescribing faster tapers.[5] These include alpha-2 agonists[ix] for the management of autonomic signs and symptoms (sweating, tachycardia), and symptomatic medications[x] for muscle aches, insomnia, nausea, abdominal cramping, or diarrhea.[5]

Provide behavioral health support

- Make sure patients receive appropriate psychosocial support.[2,3,11] Ask how you can support the patient.[5]
- Acknowledge patient fears about tapering.[5] While motives for tapering vary widely, fear is a common theme. Many patients fear stigma, withdrawal symptoms, pain, and/or abandonment.[13,18]
- Tell patients "I know you can do this" or "I'll stick by you through this." Make yourself or a team member available to the patient to provide support, if needed.[3,6] Let patients know that while pain might get worse at first, many people have improved function without worse pain after tapering opioids.[7,8,9,10,11]
- Follow up frequently. Successful tapering studies have used at least weekly follow up.[10]
- Watch closely for signs of anxiety, depression, suicidal ideation, and opioid use disorder and offer support or referral as needed.[2,3,6] Collaborate with mental health providers and with other specialists as needed to optimize psychosocial support for anxiety related to the taper.[2]

[viii] Acute opioid withdrawal symptoms and signs include drug craving, anxiety, restlessness, insomnia, abdominal pain or cramps, nausea, vomiting, diarrhea, anorexia, sweating, dilated pupils, tremor, tachycardia, piloerection, hypertension, dizziness, hot flashes, shivering, muscle or joint aches, runny nose, sneezing, tearing, yawning, and dysphoria.[7] Worsening of pain is a frequent symptom of withdrawal that may be prolonged but tends to diminish over time for many patients.[7]

[ix] Alpha-2 agonists clonidine and lofexidine are more effective than placebo in ameliorating opioid withdrawal.[17] There is not similar research in patients tapering from long-term opioid treatment for pain.[7] Lofexidine has an FDA-approved indication for use up to 14 days for "mitigation of opioid withdrawal symptoms to facilitate abrupt opioid discontinuation in adults."

[x] NSAIDs, acetaminophen, or topical menthol/methylsalicilate for muscle aches; trazodone for sleep disturbance; prochlorperazine, promethazine, or ondansetron for nausea; dicyclomine for abdominal cramping; and loperamide or bismuth subsalicylate for diarrhea.[5]

Special populations

- If patients experience unanticipated challenges to tapering, such as inability to make progress despite intention to taper or opioid-related harm, assess for opioid use disorder using DSM-5 criteria.[2] If patients meet criteria for opioid use disorder (especially if moderate or severe), offer or arrange medication-assisted treatment.[2,3]
- If patients on high opioid dosages are unable to taper despite worsening pain and/or function with opioids, whether or not opioid use disorder criteria are met, consider transitioning to buprenorphine.[4,12] Buprenorphine is a partial opioid agonist that can treat pain as well as opioid use disorder,[19] and has other properties that may be helpful,[3] including less opioid-induced hyperalgesia[12] and easier withdrawal than full mu-agonist opioids,[3] and less respiratory depression than other long-acting opioids.[20] Buprenorphine can then be continued or tapered gradually.[12] Transitioning from full-agonist opioids requires attention to timing of the initial buprenorphine dose to avoid precipitating withdrawal.[xi]

  Consultation with a clinician experienced in use of buprenorphine is warranted if unfamiliar with its initiation. SAMHSA's Providers Clinical Support System offers training and technical assistance as well as mentors to assist those who need to taper opioids and may have additional questions.

- Closely monitor patients who are unable or unwilling to taper and who continue on high-dose or otherwise high-risk opioid regimens. Mitigate overdose risk (e.g., provide overdose education and naloxone). Use periodic and strategic motivational questions and statements to encourage movement toward appropriate therapeutic changes.[14]

[xi] To avoid precipitating protracted withdrawal from full agonist opioids when starting buprenorphine, patients need to be in mild to moderate withdrawal (including Clinical Opioid Withdrawal Score (COWS) objective signs) before the first buprenorphine dose.[12] To do this, wait at least 8 to 12 hours after the last dose of short-acting full agonist opioids before the first dose of buprenorphine.[12] Buprenorphine buccal film (Belbuca) and buprenorphine transdermal system (Butrans) have FDA-approved indications for "the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate." The full Belbuca prescribing information and the full Butrans prescribing information include instructions for conversion from full agonist opioids. More time should be allowed before starting buprenorphine following the last dose of long-acting full agonist opioids (e.g., at least 36 hours after last methadone dose); in addition, transition from methadone to buprenorphine is likely to be better tolerated after methadone is gradually tapered to 40mg per day or less.[12] Because the duration of action for analgesia is much shorter than the duration of action for suppression of opioid withdrawal,[21] "split dosing" (e.g., 8mg sublingual tablet twice a day) rather than once a day dosing is used when buprenorphine is provided for pain management.[3,12]

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