

KAISER PERMANENTE: Taper Considerations

While we generally proceed in alignment with the CDC-opioid-guideline-endorsed 10 to 20% decrease every 1 to 4 weeks, we very much detail the taper strategy to the situation at hand. Here are some of the factors influencing how we develop a taper strategy:

Tapering Considerations:

1. Generally, a reasonable starting range is a decrease in total daily opioid dose of 10-20% per step, changing the dose every 1 to 4 weeks.
2. Prior to starting the taper, we review and assess the greater picture for each given patient and adjust the taper approach accordingly, often including patient interview. These factors include but are not limited to:
 - Reason for the taper: If there are opioid safety risks then a faster taper may be appropriate. If the patient is otherwise stable, then going slower may be reasonable, which may allow the patient to build further self-management skills during the taper.
 - Patient health status: To optimize stability, a faster/slower taper may be needed. For example, a patient with respiratory decline may need a faster taper for safety. A patient with fragile emotional health may need a slower taper.
 - Patient willingness: Some patients prefer to 'rip the Band-Aid off' and get it over with. Also, after the first slow step or two of the taper, the patient realizes how much better they feel and prefer to taper more quickly.
 - Copays: Pt may choose to decrease faster to avoid multiple Rx strengths and associated copays.
 - Current dose: At lower doses, larger relative percent changes are reasonable. If a patient has self-adjusted their dose, we start the taper at their ***prescribed*** dose, which may mean a larger % decrease for the initial step. If a patient has been out of/off of opioids for 2 to 3 days, there may no longer be a need to taper, but rather to offer supportive care for any remaining withdrawal symptoms.
 - Substance use: In certain circumstances, such as alcohol intoxication or illicit substance use, providing additional opioids for a slower taper may increase risk relative to a more rapid taper with pt's remaining supply, offering supportive care for withdrawal symptoms, and engaging in substance use treatment.
3. If there are multiple opioids, we involve the patient in the decision-making process (when appropriate) to decide which to taper first. If no preference, we often taper the long-acting opioid(s) first, followed by the short-acting opioid(s).
4. When appropriate, we include only one taper step per prescription. This helps optimize safety by reducing confusion about the current dose and limiting the opioid quantity per dispense--especially important when opioid safety concerns are present.
5. We follow up with pt throughout the taper to monitor and adjust the rate and magnitude of taper steps when appropriate. We typically administer the PEGS Questionnaire and assess for changes in pain. Active listening and empathy are key. We avoid dwelling on the pain so much as offering active listening, empathy, supportive care, and help trouble shoot ways to manage pain and any other withdrawal symptoms.
6. Focus on skill-building and self-care as a priority over pharmacologic intervention for management of pain and/or withdrawal symptoms.

“Clinicians should taper opioids in patients who have developed physiologic dependence on opioids. This includes situations of post-operative pain or long-term use. Opioid tapers should be individualized to the specific patient situation and care should be taken to engage and provide support to the patient throughout the process. Clinicians should determine the length of time of an opioid taper based on the situation and the severity of risks associated with ongoing opioid prescription. The following are some recommendations on how to approach opioid dose reduction or discontinuation. [10]

- Gradual dosage reduction (appropriate for most patients): Reduce dose by 10-25% every 1-4 weeks, larger initial dose reductions (25-50%) can be used
- Rapid dosage reduction (medically dangerous situations): Decrease dose every 1-7 days as appropriate
- Stop immediately (clear signs of unsafe or high risk use)
- Use adjuvant medications during taper”

http://ohsucancer.com/xd/health/who-we-are/upload/Safe-Opioid-Prescribing-Guideline_FINAL_12-6-18.pdf

OHSU HEALTH SYSTEM

OFFICE OF CLINICAL INTEGRATION AND EVIDENCE-BASED PRACTICE

ADULT SAFE OPIOID PRESCRIBING GUIDELINE FOR CHRONIC, NON-END-OF-LIFE PAIN AND PRACTICE RESOURCES FOR CLINICAL IMPLEMENTATION

Background: Opioids are commonly prescribed for pain. An estimated 20% of patients presenting to physician offices with non-cancer pain symptoms or pain-related diagnoses (including acute and chronic pain) receive an opioid prescription.^[1] In 2012, health care providers wrote 259 million prescriptions for opioid pain medication, enough for every adult in the United States to have a bottle of pills.^[2] Opioid prescriptions per capita increased 7.3% from 2007 to 2012, with opioid prescribing rates increasing more for family practice, general practice, and internal medicine compared with other specialties.^[3] Rates of opioid prescribing vary greatly across states in ways that cannot be explained by the underlying health status of the population, highlighting the lack of consensus among clinicians on how to use opioid pain medication.^[2]

Prevalence of Chronic Pain and Prescription Opioids:

Estimates of the prevalence of chronic pain vary, but it is clear that the number of persons experiencing chronic pain in the United States is substantial. The 1999–2002 National Health and Nutrition Examination Survey estimated that 14.6% of adults have current widespread or localized pain lasting at least 3 months.^[4] Based on a survey conducted during 2001–2003^[5], the overall prevalence of common, predominantly musculoskeletal pain conditions (e.g., arthritis, rheumatism, chronic back or neck problems, and frequent severe headaches) was estimated at 43% among adults in the United States, although minimum duration of symptoms was not specified. Most recently, analysis of data from the 2012 National Health Interview Study showed that 11.2% of adults report having daily pain. On the basis of data available from health systems, researchers estimate that 9.6–11.5 million adults, or approximately 3%–4% of the adult U.S. population, were prescribed long-term opioid therapy in 2005.^[6]

Risks of Opioids: Opioid pain medication use presents serious risks, including overdose and opioid use disorder. From 1999 to 2014, more than 165,000 persons died from overdose related to opioid pain medication in the United States. In the past decade, while the death rates for the top leading causes of death such as heart disease and cancer have decreased substantially, the death rate associated with opioid pain medication has increased markedly.^[7] Sales of opioid pain medication have increased in parallel with opioid-related overdose deaths.^[8] The Drug Abuse Warning Network estimated that >420,000 emergency department visits were related to the misuse or abuse of opioid pain relievers in 2011, the most recent year for which data are available.^[9]

Definitions:

Long-term opioid use: use of opioids on most days for > 3 months

Chronic pain: pain conditions that typically last > 3 months or past the time of normal tissue healing

LIP: Licensed Independent Provider

Non-cancer: Pain caused by an entity that is not related to an active malignancy

End-of-life: a patient with an advanced, terminal, progressing illness, likely to result in death in < 6 months, where non-curative treatment is the goal

Opioids: Schedules II through V medications under the federal Controlled Substance Act, as modified by the Oregon State Board of Pharmacy (includes codeine, hydrocodone, hydromorphone, fentanyl, methadone, morphine, oxycodone, oxymorphone, tramadol, tapentadol, and buprenorphine)

NOTE: Buprenorphine is a partial opioid-agonist.

Morphine equivalent dose is not easily translatable for buprenorphine, so buprenorphine is not subject to morphine milligram equivalents/day dose exclusion. Buprenorphine for the treatment of opioid use disorder is excluded from this guideline.

NOTE: Opioids administered through an intrathecal or epidural route has potent central nervous system effects and contributes powerfully toward a cumulative oral

morphine milligram equivalents/day dose. Conversion factors (multipliers) used in oral opioid morphine milligram equivalents conversion calculators do not apply to opioid administered through these routes and will underestimate the effective morphine milligram equivalents/day dose. Patients receiving opioid through intrathecal or epidural routes require close monitoring and, in an ambulatory setting, should receive continuous care by a pain specialist.

Guideline Eligibility Criteria: Adult and adolescent patients (≥ 15 years of age) being treated for chronic or

non-end-of-life pain not related to an active malignancy with long-term opioid prescriptions in any clinical setting (i.e., Emergency Department, outpatient, inpatient) throughout OHSU Health System

Guideline Exclusion Criteria:

- patients < 15 years of age
- patients at end-of-life
- patients with pain related to active malignancy
- patients with Sickle Cell Disease

Clinical Practice Recommendations

OHSU Health System fully endorses the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain.^[10] The CDC guideline summary is listed below with specific aspects highlighted as they pertain to clinical practice throughout OHSU Health System.

Determining When to Initiate or Continue Opioids for Chronic Pain

Non-pharmacologic therapy and non-opioid 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 non-pharmacologic therapy and non-opioid pharmacologic therapy, as appropriate.^[10]

- *Strong Recommendation; Low Quality Evidence*

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 opioid 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.^[10]

- *Strong Recommendation; Very Low Quality Evidence*

Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.^[10]

- *Strong Recommendation; Low Quality Evidence*

PRACTICE IMPLICATIONS:

- Prior to prescribing an opioid for long-term use for chronic pain, a pain focused history and examination should be performed. This evaluation should include the following elements. (See APPENDIX A for resources.)

- a. Subjective pain evaluation
- b. Functional capacity evaluation
- c. Mental health evaluation and history
- d. Substance use evaluation and history
- e. Opioid Risk evaluation including initial urine drug testing and review of the Oregon Prescription Drug Monitoring Program

- Prior to prescribing an opioid for long-term use for chronic pain, the following must be discussed with the patient and documented in the patient record. (See APPENDIX A for resources.)

- a. A specific pain diagnosis
- b. Set realistic goals for pain and function based on diagnosis (e.g., walk around block)

- c. Discuss benefits and risks (e.g., opioid use disorder, opioid withdrawal, overdose) with patient
 - d. Provide patient (and patient must read and sign) a Controlled Substance for Intractable Pain Notice and Consent Form (also known as Opioid Treatment Agreement and Material Risk Notice). The document will be part of the patient's medical record and should be renewed every year if opioids are continued
 - e. Set criteria for stopping or continuing opioids
- If cannabis is present on a urine drug test, the patient should be screened for cannabis use disorder prior to considering use of opioids for pain. OHSU Health System providers may not verbally prescribe or write a prescription for medical marijuana. OHSU Health System recognizes that new state policies regarding both medical and recreational use of marijuana have generated questions about potential therapeutic benefits as well as potential adverse health effects of marijuana, particularly as it relates to pain management involving opioids. Opioids should not be combined with ongoing marijuana use unless therapeutic benefit is determined to outweigh the risk for harm, and opioids should be avoided if cannabis use disorder is present. Some OHSU Health System clinics may choose to create additional clinic-specific policies regarding monitoring for cannabis use after initial screening or regarding the prescribing of opioids with concomitant use of cannabis.

Opioid Selection, Dosage, Duration, Follow-up and Discontinuation

When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting opioids. ^[10]

- *Strong Recommendation; Very Low Quality Evidence*

When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to > 50 morphine milligram equivalents/day, and should avoid increasing dosage to > 90 morphine milligram equivalents/day or carefully justify a decision to titrate dosage to > 90 morphine milligram equivalents/day. ^[10]

- *Strong Recommendation; Low Quality Evidence*

PRACTICE IMPLICATIONS:

- An opioid dose > 90 morphine milligram equivalents/day must not be prescribed unless the benefit of dose escalation is determined to clearly outweigh the risk for harm, and without secondary review by another licensed independent provider (LIP), a clinic opioid review board, or a Comprehensive Pain Center. (See Appendix B for an example of a template for secondary review.)
- If a patient is already prescribed > 90 morphine milligram equivalents/day and has not yet had secondary review, an opioid taper attempt is generally recommended. For best results, it is recommended that this taper have an estimated completion date. Exceptions to taper should clearly document significant benefit and small harm, and should be substantiated by secondary review by another licensed independence provider, a clinic opioid review board, or a Comprehensive Pain Center. (See Appendix C for opioid taper resources.)
- Naloxone, opioid antagonist should be prescribed to patients whose opioid dose exceeds 50 morphine milligram equivalents/day. Patient and family education should accompany the prescription. (See APPENDIX A for instructions and additional resources.)

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. If benefits do not outweigh the risks 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. ^[10]

- *Strong Recommendation; Very Low Quality*

(See APPENDIX A for resources that list opioid associated harms.)

Assessing Risk and Addressing Harms of Opioid Use

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should complete the Opioid Risk Tool or another related risk assessment tool. (See APPENDIX A for Opioid Risk Tool.) 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 morphine milligram equivalents/day), or concurrent benzodiazepine use, are present. ^[10]

- *Strong Recommendation; Very Low Quality Evidence*

PRACTICE IMPLICATIONS:

- Naloxone, opioid antagonist should be prescribed to patients whose opioid dose exceeds 50 morphine milligram equivalents/day. Patient and family education should accompany the prescription. (See APPENDIX A for instructions and additional information.)

Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for opioid overdose. Clinicians should review prescription drug monitoring program data when:

- a. starting opioid therapy for chronic pain,
- b. periodically ranging from every prescription to every three months for higher risk or new patients, and
- c. at minimum once per year during opioid therapy for chronic pain. ^[10]

- *Strong Recommendation; Very Low Quality Evidence*

PRACTICE IMPLICATIONS:

- Maintain a comprehensive treatment plan with agreed upon treatment goals.
 - a. Should review an informed consent and opioid agreement every 1 year
 - b. Should regularly review and discuss mutual treatment goals
 - c. Should regularly evaluate effectiveness and safety of opioid treatment
- Utilize the health maintenance registry to track periodic renewal of opioid agreement and monitoring of prescription drug monitoring program

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

- *Weak Recommendation; Very Low Quality Evidence*

Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible. ^[10]

- *Strong Recommendation; Low Quality Evidence*

PRACTICE IMPLICATIONS:

- If the patient is already prescribed benzodiazepines, consider tapering benzodiazepines before prescribing opioids or do not start opioids. (See APPENDIX C for benzodiazepine taper resources.)
- Should avoid concomitant use of other medications with sedating effects and/or abuse potential (e.g., barbiturates, zolpidem, etc.)
- Should advise patients against concomitant use of alcohol and opioids
- Should provide patient counseling on the risks of combining the above substances with opioids

Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder. ^[10]

- *Strong Recommendation; Moderate Quality Evidence*

Opioid Dosing Strategies for Acute Pain

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed. ^[10]

- *Strong Recommendation; Very Low Quality Evidence*

PRACTICE IMPLICATIONS:

- Complex post-operative pain and significant trauma pain should follow the guideline to prescribe the lowest effective dose for the expected duration of pain, acknowledging that higher doses may be needed for a longer period of time
- For most other acute sources of pain such as dental pain, simple fracture, etc., the 3-7 day limit should be applied
- Opioid treatment for acute pain lasting longer than 2 weeks should have an exit strategy and taper plan in place (See the APPENDIX C for opioid taper recommendations.)

Inpatient Referrals

In the hospital at OHSU, consider Acute Pain Service consultation if patient's pain is difficult to manage or if opioid dose is > 90 morphine milligram equivalents/day. Consider consulting OHSU Improving Addiction Care Team (IMPACT) if there is concern for an active substance use disorder that is complicating care in the hospital.

- *Consensus Statement*

Outpatient Consults/Referrals

Consider specialty referral to internal opioid review process, pain specialist, or addiction medicine if:

- o The patient has ongoing severe pain with no significant improvement in pain and/or function despite opioid treatment
- o Presence of significant psychological and addiction issues
- o The provider is considering prescribing opiates in combination with other psychoactive drugs (i.e., benzodiazepines) with potential for abuse
- o There is aberrant drug-related patient behavior

- *Consensus Statement*

Non-Opioid Pain Management Strategies

Alternatives to opioid prescribing should be considered in the management of patients with non-end-of-life pain, including: non-opioid medications (e.g., nonsteroidal anti-inflammatory drugs, tricyclic antidepressants, serotonin-norepinephrine reuptake inhibitors, anti-convulsants), physical treatments (e.g., exercise therapy, weight loss), behavioral treatment (e.g., cognitive behavioral therapy, mindfulness exercises), complementary and alternative medicine (e.g., chiropractic, acupuncture, massage). ^[10] (See APPENDIX A for additional resources.)

- *Consensus Statement*

Safe Opioid Prescribing for Hospitalized Patients who are Prescribed Opioids Prior to Admission

At admission check the Prescription Drug Monitoring Program to confirm opioid dosing and prior opioid prescriber.

During the course of hospitalization to guide inpatient pain management, do the following:

- a. Establish if the patient has an opioid agreement with his or her primary care provider or other provider
- b. Contact the patient's primary care provider

Prior to hospital discharge, do the following:

- a. If prescribing opioids at discharge, prescribe only the amount appropriate to manage the acute pain episode with no refills. Chronic pain should be managed by the patient's primary care provider. Prepare tapering protocol prior to discharge
- b. Avoid concomitant prescription of benzodiazepines or other sedating medications at discharge
- c. Obtain Pain Service Consultation at OHSU if the patient's pain is difficult to manage or if opioid dose is > 90 morphine milligram equivalents/day.

- *Consensus Statements*

Patients in the Emergency Department

The consensus statements below were informed by the 2016 CDC Opioid Prescribing Guideline for Chronic Pain^[10] and the 2012 Prescribing of Opioids for Adult Pains in the Emergency Department Guideline from the American College of Emergency Physicians Opioid Guideline Writing Panel.^[11]

At admission, check the prescription drug monitoring program to confirm opioid dosing and prior prescriber.

If opioids are prescribed at discharge:

- a. The prescription should be for the lowest practical dose for a limited duration (3-5 days), and the prescriber should consider the patient's risk for opioid misuse, abuse, or diversion
- b. The clinician should honor existing patient-physician pain contracts/treatment agreements and consider past prescription patterns from information sources such as prescription drug monitoring programs
- c. Establish if the patient has an opioid agreement with his or her primary care provider or other provider
- d. Avoid concomitant prescription of benzodiazepines or sedative hypnotics

- *Consensus Statements*

Opioid Tapering or Discontinuation

Clinicians should taper opioids in patients who have developed physiologic dependence on opioids. This includes situations of post-operative pain or long-term use. Opioid tapers should be individualized to the specific patient situation and care should be taken to engage and provide support to the patient throughout the process. Clinicians should determine the length of time of an opioid taper based on the situation and the severity of risks associated with ongoing opioid prescription. The following are some recommendations on how to approach opioid dose reduction or discontinuation.^[10]

- Gradual dosage reduction (appropriate for most patients): Reduce dose by 10-25% every 1-4 weeks, larger initial dose reductions (25-50%) can be used
- Rapid dosage reduction (medically dangerous situations): Decrease dose every 1-7 days as appropriate
- Stop immediately (clear signs of unsafe or high risk use)
- Use adjuvant medications during taper

- *Consensus Statements*

Patients with or Recovering from Substance Use Disorders

The recommendations above apply to patients with or recovering from Substance Use Disorders.

The consensus statement below was informed by the 2012 Center for Substance Abuse and Mental Health Services Administration Guideline.^[12]

Non-opioid pharmacological and non-pharmacological therapies, including complementary and alternative medicine, should be considered routine before opioid treatment is initiated. Opioids may be necessary and should not be ruled out based on an individual's having a history of substance abuse disorder.

- *Consensus Statement*

Quality Measures:

Structure-

- Prescription drug monitoring program link to EMRs

Process-

- Utilization of urine drug testing
- Percent of providers registered to use prescription drug monitoring program
- Utilization of prescription drug monitoring program
- Receipt of opioid agreement
- Prevalence of patients treated with opioids and mean dose
- Prevalence of concomitant use of opioids and benzodiazepines
- Referrals to IMPACT/Acute Pain Service/Comprehensive Pain Clinic/Addiction Medicine
- Utilization of naloxone in patients prescribed > 50mg morphine milligram equivalents/day

Outcome-

- Patient satisfaction with pain management
- Patient functional status

References

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10. Dowell, D., T.M. Haegerich, and R. Chou, *CDC Guideline for Prescribing Opioids for Chronic Pain--United States, 2016*, in JAMA. 2016. p. 1624-45.
11. Cantrill, S.V., et al., *Clinical policy: critical issues in the prescribing of opioids for adult patients in the emergency department*. Ann Emerg Med, 2012. **60**(4): p. 499-525.
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Guideline Preparation

This guideline was prepared by the Office of Clinical Integration (CI) and Evidence-Based Practice (EBP) in collaboration with content experts at Oregon Health and Science University, Salem Healthcare, and Tuality.

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Development Process

This guideline was developed using the process outlined in the CI and EBP Manual (2016). The review summary documents the following steps:

1. Review Preparation
 - PICO questions established
 - Evidence search confirmed with content experts
2. Review of Existing Internal and External Guidelines
 - Literature Review of Relevant Evidence
3. Critically Analyze the Evidence
4. Summarize the Evidence by preparing the guideline, and order sets

Evaluating the Quality of the Evidence

Published clinical guidelines were evaluated for this review using the **University of Pennsylvania's Trustworthy Guideline Rating Scale**. The summary of these guidelines are included in the evidence summary. The rating scale is based on the Institute of Medicine's "Standards for Developing Trustworthy Clinical Practice Guidelines" (IOM), as well as a review of the AGREE Enterprise and Guidelines International Network domains. This scale evaluates a guideline's transparency, conflict of interest, development group, systematic review, supporting evidence, recommendations, external review and currency and updates. The purpose of this scale is to focus on the weaknesses of a guideline that may reduce the trust a clinical user can have in the guideline, and distinguish weaknesses in documentation (e.g. guideline does not have a documented updating process) from weaknesses in the guidance itself (e.g., recommendations are outdated).

The **GRADE (Grading of Recommendations, Assessment, Development and Evaluation)** criteria were utilized to evaluate the body of evidence used to make clinical recommendations. The table below defines how the quality of the evidence is rated and how a strong versus

weak recommendation is established. The evidence summary reflects the critical points of evidence.

Recommendation	
STRONG	Desirable effects clearly outweigh undesirable effects or vice versa
WEAK	Desirable effects closely balanced with undesirable effects
Quality	Type of Evidence
High	Consistent evidence from well-performed RCTs or exceptionally strong evidence from unbiased observational studies
Moderate	Evidence from RCTs with important limitations (e.g., inconsistent results, methodological flaws, indirect evidence, or imprecise results) or unusually strong evidence from unbiased observational studies
Low	Evidence for at least 1 critical outcome from observational studies, from RCTs with serious flaws or indirect evidence
Very Low	Evidence for at least 1 critical outcome from unsystematic clinical observations or very indirect evidence

Recommendations

Recommendations for the guidelines were directed by the existing evidence, content experts, and consensus.

Patient and family preference were included when possible. When evidence is lacking, options in care are provided in the guideline and the order sets that accompany the guideline.

Approval Process

Guidelines are reviewed and approved by the Content Expert Team, Office of CI and EBP, Knowledge Management and Therapeutics Committee, Professional Board, and other appropriate hospital committees as deemed appropriate for the guideline's intended use. Guidelines are reviewed and updated as necessary every 2 to 3 years within the Office of CI and EBP at OHSU. Content Expert Teams will be involved with every review and update.

Disclaimer

Guideline recommendations are made from the best evidence, clinical expertise and consensus, in addition to thoughtful consideration for the patients and families cared for within the Integrated Delivery System. When evidence was lacking or inconclusive, content experts made recommendations based on consensus. Expert consensus is implied when a reference is not otherwise indicated.

The guideline is not intended to impose standards of care preventing selective variation in practice that is necessary to meet the unique needs of individual patients. The physician must consider each patient and family's circumstance to make the ultimate judgment regarding best care.

APPENDIX A: GENERAL RESOURCES

OHSU HEALTH SYSTEM POLICY STATEMENTS AND PRACTICE DOCUMENTS

Oregon Sample Material Risk Notice

<https://www.oregon.gov/omb/OMBForms1/material-risk-notice.pdf>

OTHER GUIDELINES:

CDC Guideline for Prescribing Opioids for Chronic Pain

<https://www.cdc.gov/drugoverdose/prescribing/guideline.html>

Oregon Opioid Prescribing Guidelines

<https://public.health.oregon.gov/PreventionWellness/SubstanceUse/Opioids/Documents/taskforce/oregon-opioid-prescribing-guidelines.pdf>

Washington State Agency Medical Directors' Guideline

<http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf>

PRACTICE RESOURCES

Oregon Pain Guidance Resource

<http://portlandprofessional.oregonpainguidance.org/tools-for-professionals/>

http://www.oregonpainguidance.org/wp-content/uploads/2014/04/OPG_Guidelines.pdf

My Top Care – practical resources on how to implement changes to prescribing for providers, patients and pharmacists

<http://mytopcare.org/prescribers/>

Documentation Templates – The Pain Assessment and Documentation Tool

<http://mytopcare.org/wp-content/uploads/2013/07/Passik.pdf>

Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain

<http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf>

Oregon Pain Guidance Website – useful information for patients and providers about managing pain, risks, preventing overdose, and real stories

<http://portlandmetro.oregonpainguidance.org/>

CDC Guideline Resources: Clinical Tools

<https://www.cdc.gov/drugoverdose/prescribing/clinical-tools.html>

Urine Drug Testing Resources

<http://mytopcare.org/prescribers/about-urine-drug-tests/>

OHSU Comprehensive Pain Center

<http://www.ohsu.edu/xd/health/services/pain-center/about/our-team.cfm>

PROVIDER EDUCATION

Providers' Clinical Support System for Opioid Therapy (PCSS-O)

<http://pcss-o.org/>

Providers' Clinical Support System for Medication Assisted Treatment (PCSS-MAT)

<http://pcssmat.org/>

CDC's Clinician Outreach and Communication Activity (COCA)

<https://www.cdc.gov/drugoverdose/prescribing/trainings.html>

Boston University Safe and Competent Opioid Prescribing (SCOPE)

<https://www.scopeofpain.com/>

My Top Care

<http://mytopcare.org/prescribers/>

NALOXONE

Oregon Pain Guidance Naloxone Site

<http://portlandprofessional.oregonpainguidance.org/overdose-naloxone/information-for-pharmacists/>

Naloxone for overdose prevention/treatment

<https://public.health.oregon.gov/ProviderPartnerResources/EMSTraumaSystems/Pages/epi-protocol-training.aspx>

Naloxone

<http://prescribetoprevent.org/prescribers/palliative/>

COLLEAGUE SUPPORT/MENTORING

http://pcss-o.org/?portfolio_category=oregon

http://pcssmat.org/?portfolio_category=oregon

PATIENT EDUCATION

CDC Patient and Partner Tools

<https://www.cdc.gov/drugoverdose/prescribing/patient-tools.html>

Opioid Information, Side, Pain Relief, etc

<http://mytopcare.org/patients/>

APPENDIX B: SECONDARY REVIEW TEMPLATE

Patient Name:

Chronic opioid indication (be specific):

Current morphine equivalent dose (MED):

Has patient ever attempted an opioid taper?

Other current non-opioid medications (if none or failed attempts, document reason):

Last Urine Drug Test result and date:

Prescription Drug Monitoring Program check result and date:

Last opioid agreement date with current provider:

History of Aberrant Drug Related behavior? If so, describe.

Based on the above information and face to face conversation with patient/provider, the above named patient does/does not appear to meet criteria for an exception to our general practice of prescribing less than 90mg MED per day of an opioid. The benefits/risks appear to outweigh the benefits/risks in this case at this time.

As a secondary review of the pain treatment for this patient, I recommend the following treatment plan and follow up: ***

APPENDIX C: OPIOID AND BENZODIAZEPINE TAPER RESOURCES

Oregon Pain Guidance

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

How to Approach an Opioid Taper/Cessation

Indication	Recommended Length of Taper	Degree of Shared Decision Making about Opioid Taper	Intervention/Setting
Substance Use Disorder	No taper, immediate referral	None – provider choice alone	<u>Intervention:</u> Transition to medication assisted treatment (buprenorphine or methadone) maintenance therapy, Naloxone rescue kit <u>Setting:</u> Inpatient or Outpatient Buprenorphine (OBOT) or methadone
Diversion	No taper*	None – provider choice alone	Determine need based on actual use of opioids, if any
At risk for immediate severe harms	Weeks to months	Moderate – provider led & patient views sought	<u>Intervention:</u> Supportive care Naloxone rescue kit <u>Setting:</u> Outpatient opioid taper
Therapeutic failure	Months	Moderate – provider led & patient views sought	<u>Intervention:</u> Supportive care Naloxone rescue kit <u>Setting:</u> Outpatient opioid taper <u>Option:</u> Buprenorphine (OBOT)
At risk for smaller harms	Months to Years	Moderate – provider led & patient views sought	<u>Intervention:</u> Supportive care Naloxone rescue kit <u>Setting:</u> Outpatient opioid taper <u>Option:</u> Buprenorphine (OBOT)

Table by Melissa Weimer, DO, 2016.

Tapering Dose Example: Providence Health System Example

Provided by Ruben Halperin, September 2018, for OPG Guideline

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					

Taper Examples_Providence 2

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.						

Example Tapers for Opioids⁵⁻⁹

Slowest Taper (over years) Reduce by 2 to 10% every 4 to 8 weeks with pauses in taper as needed <i>Consider for patients taking high doses of long-acting opioids for many years</i>	Slower Taper (over months or years) Reduce by 5 to 20% every 4 weeks with pauses in taper as needed MOST COMMON TAPER	Faster Taper (over weeks)^{****} Reduce by 10 to 20% every week	Rapid Taper (over days)^{****} Reduce by 20 to 50% of first dose if needed, then reduce by 10 to 20% every day
<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

