Partners Opioid Tapering Guidelines for Chronic Pain

Background

Although not supported by level 1 and 2 data, long-term (i.e., greater than 2 months) use of opioids has been associated with harm or no clear evidence of improved function or health related quality of life; thus, it is prudent to continuously reassess the need for opioid therapy. Reasons for reduction in dose or discontinuation may include resolution of pain, no significant functional improvements, intolerable side effects, medication diversion, or development of an opioid use disorder. Tapering opioids should ideally be a shared decision between patient and provider(s). Whereas voluntary opioid tapers have been associated with improved function, there is no evidence to support involuntary tapers of chronic opioid therapy for patients who are not otherwise diverting their medications. In the absence of an opioid use disorder, opioid misuse, diversion or confirmed non-medical use, social, emotional (e.g., patient fears of abandonment), and health factors must be considered. When the decision is made to taper down or off of opioids, an individualized tapering plan should be used. In general, tapering should occur gradually, though there may be cases in which a rapid taper or no taper is warranted.

Purpose/Scope

To assist prescribers in tapering chronic opioid therapy

Eligibility

Discontinuation of long-term opioid therapy should be considered in any of the following situations Concurrent referral to pain specialist is recommended:

- Resolution of the painful condition
- Patient desire to discontinue opioid therapy
- Inability to achieve or maintain significant pain relief or functional improvement despite reasonable dose escalation; this depends upon the clinical situation but would generally reflect dose escalations no greater than the range of 50 to 90 MME/day per CDC guidelines.
- Intolerable adverse effects at the minimum dose that produces effective analgesia despite adequate attempts to treat where possible
- Objective non-adherence with a Partners opioid patient agreement (Link to Partners Opioid Medication Management Agreements)
- Deterioration in physical, emotional or social functioning attributed to opioid therapy
- Development of an opioid use disorder (Appendix I)
    - Note: discontinuation of opioids without proper treatment of opioid use disorder can exacerbate symptoms
- Evidence of non-medical use of prescription opioids

Tapering plan

- **General tenets**
    - Speed of taper should be inversely correlated to duration of opioid treatment. Also consider dose, type of pain being treated and the physical and psychological attributes of the patient.
    - Taper plans should be individualized, and doses decreased as indicated (e.g., weekly, bi-weekly, monthly, etc.).
        - In general, faster tapers have more intense symptoms over a shorter period of time, and slower tapers have milder symptoms over a longer period of time.

    - The time between dose changes may vary and slowing down the taper based on patient discomfort or symptoms of withdrawal may be warranted.
    - Frequent follow-up during tapering period is recommended. Assessments should include those related to pain, withdrawal, suicidal thoughts, use of other substances, and mood changes.
    - Example: Decrease original dose by 10% of the starting dose every 1 to 4 weeks
        - The longer the duration of opioid treatment, the longer the interval between dose changes

Pharmacologic adjuvants

- Withdrawal management strategies
    - Clinical Opioid Withdrawal Scale (COWS) may assist in assessment of withdrawal symptoms: (https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf)
    - Supportive agents for opioid withdrawal:
        - Diarrhea: loperamide 4 mg loading dose followed by 2 mg after each unformed stool (maximum of 16 mg/day)
        - Nausea: ondansetron 4 mg or prochlorperazine 5-10 mg up to 3-4 doses daily
        - Abdominal cramping: dicyclomine 20 mg up to 4 doses daily
        - Nasal congestion: diphenhydramine 25-50 mg up to 4 doses daily
        - Muscle cramps: methocarbamol 750 mg up to 4 doses daily
        - Insomnia: melatonin 3-6 mg, trazodone 50-100 mg or mirtazapine 7.5 mg nightly
        - Anxiety or hypertension: clonidine 0.1-0.2 mg every 4-6 hours as needed
    - Use supportive agents in conjunction with psychological support where appropriate
- Non-opioid pharmacologic pain management therapies may be prescribed to facilitate a taper (e.g., ibuprofen or acetaminophen for pain), though may be associated with other risks (e.g., inadequate pain control) and adverse effects.
- If a patient has developed an opioid use disorder (Appendix I) , patients may be initiated on buprenorphine/naloxone (Suboxone®) by a buprenorphine waivered physician or referred directly to an addiction specialist and/or a methadone maintenance program (further information available on PCOI website: https://oi.mgh.harvard.edu/pcoi/frontpage_frames.asp). For transition to buprenorphine/naloxone (Suboxone®), no tapering is necessary as long as the total daily opioid requirement is not greater than 200 mg oxycodone equivalents (in this case, a taper to 200 mg first may be warranted).
- If clear evidence of diversion is present, opioid prescribing should be ceased entirely without a taper. Diversion is defined as the deflection of prescriptions drugs from medical sources into the illegal market. It also includes diversion of prescribed medications to family or friends for whom it has not been prescribed.

Non-pharmacological interventions

- Cognitive behavioral therapy, other behavioral approaches, and group support, in isolation or part of interdisciplinary program, are highly recommended.
- Maximizing physical therapy and alternative pain management approaches may facilitate tapering.

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Acknowledgements and Disclosures

This document was developed by the Partners Center for Drug Policy in collaboration with the clinical experts representing all relevant PHS hospitals. These Guidelines were developed by Partners for informational and educational purposes only. Any clinical decision for an individual patient must be made by a qualified, licensed, health care provider based on his or her own professional assessment and judgment of all the facts involving a particular patient. These Guidelines are not intended to be, and should not be used, to replace or as a substitute for, the professional judgment of the health care provider.

Appendix I. Opioid Use Disorder Criteria

OUD Criteria: Check all boxes that apply	
	Opioids are often taken in larger amounts or over a longer period of time than 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 to use opioids.
	Recurrent opioid use resulting in 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 use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
	*Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid
	*Withdrawal, as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms
* These criteria not considered to be met for those individuals taking opioids solely under medical supervision.	

Total Boxes Checked:_____

Severity: Mild 2-3, Moderate 4-5, Severe 6 or more

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