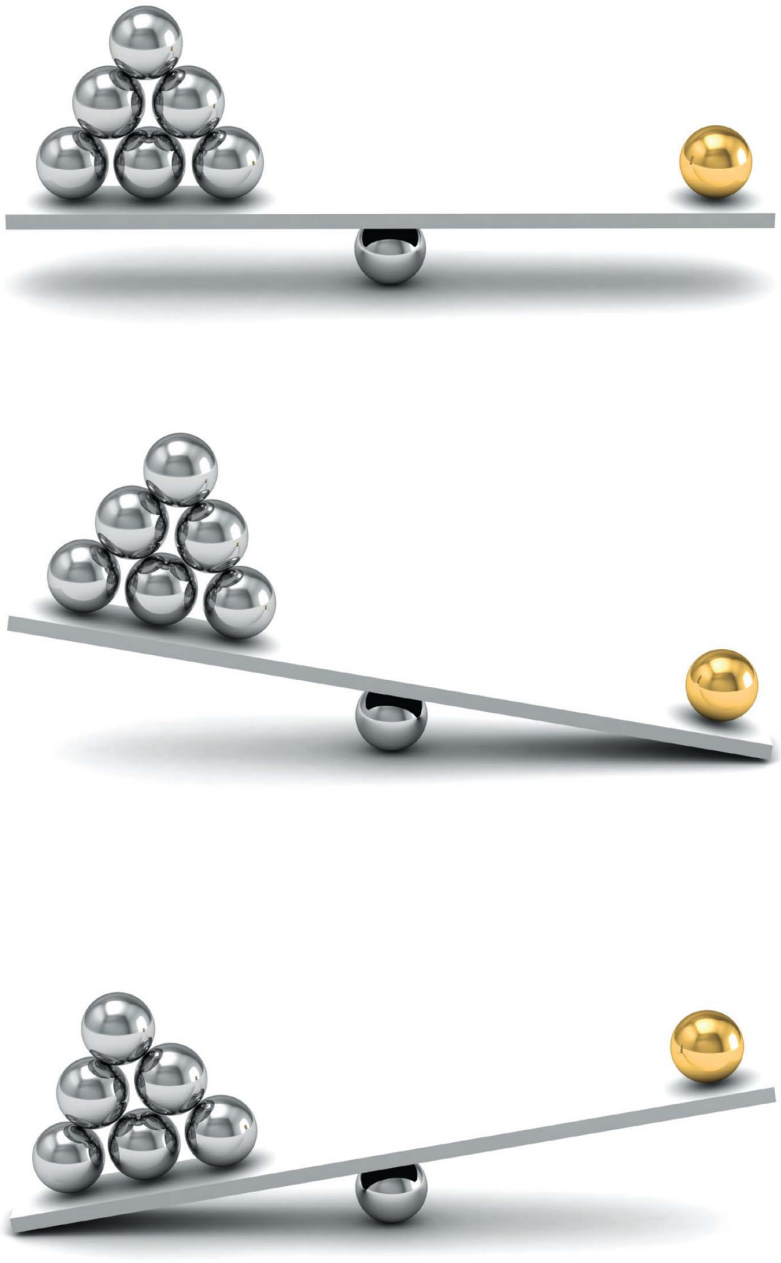

Opioid Taper Decision Tool

U.S. Department of Veterans Affairs
Veterans Health Administration
PBM Academic Detailing Service

Pain Management
Opioid Taper Decision Tool

A VA Clinician's Guide

VA | U.S. Department of Veterans Affairs

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VA PBM Academic Detailing Public WebSite:

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The Opioid Taper Decision Tool is designed to assist Primary Care providers in determining if an opioid taper is necessary for a specific patient, in performing the taper, and in providing follow-up and support during the taper.

Opioid prescribing recommendations: summary of 2016 CDC Guidelines[1]

Determining when to initiate or continue opioids for chronic pain

- Opioids are not first-line or routine therapy
- Establish treatment goals before starting opioid therapy and a plan if therapy is discontinued
- Only continue opioid if there is clinically meaningful improvement in pain and function
- Discuss risks, benefits and responsibilities for managing therapy before starting and during treatment

Opioid selection, dosage, duration, follow-up and discontinuation

- Use immediate-release (IR) opioids when starting therapy
- Prescribe the lowest effective dose
- When using opioids for acute pain, provide no more than needed for the condition
- Follow up and review benefits and risks before starting *and* during therapy
- If benefits do not outweigh harms, consider tapering opioids to lower doses or taper and discontinue

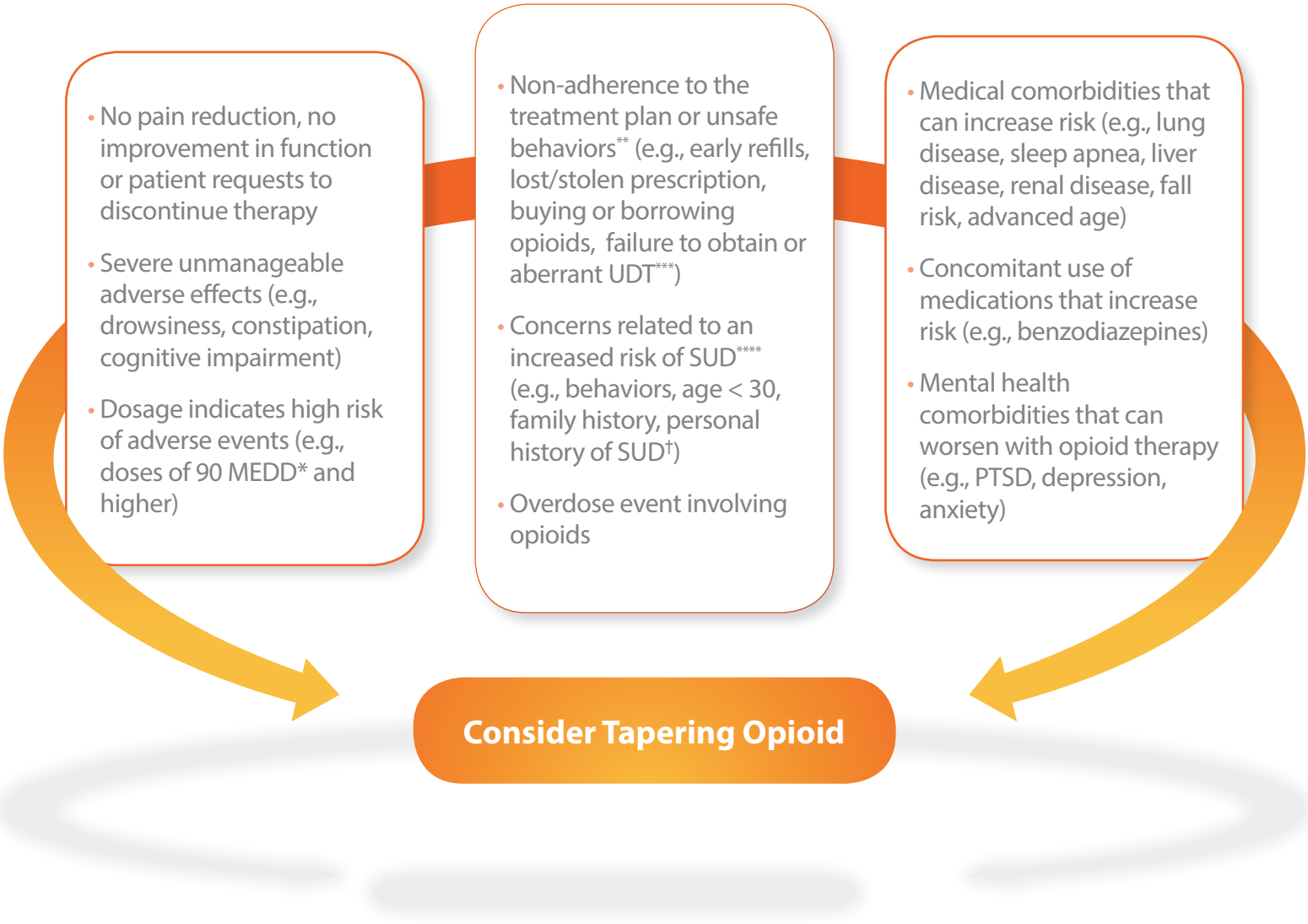
Assessing risk and addressing harms of opioid use

- Offer risk mitigation strategies, including naloxone for patients at risk for overdose
- Review PDMP* data at least every 3 months and perform UDT** at least annually***
- Avoid prescribing opioid and benzodiazepines concurrently when possible
- Clinicians should offer or arrange MAT**** for patients with OUD†

*Prescription drug monitoring program
**Urine drug testing
***Some VA facilities may require more frequent testing
****Medication-assisted treatment
†Opioid use disorder

Possible reasons to re-evaluate the risks and benefits of continuing opioid therapy:

Opioids are associated with many risks and it may be determined that they are not indicated for pain management for a particular Veteran.[1]



STOP **Prior to any changes in therapy, discuss the risks of continued use, along with possible benefits, with the Veteran. Establish a plan to consider dose reduction, consultation with specialists, or consider alternative pain management strategies.**

*Morphine equivalent daily dose
**Consider assessment for opioid use disorder (OUD)
*** Urine drug test
****Substance use disorder
†Personal history of SUD includes alcohol use disorder (AUD), opioid use disorder (OUD), and/or a use disorder involving other substances

When considering an opioid taper, monitor for conditions that may warrant evaluation and arrange primary care and/or emergency department follow-up when indicated:[2]

Disorders that may need urgent evaluation

If a patient is taking more than their prescribed dosage of opioids or showing signs of aberrant behavior, before deciding to change therapy, look for the following "**red flags**":

- Progressive numbness or weakness
- Progressive changes in bowel or bladder function
- Unexplained weight loss
- History of internal malignancy that has not been re-staged
- Signs of/risk factors for infection (fever, recent skin or urinary infection, immunosuppression, IV drug use)

Ensure screening and treatment is offered for conditions that can complicate pain management before initiating opioid taper:[1, 3, 4]

☐ **Mental health disorders** (e.g., PTSD, anxiety disorders, depressive disorders)

- If suicidal, then activate suicide prevention plan.
- If high suicide risk or actively suicidal, consult with mental health provider before beginning taper.

☐ **Opioid use disorder (OUD) and other substance use disorders (SUD)**

- The lifetime prevalence for OUD among patients receiving long-term opioid therapy is estimated to be about 41%: approximately 28% for mild symptoms, 10% for moderate symptoms and 3.5% for severe symptoms of OUD.
- Patients with chronic pain who develop OUD from opioid analgesic therapy need to have BOTH pain and OUD addressed. Either tapering the opioid analgesic or continuing to prescribe the opioid without providing OUD treatment may increase the risk of overdose and other adverse events. Refer to DSM 5 criteria for OUD.[3]
- Use a shared decision-making approach to discuss options for OUD treatment:
  - First-line: Medication Assisted Therapy (MAT)
    - PREFERRED: Opioid Agonist Therapy (OAT)—buprenorphine/naloxone (Suboxone®) or methadone maintenance*
    - ALTERNATIVE: Extended Release (ER) Injectable Naltrexone (Vivitrol®)
  - MAT can be provided in a variety of treatment settings including: residential SUD treatment, intensive outpatient SUD treatment, regular SUD specialty care clinic, primary care or general mental health clinic, or federally regulated opioid treatment program.

*Methadone must be provided through a federally regulated opioid treatment program for OUD therapy.

- ☐ **"Moral injury"** (inner conflict)
  - An act of transgression that leads to serious inner conflict typically brought on by:
    - Betrayal, disproportionate violence, incidents involving civilians, within-rank violence
  - Treatment via psychologists or chaplains is available
- ☐ **Central sensitization** (e.g., fibromyalgia, chronic headaches, and likely many other types of complex chronic pain)
- ☐ **Medical complications** (e.g., lung disease, hepatic disease, renal disease, or fall risk)
- ☐ **Sleep disorders** including sleep apnea

When a decision is made to taper, special attention must be given to ensure that the Veteran does not feel abandoned. Prior to any changes being made in opioid prescribing, a discussion should occur between the Veteran, family members/caregivers, and the provider either during a face-to-face appointment or on the telephone.

Using all the following strategies will help in the transition:

Discussion	Ask about goals	Educate the Veteran
• Listen to the Veteran's story • Let the Veteran know that you believe that their pain is real • Include family members or other supporters in the discussion • Acknowledge the Veteran's fears about tapering [use Motivational Interviewing (MI) techniques]	• Draw out their goals for life (not just being pain-free) • Have the Veteran fill out the Personal Health Inventory (PHI)* • Ask how we can support them during the taper	• Use Bio-Psycho-Social Model – e.g., PHI's "Whole Health" approach* • Offer Veterans pain education groups [especially Cognitive Behavioral Therapy (CBT) or Acceptance and Commitment Therapy (ACT) for Pain, if available] • Offer physical therapy and Complementary and Integrative Health (CIH) interventions such as: – acupuncture, meditation, yoga • Slowly tapering opioids to reduce opioid risks while not "cutting off" the Veteran • Offer non-opioid pain medications when appropriate** • Commit to working with the Veteran on other options for improved function and some decrease in pain

*PHI's Whole Health Approach: http://www.va.gov/PATIENTCENTEREDCARE/explore/about-whole-health.asp

**Pain Management Opioid Safety VA Education Guide 2014, pages 5-6: https://vaww.portal2.va.gov/sites/ad/SitePages/Pain%20Management.aspx

Considerations when formulating an opioid taper plan:

- Determine if the initial goal is a dose reduction or complete discontinuation. If initial goal is determined to be a dose reduction, subsequent regular reassessment may indicate that complete discontinuation is more suitable.
- Several factors go into the speed of taper selected:
  - Slower, more gradual tapers are often the most tolerable and can be completed over several months to years based on the opioid dose.
  - The longer the duration of previous opioid therapy, the longer the taper may take.

Most commonly, tapering will involve dose reduction of 5% to 20% every 4 weeks.

- More rapid tapers may be required in certain instances like drug diversion, illegal activities, or situations where the risks of continuing the opioid outweigh the risks of a rapid taper.
- Document the rationale for the opioid taper and the opioid taper schedule in the Veteran's medical record.

- ✓ Provide opioid overdose education and prescribe naloxone to patients at increased risk of overdose.
- ✓ Strongly caution patients that it takes as little as a week to lose their tolerance and that they are at risk of an overdose if they resume their original dose.
- ✓ Patients are at an increased risk of overdose during this process secondary to reduced tolerance to opioids and the availability of opioids and heroin in the community.

Example Tapers for Opioids[5-9]

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

*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.

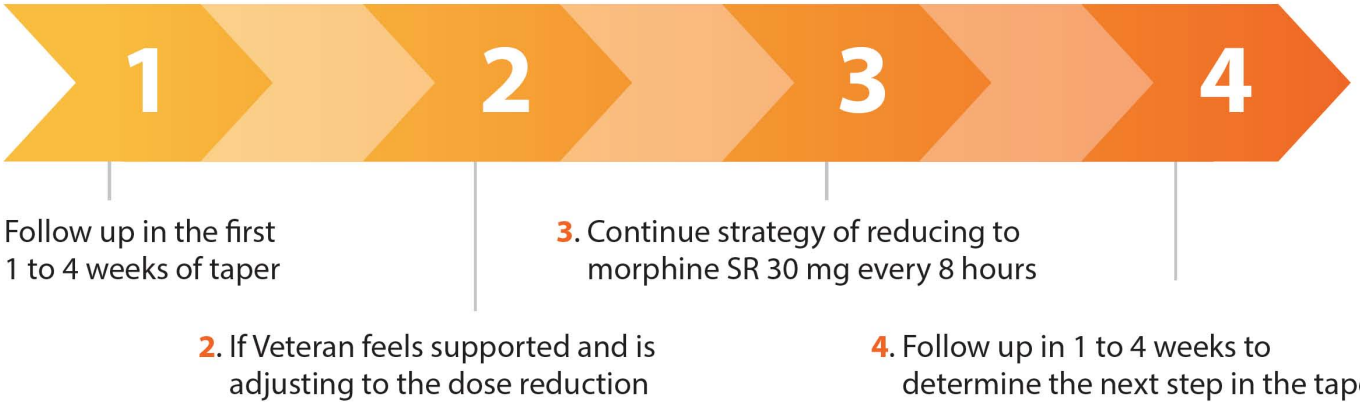
Communicate the opioid taper plan to the Veteran

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.

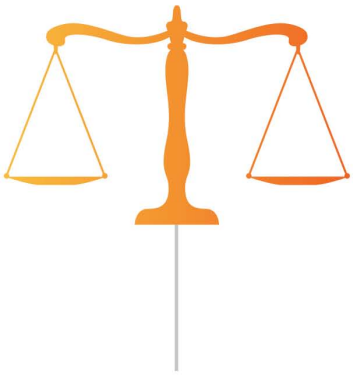
Using **morphine SR 15 mg tablets**, follow the schedule below:

	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



Scenario 2: Veteran is resisting further reduction



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

2. If Veteran strongly resists reduction, then request mental health support and consider the possibility of OUD*

3. If safe, remain at morphine SR 45 mg every 8 hours for 1 to 2 months then reassess**

4. Review the risk of the taper vs. the benefit of remaining at the current dose at each step in the taper and, if necessary, adjust the speed of the taper according to the response of the Veteran

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

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

Follow up with the Veteran during the taper:

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

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

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

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

Manage withdrawal symptoms during the taper:[10]

Short-term oral medications can be utilized to assist with managing the withdrawal symptoms, especially when prescribing fast tapers. Do not treat withdrawal symptoms with an opioid or benzodiazepine.

Not life-threatening

Withdrawal symptoms are not life-threatening and may not be seen with a gradual taper.

First 5 to 10 days

Early symptoms generally resolve 5 to 10 days following opioid dose reduction/cessation but may take longer depending on the half-life of the opioid (e.g., methadone).

Weeks to months

Some symptoms of withdrawal (dysphoria, insomnia) and prolonged craving may take longer.

Improvement over time

Patients with chronic pain may find that symptoms, such as fatigue, mental functioning, pain, and general well-being, improve over time.

Early Symptoms (hours to days)	**Late Symptoms** (days to weeks)	**Prolonged Symptoms** (weeks to months)
• Anxiety/restlessness • Rapid short respirations • Runny nose, tearing eyes, sweating • Insomnia • Dilated reactive pupils	• Runny nose, tearing eyes • Rapid breathing, yawning • Tremor, diffuse muscle spasms/aches • Piloerection • Nausea, vomiting, and diarrhea • Abdominal pain • Fever, chills • Increased white blood cells if sudden withdrawal	• Irritability, fatigue • Bradycardia • Decreased body temperature • Craving • Insomnia

Consider use of adjuvant medications during the taper to reduce withdrawal symptoms:[6-9, 11-19]

Short-term oral medications can be utilized to assist with managing the withdrawal symptoms, especially during fast tapers.

Indication	Treatment Options
Autonomic symptoms (sweating, tachycardia, myoclonus)	**First line** • Clonidine 0.1 to 0.2 mg oral every 6 to 8 hours; hold dose if blood pressure <90/60 mmHg (0.1 to 0.2 mg 2 to 4 times daily is commonly used in the outpatient setting) – Recommend test dose (0.1 mg oral) with blood pressure check 1 hour post dose; obtain daily blood pressure checks; increasing dose requires additional blood pressure checks – Re-evaluate in 3 to 7 days; taper to stop; average duration 15 days **Alternatives** • Baclofen 5 mg 3 times daily may increase to 40 mg total daily dose – Re-evaluate in 3 to 7 days; average duration 15 days – May continue after acute withdrawal to help decrease cravings – Should be tapered when it is discontinued • Gabapentin start at 100 to 300 mg and titrate to 1800 to 2100 mg divided in 2 to 3 daily doses* – Can help reduce withdrawal symptoms and help with pain, anxiety, and sleep • Tizanidine 4 mg three times daily, can increase to 8 mg three times daily
Anxiety, dysphoria, lacrimation, rhinorrhea	• Hydroxyzine 25 to 50 mg three times a day as needed • Diphenhydramine 25 mg every 6 hours as needed**
Myalgias	• NSAIDs (e.g., naproxen 375 to 500 mg twice daily or ibuprofen 400 to 600 mg four times daily)*** • Acetaminophen 650 mg every 6 hours as needed • Topical medications like menthol/methylsalicylate cream, lidocaine cream/ointment
Sleep disturbance	• Trazodone 25 to 300 mg orally at bedtime
Nausea	• Prochlorperazine 5 to 10 mg every 4 hours as needed • Promethazine 25 mg orally or rectally every 6 hours as needed • Ondansetron 4 mg every 6 hours as needed
Abdominal cramping	• Dicyclomine 20 mg every 6 to 8 hours as needed
Diarrhea	• Loperamide 4 mg orally initially, then 2 mg with each loose stool, not to exceed 16 mg daily • Bismuth subsalicylate 524 mg every 0.5 to 1 hour orally, not to exceed 4192 mg/day

*adjust dose if renal impairment; ** avoid in Veterans > 65 years old; ***caution in patients with risk GI bleed, renal compromise, cardiac disease

Online Resources Available:

Brainman & Understanding Pain (2-3 min):

- http://www.dvcipm.org/clinical-resources/joint-pain-education-project-jpep

Videos for Veterans to understand their own role in healing from the American Chronic Pain Association (ACPA):

- Four flat tires: http://www.theacpa.org/a-car-with-four-flat-tires
- Veterans in Pain: http://www.theacpa.org/video/veteransinpain

Videos Instructing on Self-paced Exercise:

- Exercise Guidelines: http://www.youtube.com/watch?v=gN-WwxfPIZo

Other web-based Education for Back Pain, Neck Pain, and Headaches:

- http://www.knowyourback.org/Pages/BackPainPrevention/Exercise/ExerciseVideo.aspx
- http://www.knowyourback.org/Documents/Cervical_Exercise.pdf

Deep Breathing Exercises:

- http://www.youtube.com/watch?v=YdsipKCACac
- http://www.t2.health.mil/apps/breathe2relax (Phone app)

Progressive Muscle Relaxation Techniques:

- http://www.militaryonesource.mil/deployment?content_id=269532

Opioid Overdose Education and Naloxone Distribution (OEND) Implementation SharePoint:

- https://vaww.portal2.va.gov/sites/mentalhealth/OEND/default.aspx

VA Dashboards That Can Identify High-Risk Veterans on Opioid Therapy:

- OTRR (VSSC Opioid Therapy Risk Report)
  https://securereports2.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?/PC/Almanac/PAIN_ProviderWEB&rs:Command=Render
- OSI (Opioid Safety Initiative) Dashboard
  http://vhacmnreport08t.vha.med.va.gov/Reports/Pages/Folder.aspx?ItemPath=/External/PBM/Opioid+Safety+Initiative+Dashboard&ViewMode=List
- STORM tool
  https://spsites.cdw.va.gov/sites/OMHO_PsychPharm/Pages/Real-Time-STORM-Dashboard.aspx

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Notes

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This reference guide was created to be used as a tool for VA providers and is available to use from the Academic Detailing SharePoint.

These are general recommendations only; specific clinical decisions should be made by the treating provider based on an individual patient's clinical condition.

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