Opioid + Benzodiazepine Tapering

General Approach to Tapering

There are many approaches to opioid tapering. Figure out the best method for you, your patient and your practice. Here are a few recommended structured approaches:

- BRAVO: A Collaborative Approach to Opioid Tapering
- HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics

How To Get Your Patient on Board with Opioid Tapering and Be Successful[1]

- **Explain** - patients need to understand individualized reasons for tapering (intrinsic motivation), beyond general, population-level concerns like addiction potential or regulatory/prescribing guidelines (extrinsic motivation)
- **Negotiate** - Share decision making and allow patients to have input (e.g. rate of tapering, which opioid to taper first if on multiple opioids)
- **Manage difficult conversations** - When patients and providers do not reach a shared understanding, difficulties and misunderstandings arise and therapeutic alliance breaks down
- **Pledge your support** - Patients need to know that their providers won't abandon them during the tapering process. Commit to more scheduled office visits, more time spent during appts, or more frequent phone call check ins between office visits

Checklist Throughout Tapering Phases

Before Taper

- Identify appropriate candidates
  - Resolution of pain, No meaningful improvement in pain/function, Adverse effects, Risk of harm outweighs potential benefits, Aberrant behavior
- Engage patients in discussion of opioid benefit/risk and tapering
- Assess readiness to taper
  - If not ready, re-visit periodically
  - Assess for substance abuse disorder
  - Provide naloxone prescription
- Implement pharmacologic and non-pharmacologic strategies to manage pain/function and establish behavioral support
- Obtain patient buy-in and share decision making

- Agree upon which opioid to taper first, duration of taper and contingency plan to manage pain and/or withdrawal while tapering
- Set date to initiate taper and approximate completion date
- Confirm patient has Naloxone at home

Initiation of Opioid Taper

- Opioid calculations and conversion steps
  - Total daily dose of current opioid: _____ mg
  - Convert to Morphine Equivalent Daily Dose (MEDD): _____ mg
    - MEDD = Total daily dose of current opioid x Conversion factor

Opioid	Conversion Factor
Codeine	0.15
Hydrocodone	1
Hydromorphone	4
Morphine	1
Oxycodone	1.5
Oxymorphone	3
Tapentadol	0.4
Tramadol	0.1

  - If rotating opioid/formulation to use for taper
    - Calculate new opioid total daily dose: _____ mg
    - Develop new prescription
      - Consider decreasing dose of new opioid prescription due to incomplete cross-tolerance
  - Calculate taper dose
    - Calculate 5% of tapering opioid dose: _____ mg
    - Calculate 10% of tapering opioid dose: _____ mg

- Individualize taper
  - Slow taper:
    - Decrease total daily MEDD by 5–10% every 2-4 weeks, as tolerated
    - Patient Candidates:
      - Most patients (unless the need to taper quickly due to imminent safety risk)
      - Preferred for long-acting opioids

- Rapid taper:
  - Decrease total daily MEDD by 5-15% per week, as tolerated
  - Patient Candidates:
    - Imminent safety concern (e.g. recent overdose, respiratory depression)
    - Preferred for shorter-acting opioids
- Buprenorphine (Micro)induction
  - Introduce small doses of buprenorphine (0.25-2mg/day) to existing full opioid agonist regimen. Gradually increase buprenorphine dose and frequency until therapeutic dose is reached (16-24mg/day), then discontinue (or quickly taper) full opioid agonists. For optimal analgesic effect, split total daily buprenorphine dose into BID-TID dosing.
  - Patient Candidates:
    - OUD, Prior failed tapering attempt, Opioid-induced hyperalgesia, Fearful of withdrawal during taper
- Taper involving a transdermal fentanyl patch
  - Transition to long-acting oral opiate, then initiate taper
    - Ex: transdermal fentanyl patch q3d → oral morphine ER q12h
      - Remove fentanyl patch → wait 12 hrs → Take ≤ 50% of new calculated morphine dose → wait 12 hrs (total 24 hrs since patch removed) → Take 100% of new calculated morphine dose
      - During this transition, consider providing a 2 - 3-day supply of IR oxycodone prn breakthrough pain
- Educate patient how to manage withdrawal symptoms
  - Teach patient how to use SOWS or COWS
  - Consider prescribing PRN medications for symptom relief

During Opioid Taper

- Commit your support
  - Duration and Frequency
    - Schedule increased office visits (every 1-4 weeks)
    - Increase time spent with patient at office visits
    - Phone/email check in weekly
  - Evaluate patient at each dose reduction:
    - Review patient's goals, reinforce benefits of tapering, assess risks/harms of tapering
- Individualize taper based on response and tolerance
  - Evaluate pain, function and withdrawal symptoms periodically
    - Treat pain/function with non-opioids
    - Treat withdrawal symptoms as needed
  - If intolerable, slow or pause taper. Do NOT increase dose.
  - Once lowest effective dose reached, extend interval between doses

- Stop opioids if taken less frequently than once a day

Withdrawal Symptoms and Management

Autonomic symptoms (sweating, myoclonus, tachycardia)	Clonidine* 0.1mg PO QID Gabapentin 100-300mg PO BID-TID Tizanidine 4mg PO TID Lofexidine 0.1mg 2 tabs PO TID
Anxiety, dysphoria, lacrimation, rhinorrhea	Hydroxyzine 25-50mg PO TID prn Diphenhydramine 25mg PO q6hr prn
Myalgias	Naproxen* 220mg PO BID QID prn APAP 650mg PO q6h prn Topicals (menthol/methylsalicylate cream, lidocaine cream/ointment)
Sleep disturbance	Trazodone 25-300mg PO qhs
Nausea/Vomiting	Prochlorperazine 5-10mg PO q6hr prn Promethazine 25mg PO or PR q6h prn Ondansetron* 4mg PO q6h prn Haloperidol 0.5-1mg PO q12hr prn Metoclopramide 10mg PO q4-6hr prn
Abdominal Cramping	Dicyclomine 20mg PO q6-8hr Hyoscyamine 0.125mg PO QID prn
Diarrhea	Loperamide* 4mg PO x 1, then 2mg with each loose stool (Max 16mg/day)

*Consider providing initial prescription when initiating opioid taper

Opioid Taper

Template

Current Dose: _____
Target Dose: _____
Timeline to Reach Taper "Target Dose": _____

	Date	# weeks	Dose 1	Dose 2	Dose 3	Total Daily Dose	Total MME
0							
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

Example Taper Using Oxycodone IR

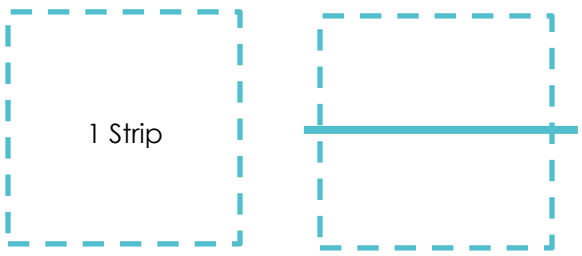
Week	Dose 1	Dose 2	Dose 3	Total Daily Dose	Total MME
0	40mg	40mg	40mg	120mg	180mg
1-2	40mg	35mg	40mg	115mg	172.5mg
3-4	40mg	35mg	35mg	110mg	165mg
5-6	35mg	35mg	35mg	105mg	157.5mg
7-8	35mg	30mg	35mg	100mg	150mg
9-10	35mg	30mg	30mg	95mg	142.5mg
11-12	30mg	30mg	30mg	90mg	135mg

Other examples: Example 1, Example 2, Example 3

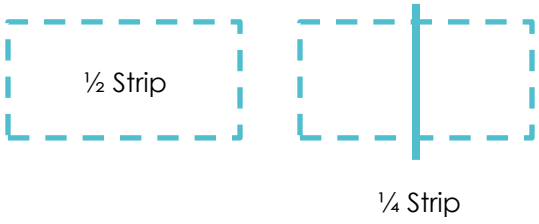
Transition to Buprenorphine and Microinduction:

- General Concept[2]
  - Precipitated withdrawal during buprenorphine induction is a common concern, especially if preceded by recent exposure to full opioid agonists. Therefore, traditional recommendations are to initiate buprenorphine once the patient is already showing signs of withdrawal.
  - To facilitate the transition from full opioid agonists to buprenorphine, consider introducing buprenorphine in a microinduction approach.
  - By utilizing buprenorphine's dose-dependent effects of mu-opioid receptor resensitization and upregulation, opioid tone is maintained while allowing a faster taper of full opioid agonists and posing minimal risk of precipitated withdrawal.
- Buprenorphine Microinduction
  - Introduce small doses of buprenorphine (0.25-2mg/day SL bup) and gradually increase the dose and frequency while co-administering full opioid agonists until a therapeutic dose of buprenorphine is reached.
  - Once therapeutic doses of buprenorphine are achieved, the full opioid agonist therapy can be discontinued or more quickly tapered than traditionally tolerated (5-10 days).
- Candidates
  - OUD, Previously failed attempts at opioid tapering, Suspected opioid-associated hyperalgesia, Needed quick taper (e.g. recent overdose), Patients fearful of withdrawing during taper
- Buprenorphine Microinduction Patient/Clinical Tool

2 – 0.5mg Suboxone Film



The first strip will be cut into 2 pieces



Half of it is then cut into 2 pieces (1/4 of a strip).

Take Suboxone According to the Table Below

Day 1: Begin to cut down your opioid use
Day 2 – 6: Continue to cut down on opioid use and utilize comfort medications
Day 7: Aim to stop other opioid use by this day

	AM	PM	Date (write in)
1	¼ film	-	
2	¼ film	¼ film	
3	½ film	½ film	
4	1 film	1 film	
5	1 ½ film	1 ½ film	
6	2 films	2 films	
7	2 – 3 films	2 – 3 films	

Time Point	Standardized Buprenorphine Microinduction Recommendation	
	Bup-nal Recommendation	**Full Opioid Agonist Recommendation**
Day 1 (Initial Appt)	0.5mg-0.125mg (¼ strip) SL daily	Continue current dose/use
Day 2	0.5mg-0.125mg (¼ strip) SL BID	Continue current dose/use
Day 3	1mg-0.25mg (½ strip) SL BID	Continue current dose/use
Day 4	2mg-0.5mg (1 strip) SL BID	Reduce dose/use by 25%
Day 5	3mg-0.75mg (1 ½ strip) SL BID	Reduce dose/use by 25%
Day 6	4mg-1mg (2 strips) SL BID	Reduce dose/use by 25%
Day 7 (Follow-Up Appt)	6mg-1.5mg (3 strips) SL BID	Reduce dose/use by 50%
Day 8	Based on craving/pain response: 16mg-4mg to 24mg-6mg once to four times daily	Reduce dose/use by 50%
Days 9-11	Based on craving/pain response: 16mg-4mg to 24mg-6mg once to four times daily	Reduce dose/use by 50-75%
Days 12-13	Based on craving/pain response: 16mg-4mg to 24mg-6mg once to four times daily	Reduce dose/use by 75%

Time Point	Standardized Buprenorphine Microinduction Recommendation	
Day 14 (Follow-Up Appt)	Based on craving/pain response: 16mg-4mg to 24mg-6mg once to four times daily	STOP or continue as needed dosing for additional pain relief
Days 15 – Beyond	Based on craving/pain response: 16mg-4mg to 24mg-6mg once to four times daily	STOP or continue as needed dosing for additional pain relief

- Other Tools:
  - Case Series (2020)
  - Bernese Method (2016)

Deprescribing

Consider Opioid Deprescribing When

- Loss of efficacy
  - Function > report
- Evidence of harm
  - Hyperalgesia
  - Adverse effects - falls, sedation, pneumonia, depression
- Anticipate risk-benefit change
  - Co-occurring health conditions (COPD, Kidney/Liver failure)
  - PK/PD changes with age
- Medication combination is a clear danger
  - High MME
  - Concurrent sedatives
- Substance use disorder

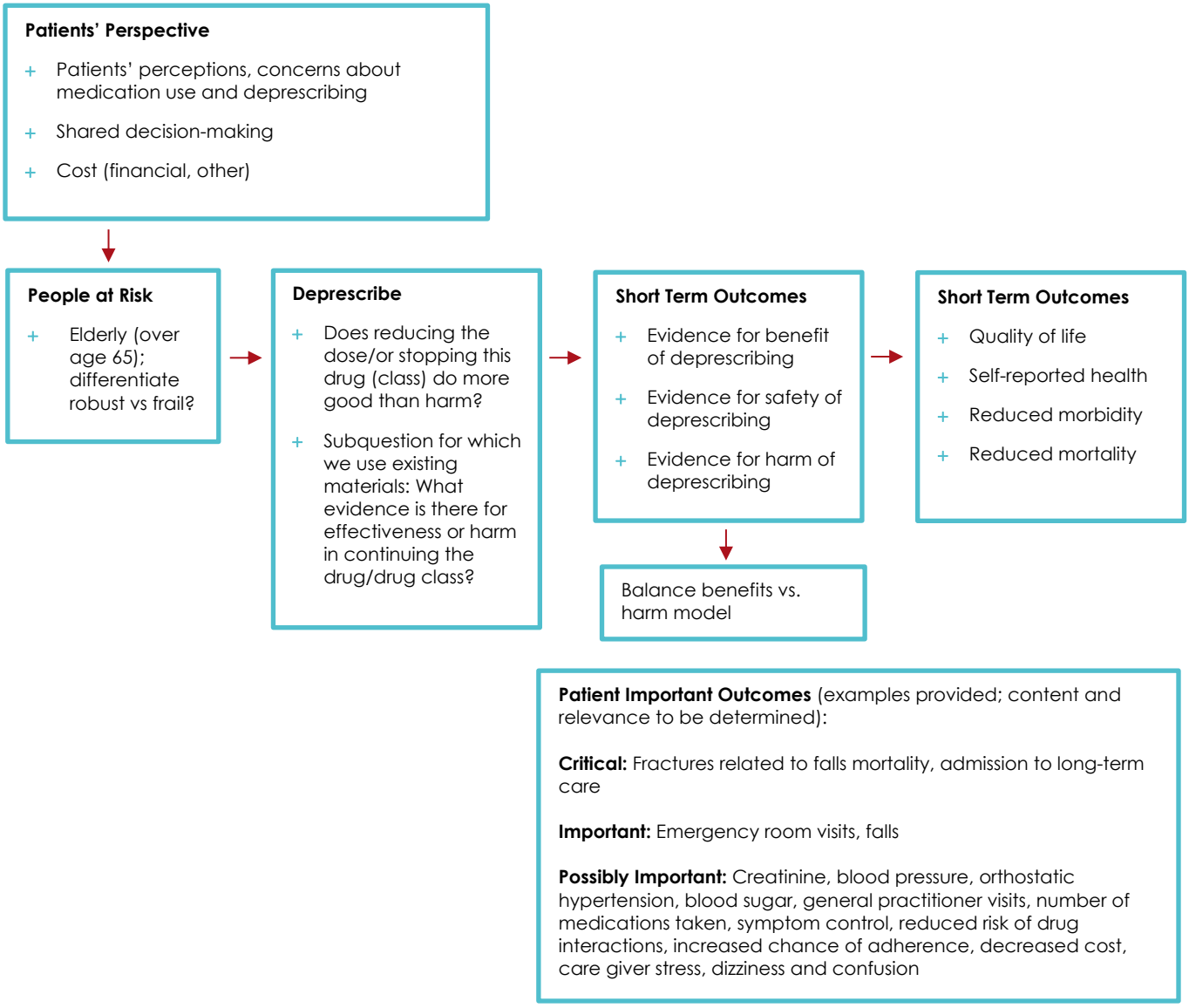
Deprescribing and Documentation

- Standardize and incorporate a Benefit-Risk Framework Analysis
  - Rationale for opioid tapering
  - Opioid-related benefit (pain, function, QOL)
  - Observed opioid-related harm
    - No mention vs mentions harm (OUD, AE)
  - Potential for opioid-related harm
    - No mention vs mention of potential harm (underlying risk factor, concerning patient behavior, polypharmacy)

Co-prescribing Opioids and Benzodiazepines

- Discuss the harms > benefits of using both opioids and benzos and the need to taper BOTH
- Taper opioids to goal dose first, then taper off benzos
- Use the Generic Deprescribing Logic Model (below) or other validated tool

Generic Deprescribing Logic Model[3]



Other Examples:

- Deprescribing.org
  - Benzodiazepine deprescribing algorithm

References:

1. Matthias MS, Johnson NL, Shields CG, et al. "I'm Not Gonna Pull the Rug out From Under You": Patient-Provider Communication About Opioid Tapering. J Pain. 2017;18(11):1365-1373. Abstract.
2. De Aquino JP, Parida S, Sofuoglu M. The Pharmacology of Buprenorphine Microinduction for Opioid Use Disorder. Clinical Drug Investigation. 2021;41(5):425-436. Article.
3. Farrell B, Pottie K, Rojas-Fernandez CH, et al. Methodology for Developing Deprescribing Guidelines: Using Evidence and GRADE to Guide Recommendations for Deprescribing. PLoS ONE. 2016; 11(8): e0161248. doi:10.1371/journal.pone.0161248. Article.

This material was prepared by the Iowa Healthcare Collaborative, the Opioid Prescriber Safety and Support contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS.

Developed in collaboration with Stader Opioid Consultants.