Opioid tapering

To help prevent toxicity, dependence and opioid use disorder (OUD), it's important to check in regularly with your patients who are taking opioid painkillers. This can help you determine if the patient's medication regimen is supporting your treatment goals. This document serves as a guide to help you determine which patients may be good candidates for an opioid taper, such as a dosage reduction or discontinuation.

This document complements the following prescribing guidelines:

- The U.S. Department of Health and Human Services (HHS) published the Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics with information about the risk and benefit considerations of a taper and how to initiate an opioid taper with shared decision-making with patients.[1] (October 2019)
- The U.S. Food and Drug Administration (FDA) issued a drug safety announcement urging healthcare professionals and patients to avoid abrupt discontinuation of opioids when there is a physical dependence and provided additional information about individualized tapering and ongoing monitoring and support.[2] (April 2019)
- The Centers for Disease Control and Prevention (CDC) released guidelines recommendations around prescribing opioids.[3] (March 2016)

To learn more about how we're addressing the opioid crisis, please visit **UHCprovider**.com > Menu > Resource Library > Drug Lists and Pharmacy > Opioid Programs and Resources.

Reasons for an opioid taper can include:

- Patient has a requested dose reduction
- Patient is using opioids in combination with benzodiazepines
- Patient experiences an overdose or other serious adverse event, or shows early signs for overdose risk (e.g., confusion, sedation, slurred speech)
- Resolution or healing of the painful condition

PCA-1-22-00224-PH-BROC_02182022

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The following scenarios may be considered for tapering: [1, 3-6]

- Total daily dose of opioids exceeds 50 morphine milligram equivalents (MME) without benefit
- Inability to achieve or maintain anticipated pain relief or function improvement despite reasonable dose escalation. Clinical meaningful improvement has been defined as at least 30% improvement on the 3-item PEG scale
- Persistent non-adherence with opioid treatment agreement or showing signs of substance use disorder. Examples:
    - Work or family problems related to opioid use
    - Difficulty controlling use, etc.
- Deterioration in physical, emotional or social functioning attributed to opioid therapy

Opioid tapering protocols

Evidence-based literature supports several tapering speeds and schedules according to individual patient need. Tapering should be scheduled based on the individual patient's condition, willingness, support systems and other factors. Shared decision-making with patients is essential for successful care plans. The following are recommendations for tapering schedules:

- HHS[1]:
    - Slow tapers of 10% per month or less, over several months or years, are better tolerated for patients with longer durations of opioid use. An example is to decrease the dose by 10% per week, or less, until 30% of the original dose is reached, followed by a weekly decrease of 10% of the remaining dose.
    - Rapid tapers over 2-3 weeks might be needed for patient safety when the risks of continuing the opioid outweigh the risks of continued use. Ultrarapid detoxification under anesthesia is associated with substantial risks and should not be used.
- Department of Veterans Affairs and the Department of Defense[7]:
    - Slower tapering schedule: Dose reductions of 5-20% of the original dose every 4 weeks completed over several months to years are suggested for patients with higher opioid dose, longer duration of opioid therapy, or when safety permits as a gradual taper is more often tolerated.
    - Faster tapering schedule: Dose reductions of 5-20% of the original dose per week may be considered if patients are non-adherent to the treatment plan, escalating high-risk medication-related behaviors, are participating in drug diversion or illegal activities, or otherwise have risks too high to consider gradual taper.
- FDA[2]:
    - Decrease by an increment of no more than 10% to 25% every 2 to 4 weeks. If the patient is experiencing increased pain or serious withdrawal symptoms, it may be necessary to pause the taper, raise the dose to the previous dose, and then proceed with a more gradual taper once stable. Some patients taking opioids for shorter time periods may tolerate a more rapid taper.

- Mayo Clinic[6]:
    - Decrease of 10% of the original dose every 5 to 7 days until 30% of the original dose is reached, followed by a weekly decrease by 10% of the remaining dose.
- CDC[3]:
    - Decrease of 10% of the original dose per week is suggested for patients who have taken opioids for a short time (weeks to months). For patients who have taken opioids for more than a year, a decrease of 10% per month may be a reasonable starting point.

Consult with specialists and treatment experts, when needed, especially for high-risk patients, including pregnant women or patients with OUD.

Withdrawal syndrome

Opioid-dependent patients may experience opioid withdrawal syndrome with tapering or ceasing opioids. Opioid withdrawal is characterized by signs and symptoms of sympathetic stimulation, due to decreasing sympathetic antagonism by opioids, including:

Abdominal cramps	Diarrhea	Lacrimation	Rhinorrhea
Agitation	Dizziness	Muscle pain	Shivering
Anorexia	Dysphoria	Mydriasis	Sneezing
Anxiety	Hot flashes	Nausea	Tachycardia
Chills	Hypertension	Piloerection	Tremor
Diaphoresis	Insomnia	Restlessness	Yawning

Symptoms typically start 2 to 3 half-lives after the last opioid dose and can be very uncomfortable. Generally, opioid withdrawal is not life-threatening in patients who don't have significant comorbidities.

You can measure opioid withdrawal symptoms using the patient-rated Subjective Opiate Withdrawal Scale (SOWS) or the objective provider assessment tool Clinical Opiate Withdrawal Scale (COWS). [8-9]

A literature review comparing detoxification protocols found better outcomes when a psychosocial intervention was associated with pharmacological support.[10]

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Medications used to help manage these symptoms when reducing opioid dosages include:

- Symptomatic pain treatments: Tapering protocols often include symptomatic treatments for muscle aches and pain, such as nonsteroidal anti-inflammatory drugs or acetaminophen
- Alpha Adrenergic Agonists: To help reduce anxiety, muscle aches, sweating and other symptoms, you can use alpha adrenergic agonists, like clonidine, lofexidine or guanfacine. Lofexidine is the only FDA-approved non-opioid treatment for management of opioid withdrawal symptoms in adults and can be used for up to 14 days. Studies with lofexidine demonstrated lower opioid withdrawal symptom severity compared to placebo.[11]
- Other medications: Other medications can be used to manage other symptoms of withdrawal, including treatment of nausea, vomiting or diarrhea

Psychosocial support

Patients with chronic pain have higher rates of depression and mental health issues; therefore, psychosocial support is critical.[5]

Screening patients with pain for psychiatric comorbidities using tools such as the Patient Health Questionnaire or PHQ-9 can be useful. If needed, refer patients to behavioral and mental health care providers for psychosocial interventions, such as cognitive behavioral therapy and interdisciplinary programs for chronic pain and OUD.

You can find local UnitedHealthcare in-network behavioral health care providers at provider.liveandworkwell.com.

Encouragement and motivational interviewing for patients

Tapering can be a difficult process for patients, so we suggest that you encourage your patients along the way and help them identify support systems. It may help to explain to your patient that, even though the pain may worsen at first, most patients experience improvements in pain and function after a taper.

Motivational interviewing is a great way to encourage in a discussion with your patient about alternative pain treatments and tapering down opioid regimens.[12] Here are some questions you may want to discuss with patients who are currently using opioid medications:

- How well is your opioid medication controlling your pain? Are you experiencing adverse effects*?*
- There are other non-opioid medicines that can be used for the management of pain, as well as treatments that don’t involve medications. What have you tried in the past?
- What concerns do you have about tapering to the lowest effective dose of opioids or stopping opioids and using other non-opioid medications to manage your pain?
- Is it time to consider other methods of pain management?

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- When taking opioid painkillers, you're at risk for an overdose if you take too much. Are you aware of the steps you can take to reduce the rise of overdose? *Consider providing information about naloxone as well as a prescription if your patient is at risk.*

Additional information

We suggest the following resources for more information on addiction, OUD and overdose:

- UnitedHealthcare Behavioral Health Providers: to find an in-network behavioral health provider, including Medication Assisted Treatment (MAT) providers, please visit provider.liveandworkwell.com
- Substance Abuse and Mental Health Services Administration (SAMHSA) Medication-Assisted Treatment Information: samhsa.gov > Programs and Campaigns > Medication-Assisted Treatment
- American Society of Addiction Medicine (ASAM) Educational Resources: asam.org > Education
- U.S. Department of Health and Human Services Treatment and Recovery Information: hhs.gov
  > A-Z Index > O > Opioids > Treatment and Recovery
- Harm Reduction Coalition: harmreduction.org > Overdose Protection > Prescribe Naloxone!

If you have questions, please contact your UnitedHealthcare representative. If you are unsure who to contact, go to **UHCprovider**.com > Menu > Contact Us > Find a Network Management Contact.

PCA-1-22-00224-PH-BROC_02182022

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Note: This document is under review by the UnitedHealthcare Community Plan in Tennessee.

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