

Opioid Tapering Recommendations

Due to concerns regarding the potential for opioid abuse, the Centers for Disease Control and Prevention (CDC) released new recommendations in March 2016 around prescribing opioids. To help prevent overuse of short-acting and long-acting opioid medications, please consider an opioid taper for your patients who are good candidates based on the following information.

Reasons for an Opioid Taper

Adverse effects often outweigh the benefits of long-term opioid treatment. We recommend an opioid taper in the following scenarios¹⁻⁴:

- Patient requested a dose reduction
- Total daily dose of opioids exceeds 50 maximum morphine equivalent (MME) without benefit
- Patient using opioids in combination with benzodiazepines
- 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 percent improvement on the 3-item PEG scale)
- Patient experiences overdose or other serious adverse event or shows early warning signs for overdose risk (e.g., confusion, sedation or slurred speech)
- Persistent non-adherence with opioid treatment agreement or showing signs of substance use disorder (e.g., work or family problems related to opioid use, difficulty controlling use)
- Deterioration in physical, emotional or social functioning attributed to opioid therapy
- Resolution or healing of the painful condition

Withdrawal Syndrome

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

- Anxiety
- Nausea
- Myalgias or arthralgias
- Hypertension
- Abdominal cramps
- Rhinorrhea
- Tachycardia
- Diarrhea
- Sneezing
- Restlessness
- Anorexia
- Lacrimation
- Mydriasis
- Dizziness
- Insomnia
- Diaphoresis
- Hot flashes
- Dysphoria
- Tremor
- Shivering
- Yawning
- Piloerection

Symptoms typically start two-to-three half-lives after the last opioid dose. 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)⁵ or the objective provider assessment tool *Clinical Opiate Withdrawal Scale* (COWS).⁶

Opioid Tapering Protocol

Evidence-based literature doesn't support a recommendation of one tapering speed or schedule over another. The following are current recommendations for tapering schedules:

Department of Veterans Affairs and the Department of Defense⁷:

- Slower tapering schedule: Weekly dosage reductions of 20 to 50 percent of the original dose is suggested for patients who aren't presenting with opioid use disorder
- Faster tapering schedule: Daily decreases of 20 to 50 percent of the initial dose down to a threshold dose (e.g., 20-45 mg of morphine daily equivalent), followed by a decrease every two to five days.

Mayo Clinic⁴:

- Decrease of 10 percent of the original dose every five to seven days until 30 percent of the original dose is reached, followed by a weekly decrease by 10 percent of the remaining dose.

CDC¹:

- Decrease of 10 percent of the original dose per week. Some patients who have taken opioids for a long time might find even slower tapers easier.

Tapering Support

The following are tapering support options to consider in conjunction with an opioid tapering schedule:

- **Alpha Adrenergic Agonists:** Anecdotal evidence suggests that withdrawal symptoms may be improved by using alpha adrenergic agonists such as clonidine or guanfacine. However, currently published data doesn't provide enough evidence to draw conclusions about the relative effectiveness of these agents.
- **Symptomatic Pain Treatments:** Tapering protocols often include symptomatic treatments for muscle aches and pain, such as nonsteroidal anti-inflammatory drugs or acetaminophen.
- **Other Medications:** Other medications can also be used to manage other symptoms of withdrawal, including nausea and vomiting or diarrhea.

- **Behavioral Health Support:** A literature review comparing detoxification protocols found better outcomes when a psychosocial intervention was associated with pharmacological support.⁸ Psychosocial interventions may include cognitive behavioral therapy and interdisciplinary programs for chronic pain.

Although we don't review the treatment of opioid use disorder (OUD) in this document, we suggest the following resources for OUD:

- Centers for Disease Control and Prevention Resources: [American Society of Addiction Medicine \(ASAM\) Live and Online CME](#)
- American Society of Addiction Medicine (ASAM) [e-Learning Center](#)
- [Substance Abuse and Mental Health Services Administration](#)

For more information, visit professionals.optumrx.com
> Resources > Notices > Prescribing Opioid Medications Safely

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