

# Opioid Tapering Recommendations

To 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 regimens are supporting your treatment goals. We developed this document to help you determine which patients may be good candidates for an opioid taper.

The recommendations in this document complement the following prescribing guidelines:

- March 2016: The Centers for Disease Control and Prevention CDC released [guideline recommendations](#) around prescribing opioids.
- April 2019: The U.S. Food and Drug Administration (FDA) issued a [drug safety announcement](#) urging health care professionals and patients to avoid abrupt discontinuation of opioids when there is physical dependence and provided additional information about individualized tapering and ongoing monitoring and support.

Opioid tapering is just one aspect of UnitedHealthcare's overall strategy to help reduce misuse and dependence on opioids. 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

The most common reasons for opioid tapers include:

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

Additionally, we recommend an opioid taper in the following scenarios<sup>1-4</sup>:

- 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 percent improvement on the 3-item PEG scale.
- Persistent nonadherence 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 doesn't support a recommendation of one tapering speed or schedule over another. You should tailor tapering schedules based on the patient's condition, willingness, support systems and other factors. The following are recommendations for tapering schedules:

### Department of Veterans Affairs and the Department of Defense<sup>5</sup>:

- 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 MME), followed by a decrease every two to five days.

### Mayo Clinic<sup>4</sup>:

- 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.

### CDC<sup>1</sup>:

- 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.

### FDA<sup>6</sup>:

- Decrease by an increment of no more than 10 percent to 25 percent every two to four 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, then proceed with a more gradual taper once stable. Some patients taking opioids for shorter time periods may tolerate a more rapid taper.

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

### Psychosocial Support

Patients with chronic pain have higher rates of depression and mental health issues; therefore, psychosocial support is critical. We suggest screening patients with pain for psychiatric comorbidities using tools such as the Patient Health Questionnaire or PHQ-9. 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](https://provider.liveandworkwell.com).

## 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:

|                  |              |              |             |
|------------------|--------------|--------------|-------------|
| 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 two to three 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](#))<sup>7</sup> or the objective provider assessment tool *Clinical Opiate Withdrawal Scale* ([COWS](#)).<sup>8</sup>

A literature review comparing detoxification protocols found better outcomes when a psychosocial intervention was associated with pharmacological support.<sup>9</sup> 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. 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.<sup>10</sup> Other alpha adrenergic agonists like clonidine or guanfacine are alternatives, though currently published data doesn't provide enough evidence to draw conclusions about the relative effectiveness of these agents.
- **Other Medications:** You can also use other medications to manage other symptoms of withdrawal, including treatment of nausea, vomiting or diarrhea.

## 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 engage in a discussion with your patient about alternative pain treatments and tapering down opioid regimens.<sup>11</sup> Here are some questions you may want to discuss with patients who are currently using opioid medications:

1. How well is your opioid medication controlling your pain? Are you experiencing any adverse effects such as ...? *Give examples.*
2. There are other non-opioid medicines that can be used for the management of pain, as well as treatments that don't involve medicines. What have you tried in the past? *Give examples, such as non-opioid alternatives, physical therapy, etc.*
3. What concerns do you have about tapering to the lowest effective dose of opioids or stopping opioids and using other non-opioid medications or other methods of managing your pain?
4. Is it time to consider other methods of pain management?
5. 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 risk of overdose? *Consider providing information about naloxone and a prescription if your patient is at risk.*

## Additional Information

Although we don't review the treatment of opioid use disorder (OUD) in this document, 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](http://provider.liveandworkwell.com).
- **Substance Abuse and Mental Health Services Administration (SAMHSA) Medication-Assisted Treatment Information:** [samhsa.gov](http://samhsa.gov) > Programs & Campaigns > [Medication-Assisted Treatment](#)
- **American Society of Addiction Medicine (ASAM) Educational Resources:** [asam.org](http://asam.org) > Education > [Educational Resources](#)
- **US Department of Health & Human Services Treatment and Recovery Information:** [hhs.gov](http://hhs.gov) > A-Z Index > O > Opioids > [Treatment & Recovery](#)
- **Harm Reduction Coalition:** [harmreduction.org](http://harmreduction.org) > Overdose Protection > [Prescribe Naloxone!](#)

If you have questions, please contact your UnitedHealthcare representative. If you are unsure of who to contact, go to [UHCprovider.com](http://UHCprovider.com) > Menu > Contact Us > Find a Network Management Contact.

### References:

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11. American Society of Addiction Medicine. Practice Support Resources: Motivational Interviewing (webpage). Online: <https://www.asam.org/education/live-online-cme/fundamentals-of-addiction-medicine/additional-resources/motivational-interviewing>

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