Opioid Tapering: Tips for Success

With careful patient selection, education, and monitoring, opioids can be safe and effective tools to improve function and pain intensity in chronic noncancer pain. However, discontinuation may become necessary, either because of inefficacy, adverse effects, or misuse. The table below provides information to help clinicians deal with this challenging patient care situation.

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<th>Clinical Question</th>
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<td>What are some situations in which opioid tapering and/or discontinuation might be considered?</td>
<td><strong>Situation</strong></td>
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| Misuse | • Re-evaluate treatment.\(^1\)  
| | • Educate patient.\(^1\)  
| | • Increase frequency/intensity of monitoring.\(^1\)  
| | • Involve addiction or mental health providers.\(^1\)  
| | • Prescribe limited quantities.\(^1\)  
| | • Egregious misuse (e.g., injecting tablets) will likely require discontinuation.\(^1\)  
| | • See our chart, Management of Opioid Dependence, for help identifying opioid use disorder and information on pharmacotherapy options. |
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| Use of illicit drugs or nonprescribed opioids | • Refer, ideally to a specialized program that can provide directly-observed therapy.\(^1\) |
| Diversion | • Usually requires immediate discontinuation.\(^1,2\)  
| | • Alternative is to refer to a specialized program that can provide directly-observed therapy.\(^1\) |
| Nonadherence to opioid agreement | • Restructure therapy (e.g., more intense monitoring, opioid tapering, addition of non-opioid or psychiatric treatment).\(^1\) |
| Overdose\(^2\) | • Dose reduction.\(^11\)  
| Adverse effects (e.g., sleep apnea, low libido, nausea, constipation)\(^1,4\) | • If discontinued, consider rapid taper over two to three weeks.\(^2\)  
| | • Consider opioid rotation (i.e., switching patient from one opioid to another).\(^1\)  
| | • Consider tapering to a safe dose and continuing.\(^2\) |

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<td>Situations in which to consider opioid tapering and/or discontinuation, continued</td>
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| How do I prepare patients for opioid discontinuation?                            | - When **starting** chronic opioid therapy, set clear expectations. This may help prevent opposition to discontinuation if it is indicated later.2  
- Use motivational interviewing techniques to identify reasons for patient opposition to discontinuation.2  
- Identify and treat depression to improve pain control and improve taper success.2,9  

**Patient education points:**  
- Chronic pain is complex; opioids are not a “cure-all,” and may not provide adequate pain relief long-term.2,4  
- Side effects of chronic opioid therapy include low hormone levels leading to fracture risk, low libido, and low energy and mood; sedation; cognitive slowing; worsening sleep apnea, leading to fatigue; and constipation.1,4,9  
- When opioids are no longer providing good pain relief, most people feel better without them.4  
- Most patients do not experience increased pain.1,3  
- You are not abandoning the patient, and will still help them with their pain.9  
- Pain will be addressed with non-opioid alternatives.2,5,9  
- Withdrawal symptoms are uncommon if the dose is tapered slowly.9  

**What can be expected if the opioid is tapered or discontinued?**  
- Patients being tapered due to lack of efficacy may or may not experience a worsening of pain.1  
  In a VA population (n = 50) being tapered for reasons other than aberrant behavior, 70% of patients had no change or less pain vs baseline despite a 46% average dose reduction.3  
- Function and quality of life may improve [Evidence level B-2].10  
- Patients should expect to have some insomnia and anxiety.3  
  - Patients should plan ahead for not feeling well.4  
- Increased pain is an early symptom of withdrawal; pain with opioid dose reduction is not a sign that the opioid is effective for the patient’s pain.4,9  
- Pain due to withdrawal should resolve after the first week.4  
- Unmasking of psychiatric conditions may occur.2  

**How should the opioid be tapered/discontinued?**  

**General concepts:**  
- High-quality evidence to guide tapering is lacking; individualize.  
- The reason for discontinuation and amount of opioid being used will influence the rate of taper.  
  - At high doses, rapid taper may cause withdrawal or drug seeking.2  
  - Discontinue immediately if there is diversion.2  
- Adjust taper based on response, such as appearance of withdrawal symptoms.2  
- Consider referral for patients who have risk factors for failure: high-dose, substance use disorder, active psychiatric disorder, previous outpatient taper failure, or benzodiazepine use.2  
- If benzodiazepine discontinuation is indicated, discontinue opioids before discontinuing benzodiazepines.2

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| Tapering/discontinuation, continued | • Consider consolidating the patient’s opioids into a single long-acting formulation.¹ (See our chart, *Equianalgesic Dosing of Opioids for Pain Management*, for help). Choose a product that offers small dose increments (e.g., morphine 10 mg) to facilitate a slow taper.⁵ A short-acting formulation can be used once the lowest dose of the long-acting formulation is reached.⁹  
  • Fentanyl patch can be tapered in decrements of 12 mcg/hr.⁹  
  • Before constructing the taper, check for insurance coverage limitations, and availability of specific opioid products/strengths at your local pharmacy. Flexibility may be needed.  
  • Consider incorporating physical therapy or cognitive behavioral therapy into the treatment plan to help patients manage chronic pain during the taper.⁹ Some patients report that self-directed exercise or other physical activity, meditation, or massage therapy has helped them cope during the taper.¹²  |
| How should the patient be monitored during dose reduction or discontinuation? | • Check pain control and functional status at each visit.²  
  • Manage increased pain with non-opioids.²  
  • Monitor for psychiatric disorders such as depression or panic disorder.²  
  • Monitor for withdrawal (e.g., flu-like symptoms, insomnia, anxiety, abdominal cramps and other GI symptoms, goose bumps, fatigue, malaise).⁴  
  • If withdrawal symptoms occur, manage the symptoms (see below) and slow the taper (e.g., to 5% per week) or suspend the taper; do not increase the dose (i.e., don’t “backpedal”).²⁴  
  • Warn patients that they are at risk of overdose if they try upping the dose on their own. Opioid tolerance is lost after a week or two of abstinence.³ Consider prescribing naloxone for use in case of an overdose emergency. See our chart, *Naloxone for Opioid Overdose: FAQs*, for information about preparing and prescribing naloxone rescue kits (U.S.).  |
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<td>What adjunctive medications may help with withdrawal symptoms?</td>
<td>• Acetaminophen or NSAIDs for <strong>malaise and myalgias</strong>&lt;sup&gt;5,6&lt;/sup&gt;</td>
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<td>• Ondansetron 8 mg q 12 h for <strong>nausea</strong> and perhaps other symptoms**&lt;sup&gt;6,8&lt;/sup&gt;</td>
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<td>• Trazodone (or hydroxyzine, below) for <strong>insomnia</strong> (25 mg to 100 mg at bedtime)**&lt;sup&gt;5&lt;/sup&gt;</td>
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<td>• Hydroxyzine 25 to 50 mg three times daily as needed for <strong>anxiety, itching, lacrimation, cramps, sweating,</strong> and <strong>rhinorrhea</strong>&lt;sup&gt;5&lt;/sup&gt;</td>
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<td>• Loperamide for <strong>diarrhea</strong> (not usually needed for gradual taper)**&lt;sup&gt;5&lt;/sup&gt;</td>
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<td>• Clonidine (e.g., for increased heart rate and blood pressure; chills; anxiety) is not usually needed for gradual tapers**&lt;sup&gt;5,13&lt;/sup&gt;</td>
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<td>Also see our chart, <strong>Treatment of Opioid Withdrawal</strong>, for clonidine dosing and more.</td>
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<td>What are some opioid alternatives for common types of pain?</td>
<td>See our charts, <strong>Analgesics for Acute Pain</strong>, <strong>Treatment of Acute Low Back Pain</strong>, <strong>Treatment of Chronic Low Back Pain</strong>, <strong>Analgesics for Osteoarthritis</strong>, <strong>Pharmacotherapy of Neuropathic Pain</strong>, and <strong>Topicals for Pain Relief</strong>.</td>
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<td>Once patients are tapered to not more than morphine 30 mg or equivalent daily, buprenorphine transdermal patch (<strong>Butrans</strong> [U.S.], <strong>BuTrans</strong> [Canada]) or buccal film (<strong>Belbaca</strong>) could be considered. See our chart, <strong>FAQs About Buprenorphine for Chronic Pain</strong>, for more information.</td>
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*Users of this resource are cautioned to use their own professional judgment and consult any other necessary or appropriate sources prior to making clinical judgments based on the content of this document. Our editors have researched the information with input from experts, government agencies, and national organizations. Information and internet links in this article were current as of the date of publication.*
Levels of Evidence

In accordance with our goal of providing Evidence-Based information, we are citing the LEVEL OF EVIDENCE for the clinical recommendations we publish.

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<tr>
<th>Level</th>
<th>Definition</th>
<th>Study Quality</th>
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| A     | Good-quality patient-oriented evidence.* | 1. High-quality RCT  
2. SR/Meta-analysis of RCTs with consistent findings  
3. All-or-none study |
| B     | Inconsistent or limited-quality patient-oriented evidence.* | 1. Lower-quality RCT  
2. SR/Meta-analysis with low-quality clinical trials or of studies with inconsistent findings  
3. Cohort study  
4. Case control study |
| C     | Consensus; usual practice; expert opinion; disease-oriented evidence (e.g., physiologic or surrogate endpoints); case series for studies of diagnosis, treatment, prevention, or screening |

*Outcomes that matter to patients (e.g., morbidity, mortality, symptom improvement, quality of life).

RCT = randomized controlled trial; SR = systematic review


Project Leader in preparation of this clinical resource (350601): Melanie Cupp, Pharm.D., BCPS

References