HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics

This *HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics* provides advice to clinicians who are contemplating or initiating a reduction in opioid dosage or discontinuation of long-term opioid therapy for chronic pain. In each case the clinician should review the risks and benefits of the current therapy with the patient, and decide if tapering is appropriate based on individual circumstances.

After increasing every year for more than a decade, annual opioid prescriptions in the United States peaked at 255 million in 2012 and then decreased to 191 million in 2017.[i] More judicious opioid analgesic prescribing can benefit individual patients as well as public health when opioid analgesic use is limited to situations where benefits of opioids are likely to outweigh risks. At the same time opioid analgesic prescribing changes, such as dose escalation, dose reduction or discontinuation of long-term opioid analgesics, have potential to harm or put patients at risk if not made in a thoughtful, deliberative, collaborative, and measured manner.

Risks of rapid opioid taper

- Opioids should not be tapered rapidly or discontinued suddenly due to the risks of significant opioid withdrawal.
- Risks of rapid tapering or sudden discontinuation of opioids in physically dependent[ii] patients include acute withdrawal symptoms, exacerbation of pain, serious psychological distress, and thoughts of suicide.[1] Patients may seek other sources of opioids, potentially including illicit opioids, as a way to treat their pain or withdrawal symptoms.[1]
- Unless there are indications of a life-threatening issue, such as warning signs of impending overdose, HHS does not recommend abrupt opioid dose reduction or discontinuation.

Whether or not opioids are tapered, safe and effective nonopioid treatments should be integrated into patients' pain management plans based on an individualized assessment of benefits and risks considering the patient's diagnosis, circumstances, and unique needs.[2,3,4] Coordination across the health care team is critical. Clinicians have a responsibility to provide or arrange for coordinated management of patients' pain and opioid-related problems, and they should never abandon patients.[2] More specific guidance follows, compiled from published guidelines (the *CDC Guideline for Prescribing Opioids for Chronic Pain*[2] and the *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain*[3]) and from practices endorsed in the peer-reviewed literature.

Consider[iii] tapering to a reduced opioid dosage, or tapering and discontinuing opioid therapy, when

- Pain improves[3]
- The patient requests dosage reduction or discontinuation[2,3,5]
- Pain and function are not meaningfully improved[2,3,5]
- The patient is receiving higher opioid doses without evidence of benefit from the higher dose[2,3]
- The patient has current evidence of opioid misuse[3,5]
- The patient experiences side effects[iv] that diminish quality of life or impair function[3]
- The patient experiences an overdose or other serious event (e.g., hospitalization, injury),[2,5] or has warning signs for an impending event such as confusion, sedation, or slurred speech[2,6]
- The patient is receiving medications (e.g., benzodiazepines) or has medical conditions (e.g., lung disease, sleep apnea, liver disease, kidney disease, fall risk, advanced age) that increase risk for adverse outcomes[3,5]
- The patient has been treated with opioids for a prolonged period (e.g., years), and current benefit-harm balance is unclear

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[i] https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html

[ii] Physical dependence occurs with daily, around-the-clock use of opioids for more than a few days and means that the body has adapted to the drug, requiring more of it to achieve a certain effect (tolerance). Patients with physical dependence will experience physical and/or psychological symptoms if drug use is abruptly ceased (withdrawal).

[iii] Additional tools to help weigh decisions about continuing opioid therapy are available: Assessing Benefits and Harms of Opioid Therapy, Pain Management Opioid Taper Decision Tool, and Tapering Opioids for Chronic Pain.

[iv] e.g., drowsiness, constipation, depressed cognition

Important considerations prior to deciding to taper

Overall, following voluntary reduction of long-term opioid dosages, many patients report improvements in function, sleep, anxiety, and mood without worsening pain or even with decreased pain levels.[4,7,8,9,10,11] Other patients report increased pain, insomnia, anxiety, and depression.[4,7,9,12] The duration of increased pain related to hyperalgesia or opioid withdrawal is unpredictable and may be prolonged in some patients.[12] Decisions to continue or reduce opioids for pain should be based on individual patient needs.[2,13] Consider whether opioids continue to meet treatment goals, whether opioids are exposing the patient to an increased risk for serious adverse events or opioid use disorder, and whether benefits continue to outweigh risks of opioids.[2,13]

- Avoid insisting on opioid tapering or discontinuation when opioid use may be warranted (e.g., treatment of cancer pain, pain at the end of life, or other circumstances in which benefits outweigh risks of opioid therapy). ***The CDC Guideline for Prescribing Opioids for Chronic Pain does not recommend opioid discontinuation when benefits of opioids outweigh risks.***[2,4,13]
- Avoid misinterpreting cautionary dosage thresholds as mandates for dose reduction.[4] While, for example, the CDC Guideline recommends avoiding or carefully justifying *increasing* dosages above 90 MME/day, it does not recommend abruptly reducing opioids from higher dosages.[2,4] Consider individual patient situations.
- Some patients using both benzodiazepines and opioids may require tapering one or both medications to reduce risk for respiratory depression. Tapering decisions and plans need to be coordinated with prescribers of both medications.[2] If benzodiazepines are tapered, they should be tapered gradually[v] due to risks of benzodiazepine withdrawal (anxiety, hallucinations, seizures, delirium tremens, and, in rare cases, death).[2]
- Avoid dismissing patients from care. This practice puts patients at high risk and misses opportunities to provide life-saving interventions, such as medication-assisted treatment for opioid use disorder.[2,4,13] Ensure that patients continue to receive coordinated care.
- There are serious risks to noncollaborative tapering in physically dependent patients, including acute withdrawal, pain exacerbation, anxiety, depression, suicidal ideation, self-harm, ruptured trust, and patients seeking opioids from high-risk sources.[1,14]

Important steps prior to initiating a taper

- Commit to working with your patient to improve function and decrease pain.[2,7] Use accessible, affordable nonpharmacologic and nonopioid pharmacologic treatments.[2,3,7] Integrating behavioral and nonopioid pain therapies before and during a taper can help manage pain[10] and strengthen the therapeutic relationship.
- Depression, anxiety, and post-traumatic stress disorder (PTSD) can be common in patients with painful conditions, especially in patients receiving long-term opioid therapy.[15] Depressive symptoms predict taper dropout.[7,8] Treating comorbid mental disorders can improve the likelihood of opioid tapering success.
- If your patient has serious mental illness, is at high suicide risk, or has suicidal ideation, offer or arrange for consultation with a behavioral health provider before initiating a taper.[3,5]
- If a patient exhibits opioid misuse behavior or other signs of opioid use disorder, assess for opioid use disorder using DSM-5 criteria.[2,5] If criteria for opioid use disorder are met (especially if moderate or severe), offer or arrange for medication-assisted[vi] treatment.[2,3]
- Access appropriate expertise if considering opioid tapering or managing opioid use disorder during pregnancy. Opioid withdrawal risks include spontaneous abortion and premature labor. For pregnant women with opioid use disorder, medication-assisted treatment is preferred over detoxification.[2]
- ***Advise patients that there is an increased risk for overdose on abrupt return to a previously prescribed higher dose.***[2] Strongly caution that it takes as little as a week to lose tolerance and that there is a risk of overdose if they return to their original dose.[2,3,5,6] Provide opioid overdose education and consider offering naloxone.[2]

Share decision-making with patients

- Discuss with patients their perceptions of risks, benefits, and adverse effects of continued opioid therapy, and include patient concerns in taper planning. For patients at higher risk of overdose based on opioid dosages, review benefits and risks of continued high-dose opioid therapy.[2,5]
- If the current opioid regimen does not put the patient at imminent risk, tapering does not need to occur immediately.[4] Take time to obtain patient buy-in.[14]
- For patients who agree to reduce opioid dosages, collaborate with the patient on a tapering plan.[2] Tapering is more likely to be successful when patients collaborate in the taper.[vii] Include patients in decisions, such as which medication will be decreased first and how quickly tapering will occur.

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[v] Example benzodiazepine tapers and clinician guidance are available at https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Benzodiazepine_Provider_AD_%20Risk_Discussion_Guide.pdf

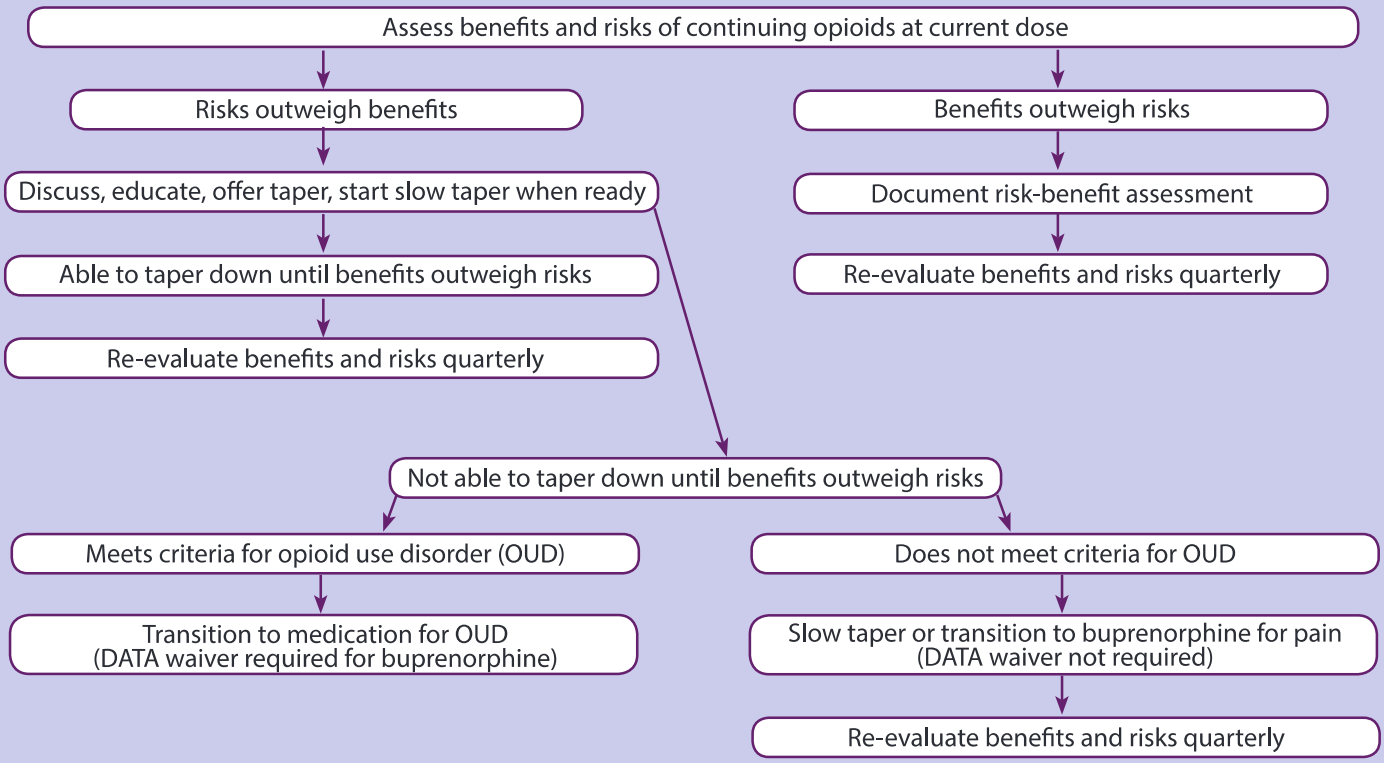
[vi] See SAMHSA's TIP 63: Medications for Opioid Use Disorder, SAMHSA's Buprenorphine Practitioner Locator, and SAMHSA's Opioid Treatment Program Directory

[vii] A recent systematic review found that when opioids were tapered with buy-in from patients who agreed to decrease dosage or discontinue therapy, pain, function, and quality of life improved after opioid dose reduction.[10]

Individualize the taper rate

- When opioid dosage is reduced, a taper slow enough to minimize opioid withdrawal symptoms and signs[viii] should be used.[2] Tapering plans should be individualized based on patient goals and concerns.[2,3,5,6]
- The longer the duration of previous opioid therapy, the longer the taper may take. Common tapers involve dose reduction of 5% to 20% every 4 weeks.[3,5]
  - **Slower tapers** (e.g., 10% per month or slower) are often better tolerated than more rapid tapers, especially following opioid use for more than a year.[2] Longer intervals between dose reductions allow patients to adjust to a new dose before the next reduction.[5] Tapers can be completed over several months to years depending on the opioid dose. See "slower taper" example here.
  - **Faster tapers** can be appropriate for some patients. A decrease of 10% of the original dose per week or slower (until 30% of the original dose is reached, followed by a weekly decrease of 10% of the remaining dose) is less likely to trigger withdrawal[7] and can be successful for some patients, particularly after opioid use for weeks to months rather than years. See "faster taper" example here.
- At times, tapers might have to be paused and restarted again when the patient is ready.[2] Pauses may allow the patient time to acquire new skills for management of pain and emotional distress, introduction of new medications, or initiation of other treatments, while allowing for physical adjustment to a new dosage.[3,5]
- Tapers may be considered successful as long as the patient is making progress, however slowly, towards a goal of reaching a safer dose,[2] or if the dose is reduced to the minimal dose needed.
- Once the smallest available dose is reached, the interval between doses can be extended [2,5,7] Opioids may be stopped, if appropriate, when taken less often than once a day.[2,7] See "example tapers for opioids" here.
- More rapid tapers (e.g., over 2-3 weeks[16]) might be needed for patient safety when the risks of continuing the opioid outweigh the risks of a rapid taper (e.g., in the case of a severe adverse event such as overdose).
- Ultrarapid detoxification under anesthesia is associated with substantial risks and ***should not be used***.[2]

Opioid Tapering Flowchart



Adapted from Oregon Pain Guidance. Tapering – Guidance & Tools. Available at https://www.oregonpainguidance.org/guideline/tapering/.

DSM-5 Opioid Use Disorder

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least 2 of the following, occurring within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain, use, or recover from the effects of opioids.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect, or
    b. Markedly diminished effect with continued use of the same amount of an opioid.

    Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.
11. Withdrawal, as manifested by either of the following:
    a. The characteristic opioid withdrawal syndrome, or
    b. Opioids (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.

    Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.

Mild: Presence of 2-3 symptoms
Moderate: Presence of 4-5 symptoms
Severe: Presence of 6 or more symptoms

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Treat symptoms of opioid withdrawal

- If tapering is done gradually, withdrawal symptoms should be minimized and manageable.
- Expectation management is an important aspect of counseling patients through withdrawal.
- Significant opioid withdrawal symptoms may indicate a need to pause or slow the taper rate.
- Onset of withdrawal symptoms depends on the duration of action of the opioid medication used by the patient. Symptoms can begin as early as a few hours after the last medication dose or as long as a few days, depending on the duration of action.[7] Early withdrawal symptoms (e.g., anxiety, restlessness, sweating, yawning, muscle aches, diarrhea and cramping[viii]) usually resolve after 5-10 days but can take longer.[5]
- Some symptoms (e.g., dysphoria, insomnia, irritability) can take weeks to months to resolve.[5]
- Short-term oral medications can help manage withdrawal symptoms, especially when prescribing faster tapers.[5] These include alpha-2 agonists[ix] for the management of autonomic signs and symptoms (sweating, tachycardia), and symptomatic medications[x] for muscle aches, insomnia, nausea, abdominal cramping, or diarrhea.[5]

Provide behavioral health support

- Make sure patients receive appropriate psychosocial support.[2,3,6,11] Ask how you can support the patient.[5]
- Acknowledge patient fears about tapering.[5] While motives for tapering vary widely, fear is a common theme. Many patients fear stigma, withdrawal symptoms, pain, and/or abandonment.[13,18]
- Tell patients "I know you can do this" or "I'll stick by you through this." Make yourself or a team member available to the patient to provide support, if needed.[3,6] Let patients know that while pain might get worse at first, many people have improved function without worse pain after tapering opioids.[7,8,9,10,11]
- Follow up frequently. Successful tapering studies have used at least weekly follow up.[10]
- Watch closely for signs of anxiety, depression, suicidal ideation, and opioid use disorder and offer support or referral as needed.[2,3,6] Collaborate with mental health providers and with other specialists as needed to optimize psychosocial support for anxiety related to the taper.[2]

[viii] Acute opioid withdrawal symptoms and signs include drug craving, anxiety, restlessness, insomnia, abdominal pain or cramps, nausea, vomiting, diarrhea, anorexia, sweating, dilated pupils, tremor, tachycardia, piloerection, hypertension, dizziness, hot flashes, shivering, muscle or joint aches, runny nose, sneezing, tearing, yawning, and dysphoria.[7] Worsening of pain is a frequent symptom of withdrawal that may be prolonged but tends to diminish over time for many patients.[7]

[ix] Alpha-2 agonists clonidine and lofexidine are more effective than placebo in ameliorating opioid withdrawal.[17] There is not similar research in patients tapering from long-term opioid treatment for pain.[7] Lofexidine has an FDA-approved indication for use up to 14 days for "mitigation of opioid withdrawal symptoms to facilitate abrupt opioid discontinuation in adults."

[x] NSAIDs, acetaminophen, or topical menthol/methylsalicilate for muscle aches; trazodone for sleep disturbance; prochlorperazine, promethazine, or ondansetron for nausea; dicyclomine for abdominal cramping; and loperamide or bismuth subsalicylate for diarrhea.[5]

Special populations

- If patients experience unanticipated challenges to tapering, such as inability to make progress despite intention to taper or opioid-related harm, assess for opioid use disorder using DSM-5 criteria.[2] If patients meet criteria for opioid use disorder (especially if moderate or severe), offer or arrange medication-assisted treatment.[2,3]
- If patients on high opioid dosages are unable to taper despite worsening pain and/or function with opioids, whether or not opioid use disorder criteria are met, consider transitioning to buprenorphine.[4,12] Buprenorphine is a partial opioid agonist that can treat pain as well as opioid use disorder,[19] and has other properties that may be helpful,[3] including less opioid-induced hyperalgesia[12] and easier withdrawal than full mu-agonist opioids,[3] and less respiratory depression than other long-acting opioids.[20] Buprenorphine can then be continued or tapered gradually.[12] Transitioning from full-agonist opioids requires attention to timing of the initial buprenorphine dose to avoid precipitating withdrawal.[xi]

Consultation with a clinician experienced in use of buprenorphine is warranted if unfamiliar with its initiation. SAMHSA's Providers Clinical Support System offers training and technical assistance as well as mentors to assist those who need to taper opioids and may have additional questions.

- Closely monitor patients who are unable or unwilling to taper and who continue on high-dose or otherwise high-risk opioid regimens. Mitigate overdose risk (e.g., provide overdose education and naloxone). Use periodic and strategic motivational questions and statements to encourage movement toward appropriate therapeutic changes.[14]

[xi] To avoid precipitating protracted withdrawal from full agonist opioids when starting buprenorphine, patients need to be in mild to moderate withdrawal (including Clinical Opioid Withdrawal Score (COWS) objective signs) before the first buprenorphine dose.[12] To do this, wait at least 8 to 12 hours after the last dose of short-acting full agonist opioids before the first dose of buprenorphine.[12] Buprenorphine buccal film (Belbuca) and buprenorphine transdermal system (Butrans) have FDA-approved indications for "the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate." The full Belbuca prescribing information and the full Butrans prescribing information include instructions for conversion from full agonist opioids. More time should be allowed before starting buprenorphine following the last dose of long-acting full agonist opioids (e.g., at least 36 hours after last methadone dose); in addition, transition from methadone to buprenorphine is likely to be better tolerated after methadone is gradually tapered to 40mg per day or less.[12] Because the duration of action for analgesia is much shorter than the duration of action for suppression of opioid withdrawal,[21] "split dosing" (e.g., 8mg sublingual tablet twice a day) rather than once a day dosing is used when buprenorphine is provided for pain management.[3,12]

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The U.S. Department of Health and Human Services Working Group on Patient-Centered Reduction or Discontinuation of Long-term Opioid Analgesics, chartered under the Assistant Secretary for Health ADM Brett Giroir, developed this guide:

Co-chairs

Deborah Dowell, MD, MPH
CAPT, US Public Health Service
Centers for Disease Control and Prevention

Christopher Jones, PharmD, DrPH
CAPT, US Public Health Service
Centers for Disease Control and Prevention

Wilson Compton, MD, MPE
National Institutes of Health

Workgroup members

Elisabeth Kato, MD, MRP
Agency for Healthcare Research and Quality

Joel Dubenitz, PhD
Office of The Assistant Secretary for Planning and Evaluation

Shari Ling, MD
Centers for Medicare and Medicaid Services

Daniel Foster, DO, MS, MPH
Food and Drug Administration

Sharon Hertz, MD
Food and Drug Administration

Marta Sokolowska, PhD
Food and Drug Administration

Judith Steinberg, MD, MPH
Health Resources and Services Administration

Meena Vythilingam, MD
CAPT, US Public Health Service
Office of the Assistant Secretary for Health

Thomas Clarke, PhD
Substance Abuse and Mental Health Services Administration

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