CEP | Providers

Opioid Tapering Template

This tool is to support primary care providers in discussing the value of opioid tapering with all adult patients currently prescribed an opioid and to support their patients in reducing opioid dosages in a safe and effective way.

Section A: Important considerations for opioid tapering

- Clinicians should engage patients in shared decision-making, including consideration of the patient's values, goals, concerns and preferences prior to tapering.[1,2]
- When possible, an interdisciplinary team approach should be used during the tapering process to support complementary non-pharmacological and pharmacological management.[1,2]
- For patients starting or continuing an opioid trial, discuss and document patients' goals on a regular basis. (**SMART goals: Specific, Measurable, Agreed-upon, Realistic, Time-based**).
- Consider the potential opioid harms and safety concerns.

CAUTION:
- Pregnancy - spontaneous abortion and premature labour have been associated with opioid withdrawal during pregnancy.
- When you have concerns about tapers destabilizing mental illnesses, destabilizing or unmasking substance use disorders including opioid use disorders or medically unstable conditions (e.g. severe hypertension, unstable CAD) consider seeking out additional consultation or supports.

Naloxone

- Naloxone is a medication that can reverse the effects of an opioid overdose. It is recommended to keep naloxone on hand in case of an accidental overdose. This is particularly important for patients on doses of >50 morphine equivalent dose (MED)/day, those with a history of overdose or concurrent benzodiazepine use.
- Ontarians with a health card are eligible for a free take-home naloxone kit. You can receive these kits and training on their use from pharmacies, community organizations and provincial correctional facilities.

For more information on where, how and when to use these kits visit: https://link.cep.health/ott1

Reasons to consider opioid tapering, reduction or discontinuation

- ❑ Patient **requests dosage reduction**
- ❑ **Problematic opioid behaviour** (e.g. diversion, altering the route of delivery, accessing opioids from other sources)
- ❑ Clear evidence of **opioid use disorder (OUD)**

Tapering **alone** is not likely an effective treatment for OUD. It may require further assessment and possible consultation to identify the optimal therapeutic options.

- ❑ **Adverse effects:**
  - ❑ Experiences **overdose** or early warning signs for **overdose risk** (e.g. confusion, sedation, slurred speech)
  - ❑ Medical **complications** (e.g. sleep apnea, hyperalgesia and withdrawal mediated pain)
  - ❑ Adverse effects **impair functioning** below baseline level
  - ❑ Patient does not tolerate adverse effects
- ❑ Opioid dosages >90 MED[1]
- ❑ Opioid dosages >**50 MED without benefit** in improving pain and/or function
- ❑ Opioid is **combined with benzodiazepines**[3]
- ❑ Other:

If pain and function are not improving despite opioid therapy, one should consider the potential harms relative to the lack of benefits, reduce opioid use and focus on other approaches.

Opioid use disorder criteria[4]

- ❑ Opioids are often taken in larger amounts or over a longer period than was intended
- ❑ Persistent desire or unsuccessful efforts to cut down or control opioid use
- ❑ Spending a lot of time obtaining the opioid, using the opioid, or recovering from its effects
- ❑ Craving or a strong desire to use opioids
- ❑ Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home
- ❑ Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
- ❑ Stopping or reducing important social, occupational, or recreational activities due to opioid use
- ❑ Recurrent use of opioids in physically hazardous situations
- ❑ Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids

Tolerance* as defined by:
- ❑ Need for markedly increased amounts to achieve intoxication or desired effect
- ❑ Markedly diminished effect with continued use of the same amount

Withdrawal* manifesting as either:
- ❑ Characteristic opioid withdrawal syndrome (see Section C: Withdrawal symptoms & management)
- ❑ Same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

- **Mild:** **Presence of 2 to 3 criteria**
- **Moderate:** **Presence of 4 to 5 criteria**
- **Severe:** **Presence of 6 or more criteria**

These criteria may be met by patients who are prescribed opioid medications for analgesia without in itself being indicative of opioid use disorder.

Talking Points

Provide information about why a taper might be needed:
- "Chronic pain is a complex disease and opioids alone cannot adequately address all of your pain-related needs."
- "I think it is time to consider the opioid dose you are on and its risk of harm. The risk of overdose and the risk of dying from overdose go up as the dose goes up."
- "Did you know that most of the evidence showing benefits from opioid use for chronic non-cancer pain supports relatively low doses (less than 100 MED)?"[1,2]
- "In some people, opioids can make their pain worse rather than better. Hyperalgesia resulting from an opioid is when the opioid makes one more sensitive to pain instead of less."

Ensure patients have clear expectations of tapering:
- "Some patients suffering with pain do better if they reduce their use of opioids."
- "Dose reduction or discontinuation of opioids frequently improves function, quality of life and pain control. This may take some time, and your pain may briefly get worse at first."

Address discrepancies between the patient's goals and their current pain management:
- "I want to make sure your pain management is as safe as possible and I want to get you back to your regular activities."

Adjust to any resistance to opioid reduction by reframing the conversation:
- "Opioids can have an effect on your central nervous system – they may be causing fatigue or lessening your ability to do daily activities. It is common to see one's alertness and function level go down when the opioid dose goes up."
- "Sounds like your pain has not improved even with the high dose you have been trying. It may be time to consider a lower dose."

Conversations about tapering require empathy and patient self-efficacy and should ideally be a joint decision. They may need to be revisited periodically depending on the patient's readiness. As this process unfolds, continue to work with your patients to provide care that is safe.

Section B: How to taper, reduce, or discontinue

For those on a higher dose and/or longer term opioids there is an increased potential for more challenges to tapering, including withdrawal symptoms.

General approach

- **Establish the opioid formulation to be used for tapering**
  - Switching from immediate release to controlled release opioids on a fixed dosing schedule may assist some patients in adhering to the withdrawal plan[1]
- **Establish the dosing interval**
  - Scheduled doses are preferred over PRN doses (to help with better pain control and withdrawal)
  - Keep the dosing interval constant (e.g. bid)
- **Establish the rate of taper based on patient health, preference and other circumstances**

  Individualize tapering schedule – there is insufficient evidence to recommend for or against specific tapering strategies and schedules[1,2]

  ❑ Slow taper should be followed unless otherwise indicated (e.g. patient preference)

  ❑ Rapid taper over 2–3 weeks

> **CAUTION:** Reducing the dose immediately or rapidly over a few days/weeks, may result in severe withdrawal symptoms and is best carried out in a medically-supervised withdrawal centre.[1]

Example of a slow tapering regimen

Current opioid: Morphine SR 120mg bid

- **Calculate total opioid dose:**

  Total Daily Morphine Dose = 240mg/d
- **Calculate daily opioid dose - typically 5–10%**

  5% = 12mg

  10% = 24mg

Reduce the dose every 2 to 4 weeks depending on how the patient is tolerating the taper and their desire to taper.

NOTE: Lowest available Morphine SR formulation is 15mg tablet or Morphine ER 10mg capsule

- **Follow up with the patient frequently (e.g. every 1–4 weeks)**[2]
- **Adjust the rate, intensity, and duration of the taper according to the patient's response (e.g. pain, function, withdrawal symptoms)**

  Tapering may be paused and potentially abandoned in patients who experience distressing or intolerable pain, withdrawal symptoms or a decrease in function that persists for more than 1 month after a small dose reduction.[1]
- **Treat pain and function with non-opioids (see Management of Chronic Non Cancer Pain tool)**
- **Treat withdrawal symptoms PRN (see Section C: Withdrawal symptoms & management)**
- **Taper to the lowest effective dose**

How long a taper should take is difficult to predict and needs to be individualized to each patient, for some a very gradual taper is required that can take months and at times years.

Legend

PRN = when necessary	bid = twice a day	SR = slow release	IR = immediate release
ER = extended release	qam = in the morning	qhs = at bedtime	

Example of slow taper

Current opioid: Morphine SR 120mg bid

Decrease Morphine SR by 15 mg

Weeks 1 & 2	Morphine SR 105mg qam and 120mg qhs
Weeks 3 & 4	Morphine SR 105mg bid
Weeks 5 & 6	Morphine SR 90mg qam and 105mg qhs
Weeks 7 & 8	Morphine SR 90mg bid
Weeks 9 &10	Morphine SR 75mg qam and 90mg qhs
Weeks 11 & 12	Morphine SR 75mg bid
Weeks 13 & 14	Morphine SR 60mg qam and 75mg qhs
Weeks 15 & 16	Morphine SR 60mg bid
Weeks 17 & 18	Morphine SR 45mg qam and 60mg qhs
Weeks 19 & 20	Morphine SR 45mg bid

Continue until the lowest effective dose is found for the patient.

Slow taper tips

Tapering reductions can be lower than 5% if gentler reductions are needed. For q24h formulation a gentler taper option is to reduce the dose by 10mg increments every 2 weeks.

For patients with no acute safety concerns (e.g. 5–10% of MED every 2–4 weeks),[1] tapers might need to be slowed once low dosages have been reached. Once the smallest available dose is reached, the interval between doses can be extended. Opioids may be stopped when taken less frequently than once a day.[3]

Example of rapid taper

Current opioid: Morphine SR 120mg bid

Decrease Morphine SR 120mg bid to 90mg bid x 3 days, then 60mg bid x 3 days, then 30mg bid x 3 days, then 15mg bid x 3 days, then 15mg qhs x 3 days, then stop

Other methods used to reduce dose, taper or discontinue:

- Switch current opioid to another opioid and reduce MED by 25% to 50% – see Opioid Manager Appendix C - Switching Opioids
- Switch to opioid agonist therapy such as buprenorphine-naloxone or methadone. If unfamiliar with protocol, clinicians should consult with someone knowledgeable with buprenorphine-naloxone use.[1] Online courses are available for providers to learn more about buprenorphine-naloxone use.
- In Canada, all physicians prescribing methadone require a federal exemption for pain or addictions.

Section C: Withdrawal symptoms & management

Withdrawal symptoms[5,6]

Opioid withdrawal can be very uncomfortable and difficult for the patient and can feel like a very bad flu. Opioid withdrawal is not usually life-threatening.

Onset and duration of withdrawal symptoms

Opioids	Onset	Duration
Short-acting	~6–24 hours after last use	~3–10 days
Long-acting	~12–72 hours after last use	~10–20 days
Some symptoms may last for weeks or months (e.g. cravings, insomnia, dysphoria).		

Talking Points

Ensure patients have clear expectations of tapering:

"Dose reduction or discontinuation of opioids could lead to withdrawal symptoms. During this time, your pain may get worse for a brief period of time, but your pain will decrease as your withdrawal symptoms lessen."

Symptoms and management[5,6]

Symptoms	Management
Muscle pain *Slower taper may be required to address these symptoms*	• Non-opioid medication (e.g. acetaminophen, ibuprofen, NSAIDs) • Refer to Management of Chronic Non Cancer Pain tool and Opioid Manager tool
Neuropathic pain *Slower taper may be required to address these symptoms*	• Tricyclic antidepressants (e.g. amitriptyline/nortriptyline) • SNRIs (e.g. duloxetine, venlafaxine) • Gabapentinoids (e.g. gabapentin/pregabalin) • Refer to Management of Chronic Non Cancer Pain tool and Opioid Manager tool
Physical symptoms of withdrawal (e.g. sweating, diarrhea, vomiting, abdominal cramps, chills, anxiety, insomnia and tremor)	• If BP >90/50 mmHg, may give clonidine 0.1mg. Check BP & HR 1 hour later. If BP <90/50, HR <50 or dizziness, do not prescribe further. May titrate up to qid prn, then taper. • Do not give clonidine if BP < 90/50 mmHg or HR < 50 bpm
Diarrhea	• Stop stool softeners and/or laxatives (e.g. sennosides, docusate sodium, lactulose) if applicable • Loperamide (if necessary) 4mg STAT, then 2mg after each unformed stool up to a maximum of 16mg per day
Insomnia	• Cognitive Behaviour Therapy for Insomnia (CBT–I) (see Management of Chronic Insomnia tool) • Do not prescribe benzodiazepines, zopiclone or zolpidem • For patients already on benzodiazepine, zopiclone or zolpidem discuss the increased risk of harm and consider tapering once the patients are tapered off opioids.
Nausea/vomiting	• Dimenhydrinate 25–100mg q4h prn • Prochlorperazine 5–10mg q6h prn • Haloperidol 0.5–1mg q12h prn • Metoclopramide 10mg q4–6h prn
Abdominal cramps	• Hyoscine butylbromide 20mg tid-qid prn for 2–3 days
Muscle cramps	• Quinine sulfate 300mg bid prn
Sweating	• Oxybutynin 2.5–5mg bid prn (short-term use) • Ensure patient is well-hydrated
Overdose prevention *Tolerance of previous dose of opioids is lost after 1–2 weeks. Patients may inadvertently take the original dose to help with withdrawal symptoms or pain resulting in possible overdose and mortality risk.*	• Naloxone kit

Section D: Tapering plan

Tapering plan

This form is designed to help primary care providers document the tapering plan agreed upon by both the patient and the primary care provider. Ensuring the patient has been part of the planning process is important for buy-in and adherence to the agreed upon plan. Have the patient repeat the plan back to you to ensure that they understand it.

When undertaking an opioid taper plan, please keep in mind that although there may be a taper schedule in place there may be a need to deviate from the plan (e.g. pausing) or adjust the rate, intensity or duration of the taper depending on how the patient is responding with regards to their pain, function, withdrawal symptoms and other life events.

Baseline details

Patient name:	DOB:
SMART goal(s):	Reason for taper:
Start date of taper:	Proposed end date of taper:
Possible target dose:	

Baseline patient

Check for:			
❑ Brief Pain Inventory (BPI) Scores			
❑ Pain (BPI scores for 3 domains, 0–10):	Domain score 1:	Domain score 2:	Domain score 3:
❑ Function (BPI score, 0–10):	Domain score:		
❑ General Activity (BPI score, 0–10):	Domain score:		
❑ Mental health stability: Consider slowing down or pausing the taper in the presence of a mental health issue. ❑ PHQ-9 ____________ ❑ GAD-7 ____________			
Notes:			
❑ Withdrawal symptoms discussed with patient			

Taper plan

Date	Dose	Frequency	Total daily dose	Planned duration on dose	Notes

Follow-up tapering visits

This form is designed to help primary care providers document the patient's tolerance to tapering. If the patient is experiencing a high degree of withdrawal symptoms, consider adjusting the rate of taper, pausing the taper, treating withdrawal symptoms or monitoring if the patient is tolerating symptoms and is motivated to continue.

Baseline details

Patient name:	DOB:
SMART goal(s):	Progress to goal(s):

Follow-up patient assessment

Check for:			
❑ Brief Pain Inventory (BPI) Scores			
❑ Pain (BPI scores for 3 domains, 0–10):	Domain score 1:	Domain score 2:	Domain score 3:
❑ Function (BPI score, 0–10):	Domain score:		
❑ General Activity (BPI score, 0–10):	Domain score:		
❑ Mental health stability: Consider slowing down or pausing the taper in the presence of a mental health issue. ❑ PHQ-9 ______ ❑ GAD-7 ______			
❑ Ask patient if they are taking over-the-counter products (e.g. herbals, acetaminophen, NSAIDs):			
Notes:			

Management plan

Withdrawal symptoms to consider	Management (see Section C: Withdrawal symptoms & management)	Notes
❑ Blood pressure: / mmHg		
❑ Sweating (hot or cold flushes)		
❑ Restlessness		
❑ Pupil size		
❑ Bone, muscle or joint aches		
❑ Rhinitis or excessive tearing (not caused by cold symptoms or allergies)		
❑ Gastrointestinal upset or abdominal cramps ❑ Diarrhea ❑ Nausea/vomiting		
❑ Tremor observation of outstretched hands		
❑ Insomnia		
❑ Yawning		
❑ Anxiety or irritability		
❑ Gooseflesh skin (pilorection)		
❑ Other symptoms		

Pain management plan*

Physical activity	Activity:	Notes:
	Frequency:	
	Duration:	
Self-management/ psychological therapy	Therapy:	Notes:
	Frequency:	
	Duration:	
Non-opioid medication	Dosing:	Notes:
	A/E:	
	Adherence:	
Referral	❑ Specialist ❑ Multi-disciplinary clinic ❑ Intervention procedure	Notes:

*For a full pain management plan please see Management of Chronic Non-Cancer Pain tool

After you have assessed how well the patient is tolerating tapering, determine if they are ready to continue with the taper as planned at this time or decide if you will need to deviate from the plan or pause the taper.

If the patient is NOT tolerating the taper please consider:

❑ Pause taper
❑ Change taper • Rate (percentage or frequency): • Duration: • Other: • Planned next visit:

If the patient is tolerating the taper, please consider:

Current opioid dose:
Week of taper:
Next planned opioid dose:
Planned next visit:

Section F: Supporting material*

[I] Management of Chronic Non Cancer Pain - Appendices
https://cep.health/cncp

[II] Opioid Manager
https://cep.health/pain

[III] Management of Chronic Insomnia
https://cep.health/insomnia

[IV] Naloxone and Opioid Crisis Training Resources
https://link.cep.health/ott6

[V] Ontario Naloxone Kit Access & Resources
https://link.cep.health/ott7

[VI] Buprenorphine-Assisted Treatment of Opioid Dependence: An Online Course for Front-Line Clinicians
https://link.cep.health/ott9

[VII] Opioid Tapering- Information for Patients
https://link.cep.health/ott10

[VIII] Brief Pain Inventory (BPI)
https://link.cep.health/ott3

[IX] PHQ-9 Screener
https://link.cep.health/ott4

[X] GAD-7 Screener
https://link.cep.health/ott5

*These supporting materials are hosted by external organizations and as such, the accuracy and accessibility of their links are not guaranteed. The CEP will make every effort to keep these links up to date.

Section G: Resources

[1] Michael G. DeGroote National Pain Centre, McMaster University. Canadian guideline for safe and effective use of opioids for chronic noncancer pain. 2017; [cited Jan 4, 2018].

[2] Department of Veterans Affairs & Department of Defense. VA/DoD clinical practice guideline for opioid therapy for chronic pain. 2017 ; [cited Jan 4, 2018].

[3] Centers for Disease Control and Prevention (CDC): CDC Guideline for Prescribing Opioids for Chronic Pain. 2016 ; [cited Jan 4, 2018].

[4] American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th edition. Arlington: American Psychiatric Association; c2013.

[5] Michael G. DeGroote National Pain Centre, McMaster University. Opioid tapering – information for patients. [cited Jan 4, 2018].

[6] World Health Organization. Clinical guidelines for withdrawal management and treatment of drug dependence in closed settings. Geneva: 2009 ; [cited Jan 4 2018].

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