

Opioid Tapering Recommendations

To prevent toxicity, dependence and opioid use disorder, 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. In March 2016, the Centers for Disease Control and Prevention (CDC) released recommendations around prescribing opioids. To complement those prescribing guidelines, we developed this document to help you determine which patients may be good candidates for an opioid taper.

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 scenarios¹⁻⁴:

- 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 current recommendations for tapering schedules:

Department of Veterans Affairs and the Department of Defense⁵:

- 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.

Consult with specialists and treatment experts, when needed, especially for high-risk patients, including pregnant women or patients with opioid use disorder (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 opioid use disorder. You can find local UnitedHealthcare in-network behavioral health care providers at 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	Dizziness	Muscle pain	Shivering
Agitation	Dysphoria	Mydriasis	Sneezing
Anorexia	Hot flashes	Nausea	Tachycardia
Anxiety	Hypertension	Piloerection	Tremor
Diaphoresis	Insomnia	Restlessness	Yawning
Diarrhea	Lacrimation	Rhinorrhea	

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](#))⁶ or the objective provider assessment tool *Clinical Opiate Withdrawal Scale* ([COWS](#)).⁷

A literature review comparing detoxification protocols found better outcomes when a psychosocial intervention was associated with pharmacological support.⁸ 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 like clonidine or guanfacine. However, 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.⁹ 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.
- **Substance Abuse and Mental Health Services Administration (SAMHSA) Medication-Assisted Treatment Information:** samhsa.gov > Programs & Campaigns > [Medication-Assisted Treatment](#)
- **American Society of Addiction Medicine (ASAM) Educational Resources:** asam.org > Education > [Educational Resources](#)
- **US Department of Health & Human Services Treatment and Recovery Information:** hhs.gov > A-Z Index > O > Opioids > [Treatment & Recovery](#)
- **Harm Reduction Coalition:** 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 > Menu > Contact Us > Find a Network Management Contact.

References:

1. Centers for Disease Control and Prevention. Pocket Guide: Tapering Opioids for Chronic Pain. www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf. Access August 13, 2017.
2. Fishman SM. Responsible Opioid Prescribing, A Clinician's Guide. 2nd ed. Euless, TX: Federation of State Medical Boards; 2014.
3. Substance Abuse and Mental Health Services. Managing Chronic Pain in Adults with or in Recovery from Substance Use Disorder. www.samhsa.gov. Access August 13, 2017.
4. Berna C, Kulich RJ, Rathmell JP. Tapering Long-Term Opioid Therapy in Chronic Noncancer Pain: Evidence and Recommendations for Everyday Practice. *May Clin Proc.* 2015; 90(6):828-842.
5. Department of Veterans Affairs. Tapering and Discontinuing Opioids. Washington, DC: Dept. of Veterans Affairs; 2013.
6. Handelsman L, Cochrane KJ, Aronson MJ, et al. Two New Rating Scales for Opiate Withdrawal. *Am J Drug Alcohol Abuse.* 1987;13(3):293-308. <https://www.smartcjs.org.uk/wp-content/uploads/2015/07/SOWSSubjectiveOpiateWithdrawalScale.pdf>.
7. Wesson DR, Ling W. The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs.* 2003;35(2):253-259. http://www.naabt.org/documents/COWS_induction_flow_sheet.pdf.
8. Amato L, Minozzi S, Davoli M et al. Psychosocial and pharmacological treatments versus pharmacological treatment for opioid detoxification. *Cochrane Database Syst Rev.* 2011;(9):CD005031.
9. 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>