## **Opioid Tapering Decision Tree**

START

Is the patient demonstrating psychiatric illness/inappropriate substance use behavior?



# Do Not Proceed With Taper Initiate/Refer the patient to Substance Use Disorder (SUD)

Treatment<sup>1,2</sup>



# Indications that Taper May Be Appropriate:

- Patient choice
- Daily dose >50 morphine equivalent dose (MED) without clear benefit
- Concurrent benzodiazepine use
- Excess sedation/ side effects
- Resolution of condition
- Decline in activities of daily living (ADLs) attributed to treatment





## STOP

If the patient is stable, do not proceed with taper and ensure proper documentation of analgesic effectiveness of: Pain Enjoyment

General Activity<sup>3</sup>

This tool was developed to assist providers through the opioid tapering process for patients treated for chronic pain. The process and recommdations are a framework and are not intended to replace individual clinical judgement.



### Consider steps 1–6 to begin taper process.

#### 1. Medication Choice

• Consider if extended-release opioid formulation would be more appropriate for taper than the current short-acting opioid.<sup>4</sup>

#### 2. Speed of Taper

- Reduce dose at a rate that does not produce withdrawl symptoms.
- Consider slower taper for longer duration as this can provide a lower risk of withdrawal.
- Educate the patient on what to expect and how to identify withdrawal.

Taper down the

total daily opioid

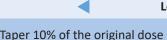
dose by 10% per

week for most

patients.

- Obtain the patient's support for tapering plan.
- Communicate often with patient regarding symptoms during taper.<sup>5</sup>

#### Taper Speed Options<sup>6</sup>



every 5 to 7 days until 30% of

the original dose is reached,

10% of the remaining dose.

followed by a weekly taper by

#### **Least Aggressive to Most Aggressive Taper**



 Slower protocol: Taper by 20% to 50% of the original dose per week

• Faster protocol: Taper with daily decreases of 20% to 50% of the initial dose down to a threshold (30–45 mg of morphine every day), followed by a decrease every 2 to 5 days.

- Speed of taper should be **inversely** correlated with duration of opioid use to prevent withdrawal symptoms
- Twice a month to monthly dose adjustments can be considered in the case of long-term opioid treatment exceeding 2 years<sup>7</sup>

#### 3. Other Pharmalogic Interventions at Dose Adjustments

• Consider use of Alpha-adrenergic agonists, such as clonidine or guanfacine, in addition to tapered opioids to suppress physicial withdrawal symptoms (flushing, tremors, etc.).8

## 4. Psychologial and Behavioral Support

- Consider psychosocial interventions combined with pharmalogical support.
- Find and coordinate psychologic care with skilled professionals.<sup>7</sup>

#### 5. Preventing Taper Failure and Patient Dropout

- Note that patient dropout is the greatest risk to taper completion.<sup>9</sup>
- Monitor patients with depression, and those who continue to report significant pain on high doses of opioids as they are higher risk for dropout or relapse. 10, 11

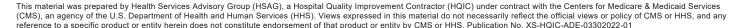
#### **6. Monitoring of Tapering Patients**

- Schedule monthly visits during opioid treatment.
- Follow up within 7 days after each dose reduction.
- Conduct routine urine drug testing to indicate if the medication is being used as prescribed.
- Potential for adjunctive use of controlled substances rises during taper.<sup>12</sup>



Find this handout along with other opioid-related resources online at www.hsag.com/hqic/tools-resources/ade





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