GroupHealth®

Tapering or Weaning Patients off of Chronic Opioid Therapy

Adapted from the *Chronic Opioid Therapy (COT) Safety Guideline For Patients With Chronic Non-Cancer Pain*

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Table 1. Indications and Recommended Taper Schedule (*See Table 3, for Referral Matrix)*

Indication	Taper method
Urine drug screen is consistent with substance abuse concerns, or • Behavior suggests that patient may be misusing or diverting medication. [1]	Over 3–7 days or 15% per day [2]
• Medication side effects indicate risks greater than benefit, [3] or • Comorbidities increase risk of complication, or • Morphine equivalent dose exceeds recommended threshold.	10% per week
• Function and pain are not improved, or • Long-term opioid prescription with tolerance, or • Comorbidities increase risk of complication.	10% every 2–4 weeks

[1] Behaviors may include:
- Stealing or borrowing drugs
- Injecting oral/topical opioids
- Aggressive demand for opioids

[2] Opioid withdrawal is unpleasant for the patient but is not dangerous. (See Table 2 for withdrawal symptoms.)

[3] Side effects of opioids may include:
- Depression
- Sleeping problems
- Worsening pain
- Sexual problems
- Fatigue
- Constipation
- Falling/ breaking bones
- Itching
- Nausea or vomiting
- Breathing problems

Treating Withdrawal

Table 2. Medications used to treat subjective symptoms during acute withdrawal and/or gradual taper

Target symptoms	Medication	Dosing
Hypertension, tremors, sweats, anxiety, restlessness	Clonidine (Catapres) [1]	0.1 mg t.i.d.
Anxiety, restlessness	Hydroxyzine (Vistaril) [2]	25 mg every 6 hrs as needed
	Diphenhydramine (Benadryl) [2]	25 mg every 6 hrs as needed
Insomnia	Hydroxyzine (Vistaril) [2]	25–50 mg every evening at bedtime
	Diphenhydramine (Benadryl) [2]	25–50 mg every evening at bedtime
Nausea	Promethazine (Phenergan) [2]	25 mg every 6 hrs as needed
	Metoclopramide (Reglan)	10 mg every 6 hrs as needed
Dyspepsia	Calcium carbonate (Tums)	500 mg 1–2 tabs every 8 hrs
	Mylanta, Milk of Magnesia	Follow package instructions
Pain, fever	Acetaminophen (Tylenol)	500 mg every 4 hrs (not to exceed 3 g/24 hrs)

[1] Clonidine is not FDA-approved for this use, although evidence supports use in this setting. Group Health recommends clonidine as the first-line agent, as it is effective in many patients. As a non-opioid treatment option, it is readily available statewide and does not have extra restrictions on prescribing. Monitor blood pressure and pulse. Dosing of clonidine depends on whether patient is acutely withdrawing or gradually being tapered.

[2] These are high-risk medications for the elderly. Please consider alternatives for patients aged 65 and older.

Table 3. Referral Matrix *

Specialty	Service requested	Reason for referral
Physical medicine Rehabilitation/Pain Specialist	Consult	• Management recommendations for patients with and neuromusculoskeletal conditions or chronic pain • Guidance regarding patients on chronic opioid therapy: • Dose at or above 120 mg MED per day • Prior to increasing to high dose • Help with tapering/discontinuing medication
Behavioral health	Counseling Medication management	• Psychiatric illness or symptoms complicating treatment of chronic pain • Psychiatric illness has not responded to standard treatment in primary care (e.g., depression, anxiety) • Complicated psychiatric illness for which specialty treatment is indicated (e.g., bipolar disorder, post-traumatic stress disorder, personality disorder) • Diagnostic uncertainty
	Chemical dependency treatment	• Urine drug screen positive for alcohol, sedative, cocaine or methamphetamine use • Patient requests help with addiction • Possible suboxone treatment
	Addiction medicine: one-time consult (WWA only)	• Help with tapering/discontinuing medication • Concern about substance use disorder • Difficulty adhering to opioid care plan • Problematic use of medications other than opioids
Other consultative specialties	Consult	• As clinically indicated

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