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Opioid Tapering Template

For use when a decision is made to reduce or discontinue an opioid in chronic non-cancer pain (CNCP).

General approach considerations:

1. Gradual tapers can often be completed anywhere in the range **of 2 weeks to 6 months**. However, some may benefit from a longer time frame of 18-24 months. Initial daily dose reductions in the range of 10% every 1-2+ weeks are reasonable.[1] Once a dose of approximately 1/3 of the original dose is reached, smaller dose reductions (e.g. 5% every 2-4+ weeks) may be more suitable for some & more likely to result in a successful taper.[1] More rapid tapers are possible and sometimes desired. In such cases, use of an opioid withdrawal scale (OWS) & corresponding withdrawal protocols may be recommended, allowing for successful withdrawal within 1-2 weeks. (See links [2,3])
2. Long-acting formulations that offer smaller dose increments are useful for more gradual tapers once in the lower end of the dosage range. {Examples: morphine long-acting: M-Eslon 10mg cap $_{q12h}$, Kadian 10mg cap $_{q24h}$.}
3. Determine if the goal of dose reduction reasonable (e.g. opioids have offered some benefit) or if complete discontinuation is more suitable (e.g. opioid trial has been highly problematic/non-helpful or there is a concern regarding opioid induced hyperalgesia).
4. If goal is to reduce dose, option to taper further & more gradually may be entertained at a later point. Tapering plan may be held/reassessed at any point if pain/function deteriorate or withdrawal symptoms persist. However, the "hold off on further taper & plan to reassess/restart taper" conversation should have a designated endpoint & be one conversation, not two!
5. Encourage functional goal setting & efforts to enhance non-drug approaches in management plan.
6. Optimize other pain management (e.g. Is something needed for neuropathic pain such as nortriptyline, gabapentin or pregabalin).
7. Anticipate likely and possible withdrawal effects and have a management plan in place. (See pg 2.)
8. Given the complexities in some cases, discussion with experienced colleagues and an **interdisciplinary approach** will help optimize management. Continue to use "best practice" tools (e.g. Opioid Manager, UDS).
9. Strongly caution patients that a) they have lost their tolerance to opioids after as little as a week or two of abstinence, & b) they are at risk for overdose if they relapse/resume their original dose.

Timeline for discontinuation or reaching a taper "target dose"

Current dose _____

Proposed target dose _____

Timeline (in weeks or months) _____ ☐weeks ☐months

⇨ Allow for gradual q3 day, weekly, bi-weekly or monthly dose reductions. Reassess as necessary.

⇨ In general, the longer the duration of previous opioid therapy, the more time should be allotted for tapering. Rate of tapering should often be even more gradual as total daily dose reaches lower end of range (e.g. ≤120 mg Morphine/day)

See page 2 for customizable tapering template.

Name: _____ **Date:** _____

Address: _____

(May switch to 50-60% equivalent morphine dose if not already on.)
Reduced dose accounts for incomplete cross tolerance. See Opioid Manager Switching Tool.

A) Tapering Schedule*: Drug _____

	Dates	(# wks)	Single Dose	Frequency	Total Dose/Day	*Quantities Needed*
0.	Current		mg		mg	
1.		x wk	mg		mg	
2.		x wk	mg		mg	
3.		x wk	mg		mg	
4.		x wk	mg		mg	
5.		x wk	mg		mg	
6.		x wk	mg		mg	
7.		x wk	mg		mg	
8.		x wk	mg		mg	
9.		x wk	mg		mg	
10.		x wk	mg		mg	
11.		x wk	mg		mg	
12.		x wk	mg		mg	

*template may be adjusted based on patient's progress; decisions on further tapering, etc. Last 20-30 mg may require more time

B) Opioid withdrawal symptoms:

- **Many of these symptoms may not be seen with a gradual taper!**
- Physical withdrawal symptoms generally resolve by 5-10 days following opioid dose reduction/cessation.
- Psychological withdrawal symptoms (dysphoria, insomnia), if seen, may take longer (months) to resolve.

Early symptoms may include:	**Late symptoms may include:**	**Prolonged symptoms may include:**
- anxiety and restlessness - sweating - rapid short respirations - runny nose, tearing eyes (minor) - dilated reactive pupils	- runny nose, tearing eyes - rapid breathing, yawning - tremor, diffuse muscle spasms/aches - pilo-erection (goose bumps) - nausea and vomiting; diarrhea - abdominal pain - fever, chills - ↑ white blood cells (if sudden withdrawal)	- irritability, fatigue; hormonal related△ - bradycardia (slower heart rate) - decreased body temperature
Early = hours to days **Late** = days to weeks **Prolonged** = weeks to months		◆ Some people with chronic pain will find that symptoms such as fatigue & general well-being are improved over time with tapering of the opioid. In such cases, gradual gains in function will be possible & should be explored.

☐ **C) NSAID** (e.g. naproxen 250-375mg twice daily or ibuprofen 400-600mg four times daily)**:** useful for pain & withdrawal aches/pains.

☐ **D) Laxative:** continue initially; with time, or if diarrhea emerges, reduce, hold & eventually stop laxative (See Q&A)[4]

☐ **E) Management of other side effects:**

1. **Clonidine** 0.1mg twice daily may be prescribed for *general relief/prevention of physical withdrawal symptoms*. Initial test dose 0.1mg x1; check BP & HR 1 hr later (if BP <90/60, postural hypotension, or HR <60, do not prescribe further). May titrate up to 4 times daily. Reassess in 3-7 days; taper to stop. [Cochrane review documented typical clonidine use for 7-14 days; longest duration was for 30 days.[5]] Clonidine not routinely needed if gradual taper.

☐ 2. **Acetaminophen** (650-1000mg every 6 hours as needed) may be used for *aches, pains, flu-like symptoms.*

☐ 3. **Loperamide** may be used as necessary for *diarrhea*; however, may not need with gradual taper.

☐ 4. **Non-drug & "sleep hygiene"** measures should be employed (e.g. regular bedtime/wake-time; sleep restriction).[6,7,8] If additional treatment necessary, short-term **trazodone** 25-50 or 100mg at bedtime would be an option.

☐ 5. **Dimenhydrinate** 50-100mg every 6 hours as needed for *nausea/vomiting* [Alternatives: prochlorperazine 5-10mg q6h, haloperidol 0.5-1mg q12h]

☐ 6. **Other**

7. Remember **tolerance to previous dose of opioid is lost after 1-2 weeks**!
   Consider *Naloxone Kit* for risk of overdose.

Physician: _____

A) Sample Slow Tapering Schedule*: Drug _____Morphine long acting_(MS Contin)

	Dates	(# wks)	Single Dose	Frequency	Total Dose/Day	*Quantities Needed*
0.	Current	-	245mg	Twice daily	490 mg	
1.		X2 wk	230 mg	Twice daily	460 mg	*(4x100mg) + (2x30mg) x14d*
2.		X2 wk	215 mg	Twice daily	430 mg	
3.		X2 wk	200 mg	Twice daily	400 mg	
4.		X2 wk	190 mg	Twice daily	380 mg	
5.		X4 wk	175 mg	Twice daily	350 mg	
6.		X4 wk	160 mg	Twice daily	320 mg	
7.		X4 wk	145 mg	Twice daily	290 mg	
8.		X4 wk	130 mg	Twice daily	260 mg	
9.		X4 wk	115 mg	Twice daily	230 mg	
10.		X8 wk	100 mg	Twice daily	200 mg	
11.		X8 wk	90 mg	Twice daily	180 mg	
12.		X8 wk	80 mg	Twice daily	160 mg	*Switch to m-Eslon, or once daily Kadian for smaller titrations*
13.		X8 wk	70 mg	Twice daily	140 mg	
14.		X12 wk	60 mg	Twice daily	120 mg	
15.						
16.						

***this template may be adjusted based on patient's progress; decisions on further tapering, etc.**

Additional information:

2017 Canadian Guideline for Opioids for Chronic Pain (May 2017) - Links

- **Link to Guideline Site:** http://nationalpaincentre.mcmaster.ca/guidelines.html
- **Opioid Tapering- Information for Patients – English:** http://nationalpaincentre.mcmaster.ca/documents/Opioid%20Tapering%20Patient%20Information%20(english).pdf
- **Opioid Tapering- Information for Patients – French:** **Sevrage des opioïdes : informations à l'intention des patients.** http://nationalpaincentre.mcmaster.ca/documents/Opioid%20Tapering%20Patient%20information%20FRENCH.pdf

Other

- **CAMH: Video discussion of issues around how to taper.** http://knowledgex.camh.net/videos/Pages/tapering_presopioids_selby2013.aspx
- **RxFiles: Opioid Taper Template & related materials at**: www.RxFiles.ca
  - Pain/Opioid Resource Links: http://www.rxfiles.ca/rxfiles/uploads/documents/RxFiles-Pain-and-Opioid-Resource-Links.pdf
  - RxFiles Pain/Opioid Newsletter – Fall 2017: http://www.rxfiles.ca/rxfiles/uploads/documents/Opioids-Pain-2017-Newsletter.pdf
- **Opioid Manager tool from Canadian CNCP guideline group** (awaiting 2017 update, expected in Aug/2017): http://nationalpaincentre.mcmaster.ca/opioidmanager/
- **CDC - POCKET GUIDE: Tapering Opioids For Chronic Pain**: https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf

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[1] Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain — Part B: Recommendations for Practice, Version 5.5 April 30, 2010. [NOUGG] Accessed at: http://nationalpaincentre.mcmaster.ca/documents/opioid_guideline_part_b_v5_6.pdf

[2] Opioid withdrawal scales, Saskatoon Health Region, Saskatchewan. http://pauliplace.com/02%20Involuntary%20DSS/03%20YIAP&MA%20hyperlinks/YIDSMAIS%2008%20SHR%20Opiate%20Withdrawal%20Scale.pdf

[3] Butt P, McLeod M. Opioid withdrawal protocol, Saskatchewan. http://www.quadrant.net/cpss/pdf/Opioid_Withdrawal_Protocol.pdf

[4] http://www.rxfiles.ca/rxfiles/uploads/documents/members/Opioid-Induced-Constipation-QandA.pdf

[5] Gowing L, Farrell MF, Ali R, White JM. Alpha2-adrenergic agonists for the management of opioid withdrawal. Cochrane Database Syst Rev. 2014 Mar 31;3:CD002024.

[6] Merrigan JM, Buysse DJ, Bird JC, Livingston EH. JAMA patient page. Insomnia.JAMA. 2013 Feb 20;309(7):733. Accessed online 21 Oct, 2013 at http://jama.jamanetwork.com/article.aspx?articleid=1653524.

[7] Sedative Patient Information Sheet (RxFiles) http://www.rxfiles.ca/rxfiles/uploads/documents/PSYC-Sedative-PtHdout.pdf

[8] Chronic Insomnia in Older Adults (RxFiles Q&A) http://www.rxfiles.ca/rxfiles/uploads/documents/Insomnia-Older-Adults-QandA.pdf

OPIOID TAPERING – *when reducing or discontinuing an opioid in chronic non-cancer pain (CNCP).*

Loren Regier © **www.RxFiles.ca** Oct 2017

A) General Considerations

1) Determine if the goal of dose reduction is reasonable (e.g. opioids have demonstrated some benefit) or if complete discontinuation is more suitable (e.g. trial has been highly problematic/ineffective, opioid induced hyperalgesia is a concern, or patient is addicted &/or at very high risk).
2) If goal is to reduce dose, option to taper further & more gradually may be considered at a later point. Tapering plan may be paused/reassessed at any point if pain/function deteriorates or withdrawal symptoms persist. However, the "hold off on further taper & plan to restart taper" conversation should have a designated endpoint and be one conversation, not two!
3) Gradual tapers can often be completed in 2-26 weeks, but some may benefit from a longer time frame of 18 to 24 months. Literature varies. Some may benefit from **opioid maintenance option**.
4) **Initial daily dose reductions in the range of 10-20% every 1-2+ weeks may be reasonable.[1] Once 1/3 of the original dose is reached, smaller dose reductions (e.g. 5-10% every 2-4+ weeks) may be more optimal for a successful taper.[1] (May require formulation change).**
5) Long-acting formulations that offer small dose increments are useful for more gradual tapers once in the lower end of the dosage range. {Examples: morphine long-acting: M-Eslon 10mg cap $_{q12h}$, KADIAN 10mg or 20mg cap $_{q24h}$}
6) More rapid tapers are possible & sometimes desired. In such cases, use of an opioid withdrawal scale (OWS) & corresponding protocols may be recommended, allowing for successful withdrawal within 1-2 weeks. (See links)[2,3]
7) Given the complexities in some cases, discussion with experienced colleagues and an interdisciplinary approach will help optimize management. Continue to use "best practice" tools (e.g. functional assessment, *Opioid Manager* from Canadian guidelines, urine drug screens, etc).

PATIENT MANAGEMENT

1) Anticipate withdrawal effects & have a plan to manage.
2) Optimize other pain management (e.g. non-drug e.g. CBT, interdisciplinary team; add co-analgesics for neuropathic pain e.g. nortriptyline, duloxetine, gabapentin or pregabalin).
3) Encourage functional goal setting & **enhance non-drug approaches to pain & anxiety** in the management plan.[9]
4) Strongly caution patients that a) they have lost their tolerance to opioids after as little as a week or two of taper or abstinence, and b) they are at high risk for overdose if they relapse/resume their pre-taper dose.

B) Timeline & Tips for Stopping or Tapering e.g. for those on >90 MEQ/day

- **Allow for gradual dose reductions**: q3 day, weekly, bi-weekly or monthly. Reassess as necessary. In general, the higher the dose & longer the duration of previous opioid therapy, the more time should be allotted for tapering.
- May consider ***cross-over rotation taper*.** Eg. Switch to alternate opioid at 50-60% equivalent dose (lower dose accounts for incomplete cross tolerance). Slowly (over ~4 weeks) up-titrate new opioid to ~50% dose while tapering off previous opioid.
- Tapering the last 20-60mg/day morphine equivalent (MEQ), may require more time.

C) Opioid Withdrawal Symptoms (See table to the right.)

- **Many of these symptoms may not be seen with a gradual taper!**
- Physical withdrawal symptoms generally resolve over 5-10 days.
- Psychological withdrawal symptoms (dysphoria, insomnia) may take longer.

EARLY symptoms may include:	LATE symptoms may include:	PROLONGED symptoms may include:
- anxiety / restlessness - sweating - rapid short respirations - runny nose, tearing eyes - dilated reactive pupils - other: sympathetic/stimulation - brief hyperalgesia (pain)[9]	- runny nose, tearing eyes - rapid breathing, yawning - tremor, diffuse muscle spasms, bone/joint aches - pilo-erection (gooseflesh skin) - nausea and vomiting; diarrhea; abdom. pain - dysphoria; - fever, chills - ↑ white blood cells (if sudden withdrawal)	- irritability, fatigue, malaise, psychological/wellbeing (dysphoria, coping, craving) - bradycardia - decreased body temperature ◆ Some people with chronic pain will find that fatigue, function & general well-being improve over time with opioid tapering.[4,5] In such cases, gradual gains in function will be possible & should be explored.
Early = hours to days **Late** = days to weeks **Prolonged** = weeks to ~6 months		

D) Management of Other Withdrawal Related Side Effects

Aches/Pains/Myalgia:
⇨ **NSAID** (e.g. naproxen 375-500mg twice daily or ibuprofen 400-600mg four times daily)**:** useful for pain & withdrawal. **(Give regularly initially.)**
⇨ **Acetaminophen** (650-1000mg every 6 hours as needed) may be used for *aches, pains, flu-like symptoms.*)

Bowel Function (Constipation / Diarrhea):
⇨ **Laxative** - continue initially to prevent constipation; with time, reduce, hold & eventually stop laxative (See RxFiles Opioid Induced Constipation, page 61)
⇨ **Loperamide** - used if necessary for *diarrhea*; may not need with gradual taper.

Nausea/Vomiting:
⇨ **Dimenhydrinate** 50-100mg q6 hours as needed [More effective alternatives: **prochlorperazine** 5-10mg po q6-8h; **haloperidol** 0.5-1mg po q8-12h]

Anxiety, Irrritability, Lacrimation, Cramps, Rhinorrhea, Diaphoresis, Insomnia:
⇨ **hydroxyzine** 25-50mg po TID PRN, or sometimes just needed at HS (short-term)

Insomnia:
⇨ **Employ non-drug & sleep hygiene measures** (e.g. CBT, regular bedtime & wake-time; sleep restriction).[6,7,8] If short-term pharmacologic tx necessary, options: **trazodone** 25mg po HS $^{$12}$ up to 100mg; **amitriptyline** 10mg po HS $^{$13}$, **doxepine** SILENOR 3-6mg po HS $^{$30-50}$.

Physical Withdrawal Symptoms – by ↓ of sympathetic activity (α_2-adrenergic agonist)**:**
⇨ **Clonidine 0.1mg twice daily may be prescribed for general relief/prevention**. Initial test dose 0.1mg x1; check BP & HR 1 hr later (if BP <90/60, postural hypotension, or HR <60, do not prescribe further). May titrate up to 3-4x/day. Reassess in 3-7 days; taper, over ~7-10 days, to stop. [Cochrane review documented typical clonidine use for 7-14 days; longest duration was for 30 days.[9]] Clonidine not routinely needed if gradual opioid taper. However there is some evidence that it may ↑ duration of abstinence decoupling stress from craving.[10]

Sweating: ⇨ **Oxybutynin** 2.5-5mg po BID PRN (short-term)

See also the RxFiles Opioid Tapering Template - version of this document, online.
http://www.rxfiles.ca/rxfiles/uploads/documents/Opioid-Taper-Template.pdf

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Additional information:

2017 Canadian Guideline for Opioids for Chronic Pain (May 2017) - Links

- **Link to Guideline site:** http://nationalpaincentre.mcmaster.ca/guidelines.html
- **Opioid Tapering- Information for Patients – English:** http://nationalpaincentre.mcmaster.ca/documents/Opioid%20Tapering%20Patient%20Information%20(english).pdf
- **Opioid Tapering- Information for Patients – French:**
- **Sevrage des opioïdes : informations à l'intention des patients.** http://nationalpaincentre.mcmaster.ca/documents/Opioid%20Tapering%20Patient%20information%20FRENCH.pdf

Other

- **CAMH: Video discussion of issues around how to taper.** http://knowledgex.camh.net/videos/Pages/tapering_presopioids_selby2013.aspx
- **RxFiles: Opioid Taper Template & related materials at**: www.RxFiles.ca
  - Pain/Opioid Resource Links: http://www.rxfiles.ca/rxfiles/uploads/documents/RxFiles-Pain-and-Opioid-Resource-Links.pdf
  - RxFiles Pain/Opioid Newsletter – Fall 2017: http://www.rxfiles.ca/rxfiles/uploads/documents/Opioids-Pain-2017-Newsletter.pdf
- **Opioid Manager tool from Canadian CNCP guideline group** (awaiting 2017 update, expected in Fall/2017): http://nationalpaincentre.mcmaster.ca/opioidmanager/
- **CDC - POCKET GUIDE: Tapering Opioids For Chronic Pain**: https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf

RxFiles Opioid Taper Template TOOL: http://www.rxfiles.ca/rxfiles/uploads/documents/Opioid-Taper-Template.pdf

Tools to measure opioid withdrawal symptoms:

a) Subjective opioid withdrawal scale. https://www.ncbi.nlm.nih.gov/books/NBK143183/bin/annex10-fm2.pdf
b) Clinical opioid withdrawal scale. https://www.ncbi.nlm.nih.gov/books/NBK143183/bin/annex10-fm3.pdf
c) Other: https://www.ncbi.nlm.nih.gov/books/NBK143183/

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References

[1] Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain — Part B: Recommendations for Practice, Version 5.5 April 30, 2010. [NOUGG] Accessed at: http://nationalpaincentre.mcmaster.ca/documents/opioid_guideline_part_b_v5_6.pdf

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[3] Butt P, McLeod M. Opioid withdrawal protocol, Saskatchewan. http://www.quadrant.net/cpss/pdf/Opioid_Withdrawal_Protocol.pdf

[4] Frank JW, Levy C, Matlock DD, Calcaterra SL, Mueller SR, Koester S, et al. Patients' perspectives on tapering of chronic opioid therapy: a qualitative study. Pain Med. 2016;17:1838-47

[5] Frank JW, Lovejoy TI, Becker WC, Morasco BJ, Koenig CJ, Hoffecker L, Dischinger HR, Dobscha SK, Krebs EE. Patient Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy: A Systematic Review. Ann Intern Med. 2017 Jul 18.

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[7] Sedative Patient Information Sheet (RxFiles) http://www.rxfiles.ca/rxfiles/uploads/documents/PSYC-Sedative-PtHdout.pdf

[8] Chronic Insomnia in Older Adults (RxFiles Q&A) http://www.rxfiles.ca/rxfiles/uploads/documents/Insomnia-Older-Adults-QandA.pdf

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[10] Kowalczyk WJ, Phillips KA, Jobes ML, Kennedy AP, Ghitza UE, Agage DA,et al. Clonidine Maintenance Prolongs Opioid Abstinence and Decouples Stress From Craving in Daily Life: A Randomized Controlled Trial With Ecological Momentary Assessment. Am J Psychiatry. 2015 Aug 1;172(8):760-7.

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[9] Berna C, Kulich RJ, Rathmell JP. Tapering Long-term Opioid Therapy in Chronic Noncancer Pain: Evidence and Recommendations for Everyday Practice. Mayo Clin Proc. 2015 Jun;90(6):828-42. doi: 10.1016/j.mayocp.2015.04.003.

[10] Suttner J, Lovett A, Varnachio K. Best Practices in Tapering Methods in Patients Undergoing Opioid Therapy. Advances in Pharmacology and Pharmacy 2013;1(2)42-57.

Evidence-Based Guidelines: Summary of Recommendations Found[1]

- Individualized treatment plans[2,3,4] Offer of frequent follow up
- When initiating an opioid trial, also consider & discuss an "exit" strategy
- If switching opioids as part of a taper strategy, reduce new opioid by 50% of previous MED & titrate until analgesia achieved.
- Offer option of additional treatment(s) e.g. for pain, withdrawal,
- A taper of ~10% per week recommended for community setting[5]
- Adjuvant therapies that should be considered[6]
  - Psychological treatment & CBT (helpful for most)
  - Pain specialist, multidisciplinary program or addiction medicine specialists (for more challenging patients)

CNCP Patient Perspectives Regarding Opioid Tapering[7]

BARRIERS

- **Pain in present** may trump opioid risks in the future
- **Pessimism with non-opioid options** if previous unsatisfactory experience in managing without opioids
- **Fear / anxiety over opioid withdrawal** if previous negative experience

FACILITATORS

- **Social support**
  - To identify problematic symptoms and side effects such as opioid use causing poor self-care
  - To encourage sticking with the plan for tapering (a check against bad judgment decisions)
  - Support group for empathy, encouragement & camaraderie (paper doesn't cut it!)
  - Patients who can share success stories of living better after a taper
- **Availability of a Trusted Health Care Provider**
  - Often key to willingness to initiate & sustain opioid tapering!
  - Someone who is supportive, nonjudgmental, flexible, & accessible
- **Noting benefit of improved quality of life after tapering**
  - Noted that pain level after tapering largely unchanged
  - Long term, life was better for having gone through the taper

Patient-Provider Communication: Four Themes [8]

1) Explaining-Patients needed to understand individualized reasons for tapering, beyond general, population-level concerns such as addiction potential
2) Negotiating-Patients needed to have input, even if it was simply the rate of tapering
3) Managing difficult conversations-When patients and providers did not reach a shared understanding, difficulties and misunderstandings arose
4) Non-abandonment-Patients needed to know that their providers would not abandon them throughout the tapering process

Approaches to Opioid Tapering

1. **Gradual taper** of current opioid over several weeks or months
   See RxFiles Opioid Tapering Template
   http://www.rxfiles.ca/rxfiles/uploads/documents/Opioid-Taper-Template.pdf
2. **Switch/rotate opioid to lower dose of alternate opioid** & take advantage of a potential 25-50% dose reduction due to lack of cross-tolerance
3. **Gradual crossover switch/rotation to lower dose** of alternate opioid over ~4 weeks. Allows potential to take advantage of a 25-50% dose reduction due to lack of cross-tolerance. Decreases the risk of a major adverse event (over- or under-dosing) due to the wide variation in potential equivalent dose for a given patient. However, this approach would require being on 2 opioids for a short period of time (e.g. ~4 weeks), increasing the risk of confusion & the need for weekly dispensing intervals & follow-up.
4. **Structured Opioid Therapy with Suboxone or Methadone** is especially useful for Opioid Use Disorder (OUD) [9]
   - **Buprenorphine-naloxone** *SUBOXONE*: for maintenance; preferred over abstinence only; if withdrawal, opioid use or cravings persistent, switch to methadone
   - **Methadone Maintenance**: preferred over abstinence only
   - **Adjunct Naltrexone:** may consider oral naltrexone for use as adjunct treatment after patient discontinues opioid.

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[1] CADTH Rapid Response Report. Summary of Abstracts. Strategies for the reduction or discontinuation of opioids: Guidelines. April 2017. Accessed online 26Jul17 at https://www.cadth.ca/sites/default/files/pdf/htis/2017/RB1078%20-%20Opioid%20Tapering%20Final.pdf .

[2] Pain: assessment, non-opioid treatment approaches and opioid management [Internet]. Bloomington (MN): ICSI; 2016 [cited 2017 Apr 03]. Available from: https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/catalog_neurological_guidelines/pain/ {*See: 13.7 Opioid Rotation and Conversion; 13.10. Offer Discontinuation of Opioids or Taper at Intervals of Six Months, pages* 77-80}

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[6] Guideline for prescribing opioids to treat pain in injured workers. In: National Guideline Clearinghouse [Internet]. Rockville (MD): Agency for Healthcare and Research Quality (AHRQ); 2013 [cited 2017 Apr 03]. Summary available from: https://www.guideline.gov/summaries/summary/43745/guideline-for-prescribing-opioids-to-treat-pain-in-injured-workers?q=opioid *See: Discontinuing COT, page 6*

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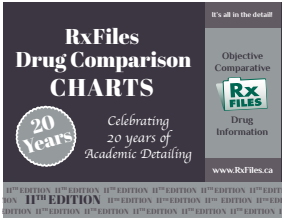

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