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. In discussion with the patient, set a reasonable start date for the taper.
2. Gradual tapers can often be completed in the range **of 1 to 6 months**. However, some may benefit from a longer time frame of 12-24 months. Initial daily dose reductions in the range of 5-10% every 2-4 weeks are reasonable.[1] Once a dose of approximately 1/3 of the original dose is reached, smaller dose reductions (e.g. 5% every 4-8 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 (e.g. COWS) & corresponding withdrawal protocols may be recommended, allowing for successful withdrawal within 1-2 weeks. (See links [2-4])
3. 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 $_{\mathbf{q12h}}$, **KADIAN** 10mg cap $_{\mathbf{q24h}}$.}
4. Consider daily dispensing of opioids or blister packs for those at high risk of overdose or aberrancy use.
5. Determine if the goal of dose reduction is 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).
6. 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 for 1 month or more. However, the "hold off on further taper & plan to reassess/restart taper" conversation should have a designated endpoint & be one conversation, not two!
7. Encourage functional goal setting & efforts to enhance non-drug approaches in management plan.
8. Optimize other pain management (e.g. Is something needed for neuropathic pain such as nortriptyline, gabapentin or pregabalin).
9. Anticipate likely and possible withdrawal effects & have a management plan in place. (See Pg 2 & Withdrawal Rx)
10. 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).
11. 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. OTC: Consider a Take Home Naloxone Kit ✗ ▼ !

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, or go online for customizable Opioid Withdrawal Prescription.

© www.RxFiles.ca

Name: ______________________________ **Date:** ______________

Address: ____

(May switch/rotate to 50-75% equivalent morphine dose of an alternate opioid.)
Reduced dose accounts for incomplete cross tolerance. See Opioid Manager Switching Tool.

A) Tapering Schedule*: Drug ______________________

	Dates	(# wks)	AM Dose**	PM Dose	Other	Total Dose/Day	*Quantities Needed*
0.	Current Regimen	_$	mg	mg		mg	
1.	*Start Date!*	x wk	mg	mg		mg	
2.		x wk	mg	mg		mg	
3.		x wk	mg	mg		mg	
4.		x wk	mg	mg		mg	
5.		x wk	mg	mg		mg	
6.		x wk	mg	mg		mg	
7.		x wk	mg	mg		mg	
8.		x wk	mg	mg		mg	
9.		x wk	mg	mg		mg	
10.		x wk	mg	mg		mg	
11.		x wk	mg	mg		mg	

*template may be adjusted based on patient's progress; decisions on further tapering, etc. Last 20-30 mg may require more time.
**if once daily formulation (eg. morphine SR KADIAN) record dose in respective AM or PM column & "0" in other.
$individualize duration! May begin by reducing dose q2-4 weeks and then q4-8 weeks once 1/3 of the dose is reached.

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 - brief ↑ in pain (usually few days)	- 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 ~6 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)[5]

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

1. **Clonidine** 0.1mg twice daily PRN (up to 4 times daily) may be prescribed for *general relief/prevention of physical withdrawal sxs.* (Caution if SBP <100, orthostasis, or HR <60); Some patients may not require if gradual taper. May use SOWS (patient administered scale) for monitoring (e.g. score 10-20 take clonidine) see Pg 9. [Cochrane review documented use for 7-14 days up to 30 days,[6] but some may need longer]. If used regularly, taper, over ~7-10d, to stop.
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. U of R pain course www.onlinetherapyuser.ca/pain; regular bedtime/wake-time; sleep restriction).[7-9] If additional tx required, short-term **trazodone** 25-50-100mg HS is 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* OTC ✗ ▼ for risk of overdose!

Physician: ______________________

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

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

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

if once daily formulation (i.e. **KADIAN) record dose in respective AM or PM column and "0" in other.

Additional information:

[1]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 Part 1 – Fall 2017: http://www.rxfiles.ca/rxfiles/uploads/documents/Opioids-Pain-2017-Newsletter.pdf
- **TheWell (Centre for Effective Practice):**
  - **Opioid Tapering Template (2018) at:** https://thewellhealth.ca/opioidtaperingtool
  - **Opioid Manager tool to support the Canadian Opioids in CNCP guideline:** https://thewellhealth.ca/pain
- **CDC - POCKET GUIDE: Tapering Opioids For Chronic Pain**: https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf

[2] Clinical Opiate Withdrawal Scale (**COWS**). https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf

[3] Subjective Opiate Withdrawal Scale (**SOWS**). http://www.bccsu.ca/wp-content/uploads/2017/08/SOWS.pdf

[4] Butt P, McLeod M. Opioid withdrawal protocol, Saskatchewan.

[5] Opioid Induced Constipation Q&A: http://www.rxfiles.ca/rxfiles/uploads/documents/members/Opioid-Induced-Constipation-QandA.pdf

[6] 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.

[7] 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.

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

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