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Opioid Tapering Protocol

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Agenda

- Background
- Opioid Taper Protocol Development Process
- Protocol Overview
- Conclusion

Background -Solving the Opioid Crisis[2]

- HHS and the National Institutes of Health (NIH) are focusing on solving the opioid crisis by:
  - Enhancing access for treatment and recovery
  - Prescribing overdose-reversing drugs
  - Increasing public health surveillance
  - Research
  - Pain management improvements

Background –Pain Management Improvements

- Worked with providers to decrease quantities of doses dispensed for acute pain treatment
- Developed multimodal pain management approaches in many areas through multidisciplinary workgroups
- Expanded use of the PDMP
- Implemented a controlled substance take back program
- Made reversal agents available in all pharmacies
- Developed a process for tapering patients on chronic opioid therapy – Focus of today

Opioid Taper Protocol Development Process

- Pharmacists and physicians collaborated on the protocol development
- Protocol developed to be able to be used independently by a provider or with pharmacist assistance
- Protocol was approved by the Pharmacy and Therapeutics Committee
- Protocol was distributed to all providers
- Pharmacist assisted protocol use offered to providers until comfortable with the protocol

Protocol Overview- Why Discontinue Opioids?[4]

- Opioid-induced hyperalgesia
- Major adverse effects or intoxication
- Patient desire to discontinue opioid therapy
- Non-adherence to pain management agreement
- Addiction suspicion
- Behaviors indicating abuse/diversion
- Unnecessary therapy

Protocol Overview- Dose Taper[4]

- Chronic opioid therapy should not be abruptly discontinued due to possible withdrawal symptoms. Utilize a dose taper to minimize symptoms such as:
  - Anxiety
  - Insomnia
  - Irritability
  - Dysphoria
  - GI symptoms
  - Musculoskeletal symptoms
  - Sympathetic hyperactivity

Protocol Overview-Special Considerations[4]

- Pregnancy
  - Withdrawal is associated with premature labor and spontaneous abortion
- Unstable psychiatric conditions
  - Withdrawal symptoms can lead to anxiety which can worsen psychiatric disorders
- Addiction
  - Outpatient tapering will most likely be unsuccessful
- Concurrent medications
  - Avoid sedative-hypnotic medications during opioid taper
    - Ex: Benzodiazepines

Protocol Overview- Considerations Prior to Opioid Taper[4]

- Behavior risk → Addiction specialist
- Risk for complex withdrawal symptoms → May need referral
- Complete evaluation of patient –Comorbidities and pysch status
- Establish treatment plan with patient, including opioid taper and goals
- Educate patient-goals, withdrawal symptoms, risks
- Determine appropriate taper rate
  - Diversion or non-medical use: Immediately discontinue
  - Severe adverse effects/substance use disorder: Rapid taper over 2-3 weeks
  - No safety concerns: Gradual taper
  - Complex comorbidities/cardiorespiratory condition/long-term therapy/no improvement/anxiety with tapering process: Slow taper

Protocol Overview- Initiating Opioid Taper[4]

- Use opioid monotherapy with morphine equianalgesic dosing (MED)
  - Preferred agent: Morphine
- Account for incomplete cross-tolerance
  - Start with a 50% dose reduction from the equianalgesic dose when switching medications
    - May use a greater dose reduction dependent on age, liver function, renal function, drug interactions, baseline pain control, etc.
  - Divide daily dose if necessary
  - Titrate to safe and effective pain control

Protocol Overview-Equianalgesic Dosing[4]

Opioid	Approximate Equianalgesic Dose (oral and transdermal)
Morphine (reference)	30 mg
Codeine	200 mg
Fentanyl (transdermal)	12.5 mcg/hr
Hydrocodone	30 mg
Hydromorphone	7.5 mg
Oxycodone	20 mg
Oxymorphone	10 mg
Tapentadol	75 mg
Tramadol	300 mg

From Washington State Agency of Medical Directors' Group 2015 which was adapted from Von Korff 2008 and FDA labeling

Protocol Overview-Long-Acting Opioid Taper Protocol[4]

Rapid Taper (25% reduction every 3-7 days) and/or referral to addiction specialist	Gradual Taper -10% weekly reduction until 1/3 initial opioid dose then reduce rate to 5% weekly reduction (or 10% of remaining 30% of initial taper)	Slow Taper -10% reduction every 2-4 weeks until 1/3 initial opioid dose then reduce rate to 5% every 2-4 weeks (or 10% of remaining 30% of initial taper)
-Addiction -Misuse/diversion -Non-adherent to pain agreement -Major adverse effects/intoxication -Opioid-induced hyperalgesia	-Standard tapering schedule	-Complex comorbidities -Cardiorespiratory conditions -Long-term therapy -No improvement -Anxiety about tapering process

Protocol Overview-Clinical Pearls[4]

- Long-acting opioids are preferred when compared to short-acting opioids.
- Scheduled dosing is encouraged compared to PRN dosing.
- The longer the duration of opioid therapy, the slower and longer duration for the planned taper.
  - Duration: 2 weeks to 6 months
- May slow or pause the taper but never reverse it.
- Taper short-acting opioids first.
- Follow up weekly with the patient if possible when tapering opioids.
- Manage opioid withdrawal symptoms if applicable.

Protocol Overview-Management of Opioid Withdrawal Symptoms[4]

- HTN/cramps/tremors/restlessness/diaphoresis
  - Clonidine
- Anxiety/restlessness
  - Hydroxyzine or diphenhydramine
- Insomnia
  - Mirtazapine, trazodone, nortriptyline, hydroxyzine, diphenhydramine
- Nausea/vomiting
  - Promethazine, metoclopramide
- Dyspepsia
  - Calcium carbonate, Mylanta/Milk of Magnesia
- Pain/fever
  - Acetaminophen, NSAIDs
- Diarrhea
  - Loperamide, Lomotil
- Muscle spasm
  - Methocarbamol

Conclusion

- The opioid crisis is a public health issue requiring action.
- Many interventions are being implemented to address and resolve this national problem.
- CHI St. Alexius Health has decreased opioid doses dispensed by 25%.
- Tapering patients off of chronic opioid therapy can be complex and the approach needs to be individualized
- Pharmacists can assist in many ways including tapering patients' opioid medications

References

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