Walking the Line: Opioid Dose De-escalation

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Disclosures

- Axial Healthcare – Consultant
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- The views and opinions expressed in this presentation are those of the author and do not necessarily reflect the official policy or position of any agency of the United States government, including the Department of Veterans Affairs, as well as employers, employee affiliates and/or pharmaceutical companies mentioned or specific drugs discussed. It was not prepared as part of official government duties for Dr. Kominek.

Learning Objectives

- Identify reasons to initiate an opioid taper, either to a lower dose or to discontinuation.
- Explain how to plan, present to the patient, and execute an opioid taper.
- Describe situations in which opioids should be discontinued.
- Provide a rationale for continuing to prescribe opioids at a lower dose or discontinuing opioids all-together.

PAINWEEK

Question #1

- Mr. Miller is a 57 yo male with LBP prescribed oxycodone CR 40 mg PO Q12H. The patient is also prescribed diazepam 10 mg PO TID PRN for anxiety. He has been stable on this regimen for over 10 years. After discussing the risks, patient opts to taper off the oxycodone CR. How would you taper the patient off?

A. Reduce by 5 mg/day q3 days
B. Reduce by 5 mg/day q4 weeks
C. Reduce by 10 mg/day q3 days
D. Reduce by 10 mg/day q4 weeks

PAINWEEK

Question #2

- A rapid taper would be indicated in which circumstance

A. Patient on opioids for 10 years and requesting a taper
B. Patient with recent overdose
C. Patient with no functional benefit with high dose opioids
D. Patient with negative UDM for prescribed scheduled long-acting opioid

PAINWEEK

Current Situation

- Numerous risks associated with opioids
- Guidelines and legislation focused on opioid dose
- Little guidance on when and how to taper

PAINWEEK

Reasons to Taper

Lack of benefit
Adverse effects
High dosage
Nonadherence to the treatment plan or unsafe behaviors
Substance use disorder
Opioid overdose
Comorbidities that increase risk
Concomitant medications that increase risk
Mental health comorbidities that can be worsened

PAINWEEK

1. Dowell D, Haegerich TM, Chou R; CDC guideline for prescribing opioids for chronic pain – United States, 2016. MMWR 2016;65(1-49).
2. Department of veterans affairs. Veterans Health Administration. PBM Academic Detailing Service. Opioid Taper Decision Tool. October 2016. Available at: https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf.

Opioid Risks

- Duration of opioids
- Dose of opioids
- Severe respiratory instability
- Sleep disordered breathing
- Acute psychiatric instability or intermediate-to-high acute suicide risk
- History of drug overdose
- < 30 years of age
- Mental disorders (current or history of substance use disorder, depression, generalized anxiety, borderline, antisocial, posttraumatic stress disorder)

PAINWEEK

1. VA/DoD Clinical Practice Guidelines for Opioid Therapy for Chronic Pain. February 2017.

Opioid Risks

- Co-administration of medication capable of fatal drug-drug interaction
- QTc interval > 450 msec with methadone
- Evidence for or history of diversion of controlled substances
- Intolerance, serious adverse effects, or history of inadequate beneficial response to opioids
- Impaired bowel motility unresponsive to therapy
- Traumatic brain injury
- Pain conditions worsened by opioids (fibromyalgia, headache)
- True allergy to opioid agents that can't be resolved by switching classes

PainWeek

1. VA/DoD Clinical Practice Guidelines for Opioid Therapy for Chronic Pain. February 2017.

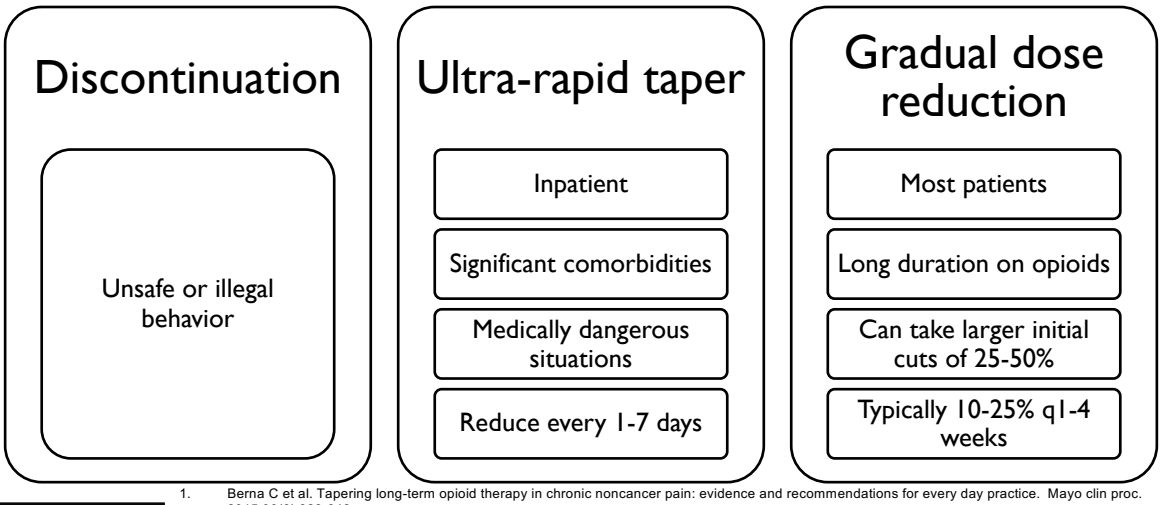
Taper Considerations

25% of the previous day's dose to prevent acute withdrawal	Individualize to the patient	Taper can be slowed but don't reverse the taper
Determine goal • Reduction vs. cessation	**Medication** • Use current meds • Reduce dose first then change frequency	**Speed of taper** • Varies

PainWeek

1. Berna C et al. Tapering long-term opioid therapy in chronic noncancer pain: evidence and recommendations for every day practice. Mayo clin proc. 2015;90(6):828-842.
2. Department of Veterans Affairs. Veterans Health Administration. PBM Academic Detailing Service. Opioid dose adjustments. July 2014. Available at: https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Pain_Provider_AD_Opioid_Dose_Reduction_Factsheet.pdf.

Taper Speed



PainWeek

1. Berna C et al. Tapering long-term opioid therapy in chronic noncancer pain: evidence and recommendations for every day practice. Mayo clin proc. 2015;90(6):828-842.
2. Department of Veterans Affairs. Veterans Health Administration. PBM Academic Detailing Service. Opioid dose adjustments. July 2014. Available at: https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Pain_Provider_AD_Opioid_Dose_Reduction_Factsheet.pdf.

Examples of Tapering Strategies

Slowest Taper (years)	• ↓ by 2-10% every 4 to 8 weeks with pauses in taper as needed • Consider for patients taking high doses of long-acting opioids for many years
Slower Taper (months or years)	• ↓ by 5-20% every 4 weeks with pauses in taper as needed • Most common taper
Faster Taper (weeks)	• ↓ by 10-20% every week
Rapid Taper (days)	• ↓ by 20-50% of first dose if needed, then reduce by 10-20% every day

PainWeek

1. Department of Veterans Affairs. Veterans Health Administration. PBM Academic Detailing Service. Opioid Taper Decision Tool. October 2016. Available at: https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf.

Opioid Tapering Clinical Pearls

- Short-term use (<30 days) and low MEDD (<20-30mg) requires no taper
- Do not reverse the opioid taper but pause or slow taper
- For fentanyl patch, reduce the dose by 12mcg/hr increments
- UDM should be performed
- Consider tablet counts or ordering taper in short days supply
- Consider ordering naloxone rescue kit
- Avoid simultaneous tapering of both ER/LA opioid and IR opioid
- Avoid simultaneous tapering of both opioid and benzodiazepine medications
  - AMDG guidelines recommend tapering the opioid first

1.Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):[1-49].
2.VA/DoD Clinical Practice Guideline. Management of Opioid Therapy for Chronic Pain. Washington, DC: US Department of Veterans Affairs; version 3.0 – 2017. Available at: https://www.healthquality.va.gov/guidelines/Pain/cot/.
3.Washington State Agency Medical Directors' Group. AMDG 2015 interagency guideline on prescribing opioids for pain. Olympia, WA: Washington State Agency Medical Directors' Group; 2015. http:// www.agencymeddirectors.wa.gov/guidelines.asp.
4.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;90:828–42. http://dx.doi.org/10.1016/j.mayocp.2015.04.003.

PAINWEEK

"Bridging Therapies"

- Minimal risk short-term therapies that can be implemented to help patients transition to more active strategies from less safe, passive strategies.
  - Acupuncture
  - Spinal manipulation (e.g., chiropractic care)
  - Physical modalities (e.g., self-applied electrical stimulation, etc.)
- Invasive therapies that can be implemented when the benefits of facilitating active treatment strategies outweigh the potential risks of therapy.
  - Trigger point injections
  - Joint injections
  - Nerve blocks
  - Spinal injections

PAINWEEK

Taper Outcomes

Article	Harden et al 2015	Cunningham 2016 et al	Frank et al 2016	Sullivan et al 2017
Population	50 patients prescribed chronic opioid therapy and agreed to taper	55 patients taking daily opioid entering IDT pain rehab program	24 adult primary care patients	35 patients on chronic opioids and interested in taper
Intervention	Retrospective and prospective chart review	Retrospective review	In-person, semi-structured interviews	22-week taper support
Comparison	Baseline and 12 months	None	None	Usual care
Outcome	70% experience no change in pain or less pain	Significant improvements in NRS, depression, catastrophizing health perception	12 patients undergoing taper, 6 completed taper. Improved QOL after taper.	Taper support improved significantly more in pain interference, self-efficacy, and opioid problems

PainWeek

1. Harden P et al. Clinical implications of tapering chronic opioids in a veteran population. Pain Med. 2015;16(10):1975-1981.
2. Cunningham JL et al. Opioid tapering in fibromyalgia patients: experience from an interdisciplinary pain rehabilitation program. Pain med. 2016;17:1676-1685.
3. Frank JW et al. Patients' perspectives on tapering of chronic opioid therapy: a qualitative study. Pain med. 2016;17(10):1838-1847.
4. Sullivan MD et al. Prescription opioid taper support for outpatients with chronic pain: a randomized controlled trial. J pain. 2017;18(3):308-318.

Presenting the Plan to the Patient

Advise
- Provide medical advice about risks of long-term opioid use

Assess
- Patient's readiness to discontinue opioid

Assist
- Provide written taper schedule or review ultimate goal

PainWeek

1. Department of Veterans Affairs. Veterans Health Administration. PBM Academic Detailing Service. Re-evaluating the use of benzodiazepines: A focus on high-risk populations. August 2016. Available at: https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/22_Benzodiazepine_Provider_AD_Educational_Guide_IB_10_928.pdf.

Presenting the Plan to the Patient

Discussion	Ask about Goals	Educate the Patient
• Listen to the patient's story, concerns, and fears • Acknowledge the patient's fears about tapering	• Draw out their goals for life • Discuss how you as a provider can support the patient during the taper	• Use the biopsycho-social model • Offer alternative treatment modalities, as available • Slowly taper the opioid but not "cutting off" the patient • Offer non-opioid pain medications

PAINWEEK

1. Department of Veterans Affairs. Veterans Health Administration. PBM Academic Detailing Service. Opioid Taper Decision Tool. October 2016. Available at: https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf.

Side Note: Benzodiazepine Tapering

- Multiple guidelines recommend *against* the use of concomitant opioids and benzodiazepines
- Serious adverse consequences associated with benzodiazepines:
  - Depressed mood
  - Disinhibition
  - Cognitive impairment
  - Falls/hip fractures
  - Traffic accidents
  - Tolerance/dependence
  - Accidental overdose
  - Increased dementia risk?

1. VA/DoD Clinical Practice Guidelines for Opioid Therapy for Chronic Pain. February 2017.
2. Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):[1-49].
3. Department of Veterans Affairs. Veterans Health Administration. PBM Academic Detailing Service. Re-evaluating the use of benzodiazepines: A focus on high-risk populations. August 2016. Available at: https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/22_Benzodiazepine_Provider_AD_Educational_Guide_IB_10_928.pdf.

PAINWEEK

Side Note: Benzodiazepine Tapering

- May consider switch to a longer acting benzodiazepine
- Reduce dose by 50% the first 2-4 weeks → maintain on that dose for 1-2 months → reduce dose by 25% every 2 weeks
- Slower taper → reduce by 10-25% every 4 weeks

Benzodiazepine	Approximate Dosage Equivalents	Elimination Half-Life
Chlordiazepoxide	25mg	>100 hrs
Diazepam	10mg	>100 hrs
Clonazepam	1mg	20-50 hrs
Lorazepam	2mg	10-20 hrs
Alprazolam	1mg	12-15 hrs
Temazepam	30mg	10-20 hrs

PAINWEEK

1. Effective treatments for PTSD: Helping patients taper from benzodiazepines. National Center for PTSD. 2013.

Side Note: Benzodiazepine Tapering

Supratherapeutic Doses

- Consider conversion to long t1/2 drug
- First dose reduction by 25-30%
- Subsequently reduce by 5-10% daily to weekly

Therapeutic Doses – Bedtime

- Reduce by ~25% weekly
- Address potential for rebound insomnia
- Teach sleep hygiene and provide reassurance
- Initiate alternate treatment

Therapeutic Doses - Daytime

- Address potential for rebound anxiety
- Last step of withdrawal is likely to be challenging
- Dosing schedule changes can be challenging (TID → BID)
- Plan additional psychological support during taper

PAINWEEK

1. Effective treatments for PTSD: Helping patients taper from benzodiazepines. National Center for PTSD. 2013.

Adjunctive or First-line Medication Treatment Options

PTSD	Anxiety	Insomnia
• SSRI • SNRI • Mirtazapine • Carbamazepine • For patient with concomitant pain, consider duloxetine or amitriptyline	• SSRI • SNRI	• Doxepin • Sedative-hypnotics • Benzodiazepines • Ramelteon • Sedating antidepressants • Hydroxyzine • Melatonin

1. Effective treatments for PTSD: Helping patients taper from benzodiazepines. National Center for PTSD. 2013.
2. Department of Veterans Affairs. Veterans Health Administration. PBM Academic Detailing Service. Re-evaluating the use of benzodiazepines: A focus on high-risk populations. August 2016. Available at: https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Academic_Detailing_Educational_Material_Catalog/22_Benzodiazepine_Provider_AD_Educational_Guide_IB_10_928.pdf

PAINWEEK

Wheel of Tapering

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Wheel of Tapering Cases

- Aberrant UDM v1
- Aberrant UDM v2
- Aberrant UDM v3
- Aberrant UDM v4
- No functional benefit
- Concomitant benzo
- Significant comorbidities
- Significant PDMP results
- Recent overdose
- Benzodiazepine taper

PAINWEEK

Aberrant UDM v1

- Mr. Fox is a 55 yo male who recently transferred his care from out-of-state.
- He has been diagnosed with chronic neck and back pain as well as diabetic neuropathy pain.
- His pain medication regimen includes
  - Morphine SR 60mg Q8H,
  - Hydromorphone 4mg PO TID
  - Pregabalin 150mg PO BID
  - Topical lidocaine.
- In reviewing his records brought to the office, nothing significant is noted other than his high dose opioid regimen.
- A random UDM is collected

PAINWEEK

Aberrant UDM v1

Immunoassay Test	Result
Opiates	POSITIVE
Oxycodone	NEGATIVE
Methadone	NEGATIVE
Amphetamines	NEGATIVE
Benzodiazepines	NEGATIVE
Cocaine	POSITIVE
Marijuana	NEGATIVE

Confirmatory UDM Results
Morphine
Hydromorphone
Benzoylecgonine
Pregabalin

How would you proceed with the opioid taper?

PainWeek

Aberrant UDM v1 ANSWERED

Characteristic	Recommendations
Type of taper	Rapid
Taper regimen	Taper morphine SR first 45mg PO Q8H x3-5 days 30mg PO Q8H x3-5 days 30mg PO Q12H x3-5 days 15mg PO Q12H x3-5 day STOP Then, taper hydromorphone 2mg PO TID x3-5 days 2mg PO BID x3-5 days 2mg PO daily x3-5 days STOP
Other recommendations	• Offer referral to mental health for treatment of substance use disorder • Provide naloxone kit and overdose education • Offer non-opioid and nonpharmacologic alternatives

Aberrant UDM v2

- Ms. Smith is a 45 yo female diagnosed with a combination of chronic low back pain and HIV neuropathy pain.
- She is currently prescribed methadone 10mg PO Q8H in addition to gabapentin and duloxetine.
- She follows regularly with the pain psychologist and is active in a local yoga group.
- While she has a remote history of alcohol misuse and marijuana use, her UDM have been appropriate for the last several years. As part of routine opioid compliance monitoring, a random UDM is collected.

PainWeek

Aberrant UDM v2

Immunoassay Test	Result
Opiates	NEGATIVE
Oxycodone	NEGATIVE
Methadone	POSITIVE
Amphetamines	NEGATIVE
Benzodiazepines	NEGATIVE
Cocaine	NEGATIVE
Marijuana	POSITIVE

Comprehensive UDM Results
Methadone
EDDP
THC
Gabapentin

How would you proceed with the opioid taper?

PainWeek

Aberrant UDM v2 ANSWERED

Characteristic	Recommendations
Type of taper	Faster
Taper regimen	Taper methadone 10mg-5mg-10mg (separate doses by 8 hours) x 1-4 weeks 10mg PO BID x 1-4 weeks 5mg PO QAM + 10mg PO QHS x 1-4 weeks, 5mg PO BID x 1-4 weeks 5mg PO daily x 1-4 weeks STOP
Other recommendations	• Offer referral to mental health for treatment of substance use disorder • Provide naloxone kit and overdose education • Offer non-opioid and nonpharmacologic pain management

PAINWEEK

Aberrant UDM v2 ANSWERED

- Alternate plan:
  - One-time warning and continuation of opioid therapy as currently prescribed
  - Counsel/educate patient on the plan to taper opioids should she test positive for marijuana again
  - Repeat UDM at more regular intervals at future appointments

PAINWEEK

Aberrant UDM v3

- Mr. White is a 63 yo man followed in the chronic pain clinic for chronic cervical pain with radiculopathy as well as diabetic neuropathy pain.
- He presents to his regular follow-up appointment for medication renewal in his motorized scooter, but is sedated in clinic, even falling asleep during the clinical interview.
- He is prescribed morphine SR 30mg PO Q12H and morphine IR 7.5mg PO BID PRN pain.
- He admits to occasionally taking his wife's sleep medication at night, but otherwise denies medication misuse.
- A random UDM is collected.

PainWeek

Aberrant UDM v3

Immunoassay Test	Result
Opiates	POSITIVE
Oxycodone	NEGATIVE
Methadone	NEGATIVE
Amphetamines	NEGATIVE
Benzodiazepines	POSITIVE
Cocaine	NEGATIVE
Marijuana	NEGATIVE

Comprehensive UDM Results
Morphine
Hydromorphone
Nordiazepam
Temazepam
Oxazepam

How would you proceed with the opioid taper?

PainWeek

Aberrant UDM v3 ANSWERED

Characteristic	Recommendations
Type of taper	Faster
Taper regimen	Taper morphine SR first 15mg PO QAM + 30mg PO QPM x7 days 15mg PO Q12H x7 days 15mg PO daily x7 days STOP Then, taper morphine IR Decrease to 7.5mg PO daily PRN x7 days STOP
Other recommendations	• Provide naloxone kit • Offer non-opioid and nonpharmacologic pain management • Offer referral for insomnia treatment

PAINWEEK

Aberrant UDM v4

- Ms. Coon is a 39 yo female patient diagnosed with chronic knee pain.
- She is a relatively new patient to your clinic, but has not demonstrated any aberrant behaviors.
- She has trialed acupuncture and tai chi and completed an 8-week chronic pain group.
- Currently, she is prescribed fentanyl patch 25 mcg/hr apply Q72H as well as milnacipran and amitriptyline for her pain.
- During the clinic visit, you visualize the patch in place on her left upper arm and confirm the patch strength. She confirms changing the patch as instructed and denies having any issues with the patch falling off.
- A random UDM is collected as part of opioid compliance monitoring.

PAINWEEK

Aberrant UDM v4

Immunoassay Test	Result
Opiates	NEGATIVE
Oxycodone	NEGATIVE
Methadone	NEGATIVE
Amphetamines	NEGATIVE
Benzodiazepines	NEGATIVE
Cocaine	NEGATIVE
Marijuana	NEGATIVE
Fentanyl	NEGATIVE

Prior to sending for comprehensive UDM you discuss the results with the patient.

- How would you proceed with the opioid taper?

PainWeek

Aberrant UDM v4 ANSWERED

Characteristic	Recommendations
Type of taper	None needed
Taper regimen	Not using fentanyl patch regularly or appropriately (and admits to just putting the patch on in the morning of her scheduled appointments), no taper is warranted
Other recommendations	• Depending on the circumstance, offer referral to mental health for SUD treatment • Offer non-opioid pain management

PainWeek

No Functional Benefit

- Mr. Hunter is a 72 yo man who has been on chronic opioid therapy for 10+ years.
- He has been referred to the chronic pain clinic by his PCP as he is no longer active and is now using a motorized scooter to get around. He no longer does household chores or yard work and refuses to try a walking regimen using an assistive device.
- He admits to feeling depressed but also reports 10/10 pain on his current opioid regimen of oxycodone CR 40mg PO Q12H and oxycodone/acetaminophen 10/325mg 1 tab PO QID PRN pain.
- He agrees to work with the pain psychologist and trial acupuncture. You have also convinced him to start duloxetine for both depression and chronic pain.
- How would you proceed with the opioid taper?

PAINWEEK

No Functional Benefit ANSWERED

Characteristic	Recommendations	
Type of taper	Slower	
Taper regimen	Taper oxycodone CR first 30mg PO QAM + 40mg PO QHS x4 weeks 30mg PO Q12H x4 weeks 20mg PO QAM + 30mg PO QHS x4 weeks 20mg PO Q12H x4 weeks 10mg PO QAM + 20mg PO QPM x4 weeks 10mg PO Q12H x4 weeks 10mg PO daily x4 weeks STOP	Then, taper oxycodone/acetaminophen 10/325mg 1 tab PO TID PRN x4 weeks 10/325mg 1 tab PO BID PRN x4 weeks 5/325mg 1 tab PO BID PRN x4 weeks, 5/325mg 1 tab PO daily PRN x4 weeks STOP
Other recommendations	• Provide naloxone kit and overdose education • Offer non-opioid and nonpharmacologic pain management	

PAINWEEK

Taper to CDC Guideline Recommendation

- Ms. Fields is a 40 yo female and a former patient of the chronic pain clinic, now re-consulted by her PCP for opioid dose reduction to be in compliance with the 2016 CDC guideline recommendations.
- Her current pain medication regimen includes fentanyl patch 100 mcg/hr apply Q48H, oxycodone IR 30mg PO QID PRN, and gabapentin 1200mg PO TID.
- She is reluctant to proceed with the opioid taper and admits to being scared because she does not know how she will function on a lower dose of opioids.
- She refuses to engage in other pain clinic services at this time, but agrees to reconsider them in the future depending on how she feels as the opioids are being tapered.
- How would you proceed with the opioid taper?

PAINWEEK

Taper to CDC Guideline Recommendation ANSWERED

Characteristic	Recommendations
Type of taper	Slowest or slower
Taper regimen	Taper fentanyl patch first – goal 25 mcg/hr Q72H (60 MEDD) or lowest functional dose Reduce by 12 mcg/hr q4 weeks Then, taper oxycodone IR – goal 20 mg/day (30 MEDD) or lowest functional dose Decrease by 10 mg/day q4 weeks until at 20 mg PO q6h Then reduce by 5 mg/day q4 weeks
Other recommendations	• May need to pause opioid taper • Provide naloxone kit and overdose education • Offer non-opioid and nonpharmacologic pain management

Disclaimer:
Consider the risks:benefits of continuing opioid therapy. Don't just taper to taper and don't just treat the MEDD number – treat the WHOLE patient.

PAINWEEK

Concomitant Benzodiazepine

- Mr. Pitt is a 33 yo man diagnosed with chronic low back pain as well as anxiety and PTSD.
- He has been managing his chronic pain with morphine IR 30mg PO QID PRN, but has refused other pain management modalities.
- For his anxiety he is prescribed sertraline as well as alprazolam 1mg PO TID PRN.
- You have discussed the increased risks for respiratory depression and overdose associated with the combination of opioids and benzodiazepines.
- Pt prefers to continue his benzodiazepine and taper his opioid while pursuing non-opioid pain management strategies.
- How would you proceed with the opioid taper?

PAINWEEK

Concomitant Benzodiazepine ANSWERED

Characteristic	Recommendations
Type of taper	Slower
Taper regimen	Taper morphine IR 15mg PO QAM + 30mg PO TID x4 weeks 15mg-30mg-30mg-15mg x4 weeks 15mg-15mg-30mg-15mg x4 weeks 15mg PO q6h x4 weeks 15mg PO TID x4 weeks 15mg PO BID x4 weeks, 7.5mg PO BID x4 weeks, 7.5mg PO daily x4 weeks STOP
Other recommendations	• Provide naloxone kit • May need to pause opioid taper • Offer non-opioid and nonpharmacologic pain management

PAINWEEK

Significant Comorbidities

- Ms. Carter is a 62 yo female with post laminectomy syndrome.
- She has COPD with moderate control.
- Recently, her husband reported that she snores a lot at night, so she had a sleep study completed. The report states that she has severe sleep apnea. She just went to get her CPAP and she refuses to take it home with her.
- She is currently prescribed hydrocodone ER 40 mg PO q12h.

- How would you proceed with the opioid taper?

PainWeek

Significant Comorbidities ANSWERED

Characteristic	Recommendations
Type of taper	Slower
Taper regimen	Taper hydrocodone ER 30 mg PO QAM and 40 mg PO QHS x4 weeks 30 mg PO q12h x4 weeks 20 mg PO QAM and 30 mg PO QHS x 4 weeks 20 mg PO q12h x4 weeks 15 mg PO QAM and 20 mg PO QHS x4 weeks 15 mg PO q12h x4 weeks 10 mg PO QAM and 15 mg QHS x4 weeks 10 mg PO q12h x4 weeks 10 mg PO daily x4 weeks STOP
Other recommendations	• Provide naloxone kit and overdose education • May need to pause opioid taper • Offer non-opioid and nonpharmacologic pain management

Pa

Significant PDMP Query Results

- Mr. Oz is a 79 yo male who has been a patient of his local retail pharmacy for many years.
- As the float pharmacist covering for the weekend, you review the prescriptions he drops off to have filled: oxycodone CR 80mg PO Q8H and oxycodone IR 30mg PO TID PRN pain.
- You feel that it would be most appropriate to check the state's PDMP database prior to filling the prescription, as there are no notes on his file indicating that this has been done recently.
- Your query includes the last calendar year and the results are quite startling; he has been filling oxycodone CR and IR prescriptions via self-pay at another retail pharmacy about 30 minutes away every month for the last 8 months.
- How would you proceed with the opioid taper?

PAINWEEK

Significant PDMP Query Results ANSWERED

Characteristic	Recommendations
Type of taper	No taper needed
Taper regimen	Filling duplicate opioids at another pharmacy for several months, no taper is warranted
Other recommendations	Alert both prescribing providers to the significant PDMP results

PAINWEEK

Recent Overdose

- Mr. Ocean is a 52 yo man diagnosed with CRPS in the RLE due to an injury
- He had been stable on his regimen of hydrocodone/acetaminophen 10/325mg PO q6h PRN in combination with clonidine and venlafaxine SA
- However his wife has contacted the clinic to alert you that he has been admitted to a local hospital due to opioid overdose.
- The patient presents to the clinic 2 days post-hospital discharge.
- He indicates that he has been taking more hydrocodone/acetaminophen than prescribed (up to 8-10 tablets per day) and had been drinking alcohol due to his pain and feeling depressed the day he overdosed.
- The hospital discharged him on a lower dose of hydrocodone/acetaminophen (5/325mg) and patient reports having 10 tablets left.

- How would you proceed with the opioid taper?

PainWeek

Recent Overdose ANSWERED

Characteristics	Recommendations
Type of taper	Rapid
Taper regimen	Taper hydrocodone/acetaminophen 5/325mg – use only remaining tablets he has left! 1 tab PO TID x2 days, 1 tab PO BID x1 day, 1 tab PO daily x2 days STOP
Other recommendations	• Offer referral to mental health for treatment of substance use disorder • Perform suicide risk assessment • Provide naloxone kit and overdose education • Offer non-opioid and nonpharmacologic pain management

PainWeek

Benzodiazepine Taper

- Ms. Bloomfield is a 45 yo female diagnosed with low back pain and cervicalgia as well as anxiety.
- She is taking morphine SR 30mg Q12H, oxycodone IR 5mg PO QID PRN pain, duloxetine 60mg PO daily, and diazepam 5mg PO TID PRN anxiety.
- As her primary care provider, you review the most recent guideline recommendations regarding concomitant benzodiazepine and opioid use as well as your concerns for her safety.
- During this open conversation, she expresses her wish to taper off diazepam and remain on her opioids for ongoing pain management.

PAINWEEK

Benzodiazepine Taper ANSWERED

Characteristics	Recommendations
Type of taper	Benzodiazepine
Taper regimen	Taper diazepam 5mg: 7.5mg (1.5 tabs) PO BID x1-2 months 5mg (1 tab) PO QAM + 7.5mg (1.5 tabs) PO QPM x2 weeks 5mg (1 tab) tab PO BID x2 weeks 2.5mg (½ tab) PO QAM + 5mg (1 tab) PO QPM x2 weeks 2.5mg (½ tab) PO BID x2 week 2.5mg (½ tab) PO daily x2 weeks STOP
Other recommendations	• Provide naloxone kit and overdose education • Offer non-benzodiazepine and nonpharmacologic anxiety treatment/interventions

PAINWEEK

3 Things for Monday

- All about risks vs. benefits
- Speed of taper is determined by reason for taper
- Utilize risk mitigation strategies during tapers

PAINWEEK

Question #1

- Mr. Miller is a 57 yo male with LBP prescribed oxycodone CR 40 mg PO Q12H. The patient is also prescribed diazepam 10 mg PO TID PRN for anxiety. He has been stable on this regimen for over 10 years. After discussing the risks, patient opts to taper off the oxycodone CR. How would you taper the patient off?

A. Reduce by 5 mg/day q3 days
B. Reduce by 5 mg/day q4 weeks
C. Reduce by 10 mg/day q3 days
D. Reduce by 10 mg/day q4 weeks

PAINWEEK

Question #2

- A rapid taper would be indicated in which circumstance

A. Patient on opioids for 10 years and requesting a taper
B. Patient with recent overdose
C. Patient with no functional benefit with high dose opioids
D. Patient with negative UDM for prescribed scheduled long-acting opioid

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Walking the Line: Opioid Dose De-escalation

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