APPENDIX E

HOW TO APPROACH AN EXIT STRATEGY FROM LONG-TERM OPIOID THERAPY

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ARIZONA DEPARTMENT
OF HEALTH SERVICES

APPENDIX E: HOW TO APPROACH AN EXIT STRATEGY FROM LONG-TERM OPIOID THERAPY

Opioid tapering is the seemingly logical approach to stopping long-term opioid therapy and patients can experience improved pain, function and quality of life when opioids are tapered and discontinued, particularly when tapering occurs in the context of a whole-person care plan. There are some patients, however, such as those with opioid use disorder, for whom tapering may contribute to the overall risk calculation (e.g. possibly increasing the risk of illicit opioid acquisition or worsening of underlying psychiatric illnesses).

Clinicians should consider a broader concept of an opioid exit strategy. As recommended in *Guideline #17,* two additional exit strategies beyond tapering (Strategy (a)) include rotation to buprenorphine with subsequent gradual reduction of the buprenorphine dose (Strategy (b)), and medication-assisted treatment for patients with opioid use disorder (Strategy (c)). There is clear evidence for the effectiveness of treating an opioid use disorder with medication-assisted treatment, but otherwise little evidence to guide which opioid exit strategy is best for an individual. The following can be considered in choosing an initial strategy, but a switch to another strategy can be made at any time, depending on the clinical situation:

- For patients with prescriptions of lower MEDs, lower pain-related dysfunction, and lower psychiatric and substance use disorder comorbidities, consider opioid tapering (Strategy (a)). See the Opioid Tapering subsection within this *Appendix.*
- For patients with prescriptions of higher MEDs, higher pain-related dysfunction and higher psychiatric and substance use disorder comorbidities, consider Strategy (b), rotation to buprenorphine with subsequent gradual reduction of the buprenorphine dose.
- For patients with opioid use disorder, offer or arrange for medication assisted treatment (Strategy (c)). See *Guideline #15* and *Appendices C* and *D* for diagnosis and management of opioid use disorder.

Complex persistent opioid dependence is a condition recently described in the literature as a clinical and physiologic state that exists on the continuum between simple opioid dependence (which presents with short-lived and self-limited withdrawal symptoms after opioids are discontinued) and opioid use disorder (defined by DSM-5 criteria). In these patients, opioid tapering or cessation may lead to worsening pain, function, affective symptoms and sleep disturbances. As of the writing of this guideline, there is no clear evidence to guide the best exit strategy for these patients, but options include Strategy (a) (opioid tapering), while optimizing treatment of psychiatric comorbidities, non-pharmacologic and non-opioid pharmacotherapy for pain or (Strategy (b)), buprenorphine followed by its gradual dose reduction.

Abrupt opioid discontinuation is not recommended unless required for immediate safety concerns.

Opioid Tapering

The following risks should be taken into consideration when determining the overall risks with long-term opioid therapy for pain, recognizing that having multiple risk factors indicates a larger, cumulative risk:

- No pain reduction, no improvement on opioid regimen
- Severe, unmanageable adverse effects (drowsiness, constipation)
- High risk dosage (e.g. ≥90 MED)
- Non adherence to treatment plans
- Concerns related to an increased risk of substance use disorder
- Overdose event involving opioids
- Medical comorbidities that can increase risk (e.g. lung disease, sleep apnea, liver disease, renal disease, fall risk, advanced age)
- Concomitant use of medications that increase risk (benzodiazepines, sedative-hypnotics)
- Mental health comorbidities that can worsen with opioid therapy (e.g. PTSD, depression, anxiety)

Before Starting Taper

- Ensure screening and treatment is offered for conditions that can complicate pain management before initiating opioid taper, such as mental health disorders, opioid use disorder and other substance use disorders, medical comorbidities and sleep disorders.
- Discuss risks and benefits of continued use of opioids with patient, including that tolerance to the prior opioid dose can be lost within a week and people are at risk of an overdose if they resume their prior dose.[97]
- Offer Naloxone as a safety measure to all patients at risk for overdose (see *Guideline #16*).

- Identify a multimodal care team, made up of behavioral health specialists and addiction specialists to assist during the taper.
- Acknowledge fears about tapering, and help patients develop goals for life (besides being "pain-free") and offer other nonpharmacological or non-opioid medications.
- Determine speed of taper: Slow tapers are often the most tolerable and can be completed over several months to years, but more rapid tapers may be required in instances like illegal or dangerous behaviors or situations where the risks of continuing the opioid outweigh the risks of a rapid taper.

Example Tapers for Opioids[98 99 100 101 102]			
Slowest Taper (over years)	**Slower Taper (over months to years) *MOST COMMON***	**Faster Taper (over weeks)**	**Rapid Taper (over days)**
Reduce MEDs by 2-10% every 4-8 weeks with pauses in taper as needed.	Reduce MEDs by 5-20% every 4 weeks with pauses in taper as needed.	Reduce MEDs by 10-20% every week.	Reduce MEDs by 20-50% of first dose if needed, then reduce by 10-20% every day.

Follow-up and Support During Taper

- Provide opioid overdose education and prescribe naloxone to patients, given the reduced tolerance to opioids and availability of opioids in the community (see *Guideline #16*).
- Follow-up on patient function, pain intensity, sleep, physical activity, personal goals and stress level – the frequency and location of follow-up determined by the tapering approach.

Follow-up during opioid tapers[98 99 100 101 102]			
Slowest Taper (over years)	**Slower Taper (over months to years) *MOST COMMON***	**Faster Taper (over weeks)**	**Rapid Taper (over days)**
Follow up every 1-4 weeks after starting taper then monthly before each reduction. Can be done in clinic and/or telephone, depending on risk.	Follow up every 1-4 weeks after starting taper then monthly before each reduction. Can be done in clinic and/or telephone, depending on risk.	Follow up weekly before each dose reduction. Can be done in clinic and/or telephone, depending on risk.	Follow up daily before each dose reduction or offer inpatient admission.

- For patients who struggle with opioid tapering, consider slowing or pausing the taper and evaluate for psychiatry comorbidities and substance use disorders. A switch to another exit strategy may be appropriate. Consider switching to Strategy (b), rotation to buprenorphine with subsequent gradual tapering over several months if complex persistent opioid dependence is suspected. Further, consider switching to Strategy (c), (medication assisted treatment) if opioid use disorder is recognized during the tapering process of the opioid or buprenorphine dose.
- Generally, withdrawal symptoms can be minimized or avoided with gradual tapers. Reassure patients that withdrawal symptoms can be managed with medication and non-medication treatments (e.g. meditation, relaxation, deep breathing).[42 98 99 100 101 102 103 104 105 106 107 108 109] Withdrawal symptoms should not be treated with an opioid or benzodiazepine. Treatment should be provided or arranged when these conditions are present.

Indication	Treatment Options
Autonomic symptoms (sweating, tachycardia, myoclonus)	First line: Clonidine; Alternatives: Baclofen, Gabapentin, Tizanidine
Anxiety, dysphoria, lacrimation, rhinorrhea	Hydroxyzine, Diphenhydramine
Myalgias	NSAIDs, Acetaminophen, Topical medications like menthol/methyl salicylate cream, lidocaine cream/ointment
Sleep disturbance	Trazodone
Nausea	Prochloperazine, Promethazine, Ondansetron
Abdominal cramping	Dicyclomine
Diarrhea	Loperamide, Bismuth subsalicylate