

# BRAVO!

## A Collaborative Approach to Opioid Tapering

### Introduction

This booklet provides primary care providers with guidelines and tools to support them as they work with patients on long term opioid therapy. It is also intended to provide materials for academic detailing on tapering.

It incorporates guidance and content from these key sources:

- U.S. Department of Health and Human Services [Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics](#) October 2019
- Oregon Health Authority – [Opioid Tapering Guidelines - Recommendations for individualized care to reduce harm from opioid use](#)
- BRAVO – A protocol developed by Dr. Anna Lembke (credits below)
- Risk Benefit Analysis flowchart – Developed by the Oregon Pain Guidance Clinical Advisory Group and incorporated into the HHS guidelines on tapering
- Veterans Health Administration [Opioid Taper Decision Tool](#) (withdrawal medications)

We are also grateful for the academic detailing framework provided by the National Resource Center for Academic Detailing ([NaRCAD](#)).

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**B**  
**Broaching the Subject**



- Involve the patient
- Take more time
- Get the support of your team
- Use motivational interviewing (reflection, validation, support)
- For inherited patients, maintain the current dose and document if considering a taper



**R**  
**Risk Benefit Assessment**



Consider tapering for the following reasons:

- Patient request
- Pain and function not improved
- Adverse opioid effects
- Co-occurring conditions (including mental health)
- Dose over 90 MED
- Concurrent sedatives
- Opioid use disorder
- Opioid overdose


**A**  
**Addiction and Dependence Happen**

- Addiction = The 3 C's: *Control, Craving, continued use despite Consequences*
- Dependence = Tolerance, withdrawal, without the 3 C's
- Anyone can become addicted or dependent
- Reassure patients there is effective treatment for both
- Consider buprenorphine


**V**  
**Velocity and Validation**

- Go slowly (*Tapering Examples*)
- Maintain the same schedule (BID, TID)
- Let the patient drive “*Which opioid would you like to taper first?*”
- Take breaks, but never go backwards
- Warn patients that pain gets worse before it gets better
- Validate that opioid tapering is hard



**O**  
**Other Strategies for Coping with Pain**

- Help patients understand how pain works
- Encourage regular, restful sleep
- Promote healthy activities
- Maintain a positive mood
- Foster social connections
- Make good nutritional choices
- Consider non-opioid pain medications



# B



## Broaching the Subject

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Start with empathy and compassion for your patient's situation. Your patient is likely to be anxious about any change in their pain medications. It is normal for you to be anxious or uncomfortable as well. Simply naming this anxiety in your patient and in yourself can be very helpful. If the patient is not in imminent danger, take the time to build a trusting and supportive relationship before making any changes to the pain medication. Reassure your patient that you will not abandon them and will continue to work with them to improve their function and quality of life. Explain that you will go slowly if necessary and that patients can experience improved quality of life after lowering pain medications.

**Involve the patient** – Ask the patient about their perceptions of risks, benefits, and adverse effects of continued opioid therapy. Clear up any misconceptions they may have. Give them your assessment of the risks, benefits, and alternatives to opioids. Involve them in decisions, such as which medication or dose to change first and how quickly the changes will occur. Tapering will be more successful with the patient's input and collaboration.

**Take more time** – Schedule a longer appointment when you discuss possible tapering. Use the extra time to listen to your patient's story about their pain and their concerns about any changes to their treatment. Patients often report that providers don't take the time to hear their story. Make sure your patient feels you fully understand their perspective. This promotes empathy and builds a therapeutic alliance.

**Get the support of your team** – Making changes to pain medications is best managed by the entire healthcare team. It is ideal if all team members are aware of the treatment plan and communicate their empathy and support for the patient on a regular basis. If the conversation with the patient gets stressful, have a team member standing by to join you to diffuse the situation. During the tapering process, arrange for a team member to check in with the patient every week or more often via phone, text, clinic visit, etc.

**Use motivational interviewing (reflection, validation, support)** – Be sensitive to the patient's reactions to your conversation with them. Remember, you don't have to agree with the patient to show that you understand and validate their feelings. Here are some example phrases.

**Reflection:** *"You seem upset by what I have said. Can you talk about how you are feeling right now?"*

**Validation:** *"I absolutely believe your pain is real." "I know it is very challenging for you to make changes to your medication." "It's perfectly normal for you to be anxious, fearful, and angry."*

**Support:** *"I know you can do this, and I am going to stick by you on this journey." "I am sorry to see you suffering. I care about you and I want your health to improve." "I see that you are suffering right now. By working together I am confident you can do this and that over time your quality of life will improve"*

**For inherited patients, maintain the current dose and document if considering a taper** – If safety allows, do not make any medication changes at the first visit. Explain that you are making a careful assessment of the risks and benefits of continued opioid therapy. Reassure your patient that you will involve them before making any changes. Assure them of your concern for their health and safety. In your documentation, make it clear that you are maintaining the current dose of opioids in the broader context of assessing risks and benefits and developing a relationship of trust.

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**If the patient is not in imminent danger, take the time to build a trusting and supportive relationship before making any changes to the pain medications.**

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## Risk Benefit Assessment

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The prescriber needs to do a careful assessment of the risks and benefits of continued long-term opioid therapy. If your patient is doing well, engaging in activities, taking medication as prescribed, and has no other concerning risk factors, there may be no need to taper them off their current dose. But remember, the patient's subjective report is just one data point. Be sure to check other data points, such as collateral information from family, the Prescription Drug Monitoring Program, and urine drug screening. Document your assessment and monitor patients at least quarterly for any change in status. Remember patients can develop problems at any point in their opioid therapy. Review [Broaching the Subject](#) for advice on how to discuss tapering with your patient. For specific language on how to talk to your patients about opioid risks, see [Weighing the Risks and Benefits of Chronic Opioid Therapy](#)

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**Carefully assess the risks and benefits of continued long-term opioid therapy. If the patient is doing well with no other concerning risk factors, continuing opioids may be appropriate. If the risks outweigh the benefits, tapering is recommended.**

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Consider tapering for the following reasons:

**Patient request** – If your patient requests reducing or eliminating opioids, you should initiate tapering. If pain is still a problem, offer alternatives. See [Other Strategies for Coping with Pain](#).

**Pain and function not improved** – If your ongoing evaluation of the patient demonstrates that their pain and function are not meaningfully improved, then tapering is recommended.

**Adverse opioid effects** – Consider tapering if your patient is suffering adverse opioid side effects such as constipation, lethargy, sexual dysfunction, confusion, depression, increased risk for falls, immune suppression, or respiratory depression. Tolerance, dependence, and withdrawal can be adverse effects, and may themselves be indication for a taper.

**Co-occurring conditions (including mental health)** – Consider tapering if your patient has co-occurring health conditions such as lung disease, sleep apnea, liver disease, kidney disease, cardiac arrhythmias, obesity, or dementia. If your patient suffers from depression, anxiety, PTSD, or childhood trauma, they are at higher risk for developing opioid misuse or an opioid use disorder. Integrating mental health treatment alongside chronic pain treatment increases the odds of a successful and therapeutic opioid taper.

**Dose over 90 MED (Morphine Equivalent Dose)** – Morphine Equivalent Dosing (MED) is a patient's cumulative intake of all opioids over 24 hours measured in morphine milligram equivalents. Adverse outcomes are dose and duration dependent. Some patients at higher doses may be fully adherent and functioning well with no other risk factors. However, the risks of overdose, addiction, and other serious side effects increase above 90 MED. At least quarterly, reassess the benefits versus the risks of continued opioid therapy at doses over 90 MED. [MED Calculator](#)

**Concurrent sedatives** – Consider tapering if your patient is prescribed benzodiazepines, carisoprodol, or other sedatives, or regularly drinking alcohol. You may want to taper the sedative before or instead of the opioid. Involve patients in the discussion of which to taper first. Check your state Prescription Drug Monitoring Program.

**Opioid Use Disorder** – Tapering is recommended if the patient meets criteria for a diagnosis of Opioid Use Disorder (OUD) (see [Addiction and Dependence Happen](#)). Also consider tapering opioids in patients at higher risk for developing an OUD, such patients on high doses, those with a personal or family history of addiction, a history of childhood trauma, co-occurring mental illness, or other psycho-social stressors that predict a poor response to opioids.. [DSM-5 OUD Criteria](#)

**Opioid Overdose** – If your patient has had an overdose or other serious medical event (e.g., hospitalization, injury) due to opioids, immediate action is needed. It is likely that tapering will be necessary in conjunction with treatment of other conditions.



## Addiction and Dependence Happen

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**Addiction** – Addiction to opioids is called opioid use disorder (OUD). There are 11 diagnostic criteria for OUD in the [DSM-5](#). A shorthand way to remember the DSM-5 criteria is by the 3 C's: Loss of *Control*, *Craving*, and continued use despite *Consequences*. Careful screening for addiction should be a part of any opioid treatment regimen. Buprenorphine, other pharmacotherapy, and/or psychosocial interventions for addiction should be used in the treatment of OUD.

**Dependence** – Some patients develop severe physiologic dependence on prescription opioids and do not tolerate tapering even when tapering is medically indicated. When the risks of continuing prescription opioids outweigh the benefits (i.e. the patient needs to taper) and severe dependence limits the patient's ability to taper, yet the patient does not meet DSM-5 criteria for opioid use disorder, then the patient has medically debilitating Prescription Opioid Dependence (POD). These patients often exhibit an exaggerated pain response, dysphoria, negative affect, reward deficiency, and social isolation with even mild dose reduction. Patients with medically debilitating POD may need to be tapered much more slowly than the average patient. In some cases, these patients may need years to get to a lower dose or off opioids.

**Anyone can become addicted or dependent** – Addiction and dependence are medical conditions that can occur with exposure to opioids, especially long-term exposure at high doses. Opioids have powerful effects, and anyone can become addicted to and/or dependent on them. Explore the possibility of these diagnoses with your patient in an objective, compassionate, and stigma-free manner.

**Reassure the patient there are effective treatments for OUD** – Let your patient know before you begin the tapering process that the taper sometimes unmasks an OUD. If an OUD is detected, this is nothing shameful, but rather an indication that another type of treatment is necessary. Detecting an OUD doesn't mean you're giving up on treating the patient's pain. It means you need to treat the OUD in addition to treating the pain.

**Consider buprenorphine for addiction and dependence** – Become [X-waivered](#) so you can utilize buprenorphine in the treatment of OUD. Just as you have developed competency and know your community's resources for managing diabetes, say, you should develop those same skills to handle OUD. Those needing a higher level of care should be referred to appropriate community services. Buprenorphine may also be a useful tool in patients with prescription opioid dependence who are unable to taper when medically indicated.

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**Opioids have powerful effects, and anyone can become addicted to and/or dependent on them. Explore the possibility of these diagnoses with your patient in an objective, compassionate, and stigma-free manner.**

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# V



## Velocity and Validation

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The biggest mistake providers make when tapering opioids is going too quickly. Tapering can be accomplished safely and humanely utilizing a few simple principles.

**Go slowly, especially as dosages decrease** – A taper protocol slow enough to minimize opioid withdrawal symptoms is best in most situations (ref 1). Tapers should be individualized and done in partnership with your patient. Most tapers involve dosage reduction of 5-20% per month. Slower tapers are better tolerated than faster tapers, especially in patients who have been on opioids for years.

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**Tapers should be individualized and done in partnership with your patient. The biggest mistake providers make when tapering opioids is going too quickly. Go slowly enough to minimize withdrawals symptoms.**

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**Maintain the same schedule (BID, TID)** – It may be helpful to keep the same dosing cadence (e.g., twice daily, three times daily), especially in the beginning of the taper. The brain is habituated to having the medication at set times. If the patient is on a regimen of taking doses two times or three times a day, keep that schedule during the taper for as long as possible.

**Let the patient drive, within reason** – “Which opioid would you like to taper first?” – Tapering is a frightening experience for many patients. People tolerate stress best when they feel empowered. If your patient is concurrently taking a prescription benzodiazepine, increasing their risk of accidental overdose, offer to taper the benzodiazepines first and then reconsider the risks and benefits of the opioid. Don’t try to taper both at once. Most patients can’t tolerate this, and by changing too many variables at the same time, it’s difficult to track patient response. Bottom line: After you’ve decided a taper is necessary, collaborate with your patient on how to do it.

**Take breaks, but never go backwards** – Breaks in the taper are appropriate. Patients can maintain a given dose for some period before continuing. For example, if the patient has an important event scheduled and does not want to risk being in low-grade withdrawal, including subtle psychological symptoms of withdrawal such as anxiety, irritability, and dysphoria, it is reasonable to defer the next decrement in dose. It is imperative never to go backward during the taper (i.e., increase the dose). Going back up on the dose risks losing the hard work already invested. Nonaddictive medications can help relieve symptoms of withdrawal.

**Warn patients that pain might get worse before it gets better** – Tell patients that their body pain will likely get worse each time the opioid dose is decreased, but that with time and with the body adjusting to the new lower dose (approximately four weeks), the pain level will return to baseline. The increased pain patients experience after the dosage decrease does not indicate progression of their underlying pain condition. Rather, the pain represents time-limited, opioid withdrawal-mediated pain. Patients with chronic pain who successfully taper down or off long-term opioid therapy often report improved pain.

**Validate that opioid tapering is hard and that you will work with the patient however long it takes** – Validate that opioid tapering can be scary and painful. Don’t try to minimize the difficulty, which can lead to patients feeling invalidated. Remind your patient that people just like them have been successful, resulting in an improved quality of life. Validate the challenges you as a provider face in helping patients taper, and avoid dismissing patients from care by having compassion for them and yourself. You can do this!



## Other Strategies for Coping with Pain

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Patients with long term chronic pain often gradually lose capabilities in many areas of their life. They tend to avoid activities that might cause discomfort. They may withdraw socially which can cause or add to depression and anxiety. They may not take care of themselves and have poor nutrition. All these things can amplify the pain they experience. The good news is that patients can also recover their capabilities if they work on improving these areas of their life. As these areas improve, patients are likely to see a reduction in the pain they experience and a general improvement in their well-being and function.



**Help patients understand how pain works** – This video explains that people often believe that pain is only a bottom-up process, where the brain receives sensory inputs from the body from tissue damage, triggering pain. But there's also a top-down process whereby the brain itself can change the pain experience. For example, stress, depression, anxiety, lack of sleep, and poor nutrition can all make pain worse independent of tissue damage. Improving mood, sleep, and nutrition can make pain better, again independent of tissue damage. Life-style improvements help reduce pain. Patients learn what can cause pain, what can reduce pain, and what they can do to improve their life despite having pain. Encourage your patient to watch this video to learn how pain works.

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**The good news is that when patients make healthy lifestyle changes, they usually have reduced pain and their well-being and function is improved.**

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**Encourage regular, restful sleep** – Most patients with chronic pain sleep poorly. Lack of sleep causes irritability, memory issues, trouble concentrating, and poor balance. It can amplify depression and anxiety, weaken the immune system, lower sex drive, and cause high blood pressure. Getting good, restful sleep on a regular basis can have a very positive effect on pain. Check if your patient has problems sleeping. If they do, have them watch this video. Work with them to improve their sleep.



**Promote healthy activities** – Patients with chronic pain may avoid activity for fear of re-injuring themselves. Their brains can be overly protective, equating hurt with harm. Gradually their bodies lose fitness and even simple tasks can become exhausting. It is important that patients re-engage in physical activities as tolerated. They need to pace themselves to avoid flare-ups caused by overdoing things. Encourage your patient to watch this video on being active.



**Maintain a positive mood** – Mood, stress, and pain are closely linked. Chronic pain can cause depression, anxiety, and anger. Stress can trigger the body's stress response system, increasing heart rate and blood pressure and causing muscles to tense up. When patients work on improving mood, many other aspects of their life improve as well. Patients can learn to be more positive and reduce stress. Several techniques can help, such as practicing mindfulness or meditation, reframing negative thoughts, and engaging in social activities. Encourage your patient to watch this video on improving mood.



**Foster social connections** – Patients with persistent pain often withdraw socially. Social isolation can cause them to focus more on their pain which in turn can intensify depression, anxiety, and anger. When patients start reconnecting with old friends and make new social connections, their sense of self-worth improves. New social connections which involve new activities are especially helpful. If your patient has withdrawn socially, have them watch this video. Then explore with them how they can expand their social life.



## Other Strategies for Coping with Pain

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**Make good nutritional choices** – Nutrition is often overlooked as part of a treatment plan. A healthy gut microbiome is critical to our general health. Poor nutrition can cause inflammation and visceral pain. Good nutrition can help alleviate constipation and other side effects of medication. Discuss with your patient their eating habits and the importance of a healthy gut microbiome. Encourage them to watch this [video](#) on healthy nutrition.



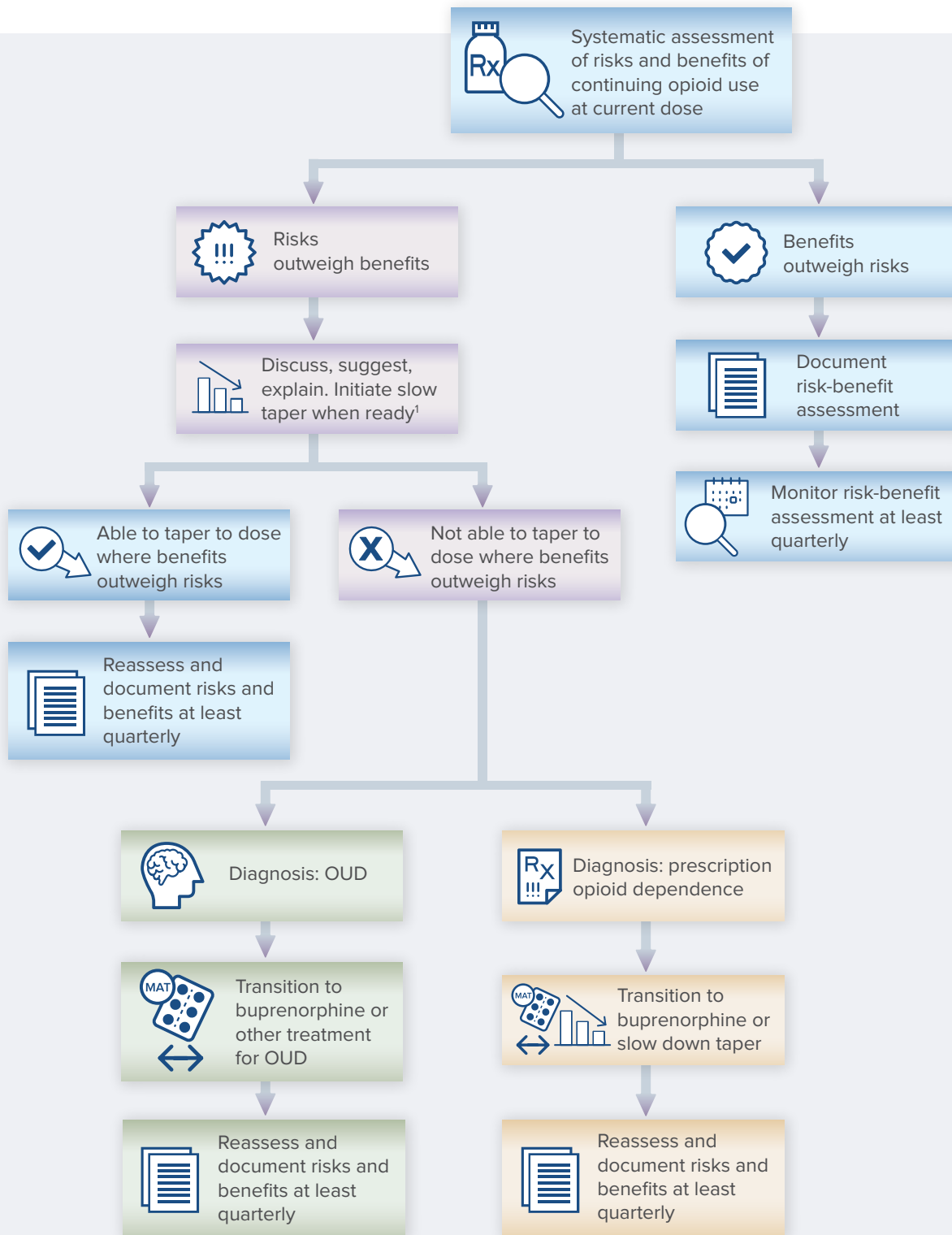
**Consider non-opioid pain medications** – Although no medication is without risk, medications like ibuprofen and acetaminophen have been shown to help with pain. In general, these medications are safer than opioids and should be considered as possible alternatives. Encourage your patient to watch this video on non-opioid pain medications.



**Plan for flareups** – For people with chronic pain, flareups are common. They can come on suddenly and cause intense pain lasting for hours or days. Patients are very concerned that something new is wrong with them. This can cause depression, anxiety, and anger. All these emotions just amplify the pain. Patients may even go to the emergency department. With education, patients can learn to become detectives and investigate possible causes or triggers. They can learn what steps they can take to anticipate and moderate their flareups. If your patient has problems with flareups, have them watch this video.



# Risk Benefit Assessment Flowchart



- Start your assessment with a systematic review of the risks and benefits of continued opioid.
- If patients have improved function, adequate pain relief, and low risk for opioid-related harms, continue their current dose, but with regular risk–benefit assessments.
- If the risks outweigh the benefits, explain the need for tapering (see [Broaching the Subject](#)) and initiate a slow taper. If tapering is successful over time, document progress and continue to assess risks quarterly.
- If patient is unable to taper to a dose where benefits outweigh the risks, check for a diagnosis of prescription opioid dependence (POD) or opioid use disorder (OUD) (see [Addiction and Dependence Happen](#)).
- For POD, consider transitioning to buprenorphine as a harm reduction strategy, or slow down the taper. Reassess at least quarterly.
- For OUD, transition to buprenorphine or other treatment for OUD. Reassess at least quarterly.

# Tapering Example

## CONSIDER THE FOLLOWING PATIENT:

- 48 year old male on oxycodone for 16 years since a motor vehicle crash
- Dose: oxycodone 30 mg four times daily = 120 mg of oxycodone = 180 mg MED
- Pain: Still rates his pain as a 10, wants to increase to 40 mg four times daily
- Function: Hasn't worked since crash. Divorced 9 years ago. Lives alone. On bed or couch 20 hours daily
- Co-morbid conditions: sleep apnea, diabetes 2, hypertension, depression, osteoarthritis of knees

After a long discussion he admits that the oxycodone doesn't help him much, but he's afraid of how bad his pain will be on less of it or without it. He reluctantly agrees to the taper when you explain that his dose is unsafe and you don't feel comfortable continuing to prescribe it.

How to taper? *Make sure other ongoing strategies are in place before you begin.* He goes to a pain education class, watches several videos and meets with the behaviorist in clinic. The behaviorist encourages him to join a pain group where he will have a chance to learn and share experiences with other patients in a similar situation.

Week	Dose 1	Dose 2	Dose 3	Dose 4	Total daily dose	MED
0	30 mg	30 mg	30 mg	30 mg	120 mg	180 mg
1-2	30 mg	25 mg	30 mg	30 mg	115 mg	172.5 mg
3-4	30 mg	25 mg	25 mg	30 mg	110 mg	165 mg
5-6	30 mg	25 mg	25 mg	25 mg	105 mg	157.5 mg
7-8	25 mg	25 mg	25 mg	25 mg	100 mg	150 mg

At the end of 8 weeks you have decreased the oxycodone by about 16%. He's had mild withdrawal symptoms, but nothing intolerable

Week	Dose 1	Dose 2	Dose 3	Dose 4	Total daily dose	MED
9-10	25 mg	20 mg	25 mg	25 mg	95 mg	142.5 mg
11-12	25 mg	20 mg	20 mg	25 mg	90 mg	135 mg
13-14	25 mg	20 mg	20 mg	20 mg	85 mg	127.5 mg
15-16	20 mg	20 mg	20 mg	20 mg	80 mg	120 mg

At the end of 16 weeks you have decreased the oxycodone by about 33%. Withdrawal symptoms mild. He has noticed that his pain isn't any worse. Even so, he tells you he is afraid to keep going, but agrees that everything you told him has been correct.

Week	Dose 1	Dose 2	Dose 3	Dose 4	Total daily dose	MED
17-18	20 mg	20 mg	15mg	20 mg	75 mg	112.5 mg
19-20	20 mg	15 mg	15 MG	20 MG	70 MG	105 MG
21-22	20 mg	15 mg	15 mg	15 mg	65 MG	97.5 90
23-24	15 mg	15 mg	15 mg	15 mg	60 MG	90 MG

At 24 weeks he is on 50% of his starting opioid dosing. He admits that his pain is no worse. He also tells you his mind feels less foggy and he's been using some of the relaxation techniques when he does feel pain. He began physical therapy a few weeks back and is now walking 15 – 20 minutes daily

# Tapering Example

Week	Dose 1	Dose 2	Dose 3	Dose 4	Total daily dose	MED
25-26	15 mg	15 mg	10 mg	15 mg	55 mg	82.5
27-28	15 mg	10 mg	10 mg	15 mg	50 mg	75 mg
29-30	15 mg	10 mg	10 mg	10 mg	45 mg	67.5 mg
31-32	10 mg	10 mg	10 mg	10 mg	40 mg	60 mg

At 32 weeks he is on 30% of his starting opioid dosing. Pain is not worse, in fact he thinks it might be a little better. He's now walking up to an hour daily. He says, I think I want to go to 10 mg 3 times daily and then cut down from there.

Week	Dose 1	Dose 2	Dose 3	Total daily dose	MED
33	10 mg	10 mg	10 mg	30 mg	45 mg
34	Same dose as week 33: he has a little more withdrawal and asks to stay on 10 mg TID for another 2 weeks				
35-36	10 mg	10 mg	10 mg	30 mg	45 mg
37	10 mg	5 mg	10 mg	25 mg	37.5 mg
38	Same dose as week 37: he wants to cut the morning dose before evening dose because he is worried he won't sleep well				
39-40	5 mg	5 mg	10 mg	20 mg	30 mg
40	5 mg	5 mg	5 mg	15 mg	22.5 mg

At 40 weeks he is on 12.5% of his starting opioid dosing. He cut down a little faster in last 2 weeks. He is excited by the prospect of getting off completely but still feels like he needs to keep tapering and can't just stop at this dose

Week	Dose 1	Dose 2	Dose 3	Total daily dose	MED
41-42	5 mg	2.5 mg	5 mg	12.5 mg	18.25 mg
43-44	5 mg	5 mg		10 mg	15 mg
45-46	2.5 mg	5 mg		7.5 mg	11.25 mg
47	X	5 mg		5 mg	7.5mg
48	0			0 mg	0 mg

It took 48 weeks – almost a year, but he successfully came off of a high dose opioid he had been on for 16 years. He admits that his pain is minimal. He is more active than he has been in years, has lost 18 lbs. and he is contemplating going back to work.

# Medications to Treat Opioid Withdrawal Symptoms

Sometimes medications can be used to help mitigate the symptoms of opioid withdrawal. These medications should be used sparingly and with caution. Ideally if the taper is slow enough, patients are experiencing minimal and tolerable opioid withdrawal and don't need adjunctive medication. Be wary of using addictive medications, like benzodiazepines and/or cannabis to help patients get off of opioids. This can lead to patients becoming dependent on and addicted to another set of medications.

INDICATION	TREATMENT OPTIONS
<b>Autonomic symptoms (sweating, tachycardia, myoclonus)</b>	<p><b>FIRST LINE</b></p> <ul style="list-style-type: none"> <li>• <b>Clonidine</b> 0.1 to 0.2 mg oral every 6 to 8 hours; hold dose if blood pressure &lt;90/60 mmHg (0.1 to 0.2 mg 2 to 4 times daily is commonly used in the outpatient setting)               <ul style="list-style-type: none"> <li>– Recommend test dose (0.1 mg oral) with blood pressure check 1 hour post dose; obtain daily blood pressure checks; increasing dose requires additional blood pressure checks</li> <li>– Re-evaluate in 3 to 7 days; taper to stop; average duration 15 days</li> </ul> </li> </ul> <p><b>ALTERNATIVES</b></p> <ul style="list-style-type: none"> <li>• <b>Baclofen</b> 5 mg 3 times daily may increase to 40 mg total daily dose               <ul style="list-style-type: none"> <li>– Re-evaluate in 3 to 7 days; average duration 15 days</li> <li>– May continue after acute withdrawal to help decrease cravings</li> <li>– Should be tapered when it is discontinued</li> </ul> </li> <li>• <b>Gabapentin</b> start at 100 to 300 mg and titrate to 1800 to 2100 mg divided in 2 to 3 daily doses*               <ul style="list-style-type: none"> <li>– Can help reduce withdrawal symptoms and help with pain, anxiety, and sleep</li> </ul> </li> <li>• <b>Tizanidine</b> 4 mg three times daily, can increase to 8 mg three times daily</li> </ul>
<b>Anxiety, dysphoria, lacrimation, rhinorrhea</b>	<ul style="list-style-type: none"> <li>• Hydroxyzine 25 to 50 mg three times a day as needed</li> <li>• Diphenhydramine 25 mg every 6 hours as needed**</li> </ul>
<b>Myalgias</b>	<ul style="list-style-type: none"> <li>• <b>NSAIDs</b> (e.g., naproxen 375 to 500 mg twice daily or ibuprofen 400 to 600 mg four times daily)***</li> <li>• <b>Acetaminophen</b> 650 mg every 6 hours as needed</li> <li>• <b>Topical medications</b> like menthol/methylsalicylate cream, lidocaine cream/ ointment</li> </ul>
<b>Sleep disturbance</b>	<ul style="list-style-type: none"> <li>• <b>Trazodone</b> 25 to 300 mg orally at bedtime</li> </ul>
<b>Nausea</b>	<ul style="list-style-type: none"> <li>• <b>Prochlorperazine</b> 5 to 10 mg every 4 hours as needed</li> <li>• <b>Promethazine</b> 25 mg orally or rectally every 6 hours as needed</li> <li>• <b>Ondansetron</b> 4 mg every 6 hours as needed</li> </ul>
<b>Abdominal cramping</b>	<ul style="list-style-type: none"> <li>• <b>Dicyclomine</b> 20 mg every 6 to 8 hours as needed</li> </ul>
<b>Diarrhea</b>	<ul style="list-style-type: none"> <li>• <b>Loperamide</b> 4 mg orally initially, then 2 mg with each loose stool, not to exceed 16 mg daily</li> <li>• <b>Bismuth subsalicylate</b> 524 mg every 0.5 to 1 hour orally, not to exceed 4192 mg/day</li> </ul>

\*Adjust dose if renal impairment; \*\*avoid in patients > 65 years old; \*\*\*caution in patients with risk GI bleed, renal compromise, cardiac disease

# DSM-5 OUD Criteria\*

A problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period.

CHECK ALL THAT APPLY:	
<input type="checkbox"/>	1. Opioids are often taken in larger amounts or over a longer period of time than was intended.
<input type="checkbox"/>	2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
<input type="checkbox"/>	3. A great deal of time is spent in activities to obtain the opioid, use the opioid, or recover from its effects.
<input type="checkbox"/>	4. Craving, or a strong desire or urge to use opioids.
<input type="checkbox"/>	5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
<input type="checkbox"/>	6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of opioids.
<input type="checkbox"/>	7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
<input type="checkbox"/>	8. Recurrent opioid use in situations in which it is physically hazardous.
<input type="checkbox"/>	9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that's likely to have been caused or exacerbated by the substance.
<input type="checkbox"/>	10. Tolerance, as defined by either of the following: a. A need for markedly increased amounts of opioids to achieve intoxication or desired effect b. A markedly diminished effect with continued use of the same amount of an opioid <b>Note:</b> This criterion is not met for individuals taking opioids solely under appropriate medical supervision.
<input type="checkbox"/>	11. Withdrawal, as manifested by either of the following: a. The characteristic opioid withdrawal syndrome a. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms <b>Note:</b> This criterion is not met for individuals taking opioids solely under appropriate medical supervision.
Total number of symptoms: _____	
<input type="checkbox"/> <b>Mild</b> = 2–3 symptoms <input type="checkbox"/> <b>Moderate</b> = 4–5 symptoms <input type="checkbox"/> <b>Severe</b> = 6 or more symptoms	

\*Criteria from American Psychiatric Association (2013) Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Washington, DC, American Psychiatric Association page 541.

# References

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- Bohnert ASB, Valenstein M, Bair MJ, et al. [Association between opioid prescribing patterns and opioid overdose-related deaths](#). JAMA - J Am Med Assoc. 2011;305(13).
- Criteria from American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition., Washington, DC, American Psychiatric Association page 541.
- Chou et al. [The effectiveness and risks of long-term opioid therapy for chronic pain: a systematic review for a National Institutes of Health Pathways to Prevention Workshop](#). Ann Intern Med. 2015 Feb 17;162(4):276-86. doi: 10.7326/M14-2559.
- Chou, R., Ballantyne, J., Lembke, A., [Rethinking Opioid Dose Tapering, Prescription Opioid Dependence, and Indications for Buprenorphine](#), Annals of Internal Medicine, 2019; doi:10.7326/M19-1488.
- Department of Veterans Affairs. Department of Defense. VA/DoD [Clinical Practice Guideline for Opioid Therapy for Chronic Pain](#). Version 3.0 – 2017. VADoDOTCPG022717.pdf.
- Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2016. MMWR Recomm Rep. 2016 Mar 18;65(1):1-49.
- Eamonn M. M. Quigley, MD, FRCP, FACP, FACG, FRCPI. [Gut Bacteria in Health and Disease](#). Journal of Gastroenterology & Hepatology.
- Edlund MJ, Martin BC, Russo JE, Devries A, Braden JB, Sullivan MD. [The Role of Opioid Prescription in Incident Opioid Abuse and Dependence Among Individuals With Chronic Noncancer Pain](#). Clin J Pain. 2014;30(7).
- Frank JW, Lovejoy TI, Becker WC, et al. [Patient Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy: A Systematic Review](#). Ann Intern Med. 2017 Aug 1;167(3):181-191.
- Harrison, T. K., Kornfeld, H., Aggarwal, A. K., & Lembke, A. [Perioperative Considerations for the Patient with Opioid Use Disorder on Buprenorphine, Methadone, or Naltrexone Maintenance Therapy](#). Anesthesiology Clinics, 2018; 36(3), 345–359.
- [HHS Guidance for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics](#). Deborah Dowell, MD, MPH.
- Krebs EE, Gravely A, Nugent S, et al. [Effect of opioid vs non-opioid medications on pain-related function in patients with chronic back pain or hip or knee osteoarthritis pain the SPACE randomized clinical trial](#). JAMA - J Am Med Assoc. 2018. doi:10.1001/jama.2018.0899.
- Lembke, A., Humphreys, K., Newmark, J. [Weighing the Risks and Benefits of Chronic Opioid Therapy](#), American Family Physician, 2016; 93(12):982-990.
- Lembke, A., [Tapering Long Term Opioid Therapy](#), American Family Physician, 2020; 101 (1).
- Lembke, A. Ottestad, E., Schmiesing, C. [Patients Maintained on Buprenorphine for Opioid Use Disorder Should Continue Buprenorphine Through the Perioperative Period](#), Pain Medicine, 2019; 20(3):425-428.
- Sullivan MD. [Depression Effects on Long-term Prescription Opioid Use, Abuse, and Addiction](#). Clin J Pain. 2018 Sep;34(9):878-884.
- Veterans Health Administration PBM Academic Detailing Service. [Pain Management Opioid Taper Decision Tool\\_A VA Clinician's Guide](#).

# Resources

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## VIDEOS

- [Understanding Pain and Healthy Life-Style Changes](#) – Eight videos on understanding pain, nutrition, activity, sleep, mood, social, flareups, and non-opioid medications.
- [Broaching the Subject of Collaborative Opioid Management](#) – Practical tips for raising the subject of opioid addiction or dependence with patients.
- [High Risk Low Benefit](#) – (6:03 min): Provider uses good listening skills, motivational interviewing, and overall effective communication strategies in the face of a poorly motivated patient.
- [Motivational Interviewing for Change](#) – Provider skillfully navigates a conversation about changes to opioid prescriptions using [PEG](#), a three-item Scale Assessing Pain Intensity and Interference.

## ONLINE TRAINING

- [BRAVO! How to Taper Patients Off Opioids](#) – Free one hour course from Stanford
- [Changing the Conversation about Pain](#) – Free one hour CME course from the Oregon Pain Management Commission.
- [Free X-Waiver Online Training](#) – From Providers Clinical Support System

## WEBSITE RESOURCES

- [Oregon Pain Guidance](#) – This website has guidelines and tools for healthcare professionals helping patients with chronic pain, including those on long term opioid therapy.
- This booklet online – [OPIOID TAPERING: A Collaborative Management Approach](#)

## MORPHINE EQUIVALENT DOSE (MED) CALCULATOR

- <https://www.oregonpainguidance.org/opioidmedcalculator/>