Opioid Tapering in Chronic Pain Management

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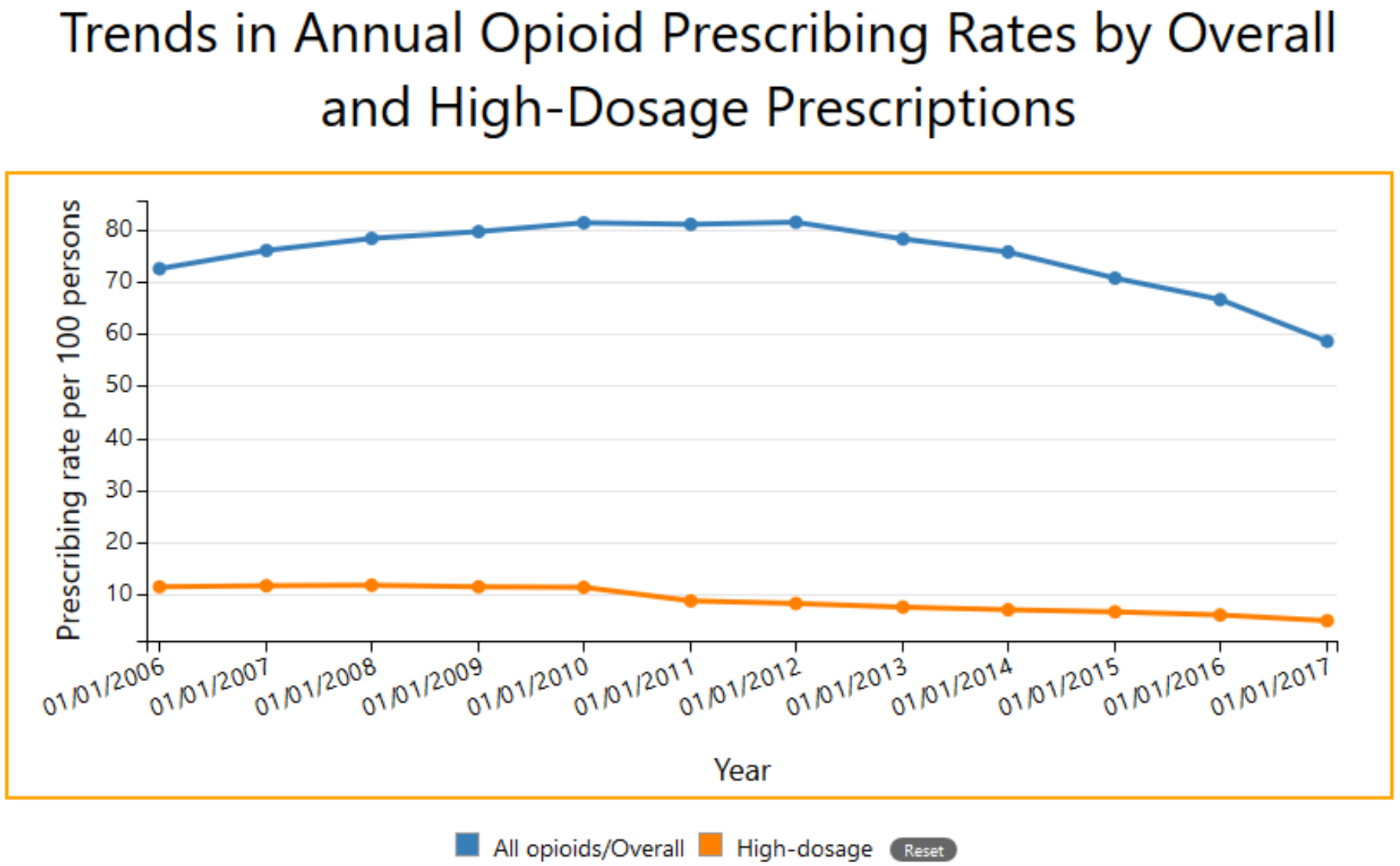
Objectives

- List indications for tapering opioids
- Provide current recommendations on tapering protocols
- Describe common opioid withdrawal symptoms which could occur during opioid tapering
- List treatment options for specific withdrawal symptoms
- Develop a patient-specific taper regimen in a chronic pain management setting

Opioid Use and Concerns



https://www.cdc.gov/drugoverdose/data/prescribing/prescribing-practices.html

CDC Guideline for Prescribing Opioids for Chronic Pain 2016: 12 Recommendations

1. Try nonpharmacological and nonopioids first: opioids are not first line
2. Determine baseline pain and function establish realistic goals
3. Educate the patient on risks and benefits of opioid therapy
4. If opioids are started, start with immediate release opioids
5. Use lowest dose possible
   - Risk vs benefits when approaching ≥50MME/day
   - Take a hard look at the situation when considering increasing dose ≥90MME/day
6. Limit quantities for acute pain
7. Reassess frequently
   - 1-4 weeks after initiation or dose adjustment
   - Continual reassessment at a minimum every 3 months
8. Evaluate Risk factors for opioid related harms
   - Consider if patient is a candidate for naloxone
9. Utilize PDMP data
10. Utilize Urine Drug Testing as part of monitoring
11. Avoid concurrent opioid and benzodiazepine prescribing
12. Order treatment for opioid use disorder if needed

https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf

JAMA Network Open

Original Investigation | Pharmacy and Clinical Pharmacology

Trends and Rapidity of Dose Tapering Among Patients Prescribed Long-term Opioid Therapy, 2008-2017

Joshua J. Fenton, MD, MPH; Alicia L. Agnoli, MD, MPH, MHS; Guibo Xing, PhD; Lillian Hang, MBA, MPH; Aylin E. Altan, PhD; Daniel J. Tancredi, PhD; Anthony Jerant, MD; Elizabeth Magnan, MD, PhD

- Retrospective cohort study
- 99,874 patients on long term opioid therapy
  - Commercial or Medicare Advantage insurance
  - Opioid dosing >50MME for at least 12 months baseline and 2 or more months of follow-up within the study time period

- Objectives:
  - Evaluate trends in opioid tapering from 2008 to 2017
  - Identify patient-level variables associated with tapering
  - Identify patient-level variables with rapid tapering

Fenton J, Agnoli A, Xing G, et al. Trends and Rapidity of Dose Tapering Amonth Patients Prescribed Long-term Opioid Therapy 2008-2017. JAMA Network Open. 2019;2(11):

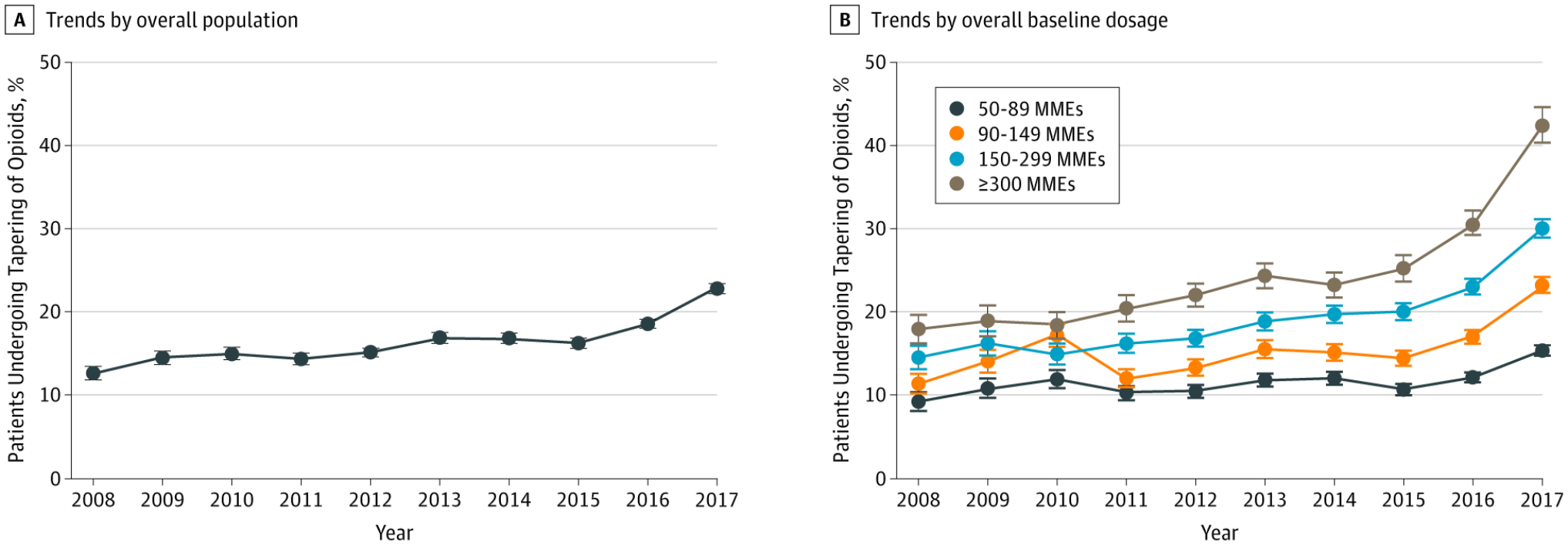


Figure Legend:

Age- and Sex-Standardized Rates of Dose Tapering Among Patients Using Long-term Opioid Therapy, 2008-2017A, Trends among the overall population. B, Trends by baseline dosage in morphine milligram equivalents (MMEs). Error bars indicate 95% CIs.

From: **Trends and Rapidity of Dose Tapering Among Patients Prescribed Long-term Opioid Therapy, 2008-2017**

JAMA Netw Open. 2019;2(11):e1916271. doi:10.1001/jamanetworkopen.2019.16271

CDC Advises Against Misapplication of the *Guideline for Prescribing Opioids for Chronic Pain*

Some policies, practices attributed to the Guideline are inconsistent with its recommendations

Misapplication of Guidelines could put patients at risk

- **Hard limits or "cutting off" opioids:**
  - Guidelines do not suggest discontinuation of higher dosed opioids.
- **Tapering or sudden discontinuation of opioids:**
  - Not supported by Guidelines since this can increased risk of withdrawal and/or psychological distress.
  - Does not support individualized patient care
- **Applying guidelines to patients outside scope:**
  - Guideline is directed at PCPs treating patients with chronic pain who are 18 years and older
  - Guidelines should not be used in patients with active cancer, acute sickle cell crisis, or post-op treatment pain
- **Medication-assisted treatment for opioid use disorder:**
  - Dosing recommendations in guidelines are for opioids used in chronic pain management, not treatments associated with MAT

https://www.cdc.gov/media/releases/2019/s0424-advises-misapplication-guideline-prescribing-opioids.html

Dowell D, Haegerich T, Chou R. No shortcuts to safer opioid prescribing. *N Engl J Med*. 2019;380(24):2285-2287. doi:10.1056/NEJMp1904190

FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering

FDA Drug Safety Communication

Safety Announcement

[4-9-2019] The U.S. Food and Drug Administration (FDA) has received reports of serious harm in patients who are physically dependent on opioid pain medicines suddenly having these medicines discontinued or the dose rapidly decreased. These include serious withdrawal symptoms, uncontrolled pain, psychological distress, and suicide.

FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering

FDA Drug Safety Communication

- Health Care Professionals
  - Do not abruptly discontinue opioids who is physically dependent
  - Develop a plan for safe and effective taper with the patient if appropriate
  - No standard taping protocol exists
  - Taping schedule must be developed for each individual patient
  - Close monitoring and support is needed during an opioid taper

- Patient
  - Do not abruptly discontinue current opioid therapy
  - Discuss any opioid tapering or discontinuation plans with your prescriber
  - Withdrawal symptoms can still occur despite gradual taper
  - Report any changes in mood, suicide thoughts, elevation in pain, or withdrawal symptoms to your health care professional during an opioid taper

https://www.fda.gov/drugs/drug-safety-and-availability/fda-identifies-harm-reported-sudden-discontinuation-opioid-pain-medicines-and-requires-label-changes

Opioid tapering: questions

Candidates:

- Which patients are candidates for tapering in an outpatient setting?
- Are there certain patients who will need a slower taper?

Referral:

- When should I consider referring a patient for psychological support?
- When should I refer a patient to an addiction specialist?

Tapering Process:

- What guidelines recommend these taper regimens?
- How should the taper be completed?
- What opioid is the best to use in a tapering situation?
- How quickly can a taper be completed?
- What if the patient is also on a benzodiazepine and I want to taper both?

Withdrawal concerns:

- What are common withdrawal reactions that could occur?
- How can I treat these reactions if they occur?

Many Patient Scenarios to Consider

Group 1

Pts with no acute safety concerns

- Lack of perceived efficacy
- Risks vs benefits
  - Side effects
  - Opioid induced hyperalgesia
- Pt request for taper
- General attempt to minimize opioid use

Our Focus for this Presentation

Group 2

- Severe adverse outcomes
  - Overdose
- Substance use disorder
- Deterioration in physical, emotional, or social functioning

Rapid taper indicated over 2-3 week period

Group 3

- Diversion confirmed or suspected
  - Negative UDA
- Non-medical use of opioids
  - Negative UDA
- Refusing UDA

Immediate discontinuation

Interagency Guideline on Prescribing Opioids for Pain 2015

Opioid Tapering

Best Practices, Research Gaps, and Future Priorities to Support Tapering Patients on Long-Term Opioid Therapy for Chronic Non-Cancer Pain in Outpatient Settings

Robert "Chuck" Rich, Jr., MD, FAAFP, Bladen Medical Associates and Campbell University; **Roger Chou, MD,** Oregon Health and Science University; **Edward R. Mariano, MD, MAS,** American Society of Anesthesiologists; **Anna Legreid Dopp, PharmD,** American Society of Health-System Pharmacists; **Rebecca Sullenger,** National Academy of Medicine; **Helen Burstin, MD, MPH,** Council of Medical Specialty Societies; and the **Pain Management Guidelines and Evidence Standards Working Group** of the Action Collaborative on Countering the U.S. Opioid Epidemic

August 10, 2020

https://nam.edu/wp-content/uploads/2020/08/Best-Practices-Research-Gaps-and-Future-Priorities-Tapering-FINAL.pdf

https://www.oregonpainguidance.org/wp-content/uploads/2020/03/BRAVO-FINAL-3.13.20-1.pdf

HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics

This *HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics* provides advice to clinicians who are contemplating or initiating a reduction in opioid dosage or discontinuation of long-term opioid therapy for chronic pain. In each case the clinician should review the risks and benefits of the current therapy with the patient, and decide if tapering is appropriate based on individual circumstances.

https://www.hhs.gov/opioids/sites/default/files/2019-10/Dosage_Reduction_Discontinuation.pdf

https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf

Opioid Tapering and Discontinuation Considerations

- Improvement of pain
- Patient requests a taper
- Patient is not demonstrating meaningful improvement in function or pain
- Higher opioids doses are not providing evidence of benefit
- Side effects are negatively impacting QOL or impairing function

- Current evidence of opioid misuse
- Nonadherence to treatment plans, aberrant behaviors
- Long term opioid use where risks outweigh current benefit
- Recent overdose or related hospitalization or warning signs this could occur due to physical warning signs, or higher risk due to comorbid disease states or drug-drug interactions
- Concerns for diversion and/or addiction

HHA Guide for Clinician on the Appropriate Dosage Reduction or Discontinuation of Long-Term Analgesics.
https://www.hhs.gov/opioids/sites/default/files/2019-10/Dosage_Reduction_Discontinuation.pdf
U.S Department of Veterans Affairs. Pain Management Opioid Taper Decision Tool.
https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf

Terminology

Tolerance

- A decrease in response to a drug dose that occurs with continued use.

Dependence

- State of physical adaptation that is manifested by a drug class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, and/or decreasing blood level of a substance and/or administration of an antagonist.

Addiction

- Addiction is a treatable, chronic medical dis-ease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences.

American Society of Addiction Medicine The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder. 2020 Focused Update
https://www.asam.org/docs/default-source/quality-science/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2

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:	
☐	1. Opioids are often taken in larger amounts or over a longer period of time than was intended.
☐	2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
☐	3. A great deal of time is spent in activities to obtain the opioid, use the opioid, or recover from its effects.
☐	4. Craving, or a strong desire or urge to use opioids.
☐	5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
☐	6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of opioids.
☐	7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
☐	8. Recurrent opioid use in situations in which it is physically hazardous.
☐	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.
☐	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 **Note:** This criterion is not met for individuals taking opioids solely under appropriate medical supervision.
☐	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 **Note:** This criterion is not met for individuals taking opioids solely under appropriate medical supervision.
	Total number of symptoms: _____
☐ **Mild** = 2–3 symptoms	☐ **Moderate** = 4–5 symptoms ☐ **Severe** = 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.

https://www.oregonpainguidance.org/wp-content/uploads/2020/03/BRAVO-FINAL-3.13.20-1.pdf
Umberger W, Gaddis L. The Science of Addiction Through the Lens of Opioid Treatment for Chronic Noncancer Pain. Pain Management Nursing 2020;21:57-64.

Tapering Considerations

Variable Patient Response	• Pain levels • Insomnia, Anxiety, Depression • Duration of symptoms
Comorbid Conditions	• Psychiatric disorders • Opioid Misuse Behavior/Opioid Use Disorder REFER
Coordination of Care	• Behavioral Health Providers • Other specialists
Treatment Goals	• Patient Perceptions of Risk Benefits, overall goals • Prescriber goals
Treatment options	• Nonpharmacological treatments • Nonopioid Pharmacological treatments
Education	• Process for tapering • Possible reaction during taper • Increased risk of OD with abrupt return to previous higher dose

HHA Guide for Clinician on the Appropriate Dosage Reduction or Discontinuation of Long-Term Analgesics. https://www.hhs.gov/opioids/sites/default/files/2019-10/Dosage_Reduction_Discontinuation.pdf

Opioid Tapering: A Team Approach

- Establish the team approach
- Reasons for consideration of taper
- Focus on risks vs. benefits of current opioid therapy
- Address patients concerns or reluctance regarding tapering
- Stress commitment of support during process

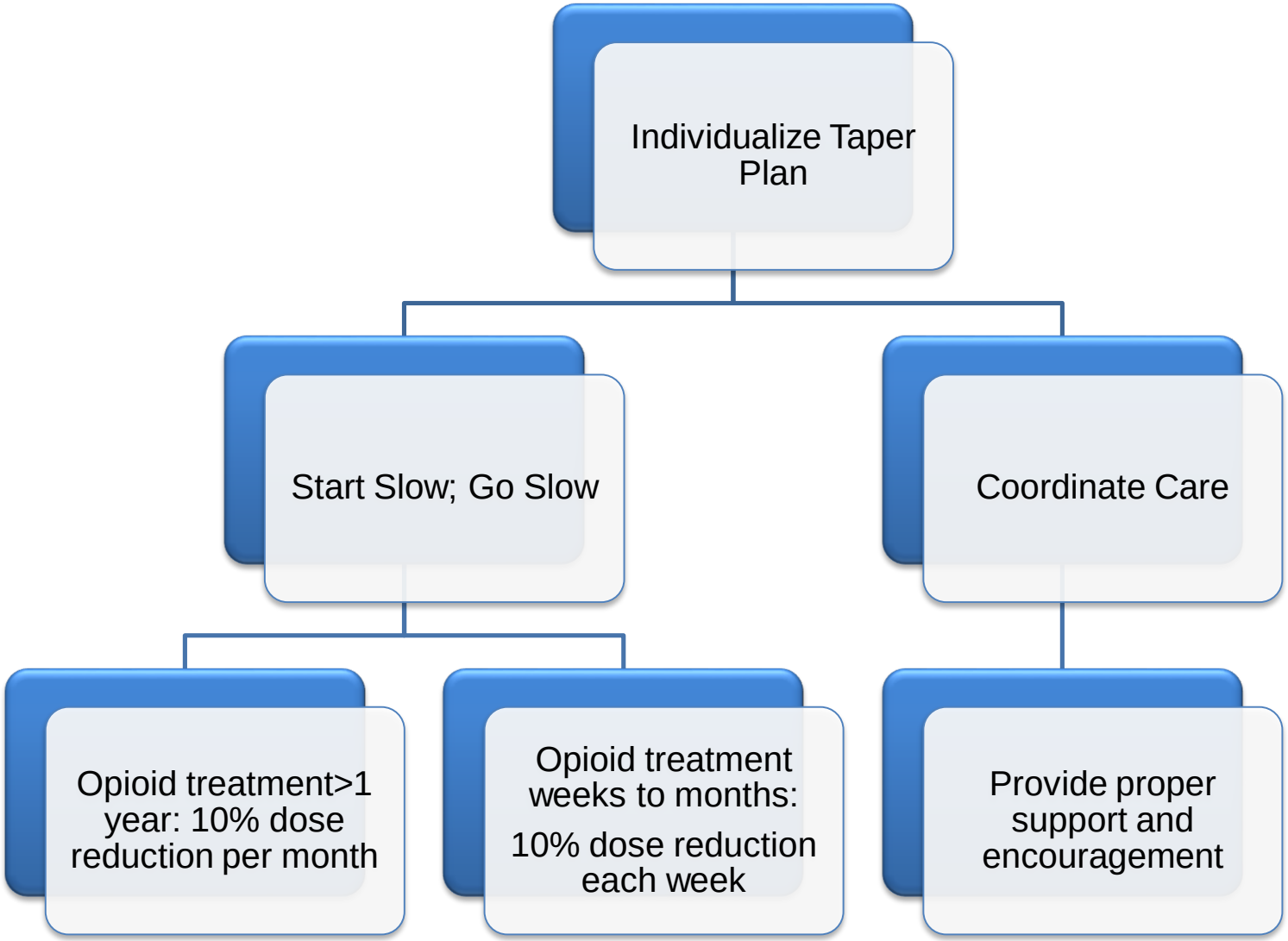
HHA Guide for Clinician on the Appropriate Dosage Reduction or Discontinuation of Long-Term Analgesics.
https://www.hhs.gov/opioids/sites/default/files/2019-10/Dosage_Reduction_Discontinuation.pdf
U.S Department of Veterans Affairs. Pain Management Opioid Taper Decision Tool.
https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf

Tapering Tips

Slow	Slow and easy, each timeline is based on the individual patient • BZD +Opioid: One at a time; Many recommend tapering opioid first
Involve	Involve the patient in the process
Maintain	Maintain a consistent dosing schedule
Flexible	Stay open to tapering pauses when needed • One way process; don't go backwards
Educate	Educate the patient on regular basis

BRAVO! A Collaborative Approach to Opioid Tapering. https://www.oregonpainguidance.org/wp-content/uploads/2020/03/BRAVO-FINAL-3.13.20-1.pdf

CDC Tapering Recommendations



Important Counseling Point:

Once tapering process begins there is an increased risk of overdose if patient returns to original opioid dose

Adapted from Pocket Guide: Tapering Opioids for Chronic Pain https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf

Tapering Options

Pain Management Opioid Taper Decision Tool: A VA Clinician's Guide

Slowest Taper (Over Years)	Slower Taper (Over Months or Years)	Faster Taper (Over Weeks)	Fastest Taper (Over Days)
Reduce dose by 2-10% every 4-8 weeks with pauses in taper as needed	Reduce dose by 5-20% every 4 weeks with pauses in taper as needed	Reduce by 10-20% every week	Reduce by 20-50% of first dose if needed, then reduce by 10-20% every day
Possible option for patients on high dose long-acting opioids over a long period of time (years)	Most common taper per VA/DoD	Increased risk of withdrawal effects, consider adjunctive agents to help minimize symptoms; consider in patient therapy	Increased risk of withdrawal effects, consider adjunctive agents to help minimize symptoms; consider in patient therapy

Table from: Veterans Health Administration PBM Academic Detailing Service. Pain Management Opioid Taper Decision Tool_A VA Clinician's Guide. https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf

Buprenorphine

- Consider buprenorphine option in patients who are taking high opioid doses and unable to taper despite worsening pain and/or function with opioid use
  - Can be considered in patients with or without meeting opioid use disorder criteria
- Proper conversion process to buprenorphine must be completed to avoid precipitating withdrawal
  - Consult experienced clinician for conversion if needed
- Two treatment options following conversion to buprenorphine
    - Continue buprenorphine
    - Begin tapering process for buprenorphine

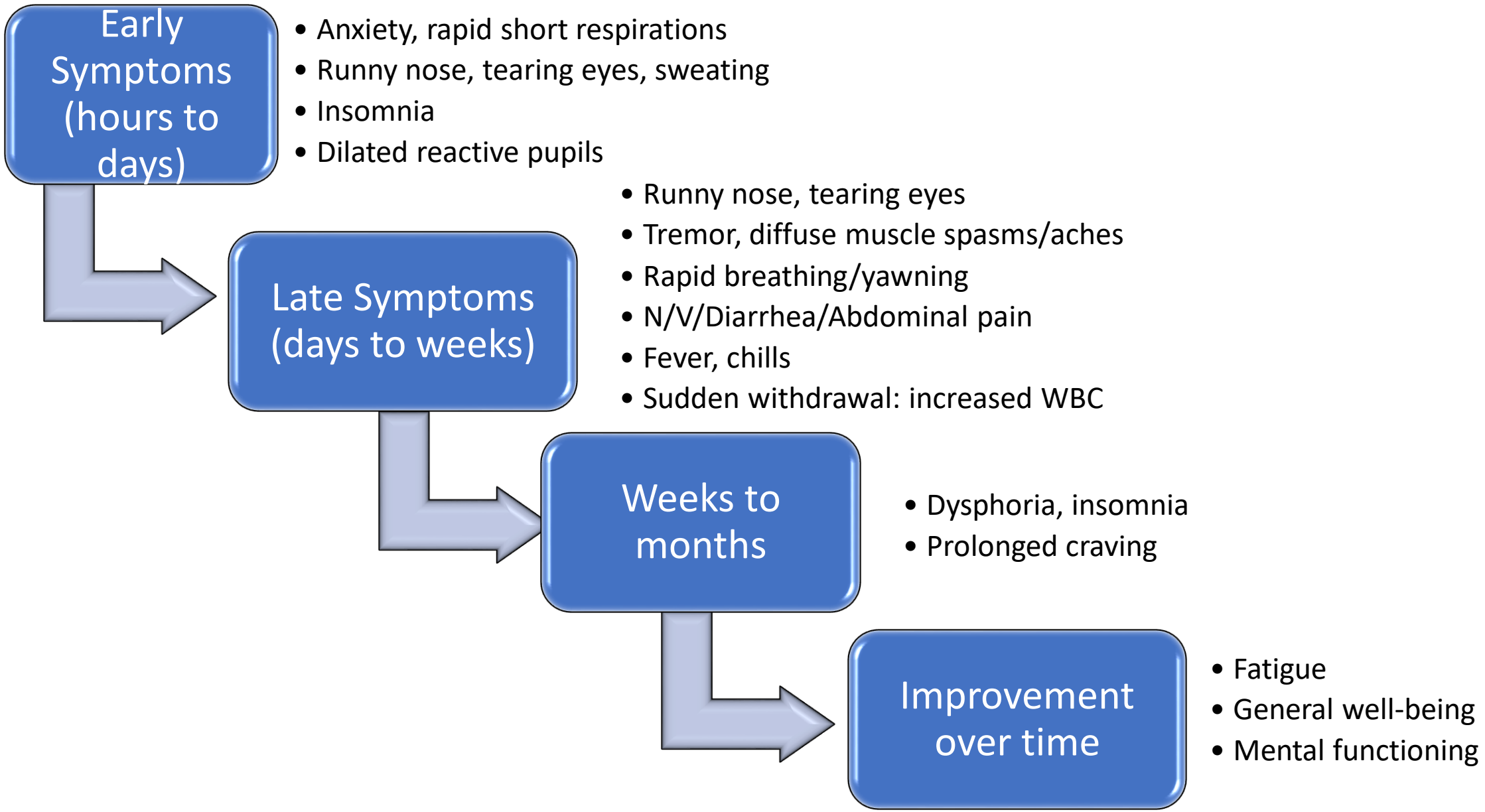
John A Sturgeon, PhD, Mark D Sullivan, MD, PhD, Simon Parker-Shames, MPH, David Tauben, MD, Paul Coelho, MD, Outcomes in Long-term Opioid Tapering and Buprenorphine Transition: A Retrospective Clinical Data Analysis, *Pain Medicine*, , pnaa029, https://doi.org/10.1093/pm/pnaa029

Withdrawal: Points to remember

- Withdrawal symptoms can start 2 to 3 half lives after last dose of opioid
  - IR products (Morphine, hydromorphone, oxycodone): 6-12 hours following last dose
  - ER products or methadone: 1-4 days after last dose
- Withdrawal symptoms are not generally life threatening in the absence of severe co-morbidities
- Post acute withdrawal syndrome (PAWS)
  - Symptoms which occur/continue after the acute withdrawal symptoms have resolved.
    - Symptoms can be cyclical
    - can occur and last up to 6 months or longer
  - Genal malaise
  - Fatigue
  - Decreased well-being
  - Difficulties with stress management
  - Opioid Craving

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(6):828-842.
Kral LA, Jackson K, Uritsky T. A practical guide to tapering opioids. Ment Health Clin [Internet]. 2015;5(3):102-8. DOI: 10.9740/mhc.2015.05.102.
Srivastava AB, Mariani JJ, Levin FR. New direction in the treatment of opioid withdrawal. Lancet 2020;395:1938-48.
SAMSHA Substance Abuse Treatment Advisory Protracted withdrawal. 2010;9(1):1-8.

Withdrawal Stages



Adapted from https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf

Clinical Opiate Withdrawal Scale (COWS)

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset**: *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

Score:
5-12: mild
13-24: moderate
25-36: moderately severe
≥36: severe withdrawal

https://www.drugabuse.gov/sites/default/files/ClinicalOpiateWithdrawalScale.pdf

Symptoms of Withdrawal	First Line Treatment Option
Autonomic Symptoms (Sweating, Tachycardia, Myclonus)	Clonidine 0.1-0.2mg po q6-8h; hold if BP<90/60; recommend test dose: Administer 0.1mg po and check BP in 1 hour. Dose increases need BP check. Re-evaluate in 3-7 days, Average Duration of use: 15 days Alternative options: • Baclofen 5mg po tid; titrate up to max of total daily dose: 40mg • Gabapentin: start at 100mg to 300mg bid or tid dosing. TDD: 1800-2100mg in divided bid to tid dosing. • Tizanidine 4mg po tid, can increase to 8mg po tid
Anxiety, Dysphoria, Lacrimation, Rhinorrhea	• Hydroxyzine 25-50mg po tid prn • Diphenhydramine 25mg po q6h prn
Myalgias	• Naproxen 375-500mg po bid • Ibuprofen 400mg to 600mg po qid • APAP 65mg q6h prn • Topical counterirritants or lidocaine agents
Sleep Disturbance	• Trazodone 25-300mg po qhs
Nausea	• Prochlorperazine 5-10mg po q4h prn • Promethazine 25mg po or rectally q6h prn • Ondansetron 4mg po q6h prn
Abdominal cramping	• Dicyclomine 20mg po q6-8h prn
Diarrhea	• Loperamide 4mg po initially then 2mg with each loose stool, NTE 16mg/day • Bismuth subsalicylate 524mg po q ½ hour to 1 hour NTE 4192mg/day

Table from: Veterans Health Administration PBM Academic Detailing Service. Pain Management Opioid Taper Decision Tool_ A VA Clinician's Guide. Available at https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_ Taper_Tool_IB_10_939_P96820.pdf

BRAVO! A Collaborative Approach to Opioid Tapering. https://www.oregonpainguidance.org/wp-content/uploads/2020/03/BRAVO-FINAL-3.13.20-1.pdf

Continued Assessment is Vital

- Continue reassessment and follow up
  - Weekly follow up appointments improve rates of success
  - Monitor for signs of anxiety, depression, suicidal ideation
- Psychosocial support
- Education
  - Pain initially might worsen but many patients experience improved pain levels and improved function after opioid taper
- Use of adjuvant medications for pain control
- Encourage nonpharmacological treatment options
- Provide Naloxone and clear overdose risk education

Patient Example

SC is a 64 y/o female presenting to clinic for second visit

Past Medical History:

- Chronic back pain following MVA 2012
  - Chronic LTOT since 2012
- Fibromyalgia
- Hyperlipidemia
- Hypertension
- Obesity
- Obstructive Sleep Apnea

- Random urine drug screens:
- Appropriate x 2 years

- PDMP Review:
- Filling history appropriate
- X 2 years.

- MRI: Minor degenerative disc disease L3-4, L4-5, L5-S1.

Patient Example

SC is a 64 y/o female presenting to clinic for second visit

Current Medications:

- Oxycodone ER 80mg 1 po q12h x 6 months
- Ibuprofen 600mg po tid
- Pregabalin 25mg tid
- Lisinopril 40mg po daily
- Atorvastatin 40mg po daily
- Senna S 2 tabs bid (OTC)
- PEG 17gm in 8oz water daily (OTC)

- Pt is requesting an opioid tapering plan in hopes of discontinuation of opioid but also open to lower doses

- Pain levels continue to be reported at 8/10 each month
- QOL: reported as poor
- Chronic Opioid Induced Constipation issues x 1 year
  - Treatment failure with all various bowel regimens

Tapering Goals

- Patient education
- Utilization of other pain management options
  - Adjuvants/nonopioids
  - Nonpharmacological options
- Develop slow taper plan based on her comfort level with pauses if needed
- Minimize and hopefully avoid any withdrawal reactions

Tapering Options

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Tapering Option

SC is a 64 y/o female presenting to clinic for second visit

Original Dose: Oxycodone ER 80mg 1 po q12h

Start with Oxycodone ER 20mg tablets

- Month 1: 4 tablets po qam, 3 tablets qpm
- Month 2: 3 tablets po q12h
- Month 3: 3 tablets po qam, 2 tablets qpm
- Month 4: 2 tablets po q12h
- Month 5: 2 tablets po qam, 1 tablet po qpm
- Month 6: 1 tablet po q12h

Switch to Oxycodone ER 10mg tablets

- Month 7: 2 tablets po qam, 1 tablet po qpm
- Month 8: 1 tablet po q12h
- Month 9: 1 tablet po daily
- Discontinue

Plan Continued

- Frequent reassessment
- Patient educated on nonpharmacological treatment options
  - Deep breathing techniques
  - Guided imagery
  - Meditation
  - Massage
  - Acupuncture
- Monitoring
  - Pain levels
  - Signs of withdrawal
  - Activity levels
  - Aberrant behavior evaluation

Tapering

INCLUDE THE PATIENT IN DISCUSSION

DETERMINE SPEED OF TAPER BASED ON PATIENT SITUATION

REFER TO SPECIALIST IF SUSPECTED OUD

SUPPLY NARCAN AND PROPER EDUCATION