DEPRESCRIBING Opioids

- Patients with a substance use disorder to a controlled drug should be referred for treatment to a gazetted addiction service under the Misuse of Drugs Act 1975; opioid substitution treatment is likely to be needed for patients with an opioid use disorder
- Consider referral to, or discussion with, a specialist service for patients who have had a previously unsuccessful taper attempt in primary care or a significant or untreated psychiatric co-morbidity
- Most other patients can be encouraged to engage with a plan to slowly decrease their opioid dose within a primary care setting, however, those taking high doses or who have signs of aberrant behaviour (but do not meet the criteria for an opioid use disorder) may need to be discussed first with a specialist service
- If more than one opioid is being taken, either taper the most potent one first, or convert all opioids into a single long-acting opioid with specialist support and then taper
- Have a written agreement defining the aims/goals (e.g. to improve function and mood) and methods of opioid tapering; ensure the patient understands the conditions documented in the agreement
- Discuss possible withdrawal symptoms, e.g. anxiety, insomnia, flu-like symptoms, abdominal pain, vomiting, diarrhoea, tachycardia, tremor, and when to seek help. The **Clinical Opiate Withdrawal Scale** can be used to assess the severity of withdrawal.
- Ensure the patient has adequate support at home (otherwise assistance from a specialist service may be needed)

Consider the patient's treatment regimen

- **Individualise the tapering schedule**; consider dose, duration of treatment and whether the opioid is immediate- or modified-release. Also consider patient goals, concerns, how they are tolerating the taper and responding to the dose reduction.
- **Check with the patient** what they are actually taking – do not assume the prescribed dose is being taken (i.e. it could be more or less)
- **Prescribe scheduled doses.** Consolidate short- and long-acting regimens and "as needed" use into a set regimen (ideally using a modified-release opioid, usually morphine). Keep the daily schedule the same for as long as possible, e.g. two or three times daily. An opioid tapering calculator can assist this process.
- **Increase the dispensing frequency** as appropriate based on the level of control the patient has over their opioid use, e.g. to weekly*, set days of the week or daily. N.B. This approach will not be appropriate for all patients, e.g. if a pharmacy is not easily accessible.

* Opioids are Class B and C controlled drugs. These are dispensed every ten days or monthly unless otherwise specified. Specifying "weekly" on the prescription means the pharmacist can more easily identify when patients are collecting their medicines early than with a longer cycle (because the day of the week stays the same).

Opioid tapering calculators

- Victoria Department of Health + NPS MedicineWise **Opioid Tapering Calculator** (Australia)
  Can be used to calculate morphine equivalent doses, then a morphine dose reduction regimen, with variable rate of taper (5% - 25% per week for 20 weeks), or reduction of individual opioids.
- AMDG **Opioid Tapering Calculator** (Washington State, USA)
  Can be used to taper a short-acting or long-acting opioid (or both), at a tapering rate of either 5% or 10% weekly or monthly.
- An app-based **opioid equianalgesic calculator** is available from the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists; an opioid dose **equivalency table** is also available.

Be flexible on the rate of taper

- **Reduce total daily dose gradually**, e.g. by 10% weekly, depending on clinical circumstances. Avoid abrupt discontinuation unless patient safety is at risk (e.g. high risk of overdose). Individualise the speed of the taper (see below). The rate of taper may need to be slowed, e.g. monthly rather than weekly dose adjustments, while managing withdrawal symptoms.
- **Start small.** Initially reducing the dose by a small amount can help build trust between the patient and clinician, ease patient fear about potential withdrawal symptoms and increase engagement in deprescribing.
- **Slow and hold the taper where needed.** Once the patient has tapered to one-third of their original dose, slow the taper to half of the previous rate. Some patients may require the taper to be slowed before they reach this point. A slower taper, e.g. 5 – 10% every four-to-eight weeks, may be needed for some patients, e.g. those who have taken opioids for a long duration, with significant co-morbidities, who are anxious about tapering, or are psychologically dependent on opioids.
- **Hold the dose where necessary**, e.g. reduced function, worsening mood or pain. Avoid increasing the dose where possible, but there may be some patients for whom returning to the previous dose is temporarily required.
- **Re-calculate dose.** As doses are re-calculated, they may not be able to be easily made up using available medicine formulations, therefore, clinical judgement is required in prescribing an appropriate dose. Once the lowest available dose is reached, consider extending the time between doses, e.g. alternate day dosing.
- **Dose reduction timing.** If possible, divide the total daily dose reduction across two doses (i.e. reduce two doses by 10 mg instead of one dose by 20 mg), however, this may only be practical for patients tapering from a high dose. For patients starting their taper from a lower dose, consider reducing the dose at the time of day when their pain is less (e.g. for a patient taking 20 mg oxycodone, twice daily, reduce the morning dose to 15 mg if this is when their pain is best controlled and leave the evening dose at 20 mg).
- **Consider switching patients taking oxycodone to morphine** (or methadone with specialist advice), as it is reportedly easier to taper. First switch the patient to the equivalent dose of morphine, and once they are stable at that dose, commence the taper. However, this will depend on individual clinical circumstances and the current dose of oxycodone being taken (low doses may be able to be tapered without switching). Regular review is required when switching, so the morphine can be titrated according to withdrawal symptoms, as cross tolerance between opioids is variable.

Regularly monitor the patient during the tapering period

- **Establish and document a monitoring plan.** Initially, monitoring should occur more often, e.g. daily or weekly, and reduce in frequency over time, e.g. monthly.
- **Monitor progress** (in person or via phone, text/email or patient portal). Ask about and document any benefits the patient is experiencing, e.g. improvements in energy levels, mood or alertness, functional status, e.g. activity levels, exercise (function rather than pain should be the focus), and withdrawal symptoms. Monitor for symptoms or signs of mental health conditions (e.g. anxiety, depression) that can be unmasked during the tapering process; manage as appropriate.
  - Reassure patients experiencing worsening pain that this is usually temporary and should reduce over time. Consider reducing the frequency and size of dose decrements if the pain is problematic.
  - For patients experiencing complicated or significant withdrawal symptoms, consider discussion with, or referral to, a pain or addiction medicine specialist
  - The **Clinical Opiate Withdrawal Scale** can be used to assess the severity of opioid withdrawal
- **Consider illicit drug use or diversion.** In some cases, it may be appropriate to have a conversation with the patient about whether they are using opioids or other prescription medicines obtained by other means or illicit drugs. Also ask whether they are sharing their medicine with anyone else and if necessary, offer advice on how to resist pressure to do this.

- **Concomitant non-pharmacological and self-management strategies** can be recommended throughout the dose tapering process, e.g. cognitive behavioural therapy, relaxation/meditation/mindfulness, exercise. This is particularly useful for patients experiencing pain, insomnia or other withdrawal symptoms, e.g. anxiety.
- **Adjunctive pharmacological treatments** are not generally encouraged but can be prescribed as required for continued management of the underlying condition or for patients experiencing problematic withdrawal symptoms, e.g. ondansetron for nausea and vomiting, hyoscine butylbromide (Buscopan) for gastrointestinal cramping, loperamide for diarrhoea, paracetamol or NSAIDs for pain. Benzodiazepines, clonidine and some opioids (e.g. buprenorphine) may have a role in opioid withdrawal but should not be prescribed to manage withdrawal symptoms without specialist advice.
- **Endeavour to complete the taper.** The length of time to complete the taper is variable, e.g. weeks to one year or more. Prepare to maintain patients on low doses for an extended period of time if they are unable to complete the taper and are willing to follow the treatment agreement or discuss with/refer the patient to a pain or addiction medicine specialist.

For further information on opioid dose tapering, and for information on opioid substitution treatment, see: **bpac.org.nz/bpj/2014/october/opioid-addiction.aspx**

Patient resources

Opioid medicines - lowering my dose (Healthify)
healthify.nz/medicines-a-z/o/opioid-medicines-lowering-my-dose/

Patient tapering plan (NPS MedicineWise)
www.nps.org.au/assets/NPS-MedicineWise-Lowering-your-opioid-dose.pdf