Opioid Tapering Decision Tree

This tool was developed to assist providers through the opioid tapering process for patients treated for chronic pain. The process and recommdations are a framework and are not intended to replace individual clinical judgement.

Stand Together for Safe Opioid Use

From Prevention to Recovery

START

Is the patient demonstrating psychiatric illness/inappropriate substance use behavior?

Yes

STOP

Do Not Proceed With Taper

Initiate/Refer the patient to Substance Use Disorder (SUD) Treatment[1,2]

No

Indications that Taper May Be Appropriate:

- Patient choice
- Daily dose >50 morphine equivalent dose (MED) without clear benefit
- Concurrent benzodiazepine use
- Excess sedation/ side effects
- Resolution of condition
- Decline in activities of daily living (ADLs) attributed to treatment

No

STOP

If the patient is stable, do not proceed with taper and ensure proper documentation of analgesic effectiveness of:

Pain
Enjoyment
General Activity[3]

Yes

Consider steps 1–6 to begin taper process.

1. Medication Choice

- Consider if extended-release opioid formulation would be more appropriate for taper than the current short-acting opioid.[4]

2. Speed of Taper

- **Reduce dose at a rate that does not produce withdrawl symptoms**.
- Consider slower taper for longer duration as this can provide a lower risk of withdrawal.
- Educate the patient on what to expect and how to identify withdrawal.
- Obtain the patient's support for tapering plan.
- Communicate often with patient regarding symptoms during taper.[5]

Taper Speed Options[6]

Least Aggressive to Most Aggressive Taper

Taper 10% of the original dose every 5 to 7 days until 30% of the original dose is reached, followed by a weekly taper by 10% of the remaining dose.	Taper down the total daily opioid dose by 10% per week for most patients.	• Slower protocol: Taper by 20% to 50% of the original dose per week. • Faster protocol: Taper with daily decreases of 20% to 50% of the initial dose down to a threshold (30–45 mg of morphine every day), followed by a decrease every 2 to 5 days.

- Speed of taper should be **inversely** correlated with duration of opioid use to prevent withdrawal symptoms
- Twice a month to monthly dose adjustments can be considered in the case of long-term opioid treatment exceeding 2 years[7]

3. Other Pharmalogic Interventions at Dose Adjustments

- Consider use of Alpha-adrenergic agonists, such as clonidine or guanfacine, in addition to tapered opioids to suppress physicial withdrawal symptoms (flushing, tremors, etc.).[8]

4. Psycholocial and Behavioral Support

- Consider psychosocial interventions combined with pharmalogical support.
- Find and coordinate psychologic care with skilled professionals.[7]

5. Preventing Taper Failure and Patient Dropout

- Note that patient dropout is the greatest risk to taper completion.[9]
- Monitor patients with depression, and those who continue to report significant pain on high doses of opioids as they are higher risk for dropout or relapse.[10, 11]

6. Monitoring of Tapering Patients

- Schedule monthly visits during opioid treatment.
- Follow up within 7 days after each dose reduction.
- Conduct routine urine drug testing to indicate if the medication is being used as prescribed.
- Potential for adjunctive use of controlled substances rises during taper.[12]

Find this handout along with other opioid-related resources online at www.hsag.com/hqic/tools-resources/ade

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