



Tapering and Discontinuing Opioids

This factsheet accompanies the 2010 VA/DoD Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain. It was created to aid with treatment of adult populations. Department of Veterans Affairs (VA) and Department of Defense (DoD) employees who utilize this information are responsible for considering all applicable regulations and policies throughout the course of care and patient education.

This factsheet informs DoD and VA providers of approved strategies to successfully taper opioid medications. The decision to taper and/or discontinue opioid treatment should be made after a discussion with the patient. Once a decision is made to discontinue therapy, providers need to decide how fast the taper should be to prevent precipitating opioid withdrawal symptoms in physically dependent patients. There is no single tapering strategy to fit all patients; however, treatment should not be stopped abruptly unless there is an urgent need to stop therapy (e.g., an allergic reaction).

Reasons to discontinue opioids include, but are not limited to:

- Existence of severe unmanageable adverse effects
- Serious non-adherence to the treatment plan
- Evidence of illegal or unsafe behaviors
- Misuse suggestive of addiction to prescribed medication
- Lack of therapy effectiveness
- A desire on the part of the patient to discontinue therapy
- Decreased level of pain in stable patients
- Goals of treatment are not met

Remember: Tapering is generally not life threatening for patients without significant co-occurring conditions, but it can be quite uncomfortable.

Recommendations for Discontinuing and Tapering:

- Decisions regarding tapering schedule should be made on an individual basis, faster or slower tapering may be warranted.
- Complete evaluation of the current treatment plan, co-occurring psychological conditions and other relevant factors should be completed prior to initiation of the taper.
- Clear written and verbal instructions should be given to patients and their families to educate them about the slow taper protocol to minimize withdrawal symptoms.
- For patients who are at high risk to engage in aberrant behaviors (e.g., parasuicidal acts, dealing/selling medications, those with severe impulse control disorders), tapering opioids in a primary care setting is not appropriate. Those patients should be referred to an addiction or pain specialist.

- Patients with complicated withdrawal symptoms should be referred to a pain specialist or a center specializing in withdrawal treatment.
- Patients who develop an opioid addiction should be referred for substance use disorder treatment. While opioid prescribing should stop and withdrawal assessed if illicit drug use is clear, opioid agonist therapy, tapering, or discontinuation of opioid therapy should be decided after the consultation.

Withdrawal

Opioid withdrawal can develop within hours of drug cessation. While the effects of withdrawal are unlikely to be life threatening in patients without significant comorbidities, it can be quite uncomfortable. Signs and symptoms of withdrawal may include gastrointestinal symptoms (e.g., abdominal cramping, nausea, vomiting, diarrhea), musculoskeletal symptoms (e.g., myalgias, arthralgias, muscle spasms), anorexia, yawning, lacrimation, salivation, rhinorrhea, piloerection, insomnia, anxiety, irritability, dysphoria and manifestations of sympathetic hyperactivity such as diaphoresis, tachycardia, fever, mydriasis or mildly elevated blood pressures. In patients with significant comorbidities, withdrawal should be medically managed.

According to Mattick & Hall (1996), medically managed withdrawal is successful to the degree that the patient:

- Is physiologically stable
- Avoids hazardous medical consequences of withdrawal
- Experiences minimal discomfort
- Reports being treated with dignity and respect
- Completes the tapering protocol (e.g., no longer requires medication for withdrawal symptom management)
- Engages in continuing care for substance use disorder

Patient Education

Patient education is essential to successfully taper opioids. Clear written and verbal instructions should be given to patients and families to educate them about the rapid and slow taper protocols that will minimize withdrawal symptoms, as well as the proper way to dispose of opioids. From the outset of treatment, providers should reassure patients that they will work with them to manage their pain.

Tapering Factors and Protocol

One objective of opioid tapering is to maintain patient safety and comfort during initial and successive phases of the taper. This includes patient preparation to discontinue opioids in order to minimize withdrawal symptoms (e.g., muscle and joint aches, nausea, anxiety, runny nose).

Remember the following patient-specific factors as you begin a new taper:

- In general, the longer the patient has been on opioids, the slower the taper should be.
- Do not treat withdrawal symptoms with opioids or benzodiazepines after discontinuing opioids. More information available at: [agencymeddirectors.wa.gov/Files/OpioidGdline.pdf](https://www.wa.gov/Files/OpioidGdline.pdf)
- Consider tapering opioids in patients who have received regularly scheduled opioids at greater than the recommended starting doses for more than a few days.
- Patients taking opioids on a non-daily, as-needed basis can typically have their medication discontinued without tapering.
- Take into consideration patient-specific factors when deciding whether the patient needs to taper and at what rate. Consider risk of precipitating withdrawal, patient's level of anxiety about discontinuing opioids, duration of opioid therapy, medical and psychological comorbidities, and clinical need for rapid taper.
- Patients who develop a true allergic hypersensitivity reaction to their opioid should have therapy discontinued immediately.
- Taper by 20-50 percent per week (of original dose) for patients who are not addicted. The goal is to minimize adverse/withdrawal effects.
- The rapid detoxification literature indicates that a patient needs 20 percent of the previous day's dose to prevent withdrawal symptoms.
- Consider using adjuvant agents such as antidepressants to manage irritability and sleep disturbance, or antiepileptics for neuropathic pain. More information available at: [agencymeddirectors.wa.gov/Files/OpioidGdline.pdf](https://www.wa.gov/Files/OpioidGdline.pdf)
- The patient on fentanyl should be rotated to a different opioid, either long-acting morphine or methadone. Once the patient is converted, the same guidelines will apply.

- Alternately, with the availability of transdermal fentanyl 12 mcg/hr patches, some patients may be tapered down on fentanyl patches and then given a brief supply of oral short-acting opioids to complete the taper.
- Clonidine 0.1 mg two or three times daily may be used to control many withdrawal symptoms if there are no contraindications. Supplemental medications will often be required as clonidine will not address all withdrawal symptoms (e.g., muscle and joint aches, nausea, diarrhea, anxiety).

More information is available in the **Consultation and Referral** fact sheet for patients who are unable to tolerate the taper as described.

Remember: If the primary care provider anticipates the need to contact a provider outside the DoD or VA regarding the patient's medical care, they must obtain the patient's permission in advance.

Suggested Tapers for...

- Methadone:
 - Decrease dose by 20-50 percent per day until you reach 30 mg/day
 - Then decrease by 5 mg/day every three to five days to 10 mg/day
 - Then decrease by 2.5 mg/day every three to five days
- Morphine SR/CR:
 - Decrease dose by 20-50 percent per day until you reach 45 mg/day
 - Then decrease by 15 mg/day every two to five days
- Oxycodone CR:
 - Decrease dose by 20-50 percent per day until you reach 30 mg/day
 - Then decrease by 10 mg/day every two to five days