Opioid Deprescribing Discussion Tool

A VA Clinician's Guide

VA

U.S. Department of Veterans Affairs

Veterans Health Administration

PBM Academic Detailing Services

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The following guide is intended to review opioid deprescribing and does not include information on all considerations necessary for safe and effective chronic and acute pain management.

Please refer to the ***VA/DOD Clinical Practice Guidelines*** for a more comprehensive overview of pain management.

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Veterans Health Administration

PBM Academic Detailing Services

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VA PBM Academic Detailing Services

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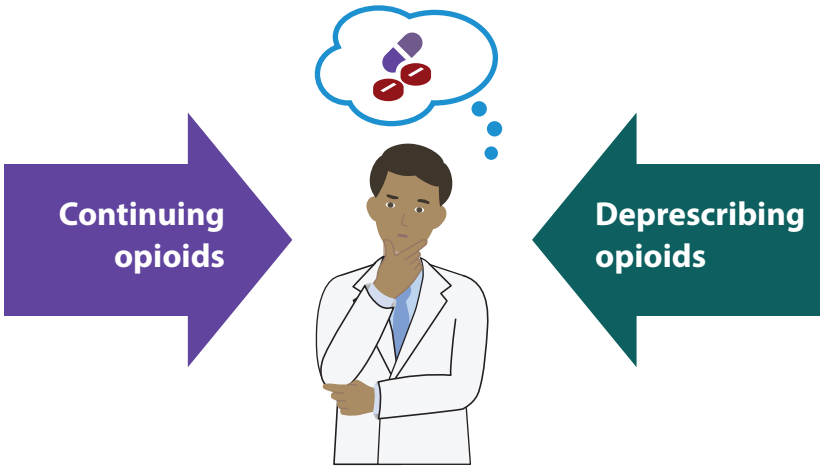
Background

Treating chronic pain is complex and continually evolving. The approach for chronic pain care in Veterans who are prescribed opioids involves an individualized and ongoing clinical assessment.

Clinicians should consider the risks and benefits of both continuing and deprescribing opioids.

Deprescribing includes when opioids are tapered to a lower dose or when they are tapered completely and stopped. One key factor that may influence whether or how to deprescribe is how urgently it needs to be done.

- Commonly, the Veteran has been taking a stable dose of opioids for many years and if deprescribing is being considered, it can be approached in a slow and methodical manner with agreement from the Veteran.
- In other cases, there may be risks present that place the Veteran at imminent risk of harm. In these cases, there is a greater urgency for deprescribing, and the Veteran may not be in agreement.[1-3]



Some patients may benefit from a continued trial of long-term opioid therapy (LTOT) as one part of a comprehensive pain treatment plan when the patient:[4]

- ☑ shows functional benefit from treatment, **and**
- ☑ has no opioid-related concerning behaviors, **and**
- ☑ is not experiencing significant medical risks from LTOT

Work closely with patients to optimize nonopioid therapies while continuing opioid therapy.[2]

Other patients may have greater harms/risks than benefits from opioids and should be considered for opioid deprescribing. A reduction in opioid dose may improve pain, function, and quality of life.

To improve the likelihood of success in reducing opioid doses:

- work in collaboration with the patient and gain agreement on dose reduction,
- reduce the opioid dose slowly, and
- offer other non-pharmacologic and non-opioid evidence-based treatments.[1,2,5-9]

Situations where deprescribing may be considered[1-3,5-9]

Increased risk for opioid-related and overdose-related adverse effects:

- **Opioid related overdose, hospitalization, or injury occurred**
- **STORM Dashboard identifies as very high risk or high risk**
- **Exhibiting opioid-related concerning behaviors**
  - Requesting early refills; loss, theft, or selling medications; obtaining opioids from nonmedical sources; falsifying prescriptions; injecting oral medications; unexpected PDMP or UDT results
- **Adverse effects noted**
  - Cognitive impairment, worsening major depression, hyperalgesia, erectile dysfunction, reduced quality of life or function, severe or unmanageable constipation
- **Concurrent medications or substances which increase the risk for overdose**
  - Alcohol, benzodiazepines, gabapentinoids,* sedative/hypnotics/z-drugs,** skeletal muscle relaxants/antispasmodics, and tricyclic antidepressants. Use of illicit substances.
- **Medical conditions that could increase the risk for overdose**
  - Sleep disorders (e.g., sleep apnea), cognitive impairment, TBI, pulmonary diseases (e.g., COPD), severe kidney or liver disease
- **Mental health conditions that could increase the risk for misuse or overdose**
  - Opioid use disorder (OUD) and other substance use disorders, post-traumatic stress disorder (PTSD), bipolar disorder, anxiety disorders, depression

*FDA reports new respiratory depression warnings for gabapentinoids. ** z-drugs = eszopiclone (Lunesta®), zaleplon (Sonata®), zolpidem (Ambien®). COPD = chronic obstructive pulmonary disease; PDMP = prescription drug monitoring program; STORM dashboard = Stratification Tool for Opioid Risk Mitigation; TBI = traumatic brain injury; UDT = urine drug testing.

Reduced benefit from opioid therapy:

- Condition has resolved (e.g., surgical repair, healed fracture, cancer remission)
- Veteran requests to reduce dose or discontinue opioid
- Insufficient improvements in function and pain despite continued or increased dose

There are gaps in the evidence of how opioid deprescribing should be optimally performed.[1,2,6-9]

There are patients who will benefit from deprescribing with improved functioning and positive outcomes.

Some patients may have a negative response to even a very slow taper.
Evaluation by a pain specialist is important to determine the optimal therapy course.

- Continuing the opioid may be the best strategy in some patients.
- Using buprenorphine for pain, or if they have opioid use disorder/opioid dependence, using buprenorphine/naloxone may be considered.

Individualize the pain treatment plan

Individualizing the pain treatment plan is a vital part of providing evidence-based pain management for Veterans. Assess the risks and benefits of opioids at each visit to ensure the Veteran's treatment plan is individualized, safe, and effective.*[,1-3]

Assess risks and benefits and adjust plan as needed	Mitigate risks	Discuss expectations and goals
Adverse effects and risks of current treatment plan	UDT	Reduction in average pain intensity level
Progress towards functional and pain treatment goals	PDMP	Improved task-oriented functioning
Adherence to safe and effective treatment plan	OEND	Minimizing risks
Mental health screening	MH and Pain Clinic treatment or referrals	Use of self-care tools for pain

*Follow up should be performed at least every 3 months if the opioid dose is stable and more frequently if needed based on individual risk factors. Please see the *VA PBM ADS Transforming the Treatment of Chronic Pain Provider Guide 2017* for more information on chronic pain management recommendations. MH = mental health; OEND = opioid overdose education and naloxone distribution; PDMP = prescription drug monitoring program; UDT = urine drug testing.

There is no VA mandate or requirement for reducing or stopping opioids in Veterans.

VA is mandated by Congress through the Comprehensive Addiction and Recovery Act of 2016 to provide safe and effective pain care.[10]

Before deprescribing opioids, add and optimize non-opioid treatments to help Veterans feel supported and that their pain will continue to be addressed. *See pages 11-12 for more information.*

The way an opioid is decreased is important.[1-4]

Risks and benefits of opioid therapy should be considered prior to reducing the dose or discontinuing an opioid. **If LTOT must be tapered, then assure limiting other risks during dose reductions; avoid abrupt discontinuation or rapid dose reduction when possible.**

If an acute or life-threatening issue is identified and abrupt changes are required, consult a specialist for support (e.g., pain clinic, substance use disorder clinic, suicide prevention coordinator, etc.). Consider adding additional protective factors including offering hospitalization if appropriate.

Risks of discontinuing opioids[3]

Abrupt or rapid discontinuation increases the risks.*

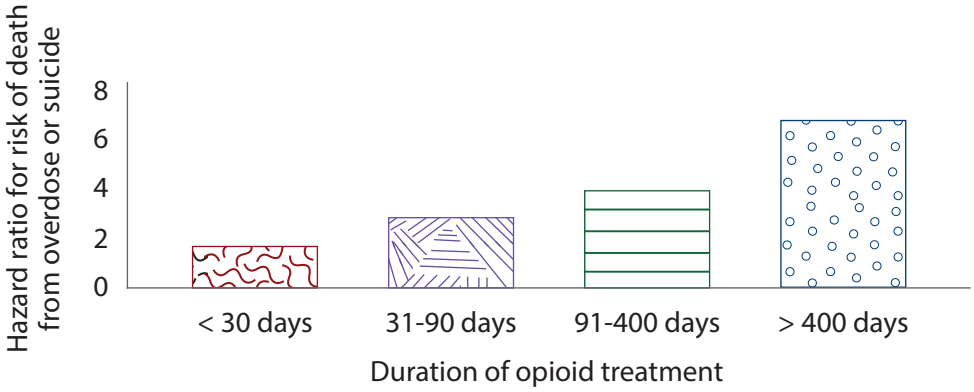
Discontinuing can lead to:

- Significant opioid withdrawal
- Exacerbation of pain
- Serious psychological distress
- Thoughts of suicide
- Patients seeking other sources of opioids to treat pain or withdrawal symptoms. This can increase the risk for overdose if containing illicitly manufactured fentanyl.

*Risks may be lower when tapering is done slowly (2-10% every 4 to 8 weeks).

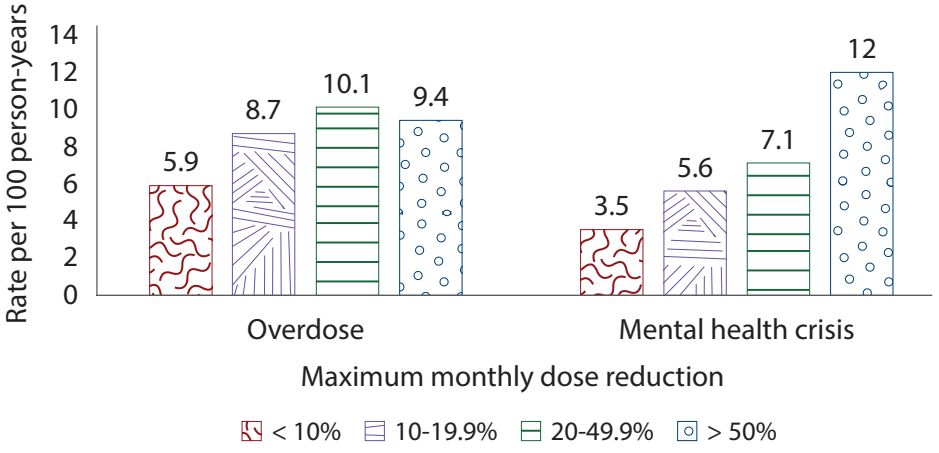
Veterans taking opioids for longer periods of time need slower tapers and more support for mental health conditions.[11]

Stopping opioid treatment was associated with a higher risk of overdose or suicide.



Opioid dose reduction may be associated with increased overdose and mental health crisis events.[12]

Percent opioid dose reduction and associated overdose and mental health crisis events



Monthly outcome counts during follow-up were modeled as a function of the maximum monthly rate of dose reduction during any previous 60-day period.

Thus, the less than 10% category may include patient periods prior to tapering, patients with gradual dose reductions, or patients with no dose change.

DID YOU KNOW

The first few months after starting or stopping opioids are times where Veterans may be at an increased risk for overdose or suicide.[11,12] This elevated risk can continue for up to 12 months. Veterans should be monitored more closely, and risk mitigation continued during any taper.

Abrupt opioid discontinuation or rapid dose reduction is not recommended unless there are indications of an immediate life-threatening issue, e.g., warning signs of impending overdose, or if the Veteran is not taking the opioid (confirmed by the Veteran or by consistent negative urine drug tests by immunoassay and confirmatory testing).[1,3]

If a more rapid dose reduction is needed, the Veteran should be referred to a pain or mental health specialist. Hospitalization may be needed in some cases.

Avoid abrupt discontinuation of opioids in most circumstances.

Starting the conversation about tapering opioids with patients on a stable opioid dose[3-5]

If a taper is found to be necessary, assure the Veteran there will be ongoing support to care for their chronic pain. The next step is talking with the Veteran about the need for a taper and what to expect during the taper.

- ☑ **Explain the risks of opioid therapy** as they apply to the Veteran and why tapering is necessary.
- ☑ **Review how the taper will be done** and how support will be provided during the taper.
- ☑ **Pauses in the taper may be necessary** for the Veteran to adjust to the new dose before further reductions are made.
- ☑ **If the Veteran has opioid use disorder (OUD)** or shows behaviors consistent with OUD or opioid dependence, **do not start an opioid taper.** First the provider should:
  - Address OUD and consider prescribing medications for opioid use disorder (mOUD), or
  - Connect the Veteran with a substance use disorder clinic that can provide OUD services.

  This same approach should be taken in circumstances where the behaviors of OUD may not be apparent prior to the taper but may present during the tapering dose reductions.

Tips for starting the conversation

	Instead of this:	Consider saying this:
Start the conversation	*"The VA wants me to stop your oxycodone. My hands are tied."*	*"I am concerned about your safety with the oxycodone I am giving you for pain. May I talk to you more about this?"*
Continue the conversation	*"I know you have pain, but I cannot give you this medicine anymore. You will have to figure something else out."*	*"Have you heard about the increase in deaths from overdose in people taking opioids like oxycodone?* *"How do you feel about this?"*
Introduce other options for pain	*"You know, acetaminophen would work just as well. How about you go to the drug store and pick up some of that?"*	*"There are other treatments and medications we can try for your pain.* *"They are safer and could be even more effective than the oxycodone. May I tell you more about this?"*
Talk about tapering the opioid	*"I am going to give you a prescription for X tablets of oxycodone.* *"For the first week, cut your dose in half. Cut by another half each week until you are off.* *"We should have it all done by the end of the month."*	*"As we start the new treatment, I recommend that we start with a very small reduction in oxycodone which will help move your dose to a safer level. This change would involve reducing by X tablets a week/month (5-10% reduction per month).* *"In some cases, patients have experienced some discomfort in the first few weeks of the taper, but it usually improves with time.* *"What are your thoughts on reducing the oxycodone?"*
Provide support and follow up	*"I will schedule you to follow up in 6 months."*	*"In 2 weeks, the PACT team (nurse, pharmacist, or provider) will give you a call and see how you are doing with the lower dose of oxycodone and the new treatment."*
Talk about possible emergence of OUD during an opioid taper	*"You are probably addicted to the opioid.* *"It's important you deal with wanting the medication and don't go to the street. That stuff will kill you."*	*"Your brain has been exposed to and has adapted to these medications over the past several years."* *"As the opioid dose is lowered,* • *your brain may react by producing a strong desire to take more opioids, or* • *you may find that you cannot take your mind off opioids or have a difficult time taking them as prescribed."* *"If you notice any of these things, please contact us right away so we can help you. We have effective treatments in case you notice any of these symptoms."*

Building a therapeutic alliance with Veterans is a key part of effective patient care. Reach out to mental health for support if you are having challenges with difficult conversations or engaging Veterans.

Tips to engage Veterans not agreeable to opioid deprescribing[13-17]

Use inclusive language

- Be respectful; use honest communication. Use language that is not stigmatizing or accusatory:
  - *"a person with opioid use disorder"* vs. *"addict"*; *"expressing increased pain"* vs. *"drug seeking"*; *"your urine drug test showed some unexpected results"* vs. *"your tox screen was dirty"*

Apply motivational interviewing techniques

- Express empathy, elicit patient's motivation for change, and guide them to changes that align with motivation (reflect back their reasons for change).
- After asking and being given permission, share experiences you may have had with patients in a similar situation who have benefited from other non-opioid pain treatments.
- Identify shared goals, summarize the patient's plan, and encourage their ability to make changes.

Emphasize new information about safe and effective pain management strategies

- Focus the discussion on new information about risks and treatment options.
- Review the Veteran's current pain management plan, pain level, and functioning.
- Reflect how they may improve with adding evidence-based non-pharmacological therapies.
- Explain that opioid tapering is done slowly, with pauses if needed. If the Veteran's condition or functioning worsens, you may need to return to a previous dose and reassess the taper.

Address concurrent problems

- Refer or provide interventions for mental health, substance use disorders, and comorbidities.
- Discuss with the Veteran how these can worsen the pain.

Correct any misconceptions

- Discuss new evidence and explain that treatments change as we learn more. Avoid placing blame on another provider or the VA.
- Correct any misconceptions and offer to speak with family/significant others.

Respect patient preferences; emphasize that options will remain available to treat their pain

- Consider patient experiences and preference; focus on safe and effective options remaining.
- If unwillingness to initiate recommended treatment plan remains:
  - Maintain open communication. Do not force tapering unless there are significant safety issues.
  - Follow up at least every 3 months and continue to look for opportunities to engage.
  - Refer or provide care for comorbidities. Consider referral to pain clinic.
  - Offer OEND and other risk mitigation strategies.
  - If there are imminent risks to safety by continuing opioids, see page 9: *Situations where there is an immediate risk from the opioid and may require a taper.*

Use shared decision making to develop a plan with the Veteran and clearly communicate the reasons for tapering. If the Veteran provides consent, include family members, friends, and/or caregivers. Special attention must be given to ensure that the Veteran does not feel abandoned.[13,14]

Communication is vital

Lay the foundation

- Listen to the Veteran's story.
- Let the Veteran know you believe that their pain is real and that you care.
- Include family members or other supporters in the discussion (with Veteran permission).

Identify goals

- Discuss their goals for life, not just to be pain free.
- Use biopsychosocial model, e.g., Whole Health approach.
- Have the Veteran fill out the Personal Health Inventory (PHI).*

Offer support for pain management and functioning goals**

- Offer education groups or individual appointments that include Cognitive Behavioral Therapy (CBT) or Acceptance and Commitment Therapy (ACT) for pain.
- Offer referral to Whole Health.
- Offer physical therapy and Complementary and Integrative Health (CIH) interventions such as acupuncture, chiropractic, aqua therapy, meditation, tai chi, or yoga.
- Commit to working with the Veteran on other options for improved function.

Collaborate with the Veteran on a taper plan

- Acknowledge the Veteran's fears about tapering (use motivational interviewing techniques).
- Tapering does not typically need to be started immediately. Work with the Veteran to establish a plan. Pauses may be needed to help the Veteran adjust to the lowered dose. In some cases, the taper may need to be stopped and possibly reversed if the Veteran's condition or functional status worsens.
- Emphasize that you will be slowly tapering opioids to reduce opioid risk, not "cutting off" the Veteran.

*PHI is part of the VA Whole Health Approach: www.va.gov/wholehealth. ***VA PBM ADS Transforming the Treatment of Chronic Pain Provider Guide 2017.*

Involuntary tapering has been associated with non-adherence with the taper, overdose, suicidal ideation, worsening depression and anxiety, and increased use of medical services.[15-17] **Consult pain management and/or mental health services to help determine next steps, if a voluntary taper is not clinically appropriate.**

Situations where there is an immediate risk from the opioid and may require a taper

If the prescribing clinician determines an imminent threat to patient safety, opioids may need to be tapered to safer levels even when the patient has not agreed. The clinician should:

1) Tell the patient their concern.
2) Ensure the patient understands the risks.
3) Consider referral to a specialist as needed and available, such as mental health, substance use disorder, pain clinic, and others.
4) Provide overdose education and prescribe naloxone.

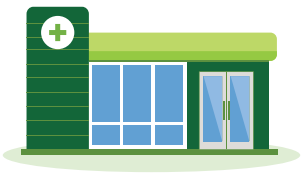
Examples of cases where significant risks to patient safety might limit appropriateness of shared decision making include:

- Evidence that opioids are being diverted to other users
- Known active illicit drug use
- Signs of sedation or intoxication during office visit
- Recent opioid overdose
- Concurrent use of other prescribed or nonprescribed CNS depressants above recommended limits (e.g., drinking excessive alcohol with unsuccessful attempts to reduce use)
- Bowel obstruction or other emergent and significant side effects

In these situations, a more rapid taper may be necessary. *See page 14 for recommendations.*

QUICK TIP

When a faster taper is needed, offering buprenorphine/naloxone for Veterans with OUD, or buprenorphine for Veterans without OUD, can be helpful to reduce pain, reduce precipitated withdrawal, reduce opioid cravings, and support the Veteran while the opioid is stopped. *See pages 18-20 for more information.*



Consider referral to pain clinic for review and assistance with opioid prescribing/deprescribing. Coordinate care between the primary care provider, mental health provider, and pain clinic:

- A review between the Veteran and a pain specialist can solidify the pain care plan and support the primary care provider in its implementation.
- Communicate with the mental health provider who may be already involved in the patient's care, or make a new referral, or involve PCMHI. When tapering and/or discontinuing opioids, providers should be aware of the risk of exacerbation of mental health crisis.
- Coordinate a meeting between the primary care provider, pain clinic, and mental health providers to discuss the care plan. This will help coordinate care, help providers use the same language when talking with the Veteran, and ensure everyone is aware of the plan.

CNS = central nervous system; PCMHI = primary care mental health integration

Before starting an opioid taper: steps to increase success

1 Address both mental health and medical healthcare needs.

Screen for and provide or refer the Veteran to services and evidence-based treatment that can adequately address both mental and medical healthcare needs. Veterans will need support during this transition and beyond (e.g., mental health services, chaplain, whole health, pain clinic).[1-3,11,12,18-20]

Mental Health (MH) Disorders

- Treat and address MH disorders to improve tapering success.
  - A study of 509 Veterans who had clinician initiated opioid discontinuation mostly due to aberrant behaviors (75%) found an increase in rates of suicide and suicidal self-directed violence in those with baseline PTSD or psychotic disorders, but not in patients with substance use disorders.[20]
- **Consult MH provider if Veteran is actively suicidal or has high or intermediate suicide risk.** Use the VA STORM dashboard to identify risk factors associated with overdose/suicide.

Opioid Dependence/Opioid Use Disorder (OUD)

- Identify Veterans who may be suffering from OUD.[18] *See page 17 for more information.*
- Consider how to transition to evidence-based medications for OUD treatment (mOUD) and request consultation or support if needed.

Other Substance Use Disorders

- Provide support for other substance use disorders associated with higher overdose risk:
  - Alcohol use disorder, sedative use disorder, stimulant use disorder, tobacco use disorder

Medical Healthcare Needs

- Ensure Veteran is referred to specialty care if necessary for screening and treatment of medical conditions that can increase the risk for overdose, including:
  - Sleep disorders (e.g., sleep apnea), pulmonary diseases (e.g., COPD), severe kidney or liver disease

Medications and Substances

Medications

- Sedative/hypnotics (benzodiazepines and z-drugs*): work with the Veteran to determine if these medications are still necessary. Slowly taper one medication at a time.
- Gabapentinoids,** tricyclic antidepressants, and muscle relaxants may increase overdose risk when used with opioids. If the Veteran is benefiting from these, continue them while tapering the opioid.

Substances

- Work with Veterans to reduce risky drinking and drinking above the recommended limits.†
- Caution Veterans that non-prescribed, non-FDA-approved drugs, particularly opioids and stimulants, can be counterfeited and contaminated with fentanyl, which greatly increases overdose risk. Provide overdose education and naloxone.

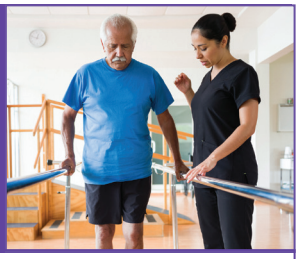
PTSD = Post traumatic stress disorder. *z-drugs = eszopiclone (Lunesta®), zaleplon (Sonata®), zolpidem (Ambien®).
**FDA warning of risk of respiratory depression with gabapentinoids.
†See VA PBM ADS Alcohol Use Disorder Campaign Materials for more information.

2 Offer multimodal pain treatments and non-opioid pain therapies.[1-3]

Behavioral therapies

- Psychosocial interventions
  - Cognitive behavioral therapy (CBT)
  - Acceptance and commitment therapy (ACT)
- Whole Health coaching*
- Nutrition
- Integrated pain team
- Mental health, substance use treatment

Physical and movement therapies



- Physical therapy
- Occupational therapy
- Recreational therapy/MOVE Strength and Wellness program
- Aquatic therapy
- Yoga
- Tai Chi

MOVE! Weight Management Program for Veterans

Medications**

- Acetaminophen, NSAIDs
- Topical therapies
  - NSAIDs (e.g. diclofenac), lidocaine, methyl salicylate, capsaicin
- Serotonin-norepinephrine reuptake inhibitor—duloxetine
- Gabapentin, pregabalin†
- Tricyclic antidepressants

Procedural and manual therapies

- TENS unit evaluation
- Sleep apnea evaluation
- Acupuncture
- Chiropractic therapy
- Orthotics, prosthetics
- Surgery§

*Whole Health website: https://www.va.gov/wholehealth.

**Refer to *VA PBM ADS Pain Quick Reference Guide* for information on specific products and dosing.
NSAIDs = nonsteroidal anti-inflammatory drugs.

†FDA warning of risk of respiratory depression when gabapentinoids.

§Some types of surgery may reduce pain levels while other surgeries may worsen pain levels. Surgery has risks and benefits that need to be reviewed by the Veteran, primary care provider, and surgeon.

Whole Health: What is it and can it help?

THE CIRCLE OF HEALTH HAS FOUR KEY ELEMENTS

Me:
The equation begins with you, the "Me" at the center. Your story is unique and your Whole Health begins with what matters to you.

Self-care:
Each of us has the power to impact our well-being. Whole Health offers the skills and support you need to make the changes you want.

Professional care:
Your healthcare team is there to help with the prevention and treatment of disease and illness.

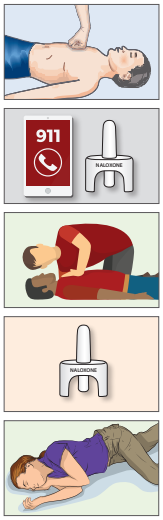
Community:
Just as there is a "Me" at the center of the circle, there is a "We" that enfolds it. Your Community is the people and groups you connect with.

The **Personal Health Inventory (PHI)** introduces the eight self-care areas on the Circle of Health above and helps Veterans determine how they affect their health. Based on the answers provided in the PHI, the tool helps Veterans determine areas where they should focus and create a **Personal Health Plan**. Veterans can then choose clinical treatments that will help them based on what matters to them the most.

For more information: The Circle of Health - Whole Health (va.gov)

3 Ensure the Veteran is offered OEND.

OEND includes not only naloxone distribution, but also education and training for Veterans on how to prevent, recognize, and respond to an opioid overdose.



1. Check for a response
2. Shout for help, call 911, and get naloxone
3. Check for breathing—if not breathing normally, give naloxone and start cardiopulmonary resuscitation (CPR)
4. Consider a second dose of naloxone if not breathing normally after 2 to 3 minutes
5. Place in recovery position

For more information, see VA PBM ADS OEND SharePoint.

4 Proactively manage opioid withdrawal before and during the taper.[21-24]

Withdrawal symptoms are generally not life-threatening and may not be seen with a slow taper. Acute withdrawal usually occurs within about 5-10 hours for immediate-release formulations and 10-15 hours for extended-release formulations. Most symptoms improve over time, with many resolving 5 to 10 days after opioid dose reduction or cessation.[21-25]

Common withdrawal symptoms:

- Sweating
- Diarrhea
- Intestinal cramps
- Nausea/vomiting
- Pupillary dilation
- Myalgia
- Irritability/anxiety
- Restless leg syndrome

Fast or rapid tapers may be more likely to cause withdrawal symptoms. Ask the Veteran if they experienced withdrawal symptoms when tapering or stopping opioids before. The Clinical Opiate Withdrawal Scale (COWS) can be used to assess severity of withdrawal (drugabuse.gov).[22]

Veterans with OUD/opioid dependence: Medications for opioid use disorder (mOUD) are indicated instead of opioid withdrawal management. Buprenorphine/naloxone would be used in most cases. *See pages 18-19.*

Veterans without OUD/opioid dependence: Slowing the rate of taper can reduce withdrawal symptoms. If this cannot be done, consider switching to buprenorphine. *See pages 19-20.* Clonidine or lofexidine (not on VA formulary) can be used for opioid withdrawal symptoms if switching to buprenorphine is not indicated.[24]

Address mental health and medical needs, provide OEND, and proactively manage opioid withdrawal before starting an opioid taper whenever possible.

5 Opioid deprescribing

When an opioid must be reduced or stopped, the way it is decreased is important.[1-3, 26-30]

Establishing an opioid taper plan with the Veteran, communicating it to the Veteran, and documenting it in the medical record significantly increases the probability that the Veteran will continue the taper.[13,14]

Example tapers for opioids[26-30]

Note: *Opioid tapers need to be individualized.*

SLOWEST TAPER Reduce by 2-10% every 4-8 weeks with pauses in taper as needed.*	**SLOWER TAPER** Reduce by 10-20% every 4 weeks with pauses in taper as needed.*	**FAST TAPER**** Reduce by 10-20% every week.*	**RAPID TAPER**** Reduce by 20 to 50% of first dose, then reduce by 10 to 20% every day.
Consider for patients taking high doses of long-acting opioids for many years.	*Consider for patients who need a slow taper but are interested in reducing slightly faster than the slowest taper.*	*Consider if the Veteran requests a faster taper, if they have been taking opioids intermittently, or for a short duration, e.g., < 3 months.*	*Consider when continuing opioid could cause the patient imminent harm.*
Ex: morphine SR 60mg Q8h = 180 mg MEDD **Month 1:** 60mg SR QAM, 45mg SR noon, 60mg SR QPM [8% reduction]** **Month 2:** 45mg SR QAM, 45mg SR noon, 60mg SR QPM **Month 3:** 45mg SR Q8h **Month 4:** 45mg SR QAM, 30mg SR noon, 45mg SR QPM **Month 5:** 30mg SR QAM, 30mg SR noon, 45mg SR QPM **Month 6:** 30mg SR Q8h **Month 7:** 30mg SR QAM, 15mg SR noon, 30mg SR QPM **Month 8:** 15mg SR QAM, 15mg SR noon, 30mg SR QPM **Month 9:** 15mg SR Q8h **Month 10:** 15mg SR Q12h **Month 11:** 15mg SR QPM†	*Ex:* morphine SR 15mg Q8h + oxycodone 5mg TID = 67.5 mg MEDD§ **Month 1:** morphine SR 15mg QAM and QPM and oxycodone 5mg TID [20% reduction]** **Month 2:** morphine SR 15mg QPM and oxycodone 5mg TID **Month 3:** oxycodone 5mg TID **Month 4:** oxycodone 5mg BID **Month 5:** oxycodone 5mg once daily	*Ex:* oxycodone 10mg IR every 4 hours prn (taking 6 tablets a day) = 90 mg MEDD Consider using 5mg oxycodone IR tablets during the taper. **Week 1:** 10 mg IR QAM, 10 mg IR noon, 10 mg IR QPM, 10 mg IR QHS [17% reduction]** **Week 2:** 10 mg IR QAM, 10 mg IR noon, 5mg IR QPM, 10 mg IR QHS **Week 3:** 10 mg IR QAM, 5 mg IR noon, 5 mg IR QPM, 10 mg IR QHS **Week 4:** 5 mg IR QAM, 5 mg IR noon, 5 mg IR QPM, 10 mg IR QHS **Week 5:** 5 mg IR QAM, 5 mg IR noon, 5mg IR QPM, 5mg IR QHS **Week 6:** 5 mg IR QAM, 5 mg IR noon, 5 mg IR QPM **Week 7:** 5 mg IR QAM, 5 mg IR QPM **Week 8:** 5 mg IR QPM	*Ex:* morphine SR 90mg Q8h = 270 mg MEDD **Day 1:** 60mg SR (15mg x 4) Q8h [33% reduction] **Day 2:** 45mg SR (15mg x3) Q8h **Day 3:** 30mg SR (15mg x2) Q8h **Day 4:** 15mg SR Q8h **Days 5-7:** 15mg SR Q12h **Days 8-11:** 15mg SR QHS, then stop¥ Consider starting buprenorphine or buprenorphine/naloxone at any step in the rapid taper. *See pages 18-20.*

*Continue taper based on Veteran response. Pauses may allow time to acquire new skills for management of pain and emotional distress while allowing for neuro-biological equilibration. **Fast and rapid tapers can cause withdrawal effects and may need treatment. Some may need inpatient care. †May consider morphine IR 15mg ½ tablet (7.5mg) twice daily. §If both long-acting and short-acting opioids are prescribed, the decision on the formulation tapered first should be individualized based on medical history, mental health diagnoses, and patient preference. Data shows that overdose risk is greater with long-acting preparations. ¥Continue taper until the desired dose of opioid reached or opioid is stopped. IR = immediate release; MEDD = morphine equivalent daily dose; SR = sustained release

Determine the appropriate taper schedule, provide written instructions, and clearly communicate each dosage reduction to the Veteran.

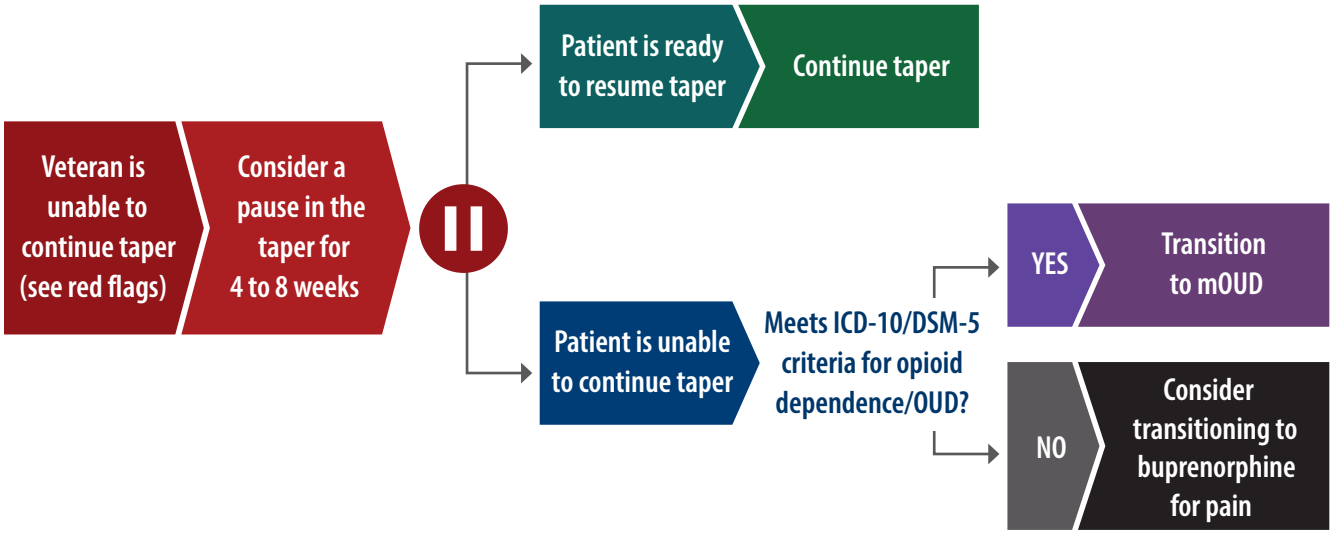
Follow-up is an important component of opioid tapers.

Frequency should be determined based not only on the speed of the taper, but also on the Veteran's reaction to the taper. **More frequent follow-up may be needed for Veterans who are experiencing symptom exacerbations or other negative consequences from the taper.**

FOLLOW-UP	SLOWEST TAPER	SLOWER TAPER	FAST TAPER	RAPID TAPER
WHEN	1 to 4 weeks after starting taper then monthly before each reduction	1 to 4 weeks after starting taper then monthly before each reduction	Weekly before each dose reduction	Daily before each dose reduction
WHO	Healthcare team who initiated the taper*			
HOW	Clinic, video telehealth, and/or telephone**			
WHAT	Patient function† and pain intensity, sleep, physical activity, personal goals, stress level			
RED FLAGS	**Veterans with these red flags might not be able to continue taper:** increased anxiety, stress, suicidal thoughts, strong desire to take more opioids, difficulty taking mind off opioids, or difficulty taking opioids as prescribed			

*Follow-up for tapering is recommended to be a team function with various team members taking on roles in which they have demonstrated specific competencies. Mental Health practitioners may need to be included in the follow-up plan. **Providers will need to determine whether a telephone, video telehealth, or in clinic appointment is appropriate based on each Veteran's risk level. If there are issues with the Veteran obtaining outside prescriptions or they are displaying other opioid-related concerning behaviors during the taper, providing follow-up in a clinic visit may be more optimal than a telephone visit.
†Quality of Life Scale for patients with pain: www.theacpa.org/resources/quality-of-life-scale

Pausing during the taper may be necessary. Assess at each follow up visit.[3]



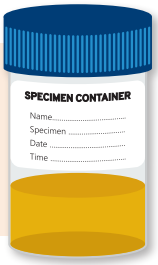
Re-evaluate the taper and assess for unmet mental health and medical needs or adverse consequences of the taper at each follow up visit.

Identifying OUD[18,19]

OUD symptoms such as drug cravings or inability to control one's use may go unrecognized if patients continue to receive an opioid analgesic. **Opioid-related concerning behaviors may become more apparent and reveal an opioid use disorder when opioids are tapered or discontinued.**

Consider how to manage unexpected results on UDT or PDMP or opioid-related concerning behaviors. This can be an opportunity to have a collaborative discussion with the patient, evaluate for opioid misuse, diversion, or use disorder, and offer treatment if indicated.

Please note: Opioids should not be stopped abruptly due to unexpected results from UDT or PDMP. Send for confirmatory testing if necessary and discuss the findings with the patient and/or family member to gain a better understanding of the result.



Provide support if opioids are tapered and discontinued. If the Veteran has OUD, switch to buprenorphine/naloxone. Prescribing of burpenorphine/naloxone can be done in primary care, mental health, and pain clinics by DEA-registered practitioners. Clinical pharmacy practitioners who are DEA registered can learn more about prescribing by reviewing: *PBM Guidance Controlled Substance Prescriptive Authority for Pharmacists.*

For questions about buprenorphine or assistance evaluating for OUD, contact your local pain and/or addiction specialists, or your Stepped Care for OUD Train the Trainer (SCOUTT) Team: https://dvagov.sharepoint.com/sites/VHASUD/SCOUTT

Access the National SUD Consultation Service

The National Telemental Health Center (NTMHC) provides consultation for the management of patients with complex SUD needs.

- **Ask the Expert** allows providers to ask any non-PHI question which is then triaged to subject matter experts nationally.
- **Direct Telehealth Videoconferencing** provides videoconferencing with Veterans for diagnostic clarification and treatment recommendations. *Please note:* The NTMHC does NOT assume the care of Veterans and does not provide direct treatment.
- **E-consult** allows expert clinicians from the NTMHC to review the Veteran's medical record and provide recommendations for care.

Email: AskTheExpert-SubstanceUseDisorder@va.gov (no PHI) or call: 203-479-8181.

OUD diagnostic criteria can be linked with practical example behaviors[18,19]

ICD-10 is the official diagnosis system used in VA medical records. The ICD-10 code "opioid dependence" is equivalent to the term "opioid use disorder" as defined in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)*.

Linking the diagnostic criteria with practical examples*

DSM-5 OUD (2-3 symptoms = mild; 4-5 = moderate; ≥ 6 = severe)	**ICD-10 Opioid Dependence** (3 or more criteria)	**Example behaviors**
1. Craving or a strong desire to use opioids	**A.** A strong desire to take the drug	Constantly thinking about the next dose
2. Using larger amounts of opioids over a longer period than initially intended	**B.** Difficulties in controlling opioid use	Taking a larger dose than prescribed Unable to control opioid use Repeatedly driving under the influence
3. Persisting desire or unable to cut down on or control opioid use		
4. Recurrent use in situations that are physically hazardous		
5. Continued use despite physical or psychological problems related to opioids	**C.** Persisting in opioid use despite harmful consequences	Request for more opioids after adverse effects (e.g., overdose, bowel obstruction, negative impact on mood or sleep)
6. Continued use despite persistent social or interpersonal problems related to opioids		Continued use despite poor work performance or family requests to stop using opioids
7. Spending a lot of time to obtain, use, or recover from opioids	**D.** Higher priority given to opioid use than to other activities and obligations	Spending a lot of time frequenting EDs or clinics with a goal of obtaining opioids
8. Failure to fulfill obligations at work, school, or home due to use		Progressive neglect of tasks (e.g., cleaning, poor work performance)
9. Activities are given up or reduced because of use		Stopping previously enjoyed activities (e.g., gardening, softball, card games)
10. Withdrawal**	**E.** A physiologic withdrawal state	Experiencing symptoms of withdrawal between use of opioids
11. Tolerance**	**F.** Tolerance	Requires larger doses for effect, whether a high or pain relief

ED = emergency department. *The criteria in Table 1 should be present at the same time within the prior 12 months in order to make the diagnosis. **Tolerance and withdrawal do not count for the DSM-5 diagnosis if taken as prescribed under medical supervision. Example: Veterans who have been taking opioids to manage pain will develop tolerance and withdrawal. However, they may not meet DSM-5 criteria for OUD.

Buprenorphine formulations for the treatment of OUD/Opioid Dependence[25,31-33]

	Buprenorphine/naloxone (Suboxone®)*[,34,35] – OR – Buprenorphine (Subutex®)[36]
Typical dosing	During initiation, titrate dose to treat withdrawal and cravings, and as tolerated. **DAY 1:** Initiate • Suboxone® 2/0.5 mg or 4/1 mg; titrate by 2/0.5 mg or 4/1 mg every 1-2 hours to a target dose of 8/2 mg/day • Subutex® 2 or 4 mg; titrate by 2 or 4 mg every 1-2 hours to a target dose 8 mg/day **DAY 2:** Start with Day 1 dose, continue titrating • Suboxone® in 2/0.5 mg or 4/1 mg increments to a target dose of 16/4 mg/day • Subutex® in 2 or 4 mg increments to a target dose of 16mg/day **Target maintenance dose:** Suboxone® 12/3 mg to 16/4 mg/day or Subutex® 12-16 mg/day in a single daily dose
Maximum dose	24 mg/day; higher doses may be used in some cases (e.g., uncontrolled withdrawal or cravings) but should be carefully monitored, and rationale for use documented
Clinical pearls	• **Initiate when in sufficient withdrawal** (e.g., Clinical Opiate Withdrawal Scale [COWS] score ≥8) to avoid precipitated withdrawal.** • **SL tablet:** Place under the tongue until dissolved. For doses requiring >1 tablet, place 2 tablets under the tongue at a time until fully dissolved and repeat with remaining tablets. • **SL film:** Place 1 film under the tongue close to the base on the left or right side and allow to completely dissolve. If a second film is needed, place on the opposite side of the mouth. If a third film is needed, wait for the first two to dissolve, then place inside the right or left cheek. Do not cut or chew. • Avoid swallowing due to reduced bioavailability. • Avoid abrupt discontinuation and gradually reduce dose to taper off.

*The dosing regimens for Zubsolv® (buprenorphine/naloxone sublingual tablet) and Cassipa® (buprenorphine/naloxone sublingual film) differ from those for Suboxone.[37-39] Sublocade (buprenorphine sustained-action injection) is another product approved for OUD. All three of these products require a non-formulary consult. For further information, refer to *Opioid Use Disorder Pharmacotherapy Recommendations for Use (RFU)* at the PBM INTRAnet.

**For strategies to taper full agonist opioids prior to starting buprenorphine, see page 14. To review conversion factors and calculate MEDD for buprenorphine, visit: www.belbuca.com/hcp/buprenorphine-dosing-titration/opioid-conversion. Consider providing a medication disposal bag for disposal of any remaining full agonist opioids.

Alternative initiation approaches for sublingual buprenorphine[40-46]

For patients with concern or history of intolerable precipitated opioid withdrawal during buprenorphine initiation, consider an alternative initiation approach:

- Continue current full agonist opioids (including use of illicit opioids) for 4 to 8 days. Consider providing a medication disposal bag for disposal of any remaining full agonist opioids.
- Gradually up-titrate sublingual buprenorphine to the lowest effective dose for management of withdrawal and cravings, as tolerated. Doses may be further up-titrated as clinically indicated. Please note the following example requires tablet splitting (using 2 mg SL film).

For more information, see the *VA PBM ADS Buprenorphine for Opioid Use Disorder Clinician Guide*.

Alternative dosing strategies to initiate buprenorphine (micro-dosing)[40-46]

	<80 mg MEDD		80-150 mg MEDD		>150 mg MEDD	
Day	**Full agonist opioids**	**SL Bup**	**Full agonist opioids**	**SL Bup**	**Full agonist opioids**	**SL Bup**
1	Continue	1 mg TDD	Continue	1 mg TDD	Continue	1 mg TDD
2	Continue	2 mg TDD	Continue	2 mg TDD	Continue	2 mg TDD
3	Continue	3 mg TDD	Continue	3 mg TDD	Continue	3 mg TDD
4	Continue	4 mg TDD	Continue	6 mg TDD	⬇ to 150 mg MEDD*	6 mg TDD
5 (+)	STOP	4 mg TDD	STOP	6 mg TDD	STOP	9 mg TDD

MEDD, morphine equivalent daily dose; SL, sublingual; Bup, buprenorphine; TDD, total daily dose. *Additional buprenorphine dosing for OUD are available at: *VA PBM ADS Buprenorphine for Opioid Use Disorder Clinician Guide.*

Use of buprenorphine for pain

Buprenorphine is a partial opioid agonist. There are two buprenorphine products that are approved for the treatment of chronic pain: buprenorphine transdermal patch and buprenorphine buccal film. These formulations are effective for pain and may have a reduced risk for respiratory depression and overdose deaths compared to full opioid agonists.

Buprenorphine has **similar efficacy** compared to other opioids for treatment of chronic low back pain, osteoarthritis, neuropathic pain, cancer pain, and post-operative pain.[47,48] Consider buprenorphine for:

- ☑ Patients with moderate to severe chronic pain requiring around-the-clock opioid treatment for an extended period, **AND**
- ☑ Patients with difficulty tapering the dose of full mu-opioid agonists **OR** one of the following:

High risk for traditional opioid therapy[1,31,47]

- History of drug overdose
- Concurrent use of CNS depressants
- Severe respiratory instability, sleep disordered breathing
- Acute psychiatric instability, high acute suicide risk, mental health disorders
- Prescribed long-term (>90 days) or high dose opioids (>120 mg MEDD)*
- Opioid tolerance but does not meet criteria for OUD
- Under the age of 30
- Traumatic brain injury

Special populations[31,47]

- Poor or unpredictable gastrointestinal absorption
- Difficulty swallowing
- Older adults
- Severe renal impairment
- Mild-moderate hepatic impairment
- Other opioids are ineffective or not tolerated
- Immunosuppressed patients
- Patients who wish to remain sexually active

See *VA PBM Buprenorphine Formulations for Pain Management Recommendations for Use (RFU)* for more information. *To review conversion factors and calculate MEDD for buprenorphine, visit: www.belbuca.com/hcp/buprenorphine-dosing-titration/opioid-conversion

Buprenorphine dosing for patients on opioids[31,47-50]

Buprenorphine transdermal patch (Butrans®)[31,49]

Initial dose:

- <30 mg MEDD: 5 mcg/hour when next dose is due
- 30-80 mg MEDD: taper to <30 mg MEDD, then initiate 10 mcg/hour when next dose is due
- >80 mg MEDD: may not be adequate analgesia, consider buprenorphine buccal film

Change patch and rotate site every 7 days

Buprenorphine buccal film (Belbuca®)[37,50]

Initial dose:

- <30 mg MEDD: 75 mcg film when next dose is due, once daily or q12hr
- 30-89 mg MEDD: taper to <30 mg MEDD, then initiate 150 mcg q12hr when next dose is due
- 90-160 mg MEDD: taper to 30 mg MEDD, then initiate 300 mcg q12hr when next dose is due

>160 mg MEDD: may not provide adequate analgesia, consider using buprenorphine/naloxone

Alternative initiation approaches for buprenorphine buccal film

Consider an alternative initiation approach for patients unable to taper to 30mg MEDD or with concern for/history of intolerable opioid withdrawal during buprenorphine initiation. Either convert directly to an equivalent dose, or cross-titrate for a short period of time. Provide a medication disposal bag.

For patients taking ≥80 mg MEDD, convert directly to an equivalent dose of buprenorphine buccal film:[40]

☑ **80-160 mg MEDD:** initiate 300 mcg 8-12 hours after last dose of full agonist opioids, q12 hr

☑ **161-220 mg MEDD:** initiate 450 mcg 8-12 hours after last dose of full agonist opioids, q12 hr

Alternatively, continue current full agonist opioids for 4 to 8 days or continue full opioid agonist as needed and gradually up-titrate buprenorphine buccal film to the lowest effective dose.[41-46]
For patients who stabilize (no withdrawal, intolerable pain) before reaching the proposed end dose, it is not necessary to proceed with further buprenorphine dose escalation.

	30-59 mg MEDD		60-89 mg MEDD		90-120 mg MEDD		121-160 mg MEDD	
Day	**Full agonist opioids**	**Buccal Bup**	**Full agonist opioids**	**Buccal Bup**	**Full agonist opioids**	**Buccal Bup**	**Full agonist opioids**	**Buccal Bup**
1	Continue	150 mcg BID (300 mcg TDD)	Continue	150 mcg BID (300 mcg TDD)	Continue	300 mcg BID (600 mcg TDD)	Continue	300 mcg BID (600 mcg TDD)
2	Continue	300 mcg BID (600 mcg TDD)	Continue	300 mcg BID (600 mcg TDD)	Continue	300 mcg QAM + 600 mcg QPM (900 mcg TDD)	Continue	300 mcg QAM + 600 mcg QPM (900 mcg TDD)
3	Continue	450 mcg BID (900 mcg TDD)	Continue	450 mcg BID (900 mcg TDD)	Continue	600 mcg BID (1200 mcg TDD)	Continue	600 mcg BID (1200 mcg TDD)
4	Continue	450 mcg BID (900 mcg TDD)	Continue	600 mcg BID (1200 mcg TDD)	Continue	600 mcg QAM + 900 mcg QPM (1500 mcg TDD)	Continue	600 mcg QAM + 900 mcg QPM (1500 mcg TDD)
5 (+)	STOP	450 mcg BID (900 mcg TDD)	STOP	600 mcg BID (1200 mcg TDD)	STOP	600 mcg QAM + 900 mcg QPM (1500 mcg TDD)	STOP	900 mcg BID (1800 mcg TDD)

Recognize warning signs for suicide

Warning signs are individual factors that signal an acute increase in risk that the Veteran may engage in suicidal behavior in the immediate future (e.g., minutes to days).[51] **Recognizing warning signs is the key to creating an opportunity for early assessment and intervention.**

The Columbia Suicide Severity Rating Scale (C-SSRS) is a suicide risk screening that is used to identify those who may be at an elevated acute risk for suicide. Screen for suicide before tapering opioids. Continue to monitor during and after a taper.

? DID YOU KNOW

The C-SSRS can be used at any time to identify Veterans at risk for suicide.

Three direct warning signs of suicide[51]

1. **Communicating suicidal thought verbally or in writing**
2. **Seeking access to lethal means (e.g., firearms or medications)**
3. **Demonstrating preparatory behaviors (e.g., giving away belongings or pets)**

These warning signs are likely to be even more dangerous if the person has previously attempted suicide, has a family history of suicide, or intends to use and has access to lethal means such as firearms or medications.[51]

If warning signs are observed or reported, it is important to ask the patient if they are experiencing thoughts of suicide. Starting a conversation can mean the difference between a tragic outcome and a life saved.

> *It sounds like you have been having a rough time and I appreciate you telling me. I am going to ask you some questions so that I can better understand your experiences and be sure that we are helping you as best we can.*

Did you know help is available? At any point in time you need support, validation, or some direction around treating a Veteran who is at risk of suicide, you can **request a free consult** with an expert in Veteran suicide risk assessment and management.

Identify Veterans who may be experiencing suicidal thoughts or suffering from an undiagnosed OUD and provide further assessment, treatment, or referral to mitigate risks.

Summary

Consider the following when evaluating for opioid deprescribing:

Is a taper needed? Evaluate the risks vs. the benefits of continuing opioid therapy.

Use shared decision-making to discuss risks and benefits of reducing the dose or stopping, and gain Veteran agreement. If the Veteran is at imminent risk for harm, tapering may need to begin without agreement.

What is the goal? Is the initial goal to reduce to a lower dose or taper to complete discontinuation?

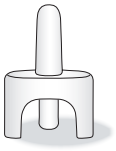
Set the taper speed. Slower tapers of 10% or less every 4 weeks are often the most tolerable and successful. Use a more rapid taper if the Veteran is at imminent risk for harm or diversion is identified.

How long has the Veteran been taking opioids? The longer the duration, the longer it should take to taper the opioid.

Provide support for other mental health, substance use, and medical conditions.

Keep directions about the taper clear for everyone! Document the rationale for the taper and its schedule in the Veteran's medical record.

Be ready for pauses in the taper and evaluate for opioid dependence or opioid use disorder when appropriate. Consider transitioning to buprenorphine transdermal or buccal film for pain if needed.



Provide overdose prevention education and prescribe naloxone for every patient who is tapering opioids.

Online resources

CLINICIAN RESOURCES

VA PBM Academic Detailing Service Educational Materials

- **VA internal SharePoint:** VA Academic Detailing Service - Home (sharepoint.com)
- **VA external website:** VA Pharmacy Benefits Management Services Academic Detailing Service (va.gov)

VA PBM Formulary Management Clinical Guidance (VA internal SharePoint)

- **Clinical Recommendations**
  - Buprenorphine Formulations for Pain Management Recommendations for Use (RFU)
  - Buprenorphine Naloxone for OUD and Pain Supplemental Information

VA Dashboards That Can Identify High-Risk Veterans on Opioid Therapy

- STORM tool (VA internal Sharepoint)
- Academic Detailing Pain Priority Panel Report (VA internal SharePoint)
- OSI (Opioid Safety Initiative) PBM Dashboard

Motivational Interviewing Resources

- **VA Resources:** VA MI and MET Training Programs (VA internal SharePoint)
- **External Resources:**
  - www.motivationalinterviewing.org
  - www.padesky.com/clinical-corner

Veterans Health Administration (VHA) Pain Management – Transforming VA Pain Care:

www.va.gov/painmanagement/index.asp

VA Opioid Overdose Education and Naloxone Distribution (OEND) Implementation Internal SharePoint:

dvagov.sharepoint.com/sites/VACOMentalHealth/oend/default.aspx

Defense and Veterans Center for Integrative Pain Management Joint Pain Education Program (JPEP):

www.dvcipm.org

PATIENT RESOURCES

Whole Health in the VA: Whole Health Home (va.gov)

Veterans Health Library Chronic Pain Patient Resources: www.veteranshealthlibrary.va.gov/DiseasesConditions/ChronicPain/

In Spanish: www.veteranshealthlibrary.va.gov/Spanish/DiseasesConditions/ChronicPain/

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Veterans Health Administration
PBM Academic Detailing Services

This reference guide was created to be used as a tool for VA providers and is available from the Academic Detailing SharePoint.

These are general recommendations only; specific clinical decisions should be made by the treating provider based on an individual patient's clinical condition.

VA PBM Academic Detailing Services Email Group:
PharmacyAcademicDetailingProgram@va.gov

VA PBM Academic Detailing Services SharePoint Site:
https://dvagov.sharepoint.com/sites/vhaacademicdetailing

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