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Opioid Deprescribing and Documentation

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Objectives

- Discuss the risks associated with opioid use
- Describe opioid withdrawal
- Design an opioid withdrawal plan
- Summarize opioid documentation strategies

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50 & 90 Morphine Milligram Equivalents (MME)

- >50 MME daily
  - No clinical evidence for improved pain control in non-palliative, non-cancer or non-end-of-life
  - Avoid increasing dose
- >90 MME daily
  - Significant increase in risk of OD
  - CDC: "carefully justify a dose higher"

MME	Retrospective Cohort Study	Nested-Case Control Study
20-49	1.44	1.32
50-99	3.73	1.92
>100	8.77	2.04
>200		2.88

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR. 2016.

90 Days of Opioid Treatment

- 90 days = definition of chronic pain
- Studies show > 90 days of continuous use, opioid treatment is more likely to become life-long
- >90 days of use → higher-risk patients

Braden et al. J Pain. 2008.
Korff et al. Clin J Pain. 2008.
Martin et al. J Gen Intern Med. 2011.

Possible Reasons for Opioid Tapering/ Discontinuation

- No clinically meaningful reduction in pain or lack on improvement in function
- Patient request
- Severe side effects (constipation, cognitive impairment)
- Dosage indicative of high risk (>90 MME)
- Non-adherence or unsafe behaviors
- Concerns around substance use disorder
- Overdose
- Medical comorbidities that ↑ risk (OSA, fall risk, advanced age)
- Concomitant medications (benzodiazepines)
- Co-morbidities that worsen with opioids (PTSD,

VA PBM. https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf; accessed 10/4/2020

Considerations for Tapering

- Determine if initial goal is **dose reduction** or **complete discontinuation**
  - Have a conversation with patient/family
- Factors in speed of taper
  - Concern for concomitant mental health disorder (anxiety, depression, PTSD)
  - Concerns for OUD
  - Central sensitization (fibromyalgia, complex chronic pain syndromes)
  - Mistrust/ 'moral injury'
  - Medical comorbidities (LFT, fall risk, sleep apnea)

VA PBM. https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf; accessed 10/4/2020

Considerations for Tapering

- Longer, slower tapers tend to me more tolerable
- The longer the duration of opioid use, the longer the taper must be to be successful (usually)
- May need to slow taper as lower doses are achieved

VA PBM. https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf; accessed 10/4/2020

Tapering Examples

Slowest Taper (over years)	Slower Taper (over months or years)	Faster Taper (over weeks)	Rapid Taper (over days)
Reduce by 2 to 10% every 4 to 8 weeks with pauses in taper as needed	Reduce by 5 to 20% every 4 weeks with pauses in taper as needed	Reduce by 10 to 20% every week	Reduce by 20 to 50% of first dose if needed, then reduce by 10 to 20% every day
May consider for patients taking high doses of long-acting opioids for many years	Most common taper	May see withdrawal effects, may use adjuvant agents to minimize withdrawal effects	May consider for high risk/OUD/ OD

VA PBM. https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf; accessed 10/4/2020

Tapering Example

Morphine SR 90 mg PO Q8H

Slowest Taper	Slow Taper	Faster Taper
Month 1: 90 mg SR qam, 75 mg noon, 90 mg qpm (5%)	Month 1: 75 mg (60 mg+15 mg)SR Q8h (16%)	Week 1: 75 mg SR Q8h (16%)
Month 2: 75 mg SR qam, 75 mg noon, 90 mg qpm	Month 2: 60 mg SR Q8H	Week 2: 60 mg SR (15 mg x 4) Q8H
Month 3: 75 mg SR (60 mg+15 mg) Q8h	Month 3: 45 mg SR Q8H	Week 3: 45 mg SR (15 mg x 3) Q8H
Month 4: 75 mg SR qam, 60 mg noon, 75 mg qpm	Month 4: 30 mg SR Q8H	Week 4: 30 mg SR (15 mg x 2) Q8H
Month 5: 60 mg SR qam, 60 mg noon, 75 mg qpm	Month 5: 15 mg SR Q8H	Week 5: 15 mg SR Q8H
Month 6: 60 mg SR Q8h	Month 6: 15 mg SR Q12H	Week 6: 15 mg SR Q12H
Month 7: 60 mg SR qam, 45 mg	Month 7: 15mg SR at bedime, then DC	Week 7: 15 mg SR QHS x 7 days, then DC

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Opioid Withdrawal

- Not life threatening
  - May not occur with slow taper
- Onset
  - IR: ~6-12 hours
  - ER: ~30 hours
- Peak symptoms: 72 hours
- 5-10 days
  - Early symptoms may resolve
- Weeks to months
  - Dysphoria and insomnia may persist
- Improvement over time
  - Fatigue, mental functioning, pain

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Opioid Withdrawal Symptoms

Early Symptoms (hours to days)	Late (days to weeks)	Prolonged (weeks to months)
Anxiety/restlessness	Runny nose, tearing eyes	Irritability/fatigue
Rapid short respirations	Rapid breathing, yawning	Bradycardia
Runny nose, tearing eyes, sweating	Tremor, diffuse muscle spasms/aches	Decreased body temperature
Insomnia	Piloerection	Craving
Dilated reactive pupils	Nausea/vomiting/diarrhea	Insomnia
	Abdominal pain	
	Fever, chills	
	Increased WBC with sudden withdrawal	

VA PBM. https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf; accessed 10/4/2020

Adjuvant Agents for Treating Opioid Withdrawal Symptoms

Indication	Treatment Options
Autonomic symptoms (sweating, tachycardia, myoclonus)	**Clonidine** • 0.1 to 0.2 mg oral every 6 to 8 hrs; hold for BP < 90/60 • 0.1 – 0.2 mg 2-4 times daily for outpatients • Re-evaluate in 3-7 days • Taper to DC, average duration 15 days
	Baclofen • 5 mg PO TID; up to 40 mg/day • Re-evaluate in 3-7 days; average duration 15 days • May continue to help decrease cravings • Taper to DC
	Gabapentin • 100 to 300 mg; up to 1800 to 2100 mg in 2-3 doses • Helpful for pain, anxiety, insomnia
	Tizanidine • 4 mg PO TID; up to 8 mg PO TID

VA PBM. https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf; accessed 10/4/2020

Adjuvant Agents for Treating Opioid Withdrawal Symptoms

Indication	Treatment Options
Myalgias	• NSAIDs (ibuprofen 400 to 600 mg PO QID) • Acetaminophen 650 mg every 6 hours as needed • Topical menthol/methylsalicylate cream, lidocaine cream/ointment
Sleep disturbance	Trazodone 25 to 300 mg PO at bedtime
Anxiety, dysphoria, lacrimation, rhinorrhea	Hydroxyzine 25 to 50 mg three times a day as needed Diphenhydramine 25 mg every 6 hours as needed
Nausea	• Prochlorperazine 5 -10 mg Q4H PRN • Promethazine 25 mg orally or rectally Q6H PRN • Ondansetron 4 mg Q6H PRN

VA PBM. https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf; accessed 10/4/2020

Adjuvant Agents for Treating Opioid Withdrawal Symptoms

Indication	Treatment Options
Abdominal cramping	Dicyclomine 20 mg Q6-8H PRN
Diarrhea	• Loperamide 4 mg orally initially, then 2 mg with each loose stool, not to exceed 16 mg daily • Bismuth subsalicylate 524 mg every 0.5 to 1 hour orally, not to exceed 4192 mg/day

VA PBM. https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf; accessed 10/4/2020

Treatment for Opioid Use Disorder and Pain Management

- Buprenorphine
  - Partial μ agonist
    - Ceiling on pain management effect
    - Indication: pain or OUD
      - OUD: injection, implant, SL tab
- Buprenorphine/naloxone (Suboxone®)
  - Partial μ agonist/opioid antagonist
    - Indication: OUD, off label for pain
- Limitations
  - Only prescribed by providers with X in DEA number
  - If adding buprenorphine or naloxone to another opioid, can precipitate withdrawal

Treatment for Opioid Use Disorder and Pain Management

- Methadone
  - μ agonist and NMDA receptor antagonist
  - Indication: pain or OUD
  - Limitations: can prescribe for pain, but MAT indication can only be prescribed certified, opioid treatment program

Documentation for Opioid Use

- 2018 Prescribing Guidelines for Pennsylvania: Treating Non-Cancer Pain
  - Initial assessment
    - Medical history with documentation of:
      - Concurrent psychiatric disorders
      - Past or current substance abuse and risk for drug-related behavior
        - NIDA drug screen, BSTAD, SOAPP
      - Conditions that increase risk for opioid related harm: OSA, COPD, concurrent benzodiazepines
      - Medications
        - Previous pain medications/non-pharmacologic therapies
      - Diagnosis
      - Treatment plan
      - Goals of therapy

https://www.health.pa.gov/topics/Documents/Opioids/Non-cancer%20Pain%20Guidelines%20Final.pdf

Documentation for Opioid Use

- 2018 Prescribing Guidelines for Pennsylvania: Treating Non-Cancer Pain
  - Initiation of therapy
    - Agreement of treatment plan with signed opioid agreement
      - Risks/benefits, reasonable goals and expectations, process of care, medication storage, adherence check (UDS)
    - Prescribed daily dose and MME
      - CDC
        - Caution > 50 MME/day
        - Avoid or justify > 90 MME/day
    - Justification if opioids are used concurrently with benzodiazepines

https://www.health.pa.gov/topics/Documents/Opioids/Non-cancer%20Pain%20Guidelines%20Final.pdf
CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR. 2016.

Documentation for Opioid Use

- 2018 Prescribing Guidelines for Pennsylvania: Treating Non-Cancer Pain
  - Chronic opioid therapy
    - Response to therapy
      - Pain intensity
      - Physical/mental functioning
        - ADLs, progress toward goals of therapy
    - Adverse effects
    - Aberrant behavior
      - UDS results
      - PDMP findings
      - Pill counts

https://www.health.pa.gov/topics/Documents/Opioids/Non-cancer%20Pain%20Guidelines%20Final.pdf

Documentation for Opioid Use

- 2018 Prescribing Guidelines for Pennsylvania: Treating Non-Cancer Pain
  - Discontinuation of treatment
    - Rationale for taper/DC
      - Risks outweigh documented benefits
    - DC or tapering plan/schedule
    - Referral for substance use disorder

https://www.health.pa.gov/topics/Documents/Opioids/Non-cancer%20Pain%20Guidelines%20Final.pdf

Other Considerations for Opioid Documentation

- Last dose of opioid
- Date of last UDS and plan for next UDS
- Red flags
  - Verbal abuse of staff
  - Early refills
  - Lost/stolen prescriptions
  - Asking for specific products
  - Reasons to avoid adjuvant therapy

Case Questions- Poll Ques #1

- Which of the following are symptoms of opioid withdrawal? Select all that apply.

A. Tearing eyes
B. Yawning
C. Pin point pupils
D. Muscle aches
E. Diarrhea

Case Questions- Poll Ques #2

- JP is a 72 yo M that has taken morphine for LBP x 10 yrs. Wants to lower his dose. Limits his IR doses to 1 Q3 days. Taking morphine ER 60 mg PO Q8H w IR 15 mg PO Q4H PRN. Which of the following would be an acceptable first step in tapering?
  - A. Morphine ER 60mg PO Q12H
  - B. Morphine ER 45 mg PO QAM, 45 mg at noon, and 60 mg QPM
  - C. Morphine ER 60 mg PO QAM, 45 mg at noon, and 60 mg QPM
  - D. Morphine IR 15 mg PO Q6H PRN

Case Questions- Poll Ques #3

- RG is an 87 yo female that has been oxycodone for her RA for 15+ years. She is now struggling with falls and cognitive impairment. Taking oxycodone ER 40 mg PO Q12H. Which of the following would be an acceptable first step in tapering her oxycodone?
  - A. Oxycodone ER 20 mg PO Q8H
  - B. Oxycodone ER 30 mg PO Q12H
  - C. Oxycodone ER 30mg PO QAM and 40 mg PO QPM

Case Questions- Poll Ques #4

- FM is a 78 yo F that has taken oxycodone for neuropathy from chemo X 15 years. During her taper, she experiences tachycardia, sweating, insomnia, and anxiety. VS: BP 120/78, HR 89. Which of the following medications would best help her symptoms?

A. Clonidine 0.1 mg PO Q8H
B. Gabapentin 300 mg PO nightly
C. Trazodone 25 mg PO nightly
D. Hydroxyzine 25 mg PO Q8H

Case Questions- Poll Ques #5

- Which of the following should be documented for a patient with opioid use? Select all that apply.

A. Goals of therapy
B. Response to therapy
C. Tapering plan
D. Concurrent psychiatric disorders
E. Justification if used with a BZD

Questions?