Opioid tapering

Basic principle: Stay engaged with patient, provide psychosocial support and manage any withdrawal symptoms.

1. Long acting opioids: decrease total daily dose by 5-10% per week
2. Short acting opioids: decrease total daily dose by 5-15% per week
3. Often once 25-50% of initial dose is reached, can slow taper rate to 5% per week
4. Regimen may need to be slowed toward end of tapering process
5. Consider adjunct medications for any opioid withdrawal symptoms:
    - Antidepressants for irritability, sleep disturbance (e.g., trazodone)
    - Hydroxyzine for anxiety and insomnia
    - Anti-epileptics for neuropathic pain
    - Clonidine for autonomic withdrawal (rhinorrhea, diarrhea, sweating, tachycardia, hypertension)
    - NSAIDS for myalgias (e.g., ibuprofen)
    - Anti-diarrheal agents for diarrhea

For additional strategies, please see the Nebraska Pain Management Guidance Document at dhhs.ne.gov

Benzodiazepine tapering

<u>Basic principle:</u> Expect anxiety, insomnia and resistance. The slower the taper, the better tolerated.

1. Convert total daily dose from short acting (alprazolam, lorazepam) to longer acting agent (clonazepam, diazepam). Stay at equivalent dose of new agent 1-2 weeks.

2. Reduce dose by 25% and follow-up in 1 week to assess tolerance

4. Reduce daily dose by 5-10% as tolerated every 2-4 weeks in divided doses

5. After reaching ½ of initial dose, can slow down taper

6. Can extend total tapering time to 6+ months

7. Consider adjunct medications to help with rebound anxiety and/or withdrawal symptoms:

    - Hydroxyzine, trazodone, SSRIs, SNRIs, clonidine

For additional strategies, please see the Nebraska Pain Management Guidance Document at dhhs.ne.gov