When to Consider Opioid Tapering

Every patient taking chronic opioid therapy should be reassessed at least quarterly for risks vs. benefits of continued opioid therapy. If the risks outweigh the benefits, opioid tapering should be initiated. This table lists common reasons for considering opioid tapering:

Opioid overdose	If your patient has had an overdose or other serious medical event (e.g., hospitalization, injury) due to opioids, immediate action is needed. It is likely that tapering or treatment with opioid agonist therapy will be necessary in conjunction with treatment of other conditions.
Opioid use disorder	Tapering or transitioning to opioid agonist therapy (buprenorphine, methadone maintenance) is recommended if the patient is misusing opioids or meets criteria for a diagnosis of opioid use disorder (OUD).
Dose over 90 MED	Morphine Equivalent Dosing (MED) is a patient's cumulative intake of all opioids over 24 hours measured in morphine milligram equivalents. Adverse outcomes are dose and duration dependent. Some patients at higher doses may be fully adherent and functioning well with no other risk factors. However, the risks of overdose, opioid use disorder, and other serious adverse effects increase above 90 MED. At least quarterly, reassess the benefits versus the risks of continued opioid therapy at doses over 90 MED.
Pain and function not improved	If your ongoing evaluation of the patient demonstrates that their pain and function are not meaningfully improved, then tapering is recommended.
Adverse opioid effects	Consider tapering if your patient is suffering adverse effects of opioids, such as: • Constipation • Lethargy • Sexual dysfunction • Confusion • Depression • Increased risk for falls • Immune suppression • Respiratory depression Adverse effects can sometimes be managed symptomatically or with an opioid rotation, but if those strategies are not effective or if the adverse effects are severe, consider tapering. Tolerance, dependence, and withdrawal are commonly seen in patients taking chronic opioid therapy. However, these may also represent adverse effects, and depending on the larger clinical picture, may themselves be indication for a taper.
Concurrent sedatives	Consider tapering if your patient is regularly drinking alcohol or taking sedatives, such as: • Benzodiazepines • Carisoprodol You may want to taper the sedative before or instead of the opioid. Involve patients in the discussion of which to taper first. Check your state Prescription Drug Monitoring Program.

Co-occurring conditions (including mental health)	Consider tapering if your patient has co-occurring health conditions that put them at higher risk of adverse outcomes with opioid therapy, such as: • Lung disease • Sleep apnea • Liver disease • Kidney disease • Cardiac arrhythmias • Obesity • Dementia Patients with the following issues are at higher risk for developing opioid misuse or an opioid use disorder: • Depression • Anxiety • Post-traumatic stress disorder • Childhood trauma Integrating mental health treatment alongside chronic pain treatment increases the odds of a successful and therapeutic opioid taper.
Patient request	If your patient requests reducing or eliminating opioids, you should initiate tapering. If pain is still a problem, offer alternatives.

Adapted from BRAVO with permission from Dr. Anna Lembke.

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