Disclosures & CME Credit

Neither the case presenter nor the didactic presenter have conflicts of interest
Off label use of medications may be discussed
PICK UP QUICK TIPS ON…Avoiding opioids and benzodiazepines to reduce risk of overdose

- Almost 1 in 10 opioid overdose deaths involve a benzodiazepine, and the combination may quadruple the risk of death versus opioids alone.
- Tapering opioids before tapering benzodiazepines may lessen anxiety that can be associated with opioid withdrawal.
- Opioid withdrawal symptoms can be highly distressing but medically nonspecific. Benzodiazepines withdrawal symptoms can be life-threatening.
- Slow opioid taper can increase and/or elucidate withdrawal symptoms. Opiate/benzodiazepine taper help minimize withdrawal symptoms.

QUICK FACTS TO CONSIDER

- Clonidine and naltrexone treatment helps.
- Opioid treatment programs can have a reduced risk of death from drug overdose.

CLINICAL PEARLS

- Opioids and benzodiazepines should not be co-prescribed.
- Use with caution and consider tapering benzodiazepines if patients with chronic pain are using for long-term treatment.
- Be mindful of potential for drug interactions.
- Be aware of potential for polypharmacy.

FIND FREQUENCY OF OPIOID & BENZODIAZEPINE COMBINATIONS IN SCRIPTS

- In this study, 25% of patients taking opioids also had benzodiazepines.
- In another study, benzodiazepine use was associated with a 20% increase in mortality.

DANGEROUS COMBINATION THERAPY

- 50% of people who died from drug overdoses had benzodiazepines.
- The combination of opioids and benzodiazepines can be highly lethal.

https://msp.scdhhs.gov/tipsc/site-page/cme-opioids-benzodiazepines-dont-mix
Talking about Tapering

- Express safety concerns
  - “I care about your safety…”
  - “I am worried”
- Use Motivational Interviewing techniques to help make decisions as equals as much as is clinically appropriate
- Listen to and acknowledge patient’s fears (e.g., fear of pain, fear of withdrawal)
  - “So you feel…”
- Share that many patients improve and do better at reduced dose or discontinuation, even if briefly worse at first
- Reassure patients you won’t abandon them
  - “I’ll stick by you”
Opioid Tapering Considerations

- Many people who taper opioids to reduced dose or discontinuation have improved function without increase in pain and may have less pain.
- Speed of taper, ranging from days to weeks to months (and even years), depends on level of concern duration of use and current dose.
- In general, the longer the duration of the opioid therapy, the slower the taper.
  - A more rapid taper may be appropriate for patients on low dose opioids for less than one month or patients with apparent harm/risk.
- Non-opioid pain medications (e.g., NSAIDS, APAP) and non-meds (e.g., PT, CBT, meditation) can be used to manage withdrawal pain.
  - It is good to have a plan in place to manage other potential withdrawal symptoms.
### SHORT-TERM MEDICATIONS TO ASSIST WITH OPIOID WITHDRAWAL SYMPTOMS*

<table>
<thead>
<tr>
<th>Autonomic symptoms (sweating, tachycardia)</th>
<th></th>
</tr>
</thead>
</table>
| - Clonidine 0.1 to 0.2 mg orally every 6-8 hours (sometimes may be used twice daily)  
  Hold if blood pressure < 90/60 mmHg  
  - Recommend 0.1 mg test dose with blood pressure check 1 hour post dose. Increasing dose requires increasing blood pressure monitoring  
  - Re-evaluate in 3-7 days (average duration 15 days). Taper to stop  
- Gabapentin start at 100 to 300mg and titrate to 1800 to 2100 mg divided in 2 to 3 daily doses (dose adjust in renal impairment) |

<table>
<thead>
<tr>
<th>Anxiety, dysphoria, lacrimation, rhinorrhea</th>
<th></th>
</tr>
</thead>
</table>
| - Diphenhydramine 25 mg every 6 hours as needed (caution in older adults)  
- Hydroxyzine 25 to 50 mg three times daily as needed |

<table>
<thead>
<tr>
<th>Muscle aches, joint pain, headache</th>
<th></th>
</tr>
</thead>
</table>
| - Ibuprofen 400 mg orally every 4 to 6 hours as needed, not to exceed 2400 mg daily (caution in older adults or those at risk for GI bleed)  
- Acetaminophen 650 to 1000 mg orally every 4 to 6 hours as needed, not to exceed 4000 daily |

<table>
<thead>
<tr>
<th>Sleep disturbance</th>
<th></th>
</tr>
</thead>
</table>
| - Trazodone 25 to 100 mg orally at bedtime  
- Doxepin 6 to 50 mg orally at bedtime |

<table>
<thead>
<tr>
<th>Nausea</th>
<th></th>
</tr>
</thead>
</table>
| - Ondansetron 4 to 8 mg orally every 12 hours as needed, not to exceed 16 mg daily  
- Prochlorperazine 5 to 10 mg orally three times daily before meals or every six hours as needed, not to exceed 40 mg daily |

<table>
<thead>
<tr>
<th>Diarrhea</th>
<th></th>
</tr>
</thead>
</table>
| - Bismuth subsalicylate 524 mg every 0.5 to 1 hour orally, not to exceed 4192 mg daily  
- Loperamide 4 mg orally initially, then 2 mg with each loose stool, not to exceed 16 mg daily |

*Maintain the patient on all appropriate non-drug therapies (e.g., cognitive behavioral therapy, sleep hygiene)

---

**References:**

Opioid Tapering Considerations

- Individualize plan
- Evaluate patient throughout the process (at least before each dose change)
- Engage the patient throughout the process
- Screen for opioid use disorder prior to initiating taper
  - Decline in functioning
  - Loss of control
  - Continued use despite negative consequences
- Be alert to signs of mental health concerns (e.g., anxiety, depression) or OUD that may unmask later during the taper
- Refer to or coordinate care with specialists and MAT providers if needed
"Slower" Tapers from Selected Guidelines

Percent reductions below are based on the original dose before starting the taper, NOT the previous dose (e.g., if the initial decrease is 15 mg, you decrease by 15 mg every time if using same percent reduction)

<table>
<thead>
<tr>
<th>GUIDELINE</th>
<th>SLOWER TAPER RECOMMENDATIONS (until discontinue or at dose reduction goal)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VA/DoD Clinical Practice Guideline</strong> for</td>
<td>• 5 - 20% reduction every 4 weeks(^3) (see taper example below)</td>
</tr>
<tr>
<td>Opioid Therapy for Chronic Pain – 2017</td>
<td>• Pauses in taper as needed</td>
</tr>
<tr>
<td><strong>Canadian Guideline</strong> for Use of Opioids</td>
<td>• 5 - 10% reduction every 2 - 4 weeks</td>
</tr>
<tr>
<td>for Chronic Non-Cancer Pain – 2017</td>
<td>• Frequent follow-up</td>
</tr>
<tr>
<td><strong>CDC Guidelines</strong> for Prescribing</td>
<td>• 10% reduction every month(^2), especially if long term use</td>
</tr>
<tr>
<td>Opioids in Chronic Pain – 2016(^2)</td>
<td>• Pauses in taper as needed</td>
</tr>
</tbody>
</table>

\(^1\)5-20% reduction every week if faster taper is needed. \(^2\)SC State Boards of Dentistry, Medical Examiners, Nursing and Pharmacy – 2017 align with CDC Guidelines. \(^3\)10% every week is a 'reasonable' starting place to minimize withdrawal symptoms.
# Opioid Taper Example

## OPIOID TAPER EXAMPLE

Morphine ER 90 mg (60 mg + 30 mg) q8h = 270 MME/day

16% monthly reduction of original 270 mg total daily dose

<table>
<thead>
<tr>
<th>Month</th>
<th>Dose Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>75 mg (60 mg + 15 mg) ER q8h</td>
</tr>
<tr>
<td>2</td>
<td>60 mg ER q8h</td>
</tr>
<tr>
<td>3</td>
<td>45 mg ER q8h</td>
</tr>
<tr>
<td>4</td>
<td>30 mg ER q8h</td>
</tr>
<tr>
<td>5</td>
<td>30 mg ER q8h</td>
</tr>
<tr>
<td>6</td>
<td>15 mg ER q8h</td>
</tr>
<tr>
<td>7</td>
<td>15 mg ER q12h</td>
</tr>
<tr>
<td>8</td>
<td>15 mg ER qhs, then stop</td>
</tr>
</tbody>
</table>

There is an **increased risk of overdose** if patient resumes a **previous dose** (using prescription or illicit drugs); **patient tolerance** (including respiratory depression) to previous opioid dose is lost after 1 – 2 weeks on a reduced dose or abstinence.

Tapers may be slowed or paused according to patient’s response, but not reversed

Once the smallest dose is reached, the interval between doses can be extended

---

FIND FREQUENCY OF OPIOID + BENZODIAZEPINE* COMBINATIONS IN SCRIPTS

Scripts (DHEC) prescriber reports, updated and emailed quarterly, include a barometer on the prevalence of selected high risk medication combinations for each individual prescriber’s patients. To view these reports in SCRIPTS, click menu then prescriber report [under Rx search].

### DANGEROUS COMBINATION THERAPY

<table>
<thead>
<tr>
<th>combo prescriptions for opioid + benzo in same month</th>
<th>combo prescriptions for opioid + benzo + carisporodol in same month</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 BY YOU</td>
<td>15 BY YOU</td>
</tr>
<tr>
<td>35 BY YOU + OTHER PREScribers</td>
<td>20 BY YOU + OTHER PREScribers</td>
</tr>
</tbody>
</table>

Total patients receiving an opioid + benzodiazepine* (+ carisporodol) in same month (both [or all 3] Rxs written by you)

Total patients receiving an opioid + benzodiazepine* (+ carisporodol) in same month (you did not write both [or all 3] Rxs)

*Includes benzodiazepines AND any other anxiolytic/sedative/hypnotic medications (barbiturate and non-barbiturate [e.g., z-drugs such as zolpidem])

Disclaimer: All SCRIPTS reports are based on data submissions from the dispenser. Contact DHEC at 803-896-0688 if not receiving your quarterly report.

Avoid combining opioids and benzodiazepines whenever possible to reduce the risk of respiratory depression and overdose; work to taper one or both to a reduced dose or discontinuation in patients already on both medications.
References


Megan Pruitt, PharmD
jamisomr@musc.edu
843-792-5915

https://msp.scdhhs.gov/tipsc/