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Opioid Use Guidance Document for Prescribers

BEFORE PRESCRIBING

☐ Confirm the patient's family physician is willing to prescribe opioids – if not why not

☐ Conduct a complete history and appropriate physical exam

- Assess mental health comorbidities as these may increase risk of addiction / opioid use disorder and overdose
- Document efficacy of other pharmacological and non-pharmacological treatment options

☐ Complete the Opioid Risk Tool

☐ Use a Written Prescribing Agreement **(Appendix 1)** to:

- Discuss the outcome goals of improving the patient's health and function
- Discuss side effects and risks of opioids
- Discuss the use of urine drug tests – initial baseline, and then frequency based on risk
- Recommend a take home Naloxone kit for patients at increased risk for opioid overdose, including:
    - History of overdose, history of substance use disorder, higher opioid doses, i.e. ≥ 90 mg morphine equivalent daily dose (MEDD), concurrent benzodiazepine use, important medical co-morbidity (ie COPD), important mental health comorbidity (severe depression with suicidal risk)
- Sign and provide a copy of the agreement to the patient or document discussion in your clinic note

☐ Use the Opioid Information handout from the Canadian Opioid Guidelines **(Appendix 2)**

☐ Document functional goals:

- Use SMART approach **(see Appendix 3)**

☐ Discuss risks and tapering off concurrent benzodiazepines **(see Appendix 4)**

INITIATING OPIOID PRESCRIBING

☐ Confirm the patient's current medications and when last filled

☐ Select one consistent pharmacy for all prescriptions (staff can do this).

☐ Cancel any outstanding opioid refills.

☐ Patient should return unused medication to pharmacy and obtain receipt if changing/switching opioids

☐ Initial prescription should only be given in 7-day part fills. This keeps meds on hand at a minimum and if dose needs to be altered there are fewer extra meds

☐ Should always prescribe 7,14, 28 days fills not 30 days, so the day of dispense remains constant and the patient does not accumulate meds at the end of refills.

☐ For higher risk patients, start with daily or weekly dispensing using blister packs
Consider tamper resistant or other opioid formulations of lower street value

☐ Prescription should never be refilled for more than 12 weeks at a time.

ONGOING OPIOID TREATMENT

☐ Re-assess within 1-2 weeks of initiating or increasing dose, at least every 12 weeks in stable dose patients

☐ Document patients function and pain at each reassessment visit

☐ Consider periodic UDS based on the risk level of the patient:

-at least annually for low risk patients on low doses of opioids
-every 3-4 months for patients at elevated risk or on moderate dose opioids
-at least monthly for patients at high risk or on high dose opioids
-UDS should ideally be random

☐ Ensure there is only one prescriber for all opioids (exceptions allowed for vacation or sick leave coverage or emergency treatment of a new acute pain problem)

☐ Send prescriptions from CAIS by fax to a single pharmacy

☐ Write prescriptions with dispensing intervals of ≤ 28 days; use q 1-2 week part-fills in elevated risk patients

☐ Always document any changes to dose, dispensed in CAIS, never by fax sheet from pharmacy unless CAIS unavailable.

☐ Reassess evidence of individual benefits and risks if considering an increase to ≥ 50 mg MED

☐ Avoid increasing new start patients to a dose ≥ 90 mg MED,

- Prescribing a dose of opioids higher than 90 MED, requires documenting a significant improvement in function, a minimum of 30% improvement in pain, without unacceptable persistent side effects and without any ambiguous drug-related behaviours; otherwise, taper and discontinue opioids. Obtain a second opinion from an experienced pain prescriber if unsure.

☐ Before rotating opioids, make sure to use a validated conversion tool **(Appendix 5)** and rotate to 50% of the calculated equianalgesic dose; provide an adequate, but short supply of immediate release opioids to reduce the risk of withdrawal during the transition

☐ Order testosterone levels only if the patient is symptomatic and there is a plan to treat

☐ Monitor for the possibility of cognitive impairment and driving risk and refer for formal testing if any doubt about driving safety

☐ Ask about and document any opioid-related side effects and recommended solutions.

TAPERING OPIOIDS

☐ The following are reasons to consider tapering opioid therapy:

- Patient request
- Pain condition resolved
- Persistent and unacceptable side effects on current dose of opioid
- Risks outweigh benefits (high risk behaviours for overdose, hyperalgesia)
- Medical complications
- Not achieving goals of therapy – pain relief or functional improvement
- Regulatory recommendation (>90mg MED)

☐ Consider inpatient taper with relevant specialist guidance for patients at high risk for complications of withdrawal (ie. pregnancy, a "fragile" medical or psychiatric condition).

Other than an inpatient switch to methadone for women with OUD, pregnant women should generally not have their opioids switched or tapered due to the withdrawal-mediated increased risk of miscarriage.

☐ Educate the patient on the risks of continuing opioids and the potential benefits of tapering (use handout from the 2017 Canadian Opioid Guidelines – **Appendix 6**). It is ideal to have a significant other present when explaining.

☐ Provide information on the process of opioid withdrawal and treatments to reduce the severity (use handout in **Appendix 7**)

☐ Negotiate the amount and speed of tapering, depending on the circumstances and the patient. Taper faster if the risk is high or the patient is managing the taper well, and longer if the risk is low or if the patient is having difficulty tolerating the taper. There is no robust published evidence for an ideal rate of taper. Generally, an acceptable rate of outpatient tapering can range from 10% weekly to 5% monthly. Use interval dispensing, every time you reduce the dose.

☐ If you are tapering because of a concern for opioid use disorder, coordinate with an Opioid Replacement Therapy provider to transition the care of the patient.

☐ Use multimodal treatments by an interprofessional team, if available, to help patients learn non-pharmacological coping strategies.

☐ Prescribe adjuvants to reduce severity of withdrawal. (see handout for physicians in **Appendix 8**)

☐ Be prepared to pause or discontinue the taper if the patient demonstrates a significant increase in pain and decrease in function that persists longer than 1 month after a dose reduction (Recommendation 9, 2017 Canadian Opioid Guideline).

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☐ The goal is to reduce the opioid dose to the lowest dose possible, not necessarily tapering below 90mg MED or discontinuing completely.

☐ Consider a switch to Suboxone and taper over a longer period for patients struggling with tapering their usual opioid. (See **Appendix 9**)

☐ Continue to explore non-opioid and non-pharmacological options to treat pain.

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APPENDIX 1: WRITTEN TREATMENT AGREEMENT

MGD Patient Agreement for Long-term Opioid Therapy

1. I, _____ agree that Dr. _____ will be the only physician prescribing OPIOID (also known as NARCOTIC) pain medication for me and that I will obtain all of my prescriptions for opioids at one pharmacy. The exception would be an emergency situation or in the unlikely event that I run out of medication. Should such occasions occur, I will inform my physician as soon as possible.
2. I will take the medication at the dose and frequency prescribed by my physician. I agree not to increase the dose of opioid without first discussing it with my physician. I will not request earlier prescription refills.
3. I will attend all reasonable appointments, treatments and consultations as requested by my physician. I agree to other pain consultations/management strategies as necessary.
4. I understand that the common side effects of opioid therapy include nausea, constipation, sweating and itchiness of the skin. Drowsiness may occur when starting opioid therapy or when increasing the dosage. I agree to refrain from driving a motor vehicle or operating dangerous machinery until such drowsiness disappears.
5. I understand that using long-term opioids to treat chronic pain may result in the development of a physical dependence on this medication, and that sudden decreases or discontinuation of the medication will lead to the symptoms of opioid withdrawal. I understand that opioid withdrawal is uncomfortable but not life threatening.
6. I understand that there is a small risk that I may become addicted to the opioids I am being prescribed. As such, my physician may require that I have blood, urine or hair testing and/or see a specialist in addiction medicine should a concern about addiction arise.
7. I understand that the use of a mood-modifying substance, such as tranquilizers, sleeping pills, alcohol or illicit drugs (such as cannabis, cocaine, heroin or hallucinogens), can cause adverse effects or interfere with opioid therapy. Therefore I agree to refrain from the use of all of these substances without prior agreement from my physician.
8. I understand that I should check with my physician or pharmacist before taking other medications including over-the-counter and herbal products.
9. I agree to be responsible for the secure storage of my medication at all times. I agree not to give or sell my prescribed medication to any other person. Depending on the circumstances, lost medication may not be replaced until the next regular renewal date.
10. I consent to open communication between my doctor and any other health care professionals involved in my pain management, such as pharmacists, other doctors, emergency departments, etc.
11. I understand that if I break this agreement, my physician reserves the right to stop prescribing opioid medications for me.

Date: _____

_____ _____

(Signature - Patient) (Signature Physician)

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APPENDIX 2: MESSAGES FOR PATIENTS TAKING OPIOIDS

Note: Opioids are a group of similar medications that are used to help with pain — there is more than one type of opioid and they have different names for example, Percocet®, OxyContin®, Tylenol® No. 2, Tramacet®.

1. **Opioids are used to improve your ability to be active and reduce pain.**
    - You and your doctor will set goals and ensure the medication is effective in achieving the goals, e.g. improving your ability to do the things you did before pain prevented you.
    - If you seem to benefit from the pain medication, your doctor will see you for follow-up visits to assess pain relief, any adverse effects, and your ability to meet your set activity goals.
2. **There are side effects from opioids, but they can be mostly controlled with increasing your dose slowly.**
    - Common side effects include:
        - nausea (28% of patients report it), constipation (26%),
        - drowsiness (24%), dizziness (18%), dry-skin/itching (15%), and
        - vomiting (15%).
    - Side effects can be minimized by slowly increasing the dose of the drug and by using anti-nausea drugs and bowel stimulants.
3. **Your doctor will ask you questions and discuss any concerns with you about your possibility of developing addiction.**
    - Addiction means that a person uses the drug to "get high," and cannot control the urge to take the drug.
    - Most patients do not "get high" from taking opioids, and addiction is unlikely if your risk for addiction is low: those at greatest risk have a history of addiction with alcohol or other drugs.
4. **Opioids can help but they do have risks — these can be managed by working cooperatively with your doctor.**
    - Take the medication as your doctor prescribed it.
    - Don't drive while your dose is being gradually increased or if the medication is making you sleepy or feel confused.
    - Only one doctor should be prescribing opioid medication for you — don't obtain this medication from another doctor unless both are aware that you have two prescriptions for opioids.
    - Don't take opioids from someone else or share your medication with others.
    - You may be asked for a urine sample — this will help to show all the drugs you are taking and ensure a combination is not placing you at risk.
    - Your doctor will give you a prescription for the amount of medication that will last until your next appointment — keep your prescription safe and use the medications as instructed — if you run out too soon or lose your prescription your doctor will not likely provide another
    - If you cannot follow these precautions it may not be safe for your doctor to prescribe opioid medication for you.

5. **If you stop taking your medication abruptly, you will experience a withdrawal reaction.**
    - Withdrawal symptoms do not mean you are addicted — just that you stopped the drug too quickly — your doctor will direct you on how to slowly stop this medication so you won't have this experience.
    - Opioid withdrawal symptoms are flu-like, e.g., nausea, diarrhea, and chills.
    - Withdrawal is not dangerous but it can be very uncomfortable.
    - If you interrupt your medication schedule for three days or more for any reason, do not resume taking it without consulting a doctor.
6. **Overdose from opioids is uncommon, but you and your family should be aware of the signs.**
    - Opioids are safe over the long term, BUT can be dangerous when starting or increasing a dose.
    - Overdose means thinking and breathing slows down — this could result in brain damage, trauma, and death.
    - Mixing opioids with alcohol or sedating drugs such as pills to help anxiety or sleeping, greatly increases the risk of overdose.
    - You and your family should be aware of signs of overdose — contact a doctor if you notice: slurred or drawling speech, becoming upset or crying easily, poor balance or, "nodding off" during conversation or activity.
7. **The medication the doctor prescribes for you can be very dangerous to others.**
    - Your body will get used to the dose your doctor sets for you but this same dose can be very dangerous to others.
    - You have reached your proper dose slowly, but someone who is not used to the medication could have a serious reaction, including death — don't give your medication to anyone else — it is illegal and could harm them.
    - Keep your medication securely stored at home — the bathroom medicine cabinet is **not** a safe place; research has shown that others, particularly teenagers might help themselves to these drugs from friends or relatives.

APPENDIX 3: SMART goals

(example in brackets)
Specific (walking)
Measurable (100m or 5 mins 3X/week to increase by 10% weekly)
Achievable (within pts present ability – cane, walker etc)
Realistic (mall walking or within home setting)
Timely (achieve goal within 1 month)

APPENDIX 4: BENZODIAZEPINE TAPERING GUIDELINES

1. Discuss benefits of a benzodiazepine taper, including increased alertness and energy, improved quality of sleep, memory, mental clarity, and mood, etc.
2. Taper with current benzodiazepine (preferred) or switch to an equivalent dose of diazepam using the table below (Note: diazepam tablets are available as 2 mg, 5 mg, and 10 mg tablets; all are scored and can be split).
3. Taper by 10% every 2 weeks or longer (generally up to 5 mg diazepam equivalent per week). Slower tapers are more likely to be successful. Alternatively, decrease by quarter- or half-tablets on select days of the week; see http://www.criugm.qc.ca/fichier/pdf/BENZOeng.pdf (case-sensitive)
4. Use the multidisciplinary team to schedule regular follow-ups and support the taper.
5. Consider referral to psychologist. Cognitive behavioural therapy combined with tapering is more effective than tapering alone.
6. Once the dose has reached 20% of the original dose, consider slowing the taper to 5% every 4 weeks or longer.

Benzodiazepine Equivalence Table Benzodiazepine	**Brand Name**	**Equivalence to Diazepam (Valium®)10 mg***
Alprazolam	Xanax®	1 mg
Bromazepam	Lectopam®	6 mg
Chlordiazepoxide	Librium®	25 mg
Clobazam	Frisium®	20 mg
Clonazepam	Rivotril®	1 mg
Clorazepate	Tranxene®	15 mg
Flurazepam	Dalmane®	30 mg
Lorazepam	Ativan®	1 mg
Nitrazepam	Mogadon®	10 mg
Oxazepam	Serax®	20 mg
Temazepam	Restoril®	20 mg
Triazolam	Halcion®	0.5 mg
Benzodiazepine-Like Z-Drugs**		
Zolpidem	Sublinox®	20 mg
Zopiclone	Imovane®	15 mg

*Please note this is a guideline only. Wide variation exists between patients.
**Listed to show dose equivalence to benzodiazepines; z-drugs are usually not converted to a benzodiazepine for tapering purposes.

Patient Resources to explain risks of benzodiazepines and sample tapering schedules:
http://www.criugm.qc.ca/fichier/pdf/BENZOeng.pdf (case-sensitive)
www.benzo.org.uk/manual

APPPENDIX 5: EQUIVALENCY DOSES

MORPHINE EQUIVALENCE TABLE = Opioid conversion table.

Opioids* Oral preparations (mg/d)	To convert to oral morphine equivalent, multiply by:	To convert from oral morphine, multiply by:
Buprenorphine[3]	• 5 µg/h patch = 9–14 mg MED/d • 10 µg/h patch = 18–28 mg MED/d	• 15 µg/h patch = 27–41 mg MED/d • 20 µg/h patch = 36–55 mg MED/d[4,5]
Buprenorphine/ naloxone SL[3]	16 mg SL = 90 mg MED	
Codeine	0.15 (0.1–0.2)	6.67
Hydromorphone	5.0	0.2
Methadone	Dose equivalents unreliable	
Morphine	1.0	1
Oxycodone	1.5	0.667
Tapentadol	0.3–0.4	2.5–3.33
Tramadol**	0.1–0.2	6
Fentanyl***	60–134 mg morphine = 25 µg/h patch 135–178 mg morphine = 37 µg/h patch 180–224 mg morphine = 50 µg/h patch 225–269 mg morphine = 62 µg/h patch 270–314 mg morphine = 75 µg/h patch 315–359 mg morphine = 87 µg/h patch 360–404 mg morphine = 100 µg/h patch	

When to switch opioids:
- Uncontrolled pain
- Intolerable adverse effects
- Switching route of administration (e.g. oral to transdermal)

How to switch:

The two methods for switching opioids are presented below. There is no evidence that favours one method over another. Careful attention must be taken when swiching an opioid to ensure the patient is seen each week and understands prescription instructions.
- **Method 1:** Decrease the total daily dose of the current opioid by 25–50% and convert to new opioid equivalent dose.
- **Method 2 (Cross Taper Method):** Decrease the total daily dose of the current opioid by 10–25% per week while titrating up the total daily dose of the new opioid weekly by 10–20% with a goal of switching over 3–4 weeks (also consider dose formulations available). Consider more regular (e.g. weekly) follow-ups, weekly dispensing and/or dosette/blisterpack if required.

See Appendix C - Switching Opioids for succinct steps and examples on how to switch opioid therapies, and fillable switching templates that can be completed and inserted into the patient medical record.

Legend: h = hour, MED = morphine equivalent dose, mg = milligram, mL = milliliter, µg = microgram, SL = sublingual
*Conversion ratio for opioids are subject to variations in kinetics governed by genetics and other drugs.
**The maximum recommended daily dose of tramadol is 300 mg–400 mg depending on the formulation.
***The information provided can be used to determine the morphine equivalents for a patient on fentanyl. If used for switching opioids the dose conversions are for **unidirectional conversion to fentanyl** in patients for chronic use and not opioid naïve patients. The dose conversions were **not intended to covert patients from fentanyl to other opioids;** doing so may result in overdose and toxicity.

SUGGESTED INITIAL DOSE AND TITRATION FOR BUPRENORPHINE TRANSDERMAL PATCH[3]

The buprenorphine transdermal patch is indicated for the management of pain severe enough to require daily, continuous, long-term opioid treatment and for which alternative options are inadequate. It can be prescribed to opioid naïve patients.

Opioid	Dosage forms	Initial dose	Minimum time interval for increase	Suggested dose increase	Maximum dose/day	50 MED	90 MED
• Buprenorphine*	• Patch: 5, 10, 15, 20 µg/h	• 5 µg/h every 7 days	• 7 days	• 5 µg/h every 7 days	• 20 µg/h every 7 days	• 20 µg/h[4,5]**	• Not available

Legend: h = hour, MED = morphine equivalent dose, µg = microgram

APPENDIX 6:

Opioid Tapering- Information for Patients

Why should I taper or decrease my opioid medication?

Taking high doses of opioids may not provide good pain relief over a long period of time. The amount of pain relief from opioids can become less at higher doses because of tolerance. Sometimes, opioids can actually cause your pain to get worse. This is called "opioid induced hyperalgesia".

The many side effects of opioids increase with higher doses. Sometimes people using opioids do not connect certain side effects to the medication. That is why many people who try a gradual taper to lower doses, report less pain, and better mood, function and overall quality of life. Sometimes, it is only after such a taper that patients appreciate how opioids were not helping as much as they thought.

What are the side effects of opioid therapy over the long term?

Some of the adverse effects of opioid therapy over the long term include:

- *Tolerance*- The medication becomes less effective over time with patients needing higher doses of opioid to achieve the same level of pain control. By itself, this does not mean patients are addicted, although in some patients it is part of addiction.
- *Physical dependence* –If you abruptly stop or decrease your opioid dose by a large amount, you may experience unpleasant symptoms called withdrawal. This is an expected response to regular opioid therapy that is not the same as addiction. *One of the early symptoms of withdrawal is an increase in pain, which is temporarily improved by taking more opioid*. *Many people on long-term opioids believe that this proves that the opioid is working, rather than being a symptom of withdrawal that will lessen with time.*
- *Constipation*- leading to nausea and poor appetite and less commonly, bowel blockage.
- *Drowsiness causing falls, broken bones, and motor vehicle accidents*
- *Fatigue, low energy, depression* -This can significantly affect your function and ability to work or do day-to-day activities.
- *Sleep apnea or impaired breathing while sleeping* – This can contribute to daytime fatigue and poor thinking ability. It increases your risk for many health conditions and also increases your risk of having a car accident.
- *Low testosterone hormone levels in men* – This can lead to low sex drive, low energy, depressed mood, slower recovery from muscle injuries and decreased bone density (thinning of the bones).
- *Low estrogen and progesterone hormones in women*- leading to decreased bone density and low energy.
- *Pain can get worse in some people, especially at higher doses (opioid-induced hyperalgesia)*

What can I expect when tapering or decreasing my opioid medication?

1. *Pain*- One of the first symptoms of opioid withdrawal is increased pain. This pain may be the same pain that you are being treated for, as well as total body joint and muscle aches. Some people will complain of a recurrence of pain at the site of an old healed injury, such as a broken

APPENDIX 7:

Managing Opioid Withdrawal – Information for Patients

Dr. Pam Squire & Dr. Roman Dovey

Most opioids provide **good pain relief at lower doses**. Unfortunately, it also seems like most people will experience some degree of tolerance if the opioids are taken regularly over time. This means that you need a higher dose of the opioid to achieve the same pain relief. This does not necessarily mean that you are addicted (although sometimes that is the case). Almost 100% of people who take opioids regularly for more than a few weeks will develop withdrawal symptoms when they stop them. If the drug you are using is alcohol, then withdrawal is a one sign of addiction. However, when you are taking a prescribed medication, such as an opioid, as directed, then withdrawal is not necessarily a sign of addiction. We are now learning that high dose **opioids may not provide good pain relief over the long term** in all patients. Many patients still report pain levels over 7/10, a sign their pain is not being well controlled by the opioid. Watch the YouTube video by Dr. Micheal Evans to learn more: https://youtu.be/7Na2m7lx-hU

In a person with chronic pain, one of the very **first symptoms of opioid withdrawal is increased pain**. It can be the same pain you are being treated for as well as total body joint and muscle pains. This can be confusing. Many people have experimented with their opioid to see if they still need it by delaying or missing a dose or taking less. In almost every case, this will cause some degree of withdrawal and the first symptom you will feel is increased pain. Taking additional opioid will relieve the pain quickly because it relieves the withdrawal. Since the opioid was not reduced enough to cause other withdrawal symptoms, **people misinterpret this fast pain relief as proof that the opioid is still working**. They often describe this as "taking the edge off" and so they believe that they will be much worse off without the opioid.

OPIOID SIDE EFFECTS

Opioids do have some **long-term side effects**. High doses can cause reduced hormone levels, particularly testosterone in men, and estrogen and progesterone in women. It appears this can increase the risk of osteoporosis and increase the risk of bone fractures in both sexes. In men, low testosterone can also lead to low sex drive, low energy, depressed mood, and can impair muscle repair. Opioids can make sleep apnea worse, resulting in poor sleep and daytime fatigue. Many people comment that they had no idea how much the opioids were affecting them until they reduced their dosage or stopped them. When the opioids are no longer providing good pain relief, most people feel much better without them.

GO SLOW

It can be scary to think of reducing or stopping your opioids. One way to test this out is to try the following: If you are taking both short-acting and long-acting opioids, ask your doctor to switch all of the short-acting opioids to long-acting opioids. Then **reduce your total daily dose of opioid by 10% for two weeks**. In the first week, you will experience increased pain as well as the other withdrawal symptoms. If the increased pain was mainly due to withdrawal, during the second week your pain should reduce back down to where it was before you started reducing the opioid. Some people are extremely sensitive to withdrawal symptoms and experience more severe symptoms than others. In this case, **try reducing by only 5% instead**. Try your best to avoid taking extra opioids to manage your withdrawal. It may help in the short term but it just delays and prolongs your withdrawal. It is best to plan ahead on not feeling great for the duration of withdrawal. Trouble sleeping and anxiety are both part of withdrawal and will also get better over time.

Opioid withdrawal symptoms are unpleasant but very rarely life threatening. The exceptions to this could be someone with another serious medical condition, such as poorly controlled angina or poorly controlled high blood pressure, or someone with a severe psychiatric condition where the risk of self-harm is high. In such cases, you should seek medical supervision when stopping your opioid medication through your own family doctor or, if necessary, at the Emergency Department of your local hospital. (also see the award-winning blog, Guinevere Gets Sober, for extra advice.)

You may experience any or all of the following **symptoms** during withdrawal:

☐ sweats	☐ muscle aches	☐ abdominal cramps	☐ vomiting	☐ fatigue
☐ chills	☐ joint aches		☐ diarrhea	☐ malaise
☐ headaches	☐ insomnia	☐ nausea	☐ anxiety	☐ "goose flesh"

APPENDIX 8:

Managing Opioid Withdrawal – Information for Clinicians

Roman D. Jovey, MD and Pam Squire, MD

1. Reassure the patient that withdrawal from opioids is **uncomfortable but rarely life threatening.** Each dosage reduction may result in symptoms similar to a severe, flu-like illness beginning within 12-36 hours and, peaking at 48-72 hours, and then tapering off after 1-2 weeks. Some people experience a period of vague dysphoria for 1-2 weeks after initial withdrawal. (Methadone withdrawal may peak later with less intensity but can go on for 4-6 weeks in some people.) More caution is required in pregnancy and in those with fragile medical or mental health conditions, where an inpatient chemical withdrawal would be safer.

2. The patient and physician can agree to withdraw more quickly (over 10-14 days) resulting in a more severe but shorter overall period of symptoms, or to taper over weeks to months and experience a milder but more prolonged withdrawal. Reduce the dose by 10% at the agreed upon interval. Use interval dispensing for every dose reduction. Consider blister packs to help the patient stay on schedule. High-risk patients may require daily dispensing. Once-daily opioid formulations (i.e., Kadian) may make the withdrawal process simpler. A methadone taper allows for a less intense but longer period of withdrawal symptoms. This requires a Federal methadone prescribing authorization. A switch to BUP-NX followed by a taper is another option – especially for a rapid opioid taper. This is available through physicians who have methadone for addiction exemptions and is also offered in some private detox clinics. A suggested 4-day BUP-NX loading protocol is attached.

3. Clonidine has been used the longest to decrease some of the autonomic symptoms of opioid withdrawal. The main side effects are orthostatic hypotension and sedation.

   Prescribe 0.1-0.2 mg po q6h prn maximum 6 tabs per day. The dose may have to be lowered if the patient reports orthostatic symptoms or has a BP less than 90/60 mmHg, 1 hour after a dose. Continue clonidine until off of opioids for 3-5 days, then taper over next 3-5 days.

4. One of the early symptoms of opioid withdrawal is increased pain – the patient's usual pain plus additional arthralgias and myalgias. This may persist longer than other withdrawal symptoms, but will eventually settle. Acetaminophen, NSAIDs, or tramadol may be helpful. If attempting to re-evaluate a patient's pain off of opioids, the opioids need to be discontinued for at least 4-6 weeks to get through withdrawal pain and to allow opioid receptors to "reset." It can take a while for an individual's endogenous opioids to begin production again.

5. Loperamide (OTC) can help decrease abdominal cramping and diarrhea if these occur.

6. Acupuncture or TENS have been shown in some studies to decrease symptoms of opioid withdrawal.

7. Short-term use of pregabalin (75-150mg bid), and/or the cannabinoid nabilone (0.5 – 1mg bid) for the first 1-2 weeks may help with pain as well as sleep and anxiety.

References:

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October 2016

BUP-NX – Buprenorphine-naloxone SL tablets

APPENDIX 9:

Appendix 6

A Suggested Outpatient Protocol for BUP-NX Induction and Taper

This protocol is for use with opioids other than methadone, in a patient who is not at high risk for addiction and should not be utilized if there are also benzodiazepines involved. Arrange a daily pickup of meds from the pharmacy for the first 4 days.

1. Make sure there is a responsible other adult present during the switchover and that you have met and discussed the protocol with them in person. Explain the possibility of precipitated withdrawal after the first dose of BUP-NX.

2. Explain the BUP-NX loading protocol and provide written materials. Discuss the common opioid withdrawal symptoms and provide a handout that describes what to expect.

3. Stop the prescription opioid at midnight.

4. The next day (Day 1) wait until the withdrawal symptoms are at least moderate to severe. The longer the patient waits, the less the risk of precipitated withdrawal. If using the COWS questionnaire to assess severity of withdrawal, aim for a total score of 14-20.

5. Take the first dose of BUP-NX 4 mg s.l. and wait 3 hours.

6. Take BUP-NX 2 mg s.l. q 3 h prn up to a maximum dose of 12 mg in the first 24 hours. If there are still some severe withdrawal symptoms, use the other meds (clonidine, loperamide, PGN or nabilone) to get through the first 24 hours.

7. On the morning of Day 2 (for 24 hours after the first dose of BUP-NX) – take the total dose of BUP-NX required on Day 1 (max 12 mg) in one dose. Wait 3 hours. If withdrawal symptoms are at least moderate to severe, start loading again if by 2 mg s.l. q 3 h up to max 24 mg daily on Day 2. **The patient should never exceed 24 mg in any 24 hour period.**

8. On Day 3 (48 hours after starting BUP-NX) – take the total dose of BUP-NX from Day 2 and split the total dose BID. Repeat this dose on the morning of Day 4.

9. On Day 4 follow-up with the MD for reassess. If the patient has had a relatively easy transition then begin the taper process. The speed of taper depends on the motivation (and stamina) of the patient. One can taper by 2 mg daily or 2 mg weekly. Reassess the patient weekly to offer support and be prepared to pause when required. Use interval dispensing not longer than 1 week apart during this time.

10. When you get to 2 mg daily, you can either split the pill into 1 mg doses or take a 2 mg pill every 2 days and then stop.

11. If the patient is still having great difficulty stopping the last 1 mg of BUP-NX then switch them to the Buprenorphine patch and taper. A 20ug/hr BUP patch is roughly equivalent to a s.l. dose of 0.5 mg buprenorphine per day. Therefore one can use a 20ug/hr patch for 1 week, then 15ug/hr for 1 week, then 10ug/hr for 1 week then 5ug/hr for 1 week then stop.

This protocol was adapted by Dr. R.D. Lovey, MD using the following references:

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Lee JD, Grossman E, DiRocco D, Gourevitch MN. Home buprenorphine/naloxone induction in primary care. J Gen Intern Med. 2009 Feb;24(2):226-32.

References:

Ashton CH. Benzodiazepines: how they work and how to withdraw; also known as The Ashton Manual. Available online at: www.benzo.org/uk/manual

Baillargeon L et al. Discontinuation of benzodiazepines among older insomniac adults treated with cognitive-behavioural therapy combined with gradual tapering: a randomized trial. CMAJ 2003;169(10):1015-1020.

Canadian guideline for safe and effective use of opioids for chronic non-cancer pain. 2010 National Opioid Use Guideline Group (NOUGG).

Tannenbaum 2014. Institut universitaire de geriatrie de Montreal. You may be at risk: you are taking one of the following sedative-hypnotic medications. Available online at: http://www.criugm.qc.ca/fichier/pdf/BENZOeng.pdf (case-sensitive)

CDC guideline for prescribing opioids for chronic pain – March 2016. US Centers for Disease Control and Prevention.