Sometimes LESS is MORE

THE ART (OR SCIENCE?) OF CONTROLLED SUBSTANCE TAPERING

NICK BOEMIO PHARMD, BCPS

CLINICAL PHARMACY SPECIALIST – PROHEALTH PHYSICIANS

CLINICAL PHARMACY INFORMATICIST – OPTUM NEW ENGLAND

Disclosure:

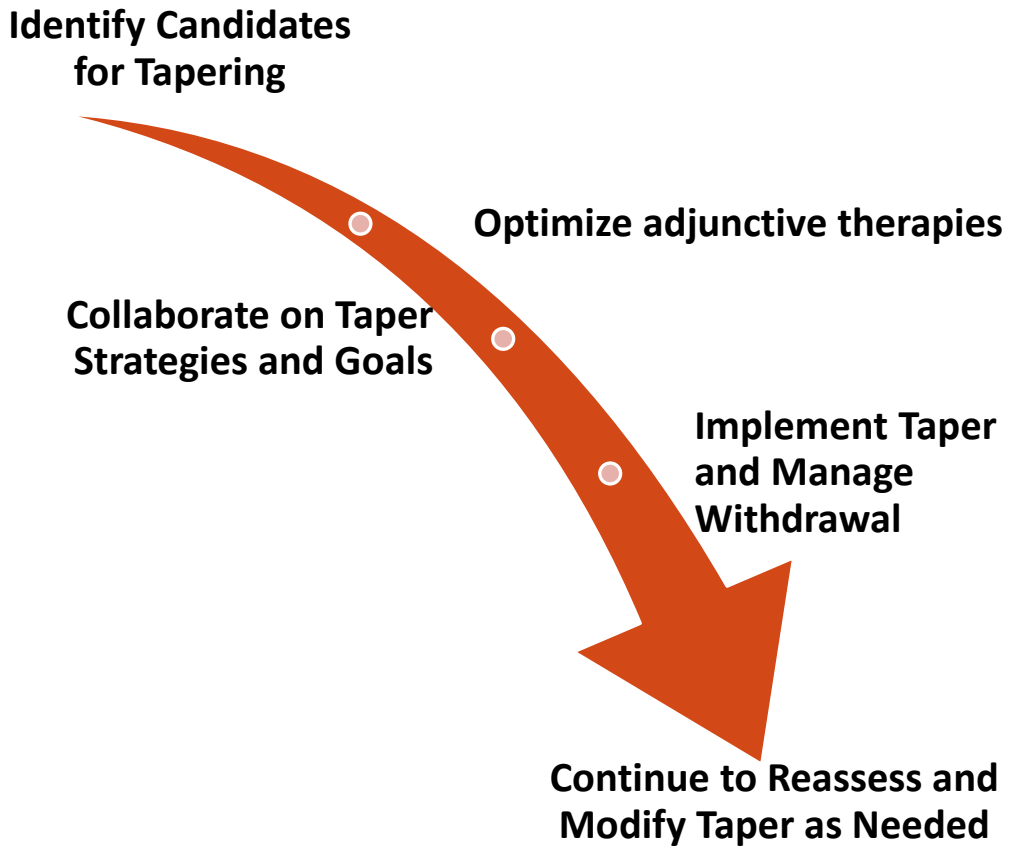
- I have no actual or potential conflicts of interest

Learning Objectives:

1. Identify opportunities to optimize adjunctive pharmacotherapy for underlying chronic pain or mental health conditions
2. Calculate morphine and lorazepam milliequivalents
3. Discuss methods of controlled substance tapering and withdrawal management
4. Review the Concomitant Use of Opioids and Benzodiazepines (COB) Quality Measure
5. Practice managing controlled substance tapers using patient cases

Please Note: Discussion on opioid tapering and management is specific to those using opioids for chronic non-cancer pain

Trust the Process:



Meet The Candidates

PROPER SELECTION OF PATIENTS FOR TAPERING CAN INCREASE SUCCESS

Candidates for Opioid Tapering:

When to Consider Opioid Taper:		
Pain condition improves (i.e. surgical correction)	Opioid ineffective	Evidence of opioid misuse or abuse
Experiencing side effects or **Hyperalgesia**	History of overdose	High-risk for overdose
Long-term opioid use (>1 year)	High-dose opioids (>50 MME/day)	Patient requested

VA/DoD Clinical Practice Guideline 2017
HHS Dose Reduction Guidelines 2019

Candidates for Benzodiazepine Tapering

- Those chronically using benzodiazepines are typically candidates for tapering when used for insomnia and anxiety disorders. Those who may be prioritized for tapering include:
  - Lack of adjunctive therapies for underlying conditions
  - Long-term use of benzodiazepines
  - Concomitant use of other CNS depressants or opioids
  - Benzodiazepine dependence

Trading Places

OPTIMIZATION OF ADJUNCTIVE THERAPIES CAN HELP REDUCE RELIANCE ON CONTROLLED SUBSTANCES

Assessing Chronic Pain:

Chronic pain is defined as: “Pain lasting longer than 3 months, or longer than the expected healing time for a tissue injury”.

Assess pain symptoms and severity for targeted therapy:

- Pain type: Musculoskeletal or Neuropathic
- Exacerbating and remitting factors
- Functional limitations
- Comorbidities (i.e. psychiatric illness, diabetes, frailty)
- Imaging

Set reasonable expectations for pain control and function

- A 30% reduction in pain and function is considered clinically meaningful

MMWR Recomm Rep. 2016;65:1-49
Clin J Pain. 2008 Jul–Aug; 24:521–527

Utilizing Non-Pharmacological Modalities:

Avoid overlooking lifestyle modifications and non-pharmacological treatment of chronic pain:

- Physical Therapy
- Cognitive Behavioral Therapy
- Surgical Intervention (when indicated and applicable)
- Weight loss
- Other modalities (i.e. yoga, meditation, acupuncture)

Often most effective when used in combination with pharmacological interventions

MMWR Recomm Rep. 2016;65:1-49
Clin J Pain. 2008 Jul–Aug; 24:521–527

Pharmacological Management of Pain:

Non-Opioids should be considered preferentially over opioid therapy for chronic pain:

Medication Class	Pain Type	Side Effects	Clinical Considerations
Acetaminophen	Musculoskeletal	Well-tolerated May cause hepatotoxicity with high-doses	Avoid doses >4g/day (>2g in those with hepatic disease)
NSAIDs (i.e. ibuprofen, naproxen, meloxicam)	Musculoskeletal	Increased risk of GI bleeding, renal injury, and thrombosis	Avoid in elderly when possible
Topical NSAIDs (i.e. diclofenac gel)		Limited systemic absorption decreases risk of side effects	Most effective for localized pain (i.e. hands, wrists, knees, feet)
Topical Lidocaine (cream, ointment)	Musculoskeletal /Neuropathic	Well-tolerated	Utilize cream or ointment at least 3-4x/day to optimize efficacy
Topical Lidocaine (patch)		Pruritus, application site reactions	Patch may be cut to fit application area Patch is to be applied for only 12-hours in any 24-hour period May apply up to 3 patches at one time
Topical Capsaicin	Musculoskeletal /Neuropathic	Localized erythema, pain	Must utilize consistently as efficacy reliant on Substance P reduction

Pharmacological Management of Pain:

Medication Class	Pain Type	Side Effects	Counseling Points
Tricyclic Antidepressants (i.e. amitriptyline, nortriptyline)	Neuropathic	Anticholinergic (i.e. dry mouth, drowsiness, dizziness, constipation, urinary retention)	Risk of side effects amitriptyline >> nortriptyline Dual benefit in depression/anxiety
Serotonin/Norepinephrine Reuptake Inhibitors (i.e. duloxetine, venlafaxine)	Neuropathic/ Musculoskeletal	HA, drowsiness, nausea, insomnia	Avoid with MAOIs **DO NOT** exceed 60mg/day with duloxetine Dual benefit in depression/anxiety
Gabapentin	Neuropathic	Peripheral edema, dizziness, drowsiness, weight gain	Use caution in renal dysfunction
Pregabalin			Pregabalin preferred in fibromyalgia
Corticosteroids (i.e. prednisone, dexamethasone)	Spinal cord compression	Hyperglycemia, healing impairment, fluid retention, weight gain	Avoid long-term use if possible; taper when necessary to avoid adrenal crisis

The Same Lessons Apply:

When tapering other controlled substances (i.e. benzodiazepines) a similar approach should be taken:

1. Assess the underlying condition (i.e. depression, anxiety, bipolar, insomnia, etc.)
2. Suggest non-pharmacological interventions (i.e. CBT, sleep hygiene)
3. Optimize pharmacotherapy with lower-risk medications which better manage the underlying condition:

Pharmacological Management:		
Selective Serotonin Reuptake Inhibitors	Serotonin Norepinephrine Reuptake Inhibitors	Tricyclic Antidepressants
Buspirone	Mirtazapine	Trazodone
Mood Stabilizers	Anticonvulsants	Bupropion

Calculation Conundrum

MASTERING OPIOID AND BENZODIAZEPINE POTENCIES IS KEY TO TAPER DEVELOPMENT

Calculating Milliequivalents:

1. **Determine 24-Hour Controlled Substance Requirement**
   - Remember to account for both scheduled and PRN doses
   - Use State PMP to verify patient's reported use (especially for PRNs) to ensure accuracy
2. **Convert 24-hour Controlled Substance Requirement into Milliequivalents**
   - Utilize appropriate conversion charts to determined Morphine Milliequivalents (MME) or Lorazepam Milliequivalents (LME)
   - Always double check your calculation
3. **Use Calculated Milliequivalents as Baseline for Taper Development**

Opioid Conversion Table:

Opioid	Parenteral Equivalent	Oral Equivalent
Morphine	10mg	30mg
Oxycodone	N/A	20mg
Hydrocodone	N/A	30-45mg
Hydromorphone	1.5mg	7.5mg
Methadone	N/A	10mg*
Tramadol	N/A	300mg
Oxymorphone	1mg	10mg

*There is limited evidence and lack of consensus on methadone conversion. The CT PMP uses a 3:1 morphine to methadone ratio. Other sources may use higher ratios or ratios which change based on methadone dose

Remember: It is only necessary to account for incomplete cross-tolerance when switching opioids **NOT** when determining 24-hour MME requirement

Opioid Conversion Tools:

Consider using validated online opioid calculators:

Opioid:	mg per day:	Morphine Equivalent Dose:
Codeine	0	0
Fentanyl transdermal (in mcg/hr)	50	120
Hydrocodone	0	0
Hydromorphone	0	0
Methadone	0	0
Morphine	0	0
Oxycodone	30 ×	45
Oxymorphone	0	0
Tapentadol	0	0
Tramadol	0	0
	Total	**165**

https://northwestpainguidance.org/opioidmedcalculator/

Benzodiazepine Conversion Table

Benzodiazepine	Dose Equivalence	Elimination Half-Life
Lorazepam	1mg	10-20 hours
Alprazolam	0.5mg	12-15 hours
Chlordiazepoxide	10mg	>100 hours
Diazepam	5mg	> 100 hours
Temazepam	10-20mg	10-20 hours

Patient Cases

DETERMINING 24-HOUR MME AND LME REQUIREMENT

Patient OP

You receive a consultation of opioid tapering for a patient on the following opioid regimen:

Oxycodone ER 20mg BID

Morphine IR 15mg q6H PRN

Based on refill history in the CT PMP, you confirm that patient is taking maximum quantities of both opioid medications.

What is OP's 24-hour MME Requirement?

A. 100 MME

B. 200 MME

C. 150 MME

D. 120 MME

Patient BD

You receive a consultation of benzodiazepine tapering for a patient on the following regimen:

Diazepam 10mg at bedtime

Alprazolam 1mg TID PRN

Based on refill history in the CT PMP, you confirm that patient is taking maximum quantities of both benzodiazepine medications.

What is BD's 24-hour LME Requirement?

A. 5 LME

B. 8 LME

C. 3 LME

D. 6 LME

The Benjamin Button Effect

HOW WORKING BACKWARD CAN PUSH OPIOID TAPERS FORWARD

Opioid Tapering:

Implementing a Taper Schedule:

1. **Determine Taper Speed:**
   - Typically individualized based on patient goals, risks of current therapy, opioid dose, and duration of opioid therapy
   - Feasibility of follow-up frequency and co-pays must also be taken into account
2. **Initiate Taper Schedule:**
   - Coordinate opioid prescriptions appropriately
   - Ensure patient is counseled on taper schedule and potential withdrawal symptoms
3. **Reassess Taper Schedule/Monitor Patient for Withdrawal:**
   - Closely monitor patient for withdrawal; utilize Clinical Opioid Withdrawal Scale (COWS) to determine severity and target specific symptoms
   - Taper may be stopped, slowed, or reversed at any point

Slow Taper (i.e. ↓10% per month or slower)

- Useful in those with ≥ 1 year of opioid use
- Reduces risk of withdrawal
- Takes months to years for completion

Intermediate Taper (i.e. ↓10-25% every 2-4 weeks)

- When faster taper warranted, but immediate discontinuation not required
- Risk of withdrawal increased, but typically manageable in the outpatient setting
- Most common taper schedule used at ProHealth Physicians

Fast Taper (i.e. ↓10% per week)

- Reserved for those experiencing severe side effects, found to have substance use disorder, or experiencing an overdose
- Risk of withdrawal is increased; close monitoring required

Fentanyl patch 75 mcg/hr q72H (Last filled: 1/15/2021 for 30 days; PMP verified; Total daily MME: 180mg)

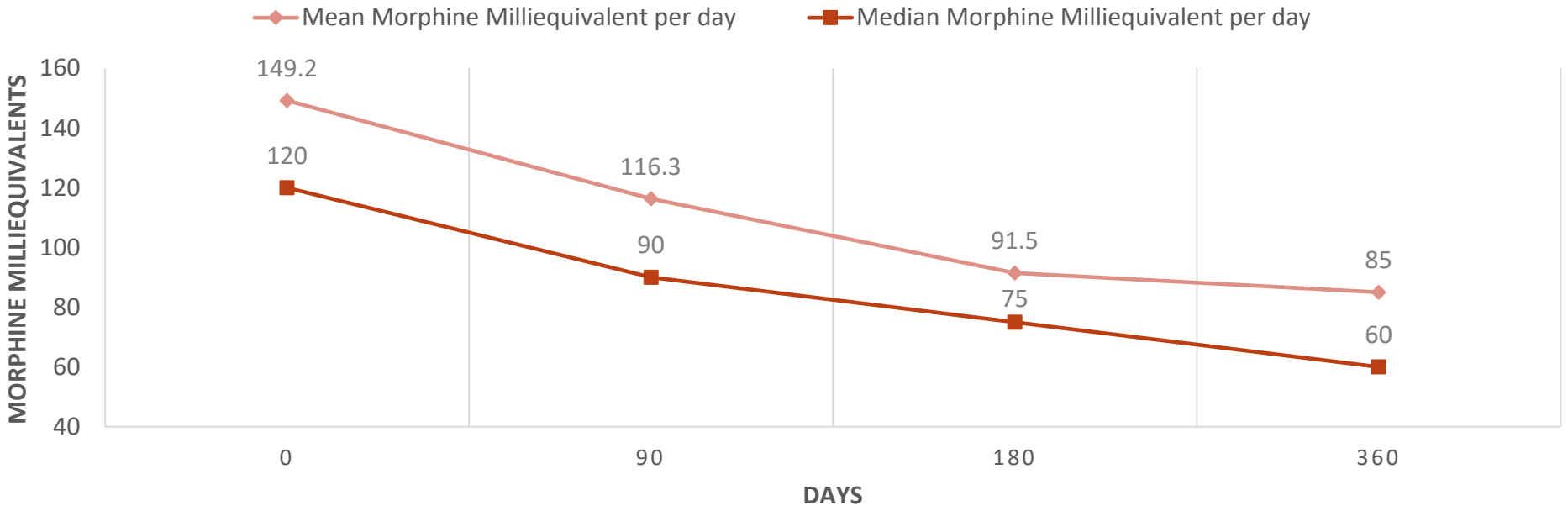
Hydrocodone 10mg/Acetaminophen 650mg BID (Last filled: 1/15/2021 for 30 days; PMP verified; Total daily MME: 20mg)

Opioid Taper Schedule:

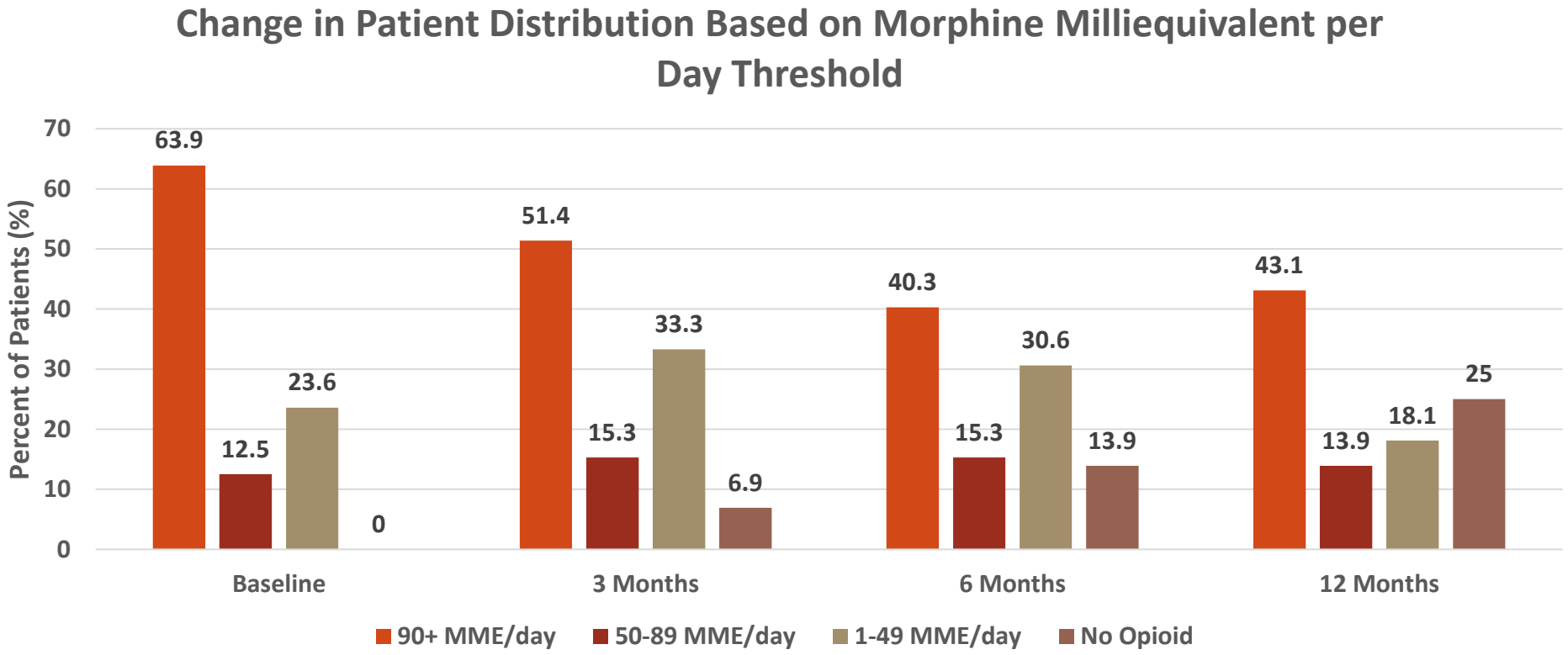
****Due to improved taper flexibility, recommend to transition from hydrocodone/acetaminophen to oxycodone IR. Increase MME potency and increased tablet strength variety of oxycodone over hydrocodone will allow for more tolerable taper transitions.

Initial MAX Total Daily MME: 200	**Fentanyl Patch**	**Oxycodone IR**	**Dose Reduction**	**MME/Day**
Week 1-3	50mcg/hr; 1 patch every 72 hours (#7 for 21 days)	10mg; 1 tablet every 6 hours (MAX: 4 tablets/day; #84) **Establishing baseline with oxycodone/acetaminophen; will account for incomplete cross-tolerance	-10% **likely less when accounting for incomplete cross-tolerance with hydrocodone	180
Week 4-6	37.5mcg/hr; 1 patch every 72 hours (#7 for 21 days)	10mg; 1 – 1 ½ tablets every 6 hours (MAX: 5 tablets/day; #105) **Dose increased to account for fentanyl patch reduction	-8%	165
Week 7-9	25mcg/hr; 1 patch every 72 hours (#7 for 21 days)	15mg; 1 tablet every 6 hours (MAX: 4 tablets/day; #84) **Dose increased to account for fentanyl patch reduction	-9%	150
Week 10-12	12 mcg/hr; 1 patch every 72 hours (#7 for 21 days)	15mg; 1 – 1 ½ tablets every 6 hours (MAX: 5 tablets/day; #105) **Dose increased to account for fentanyl patch reduction	-6%	141.3
Week 13-15	Discontinue Fentanyl patch	15mg; 1 - 1 ½ tablets every 6 hours (MAX: 5.5 tablets/day; #116) **Dose increased to account for fentanyl patch reduction	-12%	123.75

CHANGE IN MORPHINE MILLIEQUIVALENTS POST-TAPER INITIATION AT PROHEALTH PHYSICIANS (N=72)



Change in Morphine Milliequivalent per day from Baseline			
	At 3 Months	**At 6 Months**	**At 12 Months**
Mean MME/day	-22.1%	-38.7%	-43.1%
Median MME/day	-25%	-37.5%	-50%



- At 12 months, 18 patients (25%) were completely tapered off their opioid prescriptions
- At 12 months, 31 patients remained on ≥90 MME/day representing a 32.6% relative reduction from baseline

Patient KB

KB is a 41-year old male, well known to your clinic, who presents for follow-up 2 weeks s/p traumatic fall while fixing his roof. Per hospital records, patient sustained L2 and L3 spinal fractures. Surgical decompression and stabilization was performed while admitted. He was adherent to the activity restrictions and other discharge instructions provided by the orthopedic surgeon. He goes to PT 3x/week. Patient reports that he continues to have 6-7/10 pain in his lower back which is partially responsive to the opioids given to him at discharge. He has only ~2 more days of opioids before running out. Since the accident, patient reports that he has been feeling "more down in the dumps" and "isolated".

Other Notable PMH: HTN, MDD, T2DM

Current Medications: Lisinopril 10mg daily, Atorvastatin 40mg daily, Metformin 1000mg BID, Oxycodone IR 15mg q8H PRN

Patient KB

Upon further questioning, KB reports that he has been taking his Oxycodone IR three times a day “just about every day” to control his back pain. Per patient, pain is usually reduced to a 2-3/10 after taking his dose of oxycodone. Patient has always been communicative to your office and reliable for appointments and medications in the past. No personal or familial substance use history. Patient has limited social supports at home, beside his neighbor who has been helping him with errands and transportation since the accident.

Patient KB

Based on your assessment and relationship with the patient, you agree to take over his pain management. He is currently on 67.5 MME/day based on regimen of oxycodone IR 15mg q8H, but still reporting inadequate daily pain control. He will run out of his oxycodone from the hospital in 2 days. Patient denies any other medication use for pain control.

Which non-opioid option(s) below would best optimize patient's pain regimen at this time?

A. Initiate duloxetine 30mg daily, with intent to titrate to 60mg daily, if tolerated
B. Initiate Lidocaine patch
C. Initiate bowel regimen
D. All of the above

Patient KB

The patient returns to your clinic 8 weeks later for follow-up. He reports “major” improvement in pain control since initiation of duloxetine and lidocaine patch. Pain is now 1-2/10 without oxycodone and 0-1/10 after doses. He also reports improvement in mood since your last visit. Patient requests trialing an opioid taper.

Based on current opioid use (Oxycodone IR 15mg q8H), which of the following would be a the most optimal initial dose reduction for an intermediate speed taper schedule?

A. Oxycodone IR 15mg; 1 tablet BID

B. Oxycodone IR 10mg; 1 ½ tablet every morning and evening 1 tablet every afternoon

C. Oxycodone IR 15mg; 1 tablet qAM and qPM & ½ tablet at Noon

D. Oxycodone IR 10mg; 1 tablet q8H

A Whole Different B(DZ)EAST

CONQUERING A DIFFERENT KIND OF CONTROLLED SUBSTANCE TAPER

Benzodiazepine Tapering:

Implementing a Taper Schedule:

1. **Determine Taper Speed:**
   - Typically individualized based on patient goals, risks of current therapy, benzodiazepine dose, and duration of benzodiazepine therapy
   - Feasibility of follow-up frequency and co-pays must also be taken into account
2. **Initiate Taper Schedule:**
   - Coordinate benzodiazepine prescriptions appropriately
   - Ensure patient is counseled on taper schedule and potential withdrawal symptoms
3. **Reassess Taper Schedule/Monitor Patient for Withdrawal:**
   - Closely monitor patient for withdrawal; Benzodiazepine withdrawal is more dangerous than opioid withdrawal and is less responsive to supportive care.
   - Taper may be stopped, slowed, or reversed at any point

General Taper (i.e. ↓10-25% per week)

- Useful for those on therapeutic doses of benzodiazepines
- Increased risk of withdrawal symptoms with short-acting benzodiazepines

High-Dose Taper (i.e. ↓5-10% per week)

- Risk of withdrawal increased, consider referring for inpatient management in high-risk individuals

Benzodiazepine Taper Pearls

- Consider transitioning to a long-acting benzodiazepine to improved taper tolerability
- At 50% total dose reduction, consider maintaining dose for 4-8 weeks to improve taper tolerability
- Avoid prolonged tapers > 6 months due to worse outcomes
- Encourage enrollment in CBT-I due to improved taper outcomes
- Dose reduction calculations are all relative to **BASELINE LME**

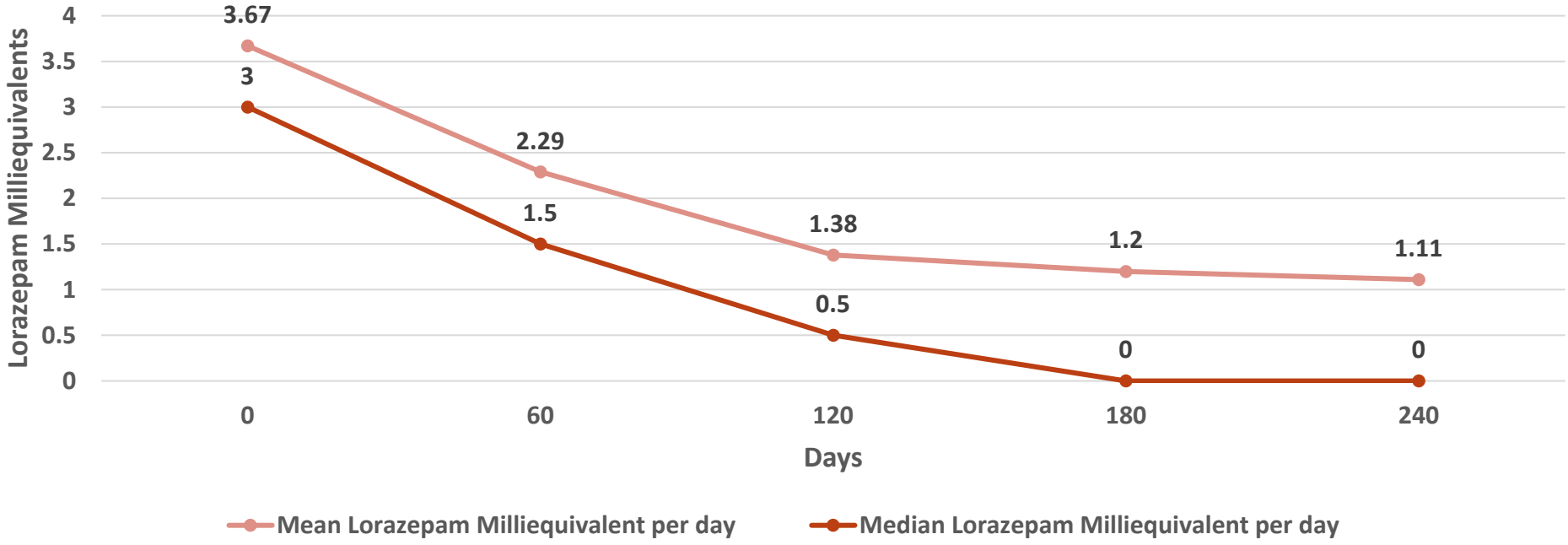
**Patient reports taking current dose 1mg BID; Previously on 1mg TID as of early May 2020

Benzodiazepine Taper Schedule:

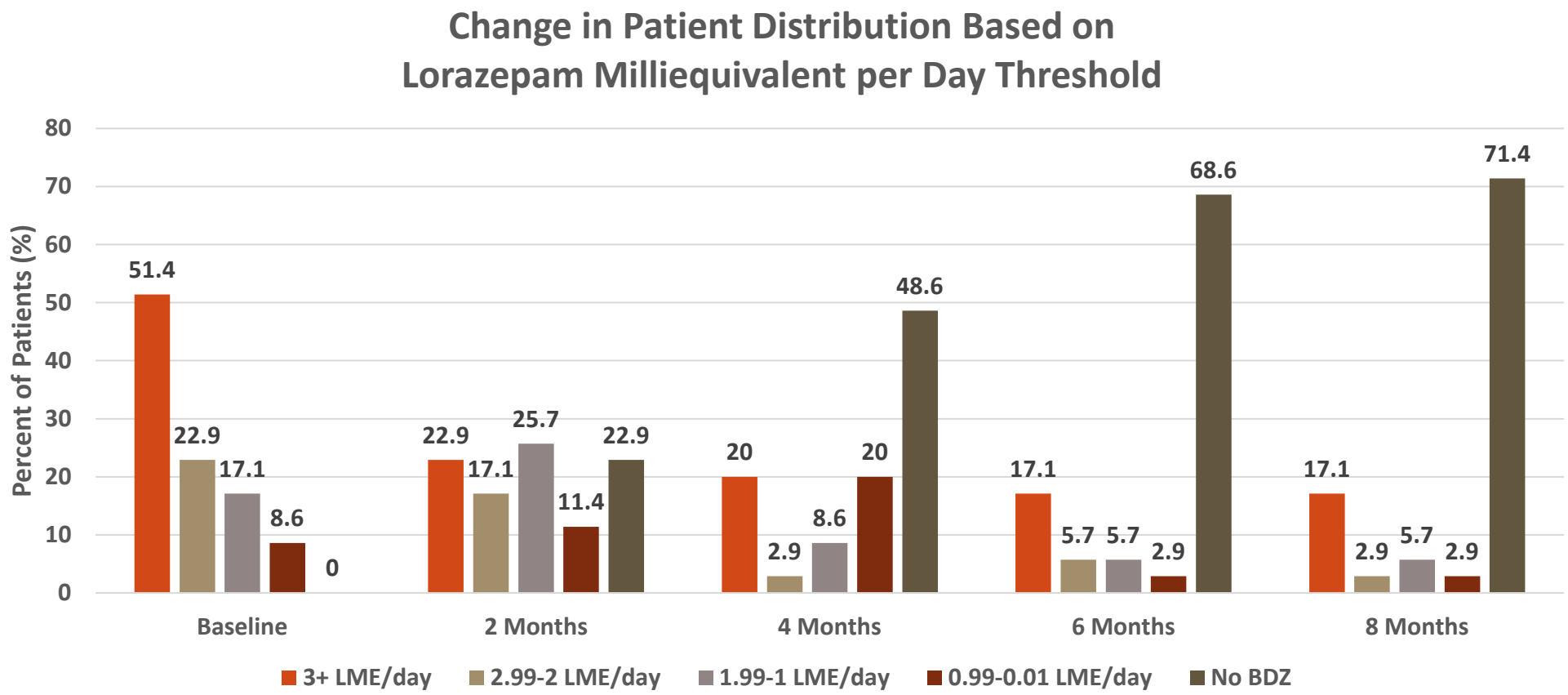
**Per discussion with PCP, patient is not reporting any clinical manifestations of benzodiazepine withdrawal besides continued insomnia. Since this is a baseline issue for patient, it appears that he tolerated initial dose decrease. Will continue taper from current dose. PCP in agreement.

Initial MAX Total Daily LME: 6mg (previously on 1mg TID)	Clonazepam	**Total Dose Reduction**	**LME/Day**
Week 1-4	Continue current dose of clonazepam 1mg BID	-33%	4mg
Week 5-6	0.5mg; Take 1 tablet TID	-50%	3mg
Week 6-13	Continue current dose; 0.5mg; Take 1 tablet TID	No change	3mg
Week 14-15	0.5mg; Take 1 tablet BID	-66%	2mg
Week 15-16	0.5mg; Take 1 tablet qHS	-83%	1mg
Week 17	Discontinue Clonazepam		0

Change in Lorazepam Milliequivalents Post-Taper Initiation at ProHealth Physicians (N=35)



Change in Lorazepam Milliequivalent per day from Baseline				
	At 2 Months	**At 4 Months**	**At 6 Months**	**At 8 Months**
Mean LME/day	-37.6%	-62.4%	-67.3%	-69.8%
Median LME/day	-50%	-83.3%	-100%	-100%



- At 8 months, 25 patients (71.4%) were completely tapered off their benzodiazepine prescriptions
- At 8 months, 6 patients remained on ≥3 LME/day representing a 66% relative reduction from baseline

Patient RW

RW is a 27 year old female, who you recently inherited from another provider in the organization who retired. Her previous records indicate she has diagnosis of generalized anxiety disorder. During your visit, patient asks if you will refill her chronic benzodiazepine that she uses regularly for anxiety. She reports that her anxiety “has been better” and that the effects of the pandemic are “making things worse”. She does not have any other complaints.

During your visit, you discuss that you do not typically prescribe chronic benzodiazepines for your patients due to the risks associated with them and potential for addition and dependence. You suggest working together to develop a plan to taper off benzodiazepines.

Other Notable PMH: None

Current Medications: Alprazolam 1mg q8H PRN, Tri-Sprintec as directed

Patient RW

RW is a little apprehensive about stopping her benzodiazepine, but is willing to work with you. She states she has already trialed sertraline in the past but discontinued it “due to the side effects”. Specifically, she noticed changes in her sex drive and experienced significant GI symptoms.

Which of the following medications would you initiate to manage RW’s anxiety?

A. Bupropion XL

B. Paroxetine

C. Buspirone

D. Amitriptyline

Patient RW

RW is agreeable to initiating buspirone to address her anxiety symptoms. After discussing further, RW reports that she uses the maximum daily amount of her alprazolam 1mg q8H prescription.

Based on patient's reported daily alprazolam use, which of the following would be a reasonable initial dose reduction?

A. Alprazolam 0.5mg; 2 tablets every morning and evening & 1 ½ tablet at Noon
B. Alprazolam 1mg; 1 tablet q12H
C. Diazepam 10mg every morning and 15mg every evening
D. Diazepam 20mg daily

Withdrawal Management & Overdose Prevention

Identifying Opioid Withdrawal: COWS

Patient's name:_____	Date and time:___/___/___:_____
Reason for this assessment:_____	
Resting pulse rate:_____beats/minute Measured after patient is sitting or lying for one minute	**GI upset:** Over last half-hour
0 pulse rate 80 or below 1 pulse rate 81 to 100 2 pulse rate 101 to 120 4 pulse rate greater than 120	0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: Over past half-hour not accounted for by room temperature or patient activity	**Tremor:** Observation of outstretched hands
0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness: Observation during assessment	**Yawning:** Observation during assessment
0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit stil l for more than a few seconds	0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute

Pupil size	Anxiety or irritability
0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or joint aches: If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored	**Gooseflesh skin**
0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing: Not accounted for by cold symptoms or allergies	**Total score:**_____ The total score is the sum of all 11 items
0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Initials of person completing assessment:_____

Clinical Opioid Withdrawal Scale Scoring:	
Mild Withdrawal	5-12 points
Moderate Withdrawal	13-24 points
Moderately Severe Withdrawal	25-36 points
Severe Withdrawal	> 36 points

UptoDate

J Pyschoactive Drugs 2003; 35:253

Managing Opioid Withdrawal:

Indication	Treatment	Counseling Points
Sweating, tachycardia	Clonidine 0.1mg q8H	Taper dose upon discontinuation to avoid rebound hypertension
Anxiety, irritability, restlessness	Diphenhydramine 50-100mg q4-6H PRN (MAX: 300mg/day)	Caution with hepatic impairment or age ≥65 years
	Hydroxyzine 25-100mg q6-8H PRN (MAX: 400mg/day)	Caution with renal/hepatic impairment or age ≥ 65 years May also help with rhinorrhea
Abdominal cramping	Dicyclomine 10-20mg q6-8H PRN (MAX: 160mg/day)	Caution with renal/hepatic impairment
Diarrhea	Loperamide 4mg ONCE then 2mg PRN after each loose stool (MAX: 16mg/day)	Monitor for dehydration; Encourage patient to maintain fluid and electrolyte levels (i.e. Pedialyte)
	Bismuth Subsalicylate 524mg (30mL) q30-60min PRN (MAX: 4200mg/day)	
Nausea/Vomiting	Ondansetron 4-8mg q8-12H PRN (MAX: 16mg/day)	Dose-dependent QTc prolongation; use caution in methadone users Caution in hepatic impairment
	Prochlorperazine 5-10mg q6-8H (MAX: 40mg/day)	Avoid in severe hepatic impairment
Insomnia	Trazodone 25-50mg qHS (MAX: 300mg qHS)	Caution in severe renal/hepatic impairment
	Mirtazapine 7.5-15mg qHS	Please note, higher doses of mirtazapine are less effective for insomnia
Myalgias, joint pain, headache	Acetaminophen 500-1000mg q4-6H PRN (MAX: 4000mg/day)	Preferred agent in those with CVD, renal/hepatic impairment, or age ≥ 65 years
	Ibuprofen 400mg q6H PRN	Avoid in CVD, renal/hepatic impairment, or age ≥ 65 years
	Naproxen 220mg q12H PRN	
	Topicals (i.e. lidocaine, counterirritants)	Most useful for localized pain
Muscle spasms	Cyclobenzaprine 5-10mg q8H PRN (MAX: 30mg/day)	Avoid in hepatic impairment
	Baclofen 5-10mg q8H PRN (MAX: 60mg/day)	Taper dose upon discontinuation to avoid withdrawal symptoms

Preventing Opioid Overdose:

Risk Factors for Opioid Overdose		
Patient on ≥50 MME/day	History of substance abuse	Certain chronic comorbidities (i.e. lung, liver, psychiatric disease)
Co-administration of benzodiazepines, sedatives, or hypnotics	History of overdose	Use of extended-release opioids

Patients with ANY of the above risk factors should be considered for prescription of an emergency supply of naloxone to be used in the event of an opioid overdose

J Addict Dis. 2016;35:42-51
J Addict Med. 2016;10:369-381

Patient KB (Continued)

To mitigate risks of an overdose, you also prescribed naloxone nasal spray to the patient during the visit. You ensure the patient is appropriately counseled on its use and instruct him to teach his neighbor and other frequent contacts, so they are prepared to respond in an emergency.

Current Opioid Dose: Oxycodone IR 15mg q8H

Based on the patient's history, what are his current risk factors for opioid overdose:

A. Hepatic dysfunction
B. Daily MME requirement ≥ 50mg
C. Renal Dysfunction
D. History of Overdose

Benzodiazepine Withdrawal

Benzodiazepine Withdrawal Symptoms			
Tremors	Anxiety	Perceptual disturbances	Dysphoria
Psychosis	Seizures	Autonomic instability	

Benzodiazepine withdrawal can be life-threatening and requires rapid identification and management

- **For patients with mild withdrawal:** Return to previous benzodiazepine dose
- **For patients with moderate-severe withdrawal:** Referral for inpatient management is required

Please Note: Supportive care measures with non-benzodiazepine medications have not shown benefit in clinical trials for withdrawal

Drug Saf. 1993; 9:93

Concomitant Use of Opioid and Benzodiazepines (COB)

A NEW QUALITY MEASURE THAT RELIES ON DEPRESCRIBING

Concomitant Use of Opioids and Benzodiazepines (COB)

Eligible population: Patients 18 years and older with continuous health plan enrollment, who do not have cancer, sickle cell disease, or who are in hospice

$$\frac{\begin{array}{c}Any\ patient\ in\ the\ denominator\ who\ are\ concurrently \\ prescribed\ benzodiazepines\ for \geq 30\ days\end{array}}{\begin{array}{c}Total\ number\ of\ eligible\ patients\ with\ at\ least\ two\ opioid\ prescriptions, \\ filled\ on\ different\ days, totaling\ 15\ days\end{array}}$$

Goal: Lower percentage is better

COB Tips and Tricks

1. **Reduce days supply of acute short-terms prescriptions for opioids and benzodiazepines to prevent overlap**
   - Consider EHR alerts to discourage concomitant use
   - Update default prescription supplies
2. **Prioritize benzodiazepine tapers over opioids**
   - Shorter taper duration
   - Higher likelihood for complete discontinuation
   - Larger impact to measure performance

Questions?

Sometimes LESS is MORE

THE ART (OR SCIENCE?) OF CONTROLLED SUBSTANCE TAPERING

NICK BOEMIO PHARMD, BCPS

CLINICAL PHARMACY SPECIALIST – PROHEALTH PHYSICIANS

CLINICAL PHARMACY INFORMATICIST – OPTUM NEW ENGLAND