tipSC | Timely Information for Providers in South Carolina

An outreach service for Medicaid providers to help identify and prevent potential gaps in evidence-based care, as well as detect fraud, abuse, overuse or inappropriate use.

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OPIOIDS & BENZODIAZEPINES JUST DON'T MIX

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

PICK UP QUICK TIPS ON...tapering opioids and/or benzodiazepines to reduce risk of overdose

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.

QUICK tip SC

Co-prescribing naloxone and opioids may save a life

QUICK FACTS TO CONSIDER

- Almost **1 in 3 opioid overdose cases involves a benzodiazepine**; the combination may quadruple risk of fatality versus opioids alone.
- **Tapering opioids before tapering benzodiazepines** may lessen anxiety that can be associated with opioid withdrawal.
- Opioid withdrawal symptoms can be highly distressful but rarely medically serious; **benzodiazepine withdrawal symptoms can be life-threatening.**
- **Slow** opioid **tapers** decrease and often eliminate withdrawal symptoms; slow benzodiazepine tapers help **minimize withdrawal symptoms.**

CLINICAL PEARLS

Risks for respiratory depression with opioids, in addition to concurrent benzodiazepines, include:

- **Use with any CNS depressant** (e.g., Rx cough suppressants, OTC sleep aids, alcohol, illicit drugs)
- **Co-existing conditions** such as older age, obesity, COPD and sleep apnea
- **Opioid doses ≥ 50 Morphine Milligram Equivalents (MME)/day** (Opioids by the Numbers [Sept 2017 Issue No. 1])

In the office, monitor closely for **sedation** that **could be an important early warning sign of respiratory depression.** The Epworth Sleepiness Scale can be used to identify or track excess sleepiness. Educate the patient, family and caregivers to report excess sleepiness, nodding off during conversations, and frequent dozing or napping during the day.

Conversations about an opioid or benzodiazepine **taper can be difficult**. Consider:

- **Expressing safety concerns** *"I care about your safety..." "I am worried..."*
- **Using Motivational Interviewing techniques** to help make decisions as equals as much as is clinically appropriate
- **Listening to and acknowledging patient's fears** (e.g., fear of pain, fear of withdrawal) *"So you feel..."*
- **Sharing that many patients** improve and **do better** at reduced dose or discontinuation, **even if briefly worse at first**
- **Reassuring patients you will not abandon them** *"I'll stick by you..."*

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

COMBO PRESCRIPTIONS FOR OPIOID + BENZO IN SAME MONTH		COMBO PRESCRIPTIONS FOR OPIOID + BENZO + CARISPORODOL IN SAME MONTH	
25	35	15	20
BY YOU	BY YOU + OTHER PRESCRIBERS	BY YOU	BY YOU + OTHER PRESCRIBERS

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

Total patients receiving an opioid + benzodiazepine* (+ carisoprodol) 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.

OPIOID TAPERING CONSIDERATIONS

When it is decided to initiate an opioid taper to a reduced dose or discontinuation, individualize the plan, evaluate the patient frequently (at least before each dose change), and engage the patient throughout the process. **Prior to initiating the taper, screen for opioid use disorder (OUD)** (e.g., decline in functioning, difficulty controlling use [Rx or illicit], continued use despite negative consequences); and **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 medication assisted treatment (MAT) providers if needed.

Substance Abuse Treatment Services Locator:
https://www.findtreatment.samhsa.gov

SC Medication Assisted Treatment Practice Support:
http://www.scmataccess.com
Phone: 843.792.5380

Many people who taper opioids to reduced dose or discontinuation **have improved function without increase in pain and may have less pain** (even though may have transitory increase at first).

Non-opioid pain medications (e.g., NSAIDS and acetaminophen) **and non-meds** (e.g., physical therapy, cognitive behavioral therapy, meditation) **can be used to manage withdrawal pain**. It is also good to have a plan in place to manage other potential withdrawal symptoms. (See: *https://msp.scdhhs.gov/tipsc/site-page/opioidwithdrawalsxmeds)*

Speed of taper, ranging from days to weeks 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 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.

Offering naloxone as a rescue to patients at risk for opioid overdose includes those on a taper. For more information on co-prescribing naloxone visit: http://prescribetoprevent.org/

"SLOWER" TAPERS FROM SELECTED GUIDELINES FOR PATIENTS ON CHRONIC OPIOID THERAPY

*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)*

GUIDELINE	SLOWER TAPER RECOMMENDATIONS (until discontinue or at dose reduction goal)
VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain – 2017	• 5 - 20% reduction every 4 weeks[1] (see taper example below) • Pauses in taper as needed
Canadian Guideline for Use of Opioids for Chronic Non-Cancer Pain – 2017	• 5 - 10% reduction every 2 – 4 weeks • Frequent follow-up
CDC Guidelines for Prescribing Opioids in Chronic Pain – 2016[2]	• 10% reduction every month[3], especially if long term use • Pauses in taper as needed

[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

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

16% monthly reduction of original 270 mg total daily dose

Month 1	75 mg (60 mg + 15 mg) ER q8h
Month 2	60 mg ER q8h
Month 3	45 mg ER q8h
Month 4	30 mg ER q8h
Month 5	30 mg ER q8h
Month 6	15 mg ER q8h
Month 7	15 mg ER q12h
Month 8	15 mg ER qhs, then stop

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

Example adapted with permission from VA PBM Academic Detailing Service. Opioid Taper Decision Tool. 2016 Oct. IB 10-939; P96820.

BENZODIAZEPINE TAPERING CONSIDERATIONS

A single written communication to the patient discussing risks of long term use and benefits of tapering **can promote successful discontinuation**. There are **few indications for benzodiazepine use beyond 4 to 6 weeks**; longer use results in loss of effectiveness for short term indications **and development of dependency**. Guidelines generally agree:

- People who taper to reduced dose or discontinuation frequently do better – **less daytime fatigue, fewer falls, improved brain performance, alertness and reflexes** – especially as patients age
- **Gradual tapers** over 2 – 6 months (maybe longer) are more likely to be successful
- **Anticipate rebound insomnia and anxiety**: consider cognitive behavioral therapy and **offer sleep hygiene advice** (even if the benzodiazepine is not used to treat insomnia). See: *https://msp.scdhhs.gov/tipsc/site-page/healthysleeppatienthandout*

BENZODIAZEPINE TAPERS FROM SELECTED GUIDELINES/RESOURCES

RESOURCE	SELECTED RECOMMENDATION
National Center for PTSD Guidance – 2013 (see taper example below)	• 10-25% reduction every 1 – 2 weeks[1], individualizing subsequent reductions based on response to initial reduction • Consider stabilizing at 50% dose before proceeding with taper • Consider switching to long acting benzodiazepine
College of Physicians & Surgeons of Alberta Clinical Toolkit – 2016	• 10% reduction every 1 – 2 weeks until the dose is at 20% of the original dose, then 5% reduction every 2 – 4 weeks **OR** • Reduce dose by no more than 5 mg diazepam equivalent per week until dose is below 20 mg diazepam equivalent, then consider 1 -2 mg diazepam equivalent reduction per week • Adjust rate of taper according to symptoms
Deprescribing.org Algorithm – 2016[2]	• ~25% reduction every 2 weeks, then, if possible, 12.5% reduction near end and/or planned drug-free days

[1] For once daily bedtime dosing, 25% reduction every week. [2] Full guideline to be published June 2018.

BENZODIAZEPINE TAPER EXAMPLE

LORAZEPAM 4 MG BID

No Switch (i.e., same benzodiazepine)

Lorazepam[1] 4 mg BID (divide total mg/day dose)	
Week 1	7 mg/day
Week 2[2]	6 mg/day (25% of initial dose)
Week 3	5 mg/day
Week 4	4 mg/day (50% of initial dose)
Weeks 5-8	4 mg/day (hold dose then reduce by 25% of current dose every 2 weeks)
Weeks 9-10	3 mg/day
Weeks 11-12	2 mg/day
Weeks 13-14	1 mg/day
Week 15	Discontinue

[1] Available as 2 mg (scored), 1 mg (scored), 0.5 mg tablets. [2] Reduce dose by 10-25% every 4 weeks for a longer taper (e.g., 6 months).

Switch to longer acting benzodiazepine

Convert to 40 mg Diazepam[1,2] Daily (divide total mg/day dose)	
Week 1	35 mg/day
Week 2[3]	30 mg/day (25% of initial dose)
Week 3	25 mg/day
Week 4	20 mg/day (50% of initial dose)
Weeks 5-8	20 mg/day (hold dose then reduce by 25% of current dose every 2 weeks)
Weeks 9-10	15 mg/day
Weeks 11-12	10 mg/day
Weeks 13-14	5 mg/day
Week 15	Discontinue

[1] Available as 10 mg (scored), 5 mg (scored), 2 mg (scored) tablets. [2] Diazepam can cause prolonged sedation in elderly and those with liver impairment. [3] Reduce dose by 10-25% every 4 weeks for a longer taper (e.g., 6 months).

NO SWITCH VS SWITCH

Switching from a short or intermediate acting to a long acting benzodiazepine has not been shown to be more effective or to reduce the severity of withdrawal symptoms.

Consider switching to a longer acting or different benzodiazepine if current benzodiazepine does *not* allow for dose reduction (e.g., capsules, tablets difficult to halve or quarter).

A **more extensive list of benzodiazepines** with a range of dose equivalency estimates (since different sources do not always agree) for conversion is available at: *https://msp.scdhhs.gov//tipsc/site-page/benzoequivtable*

Benzodiazepine Equivalency Table

Generic	Brand Example	Elimination Half-Life[1]	Dosage Form	Approximate Equivalent Dose[2]
Alprazolam[3]	Xanax®	12-15 hours	Tab	1 mg
Chlordiazepoxide	Librium®	>100 hours	Cap	25 mg
Clonazepam	Klonopin®	20-50 hours	Tab	1 mg
Diazepam	Valium®	>100 hours	Tab	10 mg
Lorazepam	Ativan®	10-20 hours	Tab	2 mg
Temazapem	Restoril®	10-20 hours	Tab	15 mg

[1] May include active metabolites. [2] These are estimates and vary among resources. [3] High dose alprazolam may not have complete cross-tolerance.

Example adapted with permission from VA PBM Academic Detailing Service. Re-evaluating the use of benzodiazepines: a focus on high-risk populations. 2016 Aug. IB 10-928; P96810.

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This information is intended to assist primary care providers in the management of pain in adults in a primary care setting. This information is advisory only and is not intended to replace sound clinical judgment nor should it be regarded as a substitute for individualized diagnosis and treatment. Special considerations are needed when treating some populations with certain conditions (such as respiratory/sleep disorders; cardiac; liver/renal impairment; addiction; debility; elderly; and pregnancy/breast-feeding). Tapering opioids and/or benzodiazepines during pregnancy/breast-feeding is beyond the scope of this issue.