**CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022**

**Recommendation 5**

*For pts already receiving opioid tx, clinicians should carefully weigh benefits and risks and exercise care when changing opioid dosage. If benefits outweigh risks of continued opioid tx, clinicians should work closely w/ pts to optimize nonopioid therapies while continuing opioid tx. If benefits don't outweigh risks of continued opioid tx, clinicians should optimize other therapies and work closely w/ pts to gradually taper to lower dosages or, if warranted based on the individual circumstances of the pt, appropriately taper and D/C opioids. Unless there are indications of a life-threatening issue such as warning signs of impending OD (e.g., confusion, sedation, or slurred speech), opioid tx should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages from higher dosages (recommendation category: B; evidence type: 4).*

**Implementation Considerations**

- Carefully weigh both the benefits and risks of continuing opioid meds and the benefits and risks of tapering opioids.

- If benefits outweigh risks of continued opioid tx, work closely w/ pts to optimize nonopioid therapies while continuing opioid tx.

- When benefits (incl avoiding risks of tapering) don't outweigh risks of continued opioid tx, optimize other therapies and work closely w/ pts to gradually taper to a reduced opioid dosage or, if warranted based on

the individual clinical circumstances of the pt, appropriately taper and D/C opioid tx.

- In situations where benefits and risks of continuing opioids are considered to be close or unclear, shared decision-making w/ pts is particularly important.

- At times, clinicians and pts might not be able to agree on whether or not tapering is necessary. When pts and clinicians are unable to arrive at a consensus on the assessment of benefits and risks, clinicians should acknowledge this discordance, express empathy, and seek to implement treatment changes in a pt-centered manner while avoiding pt abandonment.

- Pt agreement and interest in tapering is likely to be a key component of successful tapers.

- For pts agreeing to taper to lower opioid dosages and for those remaining on higher opioid dosages, clinicians should establish goals w/ the pt for continued opioid tx and maximize pain treatment w/ nonpharmacologic and nonopioid pharmacologic treatments as appropriate.

- Collaborate w/ the pt on the tapering plan; include pts in decisions such as how quickly tapering will occur and when pauses in the taper might be warranted.

- Follow up frequently (at least monthly) w/ pts engaging in opioid tapering. Team members (e.g., nurses, pharmacists, and behavioral health professionals) can support the clinician and pt during the ongoing taper process through phone contact, telehealth visits, or face-to-face visits.

- When opioids are reduced or discontinued, a taper slow enough to minimize sx and signs of opioid withdrawal (e.g., anxiety, insomnia, abdominal pain, vomiting, diarrhea, diaphoresis, mydriasis, tremor, tachycardia, or piloerection) should be used.

- Longer duration of previous opioid tx might require a longer taper. For pts who have taken opioids long-term (e.g., for ≥1 year), tapers can be completed over several months to years depending on the opioid dosage and should be individualized based on pt goals and concerns.

- When pts have been taking opioids for longer durations (e.g., for ≥1 year), tapers of 10% per month or slower are likely to be better tolerated than more rapid tapers.

- For pts struggling to tolerate a taper, clinicians should maximize nonopioid treatments for pain and should address behavioral distress.

- Clinically significant opioid withdrawal symptoms can signal the need to further slow the taper rate.

- At times, tapers might have to be paused and restarted again when the pt is ready and might have to be slowed as pts reach low dosages.

- Before reversing a taper, clinicians should carefully assess and discuss w/ the pt the benefits and risks of increasing opioid dosage.

- Goals of the taper might vary (e.g., some pts might achieve discontinuation whereas others might attain a reduced dosage at which functional benefits outweigh risks). If the clinician has determined w/ the pt that the ultimate goal of tapering is discontinuing opioids, after the smallest available dose is reached the interval between doses can be extended and opioids can be stopped when taken less frequently than once a day.

- Clinicians should access appropriate expertise if considering tapering opioids during pregnancy because of possible risks to the pregnant pt and the fetus if the pt goes into withdrawal.

- Clinicians should advise pts of an increased risk for OD on abrupt return to a previously prescribed higher dose because of loss of opioid tolerance, provide opioid OD education, and offer naloxone.

- Clinicians should remain alert to signs of and screen for anxiety, depression, and opioid misuse or OUD that might be revealed by an opioid taper and provide treatment or arrange for mgmt of these comorbidities.

- Closely monitor pts who are unable to taper and who continue on high-dose or otherwise high-risk opioid regimens (e.g., opioids prescribed concurrently w/ BZDs); work w/ pts to mitigate OD risk (e.g., by providing OD education and naloxone).

- Clinicians can use periodic and strategic motivational questions and statements to encourage movement toward appropriate therapeutic changes and functional goals.

- Clinicians have a responsibility to provide or arrange for coordinated mgmt of pts' pain and opioid-related problems, incl OUD.

- Payers, health systems, and state medical boards should not use this clinical practice guideline to set rigid standards or performance incentives related to dose or duration of opioid tx; should ensure that policies based on cautionary dosage thresholds don't result in rapid tapers or abrupt D/C of opioids; and should ensure that policies don't penalize clinicians for accepting new pts who are using prescribed opioids for chronic pain, incl those receiving high dosages of opioids, or

for refraining from rapidly tapering pts prescribed long-term opioid meds.

- Although Recommendation 5 specifically refers to pts using long-term opioid tx for subacute or chronic pain, many of the principles in these implementation considerations and supporting rationale, incl communication w/ pts, pain mgmt, behavioral support, and slower taper rates, also are relevant when discontinuing opioids in pts who have received them for shorter durations.