Oregon Pain Guidance – Tapering Guidance & Tools

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Tapering Guidance and Tools – Overview

Over the last 20 years, the liberal prescribing of opioids for chronic pain has created a population of patients who been on long term opioid therapy (LTOT) for several years if not decades. Many patients are on doses well above the CDC recommended upper limit of 90 Morphine Equivalent Dose (MED) for new starts. Patients, however, may be reluctant to taper, fearing withdrawal and increased pain. Prescribers are also asking whether or not tapering is necessary if the patient is stable and compliant on their current dose. Yet, overdose rates continue to be high compared to historical standard and it is well established that patients on high doses of opioids are at increased risk for a variety of side effects, serious morbidities, and death. Quality of life may be adversely affected, despite the fact that the patient perceives benefit in terms of pain relief. Recent research found no significant difference for pain relief between opioid and non-opioid treatment. (ref. The SPACE Randomized Clinical Trial)

For this legacy patient population, prescribers need to carefully assess the risks versus the benefits of continued opioid therapy. In some cases, where the risks are minimal and the patient appears to be doing well, continued opioid therapy may be justified. In many cases though a *thorough and systematic risk benefit assessment* (RBA) will reveal continued pain and dysfunction that indicate that a taper should be initiated and other non-opioid therapies some be employed, including referral to behavioral health or other specialists. A Systematic Review of 67 studies suggests that several types of interventions may be effective to reduce or discontinue LTOT and that pain, function, and quality of life may improve with opioid dose reduction, but the evidence is of very low quality (ref. A Systematic Review, by Frank et al 2017). It's important to recognize that tapering is an art, not an exact science and the speed and duration of the taper should be tailored to the individual needs of the patient.

Below are some guidelines and tools that will help prescribers assess and weigh risks versus benefits, and decide whether tapering is indicated. For tapering to be successful, clinicians must approach the taper as an alliance with the patient with the goal of improving their safety and quality of life.

Contributors

These tools, guidance, and resources for tapering were collected and developed by the Oregon Pain Guidance Clinical Advisory Group, Tapering Workgroup. The workgroup participants and contributors include:

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Special Credit

- **Tapering Flowchart and Risk Benefit Assessment Criteria** – Thanks to Dr. Shames, Dr. Ballantyne, Dr. Lembke, Dr. Coelho, Mr. Stephens.
- **BRAVO** – Thanks to Dr. Lembke for her BRAVO framework for approaching and tapering patients to safer doses or off opioids entirely.
- **What is a Safe Dose?** – Thanks to Dr. Ballantyne for guidance on dose.
- **Buprenorphine & X-Waivers** – Thanks to Dr. Halperin and Dr. Ballantyne for background on buprenorphine and X-Waivers.
- **Example Tapering Case** – Thanks to Dr. Halperin for the patient tapering case.
- **Frequently Asked Questions** – Thanks to Dr. Halperin.
- **References** – Thanks to Dr. Chou, Dr. Lembke, Dr. Coelho.

Tapering Risk Benefit Assessment and Flowchart

Assessing the Risks and Benefits

We recommend that all legacy patients have a systematic assessment of the risks and benefits of continued opioid therapy. In some cases, where the risks are minimal, and the patient appears to be doing well, continued opioid therapy may be justified. In many cases though a *thorough and systematic risk benefit assessment* (RBA) will reveal continued pain and dysfunction that indicate that a taper should be initiated, in conjunction with increased use of non-opioid therapies and possible referral to behavioral health or other specialists.

The patient should be monitored carefully, with a risk – benefit assessment performed quarterly. The following is a list of potential benefits and risks:

Benefits of Opioid Therapy

- **Improved quality of life** – Check if patient is engaged in more activities, has more social interactions, improved sleep, and improved mood. (Screening tools: PEG, Oswestry)
- **Improved pain relief** – Check if patient benefits from significant pain relief and that pain is less likely to interfere with activities. Note - While it is difficult to assess, patients may confuse pain relief with relief of withdrawal symptoms between doses. (Screening tools: pain scores, PEG)

Risks of Opioid Therapy

- **OUD or CPOD** – Check if patient meets criteria for a diagnosis of Opioid Use Disorder (OUD) diagnosis or Complex Persistent Opioid Dependence (CPOD). *See definitions below.*
- **Dose over 90 MED** – This factor should prompt consideration of tapering to a lower dose.
- **Addiction and mental health disorders** – Past history, family history, and psycho-social stressors are all risk factors predicting a poor response to opioids. (Screening tools: ORT, SOAPP-R, SOAPP-8)
- **Co-morbid conditions** – Co-morbid conditions can increase the risks from opioids: respiratory disease (COPD, Sleep Apnea, etc.), abnormalities in the endocrine system (depressed testosterone, hypoxemia), cardiac arrhythmias, obesity, dementia, fibromyalgia, depression, anxiety, substance use disorder, history of drug overdoses. (Screening tools: PHQ-9, GAD-7, PC-PTSD, STOP-Bang)
- **Opioid adverse effects** – Ask about opioid related adverse effects such as: constipation, lethargy, sexual dysfunction, confusion, depression, increased risk for falls and fractures, immune suppression, and respiratory depression. These adverse effects may affect quality of life or present risk for serious medical consequences.
- **Co-prescribed sedative hypnotics**. Benzodiazepines, alcohol, carisoprodol and other substances can increase the risks of serious side effects and death when combined with opioids. (Check the PDMP, avoid co-prescribing)
- **Query the Prescription Drug Monitoring Program (PDMP) database** – This should be done before a first prescription and prior to all medication refills. This ensures that you know exactly what controlled medications are prescribed to your patient and by whom.
- **Urine Drug Screens** – Random urine drug screening should be done at least quarterly. Absence of a prescribed drug, or presence of illicit drugs in a UDS requires a reassessment of patient risk.
- **Check for drug diversion** – Pill counts at every visit and episodic "call backs" for a count is a simple way to do this. This should be a policy that applies to all patients. Be aware that patients may be taking some of their prescriptions but diverting the remainder.
- **Involve family members and collateral contacts** – Encourage family members or partners to attend the clinic visits. For ongoing treatment especially involving change in behavior, close family members and partners can help patients stay on track.
- **Create an EMR template with a risk benefit checklist** – It is very helpful to have an EMR template that incorporates these risk/benefit factors. Completing the template ensures that a systematic risk

benefit assessment has been performed and simultaneously documents the results. This can be set with a quarterly reminder.

Definitions

- **Opioid Use Disorder (OUD)** - The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) uses 11 criteria to diagnose opioid use disorder (OUD) as Mild (2-3 symptoms), Moderate (4-5 symptoms), or Severe (6 or more symptoms). If the patient is diagnosed with OUD, the prescriber must either refer the patient to addiction treatment, or can continue to treat the patient with buprenorphine if they have an X-waiver.
- **Complex Persistent Opioid Dependence (CPOD)**
  Complex: Dependence is complicated by desire to continue taking opioid for the treatment of pain. Withdrawal is complicated by anhedonia and hyperalgesia which, unlike classic 'physical' symptoms, may not reverse within days.

  Persistent: Tapering is poorly tolerated. Tapering, therefore, may fail, or is highly protracted (takes months or years).

  What distinguishes CPOD from OUD:
  - No craving
  - No compulsive use
  - No harmful use that is not medically directed (patient takes opioid exactly as prescribed)
  - Social disruption is attributed to pain and not to OUD

Flowchart Description

Systematically Assess Risks & Benefits

Carefully consider all the risks and benefits above and document your findings. Based on this Risk Benefit Assessment (RBA) decide whether the benefits outweigh the risks or vice versa.

Benefits > Risks

If the benefits outweigh the risks, you have determined that the patient has a significant decrease in pain and significant improvement in function, and you are confident that the risks are minimal.

Document the RBA and Monitor Quarterly

It is important that you document your assessment of risks and benefits and your decision to continue opioid treatment. On a quarterly basis, we recommend that you review the patient's case and confirm that they continue to benefit from opioid treatment. We encourage you to also try non-opioid and non-pharmacological treatment.

Risks > Benefits

If the risks outweigh the benefits, you have determined that either the dose and/or the risks indicate that a taper should be initiated. This may well be against the strong desire of the patient to continue. We recommend that you follow the BRAVO protocol, which gives guidance on broaching the topic with the patient, checking for addiction, pacing the dose reductions, and other alternative therapies to consider.

Able to taper down until Benefits > Risks

The tapering process is likely to take months and sometimes years. The BRAVO protocol has detailed guidance on pacing and communication with the patient. We also include an example of a year-long taper based on an actual patient case. Also, other risk factors may be mitigated by changes in the patient's circumstances.

On a quarterly basis, re-assess and document the risks & benefits

Throughout the tapering process, it is very important to monitor the patient's situation for changes in the risk benefit assessment at least quarterly. Evidence of diversion, doctor shopping, illicit substances in urine drug screening (UDS), would be cause for an immediate change in opioid prescribing.

Not able to taper down until Benefits > Risks

If the patient is unable to tolerate a taper after several months, we recommend the prescriber carefully consider whether there is sufficient evidence for a diagnosis of mild, moderate, or severe OUD. If not, we recommend that the prescriber consider a diagnosis of "Complex Persistent Opioid Dependence (CPOD)." See definitions and comparison of OUD versus CPOD.

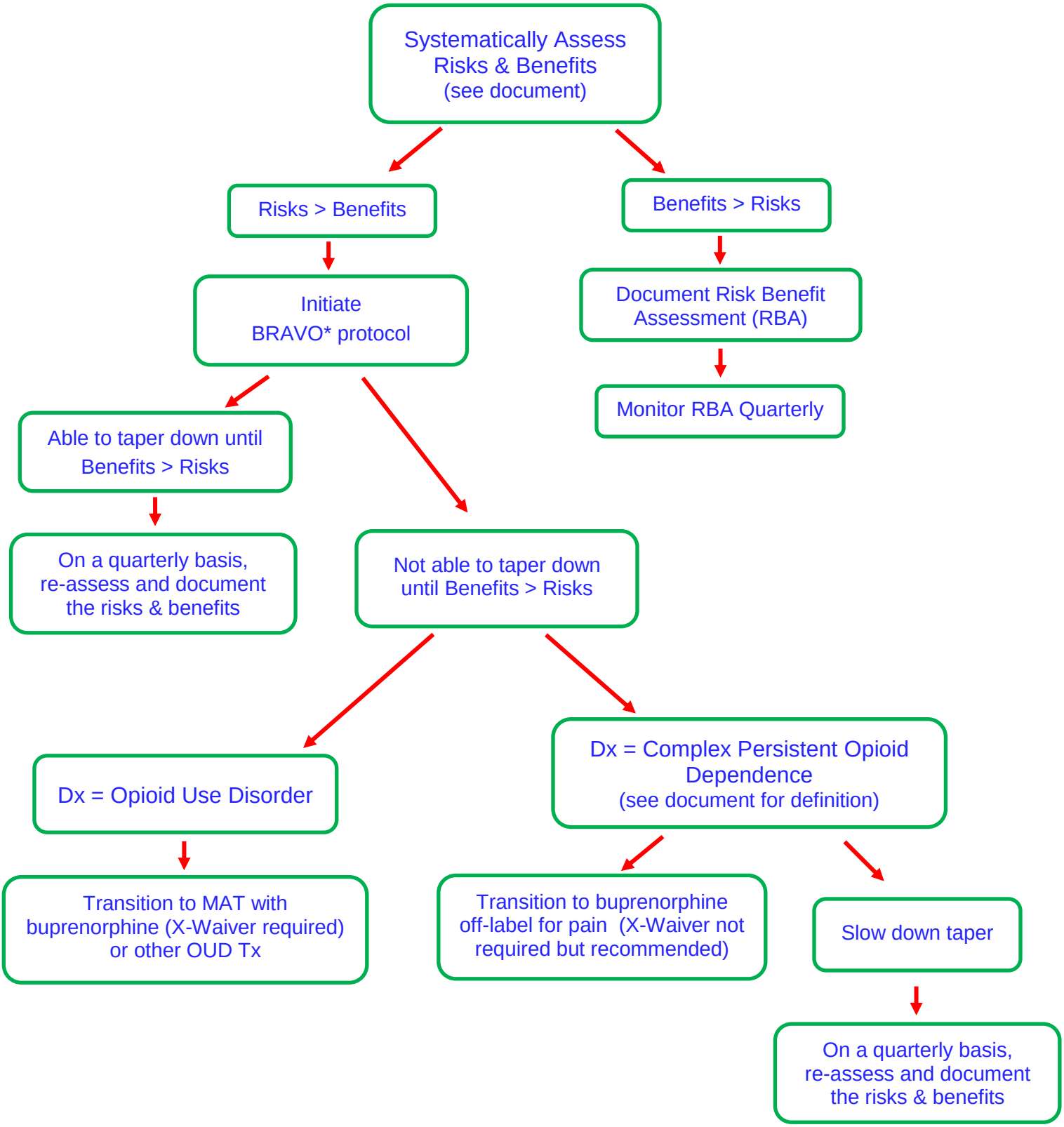
Dx = Opioid Use Disorder

If you make the diagnosis of OUD, the patient must be transitioned to an addiction treatment program. If you have an X-Waiver you can continue to treat the patient with buprenorphine. Otherwise, they must be treated within a SAMHSA approved Opioid Treatment Program. If you continue to treat them with buprenorphine, continue to monitor the patient for use of other illicit drugs or diversion.

Dx = Complex Persistent Opioid Dependence (CPOD)

If the patient does not meet the criteria for OUD, yet is unable to taper after repeated attempts over a period of several months, then consider a diagnosis of CPOD (see definition). With a diagnosis of CPOD, we recommend one of two treatment paths: use of buprenorphine off-label for pain or to continue with the taper at a much slower pace. In either case, you should continue to monitor the patient for use of other illicit drugs or diversion.

Opioid Tapering Flowchart



BRAVO: The Cardinal Principles of Tapering Patients Off of Chronic Opioid Therapy

BRAVO is an acronym that outlines Dr Anna Lembke's cardinal principles for tapering patients off of chronic opioid therapy. BRAVO stands for *Broaching the Subject, Risk-Benefit Calculator, Addiction Happens, Velocity Matters—and so does Validation and Other Strategies for Coping with Pain.*

Broaching the Subject

→ Schedule enough time with your patient to have a discussion on this difficult topic
→ Anticipate the patients strong emotional reaction
→ Identify the feelings, normalize those feelings and express empathy with the concerns they may have

Risk-Benefit Calculator

→ When assessing benefits, weigh a patients' pain relief against their functionality
→ Involve family members for more objective views on a patient's opioid use
→ Track common risks such as tolerance & opioid-induced hyperalgesia
→ Include all of these factors with discussing reasons for tapering off opioids

Addiction Happens

→ Addiction is defined by The Three C's: *Compulsive use, Continued use despite consequences, and use that is out of Control*
→ Dependence happens when a body relies on a drug to function normally
→ Dependence and Addiction are not equivalent

Velocity Matters—and So Does Validation

→ Go Slowly, take the necessary time to ease your patients down on their doses
→ Let the patient be involved when deciding how much to decrease & at what time
→ It is O.K. to take breaks in lowering the dosage
→ Never go backwards; your patient's tolerance will increase & progress will be lost

Other Strategies for Coping with Pain

Teach patients these three Dialectical Behavior Therapy (DBT) practices:
→ STOP: *Stop, Take a breath, Observe internal & external experiences, & Proceed mindfully*
→ Opposite Action Skills: acting opposite to a negative emotional urge in the service of pursuing values or goals
→ Radical Acceptance: accepting reality as it is and not as we wish it would be

These materials are part of the Stanford Medicine Center for Conitinuing Medical Education (CME) Online Activity: *How to Taper Patients Off of Chronic Opioid Therapy*

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BRAVO Online CME Course – Tapering Patients Off of Chronic Opioid Therapy

Dr. Lembke, in conjunction with the Stanford Continuing Medical Education, developed an online CME course on tapering which incorporates the BRAVO protocol. The online CME course is excellent and free! It includes videos of Dr. Lembke explaining the BRAVO principles and approach along with patient scenarios.

First register with the Stanford Continuing Medical Education system, then search for "Tapering Patients Off of Chronic Opioid Therapy" August 2018.

Link to Stanford CME system:

https://cme.class.stanford.edu/courses/course-v1:CME+045+2017/info

BRAVO Videos

Introduction to Tapering Patients Off of Chronic Opioid Therapy (5 mins.)

Laura's Story: From Opioid Dependence to Recovery (23 mins.)

Broaching the Subject of Opioid Addiction (4 mins.)

Risk-Benefit Calculator for Opioid Addiction (5 mins.)

Addiction Happens (5 mins.)

Velocity and Validation of Opioid Addiction Recovery Matters (5 mins.)

Other Strategies for Coping with Pain (4 mins.)

BRAVO Detailed Guidelines

(link to six-page guidelines with patient examples and scripts)

(link to OPG Difficult Conversations training resources)

What is a Safe Dose?

It is widely recognized that prolonged continuous high dose opioid pain treatment is neither effective nor safe for the majority of patients. Also, adverse outcomes tend to be dose dependent, such as deterioration in analgesia and hormonal, immune, and cognitive changes. For new starts, the CDC recommends evaluation and re-assessment in all patients >50 MED and to avoid doses >90 MED. These limits were set based on accumulated population data that suggest little gain and marked dose dependent risks above that dose. We accept that some patients at higher doses may continue to receive higher doses if they are established on chronic opioid therapy, fully compliant and functioning well, have no other risk factors, and are carefully monitored on a quarterly basis. However, the 90 MED dose level (as part of a complete clinical picture) remains a trigger for continued vigilance using periodic systematic assessment of benefit versus risk. The danger of continued high dose usage is not the drug itself, which can be safe and effective in the right hands, but the person who has developed a dependency that has led to high dose usage with multiple risk factors. For these patients, the aim of treatment is to reach a dose which is safe and effective, either tapering the opioid dose or switching to buprenorphine. The prescriber needs to take time to discuss his or her reasoning with the patient. The prescriber's job is to remain empathetic, yet resolute, and communicate to patients that a careful risk–benefit assessment informed by experience and compassion has led to this treatment plan and that to continue opioids under these circumstances would be to cause the patient further harm.

Buprenorphine

Methadone is a synthetic opioid and buprenorphine is a semi-synthetic opioid derived from thebaine, a constituent of opium. Both these drugs were developed and used as analgesics before they were adopted for use as maintenance treatment for OUD. Their relatively long half-life makes them particularly suited to OUD maintenance therapy. Methadone is a pure opioid agonist suitable for open ended dosing, therefore a useful drug for the treatment of severe pain, particularly at the end of life. Buprenorphine is a partial agonist and antagonist with a ceiling dose, which limits its analgesic utility to the treatment of mild to moderate pain, or chronic pain. Buprenorphine's ceiling dose also makes it one of the safest opioids because respiratory depression is unlikely to occur unless its use is combined with concomitant CNS depressants. Buprenorphine's favorable side effect profile is the reason this drug received approval for office-based treatment of opioid use disorder by providers who obtain an x-waiver. Methadone addiction treatment, on the other hand, can only be provided in a controlled setting by addiction trained providers. Unfortunately, prescribers must cope with some complicated regulations when they use methadone or buprenorphine for patients to treat pain or OUD. This is a problem when treating "legacy" patients for whom the line between use for pain versus opioid use disorder is often blurred.

In Europe buprenorphine has been used for pain for decades. In the United States, only the transdermal patch has an FDA indication for pain. The more common sublingual and buccal formulations are only indicated for treatment of OUD and require an x-waiver.

Many providers have found that buprenorphine is an effective tool to assist with tapering high dose COT patient and for some patients, buprenorphine is an effected analgesic. Using buprenorphine in the absence of a diagnosis of OUD is considered off-label, and ironically can be prescribed without obtaining an x-waiver. Even so, we strongly recommended that all

providers prescribing opioids for chronic pain obtain an X-Waiver, since the training helps in the opioid management of chronic pain and associated use disorders, and the certification protects from regulatory scrutiny when there is ambiguity between pain and OUD.

X-Waiver

Treating OUD used to mean working at an outpatient treatment program to be able to prescribe methadone. The DATA 2000 act expanded the options for opioid treatment and allowed for treatment in primary care setting. The x-waiver is provided by the DEA to physicians who have completed an 8 hour training or NPs who have completed 24 hours training. After completing the training, the DEA certificate will show the DEA number with an X in front of it to document certification to treat opioid use disorder. Taking the course and getting an x-waiver gives the primary care physician a valuable tool to recognize, diagnose and treat a commonly encountered chronic condition.

The SAMHSA website has several different courses:

https://www.samhsa.gov/medication-assisted-treatment/training-resources/buprenorphine-physician-training

Tapering – Frequently Asked Questions

Ruben Halperin – September 2018

In 2016 the CDC published the Guideline for Prescribing Opioids for Chronic Pain in response to the country's prescription drug overdose crisis, and Oregon Health Authority published additional state-specific recommendations later that year. The guideline recommendations revolve around assessing risk and benefit of chronic opioid therapy and there is a clear recommendation to carefully assess risk versus benefit when considering titrating to > 50 mg MED and to avoid doses > 90 mg MED. To mitigate risk for patient who are on high doses or who have other factors contributing to their risk, a taper down to < 90 mg MED and preferably < 50 mg MED is recommended.

The recommendation to taper patient's opioid doses have caused a lot of anxiety and some push back among physicians. It is important to address some of the more common concerns.

1. **Why should I taper a patient's opioid dose down if they are doing fine on their current dose?**

The most important question to consider is the risk/benefit calculation of their current opioid dose. It means getting a clearer sense of benefit and appropriately identifying risk. Is the patient meeting his or her functional goals? Is the pain significantly decreased? Have non-pharmacologic treatments been given an adequate trial?

If the patient is on > 50 mg MED, there is already an increased risk of accidental overdose of up to 4-fold by some studies. Is the patient being co-prescribed any medications that increase risk like benzodiazepines, sleep medications, muscle relaxants? Are there any co-morbidities that increase the patient's risk? Think of pulmonary or cardiac disease, or conditions like sleep apnea. Are there any side effects that affect quality of life?

if the patient is on > 50 mg MED, they have an increased risk of accidental overdose and the physician should consider prescribing naloxone (Narcan) as long as the patient is in this risk category.

2. **My patient has chronic pain and has not exhibited aberrant behavior. Why should I worry about addiction?**

Some patients on chronic opioid therapy have an opioid use disorder (OUD) that may become clearer if you try to taper down the dose. Making a diagnosis of an OUD is valuable to the patient since there are effective treatments for an OUD, like buprenorphine, but the diagnosis needs to be made. If you are treating a patient with chronic opioid therapy, be clear on the diagnosis.

Some chronic opioid patients develop hyperalgesia which means the opioid actually contributes to causing the pain. Whereas the patient feels like they need more pain medication, the treatment is tapering the dose down, or off.

3. **If I start tapering my patient, won't they just buy pills on the street or turn to heroin?**

Turning to street drugs, or obtaining prescriptions illicitly is consistent with opioid use disorder. Remember the 4 C's: Control, compulsion, cravings and consequences. If you are offering your patients appropriate treatment alternatives for their pain, and they are only focused on getting opioids, you may have unmasked an OUD and now have a basis for treating that condition.

4. **My patient says nothing else works for their pain. How can I not give them opioids?**

It's important to assess what treatments the patient has tried and what other conditions are contributing to their pain experience. Are there untreated or undertreated behavioral health issues like depression or anxiety? Has the patient been screened for sleep conditions that are preventing good quality sleep? If the patient states they have had physical therapy, assess how much and what kind they have had. Frequently patients are unaware of the treatment options and haven't been exposed to a multi-disciplinary approach to treatment.

Make it clear to the patient that opioids have not been shown to be effective treatment for chronic pain and that there are other treatments that have been shown to be more effective. Tapering down the opioid dose or not prescribing opioids doesn't mean you aren't taking care of the patient.

5. **Buprenorphine sounds helpful, but why should I get an X-waiver? Won't my practice just fill up with addicts?**

Being able to identify and treat OUD is a great benefit to a primary care physician. Because of the way opioids have been prescribed over the last several decades, most primary care physicians have patients on high dose opioids in their practice. Some of those will have opioid use disorder. Some of your patients will be agreeable to tapering, but won't be able to do so because of withdrawal symptoms. This inability to come off opioids, even when that is desired by the patient may be indicative of an opioid disorder.

Tapering Dose Example

Ruben Halperin – September 2018

Consider the following patient:

- 48 year old male on Oxycodone for 16 years since a motor vehicle crash
- Dose: Oxycodone 30 mg four times daily = 120 mg of oxycodone = 180 mg MED
- Pain: Still rates his pain as a 10, wants to increase to 40 mg four times daily
- Function: Hasn't worked since crash. Divorced 9 years ago. Lives alone. On bed or couch 20 hours daily
- Co-morbid conditions: sleep apnea, diabetes 2, hypertension, depression, osteoarthritis of knees

After a long discussion he admits that the oxycodone doesn't help him much, but he's afraid of how bad his pain will be on less of it or without it. He reluctantly agrees to the taper when you explain that his dose is unsafe and you don't feel comfortable continuing to prescribe it.

How to taper? Make sure other **ongoing** strategies are in place before you begin. He goes to a pain education class, watches several videos and meets with the behaviorist in clinic. The behaviorist encourages him to join a pain group where he will have a chance to learn and share experiences with other patients in a similar situation.

Week	Dose 1	Dose 2	Dose 3	Dose 4	Total daily dose	MED
0	30 mg	30 mg	30 mg	30 mg	120 mg	180 mg
1	30 mg	25 mg	30 mg	30 mg	115 mg	172.5 mg
2	same					
3	30 mg	25 mg	25 mg	30 mg	110 mg	165 mg
4	same					
5	30 mg	25 mg	25 mg	25 mg	105 mg	157.5 mg
6	same					
7	25 mg	25 mg	25 mg	25 mg	100 mg	150 mg
8	same					
At the end of 8 weeks you have decreased the oxycodone by about 16%. He's had mild withdrawal symptoms, but nothing intolerable						
Week	Dose 1	Dose 2	Dose 3	Dose 4	Total daily dose	MED
9	25 mg	20 mg	25 mg	25 mg	95 mg	142.5 mg
10	same					
11	25 mg	20 mg	20 mg	25 mg	90 mg	135 mg
12	same					
13	25 mg	20 mg	20 mg	20 mg	85 mg	127.5 mg
14	same					
15	20 mg	20 mg	20 mg	20 mg	80 mg	120 mg
16	same					
At the end of 16 weeks you have decreased the oxycodone by about 33%. Withdrawal symptoms mild. He has noticed that his pain isn't any worse. Even so, he tells you he is afraid to keep going, but agrees that everything you told him has been correct.						
Week	Dose 1	Dose 2	Dose 3	Dose 4	Total daily dose	MED
17	20 mg	20 mg	15mg	20 mg	75 mg	112.5 mg
18	same					
19	20 mg	15 mg	15 MG	20 MG	70 MG	105 MG
20	same					

21	20 mg	15 mg	15 mg	15 mg	65 MG	97.5 90
22	same					
23	15 mg	15 mg	15 mg	15 mg	60 MG	90 MG
24	same					
At 24 weeks he is on 50% of his starting opioid dosing. He admits that his pain is no worse. He also tells you his mind feels less foggy and he's been using some of the relaxation techniques when he does feel pain. He began physical therapy a few weeks back and is now walking 15 – 20 minutes daily						
Week	Dose 1	Dose 2	Dose 3	Dose 4	Total daily dose	MED
25	15 mg	15 mg	10 mg	15 mg	55 mg	82.5
26						
27	15 mg	10 mg	10 mg	15 mg	50 mg	75 mg
28						
29	15 mg	10 mg	10 mg	10 mg	45 mg	67.5 mg
30						
31	10 mg	10 mg	10 mg	10 mg	40 mg	60 mg
32	same					
At 32 weeks he is on 30% of his starting opioid dosing. Pain is not worse, in fact he thinks it might be a little better. He's now walking up to an hour daily. He says, I think I want to go to 10 mg 3 times daily and then cut down from there.						
Week	Dose 1	Dose 2	Dose 3		Total daily dose	MED
33	10 mg	10 mg	10 mg		30 mg	45 mg
34	Same: he has a little more withdrawal and asks to stay on 10 mg TID for another 2 weeks					
35	10 mg	10 mg	10 mg		30 mg	45 mg
36	same					
37	10 mg	5 mg	10 mg		25 mg	37.5 mg
38	Same: he wants to cut the morning dose before evening dose because he is worried he won't sleep well					
39	5 mg	5 mg	10 mg		20 mg	30 mg
40	5 mg	5 mg	5 mg		15 mg	22.5 mg
At 40 weeks he is on 12.5% of his starting opioid dosing. He cut down a little faster in last 2 weeks. He is excited by the prospect of getting off completely but still feels like he needs to keep tapering and can't just stop at this dose						
Week	Dose 1	Dose 2	Dose 3		Total daily dose	MED
41	5 mg	2.5 mg	5 mg		12.5 mg	18.25 mg
42						
43	5 mg	5 mg			10 mg	15 mg
44						
45	2.5 mg	5 mg			7.5 mg	11.25 mg
46						
47	X	5 mg			5 mg	7.5mg
48	0				0 mg	0 mg
It took 48 weeks – almost a year, but he successfully came off of a high dose opioid he had been on for 16 years. He admits that his pain is minimal. He is more active than he has been in years, has lost 18 lbs. and he is contemplating going back to work.						

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