Opioid Prescribing Resource in Chronic Non-Cancer Pain - Including Tapering Advice

This resource has been developed to aid Primary Care Clinicians when reviewing opioid prescribing for non-cancer pain in adults; and provide guidance on how opioid tapering can be carried out safely taking into consideration national guidance.[1]

NHS South Yorkshire ICB is the 4th highest ICB in England (and 54% above the England average) for adult patients currently prescribed an oral or transdermal opioid for greater than 3 months per 1,000 patients (data via Opioid Dashboard NHSBSA Nov 2023 to Feb 2024).[2]

Contents

Background

Clinical evidence is clear that opioids are unhelpful for most patients with chronic pain and are associated with significant safety concerns.[1,2] Taking an opioid for longer than 3 months increases the risk of dependence and addiction.[3]

There are many other potential long-term harms from taking an opioid, including: breathing difficulties; chronic constipation; reduced wound healing; reduced immunity and worsening infections; increased cancer risks[4]; endocrine changes; as well as being difficult to stop due to withdrawal reactions. Opioid-induced hyperalgesia (where long-term opioids increase, rather than decrease pain sensitivity) may also play a significant under-diagnosed role in pain syndromes, and reducing a patient's opioid may actually improve their pain.

Patients should be involved in discussions about the risks from opioid treatment at the start, so that they can balance the potential benefit of the opioid and other treatment options against potential harms.[1,2] When an opioid is prescribed, a treatment strategy including treatment duration and goals, and a plan for the end of treatment, should be documented[3] (See Ardens Opioid Agreement example).

To minimise the risk of harm and avoid tolerance, opioids should be prescribed at the lowest effective dose for the shortest period of time. Regular review with tapering is recommended in order to assess on-going benefit and side-effects.

Tapering opioid medication doses safely in chronic pain is potentially time consuming, but extremely worthwhile. People usually find that stopping medicines makes no difference to the pain but can make them feel better.[2] However, safety netting is essential. People with chronic pain often have co-morbid anxiety and depression which can temporarily worsen during opioid reduction. For some patients, the goal may not be complete cessation of opioids, but a reduction to a safer dose or to less frequent use.

A small number of patients with chronic non-cancer pain may derive some functional benefit from taking an opioid. If a patient is functioning well on a small dose of opioid, and then deteriorates if the opioid is stopped, it is safe to continue a low stable dose provided it is not causing harm e.g. enables the person to walk to the shops, participate in an activity and the risks / benefits have been considered. Aim to use immediate release (IR) opioid intermittently to improve function e.g. once or twice a week, or for a pain flare (maximum 5 days then reduce back down).

Key Headlines from Faculty of Pain Medicine:[5]

- Opioids are very good analgesics for acute pain and for pain at the end of life, but there is little evidence that they are helpful for long-term pain.
- A small proportion of people may obtain good pain relief with opioids in the long term if the dose can be kept low and especially if their use is intermittent (however, it is difficult to identify these people at the point of opioid initiation).
- The risk of harm increases substantially at doses above an oral morphine equivalent (OME) of 120 mg/day, but there is no increased benefit: tapering or stopping high dose opioids needs careful planning and collaboration.*
- If a patient has pain that remains severe despite opioid treatment it means they are not working and should be stopped, even if no other treatment is available.
- Chronic pain is very complex and if patients have refractory and disabling symptoms, particularly if they are on high opioid doses, a very detailed assessment of the many emotional influences on their pain experience is essential.

**The risk of harm appears dose related. Additional dosage increases beyond 50 mg/day OME are progressively more likely to yield diminishing returns in benefits for pain and function relative to risks to patients as dosage increases further.[5,6]*

NHS South Yorkshire Integrated Care Board

Opioid Medication Review and Discussion Around Tapering

Remember: opioids can be harmful, dangerous, and are not very effective in chronic pain

Acute/New Opioid Prescriptions (holistic techniques, patient resources, local services to support health and well-being):

- Maximise use of non-pharmacological therapies and non-opioid pharmacological treatment prior to considering an opioid.
- See NICE guidance recommendations on opioid prescribing here.
- If decision is to prescribe an opioid issue as immediate-release (IR) not modified-release (MR) and only as needed (not regular dosing) - setting a maximum dose limit. Aim to keep dose low and recommend opioid is tapered if taken regularly for more than a few days.[6]
- Avoid routinely adding opioids on hospital discharge to repeat See PIL - Managing pain after surgery.
- Provide advice on realistic benefits and known risks associated with opioid use (see PILs).
- Have a treatment strategy, including treatment duration and goals, and a plan for the end of treatment (reduce dose gradually if taken opioid > 2 weeks). See here for advice on how to perform an opioid trial. MHRA PIL - MHRA: Opioid medicines and the risk of addiction.

Repeat prescriptions (opioid review):

- Optimise non-pharmacological strategies to help manage pain and support patient moving to better quality of life e.g. signpost to support – Patient Resources, Holistic Techniques to Help Improve Pain and social prescribers.
- Ask about symptoms associated with pain and offer advice e.g. treat insomnia with sleep hygiene, anxiety with breathing techniques etc.
- Assess risk and consider physical and mental health co-morbidities, including emotional influence on pain.
- Check for OTC/illicit medication taken and signs of misuse. Opioid risk tool, concerns with dependence.

Schedule a medication review regularly, at least 6–12 monthly. Base frequency of reviews on:

- Person's preferences and circumstances.
- Medicines they are taking and the dose.

Factors that might indicate a need for frequent reviews:

- Additional care needs (e.g. learning disability or cognitive impairment).
- Taking opioid for the first time or dose is being adjusted.
- Potential adverse effects.
- Problems associated with dependence (e.g. over-ordering) or potential for opioid misuse e.g. current / history of substance misuse disorder (including alcohol) or mental health disorder.

Indications for opioid tapering:

- Consider at least every 6-12 months irrespective of dose to assess benefit and side-effects.
- Opioid no longer beneficial e.g. severe pain despite opioid. Consider using a pain scale e.g. British Pain Society Pain Scale
- High dose opioid > 120 mg /day oral morphine equivalent (OME) where evidence shows risk of harm outweighs benefit (note: diminishing benefit and increased risks at doses above 50 mg /day OME – see here)
- Condition for which opioid was prescribed has resolved e.g. joint replacement.
- Person wants to stop taking the medicine e.g. intolerable adverse effects.
- Problems associated with dependence have developed or strong evidence the person is diverting medication to others.

Explain potential benefits for opioid tapering and aim to reach an agreement using a shared decision-making approach:

- The decision to taper an opioid must be discussed with the patient. Patient choice and engagement is important.[8,9,10]
- Explain chronic pain (central sensitisation) and lack of evidence for opioids in chronic pain.
- Consider benefits and harms in continuing the medicine.
- Check indication for opioid aligns with patient's understanding.
- For NICE guidance recommendations on opioids, see here.
- Understand a person may be anxious to discuss reducing their opioid.
- Provide reassurance that stopping an opioid is unlikely to worsen pain (may actually improve pain if opioid-induced hyperalgesia reversed) and likely to feel better (improved mood, function, and ability to engage in self-management strategies).
- Potential long-term harms are avoided.
- Points to discuss around deprescribing.

Consider opioid side-effects and assess risk of potential long-term harms (increased risk at higher doses). A person is more likely to engage with the process if they recognise opioid side effects that are personally relevant to them. See long-term harms opioids aware and PILs . Harms may include:

- Constipation, weight gain
- Hormonal effects - sexual dysfunction, amenorrhea, infertility
- Depression / mood changes - people often don't realise the negative impact opioids have on their mood and function
- Reduced ability to fight infections
- Memory loss
- Increased risk of fractures (osteoporosis) and falls
- Difficulty sleeping (snoring and breathing difficulties)
- Opioid-induced hyperalgesia
- Problems associated with dependence and addiction
- Respiratory depression, increased mortality.

Agree and document a management plan:

- Acknowledge and discuss with the person any differences between their views and your own about risks and benefits of taking an opioid.
- If asked about previous prescribing decisions, explain that our understanding of the balance of risks and benefits of opioid medicines has changed over time. A small proportion of patients may continue to get benefit from taking opioids – see here.
- Offer to provide a copy of the management plan to the patient. If the decision has been made to taper the opioid, stress that it should not be stopped suddenly, and reduction may take time. This can depend on the dose and how long it has been taken for. See Opioid tapering considerations and planning or if a person declines to taper see unable to taper section.

Opioid Tapering Considerations and Planning

Aim to taper opioids without withdrawal symptoms, and where possible discontinue:
If uncertain, ask for advice from experienced practitioner:

- Check with the patient what they are taking, don't assume prescribed dose is being taken.
- Regular and not PRN dosing.
- Optimise non-opioid management of pain (consider paracetamol, NSAIDs). If concern with high doses of NSAID or paracetamol, see here.

Tapering advice for patients:

- Discuss potential opioid withdrawal symptoms and holistic techniques that may help -page 5.
- Reassure reducing opioid dose slowly helps minimise withdrawal symptoms.
- Avoid missing or delaying a dose which can bring on withdrawal symptoms.
- Explain **risk of overdose** and potentially death if higher opioid dose taken after tapering as tolerance is reduced.

Ensure mental health is adequately managed and assess risk:

- Whilst opioid withdrawal rarely has serious medical consequences, it can cause significant anxiety and insomnia with some patients at risk of a mental health crisis.
- Consider psychosocial support (NHS Talking Therapies)

When specialist input may be required:

- Pregnancy- recommend seeking specialist advice due to possible risks to pregnant patient and foetus if patient goes into withdrawal.[6]
- Addiction and unstable psychiatric medical condition that can be worsened by anxiety.
- Taking > 300 mg oral morphine equivalent (OME) per day.
- For people dependent on opioids with evidence of/or signs of drug seeking behaviour/misuse discuss with local substance misuse service.

A person may feel anxious and scared about reducing their opioid (see page 5). *Giving the person choice over how tapering is achieved gives them more control and ownership of the process and is more likely to succeed. Tapering should be individualised, flexible and use shared decision making.*[7] *Any new or different pain should be reviewed.*

Staying on the current opioid(s) for tapering is usually the preferred option as conversion factors are only an approximate guide and the patient is familiar with the opioid.

- **Tapering Plans**: codeine, tramadol, morphine, oxycodone, tapentadol, TD fentanyl and TD buprenorphine.
- Use a fixed dosing schedule during tapering [9,11] If prescribed opioid MR and IR involve patient in decision over tapering plan.
- Review current opioid formulation:
  - If prescribed IR recommend daily limits and monitor prescriptions. As tolerance falls there is a risk of overdose if fluctuating quantities of opioids are consumed. Withdrawal syndrome may be more problematic with IR. Consider changing to MR if either of these are an issue. Change opioid liquid to solid oral formulation which can be more closely monitored.
- If prescribed a weak opioid alongside a strong opioid, it should be easy to deprescribe the weak opioid.
- Aim to stop opioid or change to low dose opioid IR when required for pain flare ups / improving function; or to aid tapering near the end.

Switching between strong opioids is not routinely recommended:

- Switching from one opioid to another should only be recommended or supervised by a clinician with adequate competence and sufficient experience. See here for advice on changing between opioids. Dose equivalents are only an approximate guide and should be adjusted according to individual patient factors and response.
- The calculated dose-equivalent to the new opioid must be reduced by at least 25–50% to ensure safety. A small quantity of IR opioid can be provided for severe withdrawal or breakthrough pain whilst establishing the new dose. Changing from a patch to an oral opioid must account for the gradual fall in serum blood concentrations and is not recommended at higher doses where the risks are greater.

Rate of taper (aim to avoid withdrawal symptoms)[5,6,7,8,9,10,11]

- A decrease by 10% of the original dose every 1-2 weeks is usually well tolerated, though every 2-4 weeks may be better tolerated.
- When an opioid has been taken for a long time (e.g. ≥ 1 year) tapers of 10% per month or slower are likely to be better tolerated.
- Individualise to patient: can be slower or with smaller reductions. Some patients will need space to acclimatise to the new dose.

Slower tapering: if anxious or feeling psychologically dependent on opioids or have cardiorespiratory conditions.
Faster tapering: if experiencing significant adverse effects, displaying drug seeking behaviour, or patient preference.

Document opioid tapering plan and follow up (offer to provide copy to the patient):

- Add dose, frequency and words "Opioid Tapering" into the prescription directions so it is visible on the Summary Care Record.
- Patient should know who to contact if they have a problem or concern. Preferably same clinician to follow up/issue prescriptions.
- Frequency of review depends on rate of taper and degree of support required; but should be at least monthly during tapering.
- Ensure people are aware of tapering plan e.g. community pharmacy, carers. Avoid renewing prescription sooner than expected.

Follow up: closer monitoring is required if significant psychiatric co-morbidities.

- Ask about reduction in side effects, improvement in alertness, daily living, function, and emotional well-being, as well as withdrawal symptoms and pain. See next page for advice for patients during opioid tapering.
- Typically, the last stage of tapering is the most difficult. Once 1/3 of the original dose is reached, consider slowing taper down to half the previous rate e.g. 5-10% every 2-4 weeks, to help avoid withdrawal symptoms. Once the smallest available dose preparation is reached the interval between doses can be extended.

Tapering Advice to Patients, Including Emotional Impact and Expectations

Points to discuss with patients when deprescribing (adapted from Opioids Aware FPM)[2]

- Remain empathic. Take a full medicines history and ask the patient how well the medicines are working and reflect on whether the patient is describing severe pain despite medicines.
- Share that the experience of many patients is that taking medicines results in no observable benefit for pain.
- Explain that evidence changes and in more recent years there is little evidence to support pain relief in chronic non-cancer pain but significant evidence to support harm when used long term.
- …take responsibility for contributing to where we are now!
- Medicines for pain can be associated with significant harm.
- It matters a lot that the patient has confidence that all their medicines are working well.
- Usually stopping medicines makes no difference to the pain but can make people feel better.
- If a tapering trial does not work, we can think again.

Consider holistic techniques to help improve pain and distract from opioid withdrawal side effects

These may include Mindfulness, Relaxation, CBT, Psychological Support, Tai Chi, Exercise, Physiotherapy, Ice or Heat and Acupuncture.

Based on local specialist expertise consider with patient the purchase OTC of:

- Magnesium (dose of around 375 mg daily). Research has shown that magnesium may be helpful in a range of pain conditions, including chronic pain.[12]

See patient resources for further information such as “pacing” and sign-posting.

Emotional impact: managing anxiety and depression

Anxiety is to be expected during opioid reduction. If a patient has taken opioids for many years, they may have a sense that they will not be able to cope without them. In practice many patients experience what they feel to be withdrawal symptoms with even small dose reductions, although this is often related to anxiety rather than opioid withdrawal (anxiety exacerbates withdrawal symptoms). Plenty of reassurance is needed that this is not dangerous and is a safe reduction.

The clinical opiate withdrawal scale (COWS) can be used to quantify the severity of opioid withdrawal and help distinguish between objective and subjective symptoms that can be reassuring to both the patient and clinician. https://www.drugabuse.gov/sites/default/files/ClinicalOpiateWithdrawalScale.pdf.

Anxiety and depression often worsen during an opioid reduction, either because the long-term opioids have suppressed noradrenaline and dulled usual emotions (in which case the increased anxiety then settles back down again), or because the reduction unmasks pre-existing psychopathology. If not managed well, this can derail the opioid reduction and potentially have devastating consequences, with a risk of mental health crisis, opioid overdose, and suicide. Safety netting is essential, and consideration of whether extra psychological support is required during the opioid taper is mandatory.

Expectations: ensure the patient understands this can be difficult, and that they need support

Despite slow reductions, a person may experience withdrawal symptoms, together with increased anxiety and depression. It is important the person has engagement, understanding and support from friends and family during the process.

During a taper, some patients experience temporary increases in pain and withdrawal symptoms, but patients can be reassured this usually settles within 1 to 2 weeks.[9] Acute opioid withdrawal symptoms can last for 4-10 days for short-acting opioids, and up to 21 days for long-acting opioids.[13] It can take up to 6 months after stopping opioids to feel back to normal. Strong cravings for opioids during this time can lead to a relapse. Encourage non-drug techniques (relaxation, distraction, music, walks etc.) to manage pain and reduce the reliance on pharmacological treatment.

In the longer term, the pain may reduce to a degree due to the reversal of opioid-induced hyperalgesia. For patients with abdominal pain, this pain is also likely to improve as the opioids will have been contributing to gut dysmotility, central sensitisation will reduce, and other neurohormonal changes will normalise.

Strategies if Struggling with Opioid Tapering (including managing withdrawal symptoms) Or If Tapering Plan Cannot be Agreed

Struggling with opioid tapering:

- At times, tapers might have to be paused and restarted again when the patient is ready and might have to be slowed as patients reach low dosages.
- Consider holding the tapering dose (delaying the next dose reduction) or trying a smaller dose reduction.
- Avoid prescribing more opioid or other dependence-forming medicine to treat withdrawal symptoms. An exception to this is fentanyl TD. The fixed patch strengths don't facilitate a gradual taper. If the person is unable to cope with the dose reduction, a small quantity of IR morphine may help for a few days after each patch reduction. See here.
- Events such as withdrawal symptoms, pain crisis, worsening of mood, or impairment of physical function may be predictors for slowing or stopping the tapering process. Before reversing a taper carefully assess and discuss with patient the benefits and risks.

Withdrawal symptoms: A slow gradual taper will minimise withdrawal symptoms, but agitation, anxiety and insomnia can increase after opioid reduction. Usually if a person is aware of what to expect they are able to cope better, but the following can be considered:

- Diarrhoea: loperamide
- Abdominal cramps: mebeverine
- Nausea +/- vomiting: prochlorperazine or metoclopramide (max 5 days use)
- Muscular pain: paracetamol and/or NSAID.
- Headache: drink plenty of water (analgesia medications generally cause rebound headaches)
- Insomnia: sleep hygiene, better routines, reduce caffeine and other stimulations
- Anxiety/agitation/depressed mood: consider referral e.g. NHS Talking Therapies

Consider co-morbidities and complications that can interfere with opioid tapering:

- A new infection can cause pain.
- Inflammatory/autoimmune conditions can exacerbate pain (consider inflammatory arthritis/myositis/LFTs/infection screens).
- Hormonal dysfunction can be caused by long-term opioid use (consider checking TFTs, cortisol, HbA1c, prolactin)
- Parathyroid disease can cause pain (consider calcium, magnesium and vitamin D levels).
- If there is concern with high doses of paracetamol (check all prescription and OTC), consider LFTs/referral to A&E if appropriate. Change from co-codamol to separate paracetamol and codeine. If there is a concern with ibuprofen, consider U&Es and review for gastrointestinal adverse effects.

Person has declined to taper the opioid or is unable to complete taper

If showing evidence of drug seeking behaviour/misuse, consider discussing with local substance misuse service.

If the current prescription is continued:

- Aim to stop any further escalation in dose.
- A treatment plan should be followed, and improvement seen in pain and function.
- Agree and schedule next review e.g. in 3-6 months as dictated by patient and clinical factors.
- At each review discuss benefits of tapering and risks of continuing the opioid. Re-attempt tapering where possible.
- Clearly record the advice given to the person about the potential harms of continuing the medicines, and the reasons for continuing without a reduction.

If continuing the opioid is not in the person's best interests:

- If a shared decision to withdraw cannot be reached, the prescriber should follow the advice on 'handling patient requests for medicines you don't think will benefit them' in the GMC.

The prescriber should:

- Not prescribe a medicine if they believe it is not in the person's best interests. Note: opioids should not be stopped abruptly unless there is an exceptional medical circumstance e.g. respiratory depression.
- Explain reasons for their decision to the person.
- Document all discussions carefully and give a copy to the person. Offer the person a second opinion.[1]
- Ideally have a practice MDT discussion (may include GP, pharmacist) to agree whether an enforced wean is appropriate. Consider seeking advice from specialist in opioid prescribing. Document reasons for embarking on an enforced wean, and on attempts to gain patient agreement.

Concerns with dependence and contact details for substance misuse service:

- Information on diagnosing opioid dependence, indicators, assessment, and risk populations see FPM Opioids Aware

For patients dependent on opioids with evidence of/or signs of drug seeking behaviour/misuse, discuss with the local substance misuse service:

- Sheffield Likewise https://likewisesheffield.org.uk/ (Tel: 0114 308 7000)
- Doncaster: https://www.aspire.community/our-services/doncaster/
- Rotherham: https://www.wearewithyou.org.uk/local-hubs/rotherham-roads (Tel: 0808 1753981)
- Barnsley Recovery Steps: https://humankindcharity.org.uk/service/barnsley-recovery-steps/ (Tel: 01226 779066)

Prescribing of methadone and buprenorphine for substance misuse is only to be initiated by specialist service.
See Traffic Light Drugs List.
Prescribing should remain responsibility of the substance misuse service unless a shared-care Opioid Substitution Therapy service is provided.

SNOMED Codes to Use on Primary Care Clinical System

Adding the SNOMED code as a problem will ensure it appears on the Summary Care Record; and will aid a clinician out of hours e.g. NHS111, Yorkshire Ambulance Service:

- Opioid dosage tapering: 287041000000109
- Opioid medication review: 287031000000100
- Chronic pain: 82423001
- Chronic pain review: 860381000000107

NICE Guidance with Reference to Opioid Prescribing[1] (Excluding Palliative Care and Cancer Pain)

Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults NG215.

- NICE (NG215) Visual summary: Before starting medicines associated with dependence or withdrawal symptoms
- NICE (NG215) Visual summary: Reviewing medicines associated with dependence or withdrawal symptoms

As part of shared decision-making process, explain the lack of evidence for opioids in these conditions, and explain the risks of continuing treatment. For people where prescribing is not in line with NICE guidance, review medications and consider tapering or stopping in consultation with the person. See individual guidance for recommendations.

Chronic primary pain (ICD-11 includes fibromyalgia, chronic primary headache and orofacial pain, chronic primary visceral pain, and chronic primary musculoskeletal pain) (NG193)[14]	Do not initiate opioids. See NICE visual summary
Low back pain (NG59)	Consider weak opioids (with or without paracetamol) for managing acute low back pain only if an NSAID is contraindicated, not tolerated, or has been ineffective. Do not routinely offer opioids for managing acute low back pain. Do not offer opioids for managing chronic low back pain.
Sciatica (NG59)	Do not offer opioids for managing chronic sciatica.
Osteoarthritis (NG226)	Do not routinely offer weak opioids unless: • they are only used infrequently for short-term pain relief and • all other pharmacological treatments are contraindicated, not tolerated or ineffective. Do not offer strong opioids to people to manage osteoarthritis. Explain the risks of strong opioids outweigh the benefits.
Headaches (CG150)	Do not offer opioids for the acute treatment of tension-type headache or for the acute treatment of migraine or cluster headache.
Neuropathic pain (CG173)	Do not use morphine or tramadol unless recommended by a specialist. Exception: tramadol may be used only if acute rescue therapy is needed.

Ardens Patient Agreement for Opioid Based Medication (2 pages)

(Version from Jul 24. Recommended to access via **Ardens Opioid Template** on Primary Care Clinical System to ensure current version is used)

[insert patient name]
NHS Number:

The purpose of this agreement is for you to develop an understanding regarding the risks of taking an opiate type of medication and the responsibilities you have. Please read the information below and complete and sign it once you are happy that you fully understand the information. Please ask your prescriber to explain anything that you do not understand.

I understand that I will receive opioids from [insert practice name] as part of the management plan to treat my pain condition. This medicine is intended to improve my level of mobility and ability to perform daily tasks, improve my quality of life and reduce the intensity of my pain.

I understand and agree that:

- I have read and understand the potential side effects (page 2)
- I understand that this medication if misused can cause grave harm to myself or any other individual who may have access to it.
- I will answer calls from my prescriber and attend appointments
- I will take medication as prescribed & discuss any changes with my prescriber
- I will be responsible for my repeat prescriptions, putting the request in at least one week in advance
- I will see a mental health or pain specialist if needed
- I will keep my medication in a safe place & away from children
- I will tell my prescriber about any side effects: particularly breathing difficulty or drowsiness
- I will tell my prescriber straight away if a different prescriber gives me pain medication
- I will tell other healthcare providers about all the medication I am taking
- I will dispose of any unwanted medication safely (contact your local pharmacy)

- I will **not** share my medication
- I will **not** take any medicine that is not prescribed for me
- I will **not** mix with alcohol and will not take any illegal drugs (e.g. heroin, cocaine or amphetamine)
- I will **not** drive if I feel this medication is impairing my ability to drive safely

- I understand the benefits and risk of taking opioid based medication
- I understand that taking sleeping aids or anxiety medication together can be dangerous
- I understand that lost or stolen prescriptions will not be replaced
- I understand that if I am unable to follow these rules my opiate prescription can no longer continue.

Signed: _____ [insert patient name]

Witnessed: _____ [insert clinician name and practice name]

Date: [insert date]

Opioid Based Medication – Potential Side Effects

Respiratory depression **(caused by overdose)**	Overdose causes your breathing and thinking to slow down, your speech is slurred, and you may not be able to walk properly. Overdose is not always caused by taking too much of your medication, it can happen if something else about your health changes. Should you experience any of these symptoms, you need to seek urgent medical care.
Constipation	Constipation is a common side effect of opioids. Ensure you eat a well-balanced diet, drink plenty of water and if constipation continues, speak with your doctor. In severe cases, opioid related constipation can cause a blockage of the intestine.
Cognitive impairment	You may not think as clearly when using opioid medication and this is likely to worsen with higher doses. Taking the medication may make you feel 'spaced out' or 'relaxed' rather than reducing your pain. This might indicate that you are using the medication for the wrong reasons e.g. to relax rather than reduce pain
Depression and anxiety	There is an increased risk of depression and anxiety when you take opioids for long periods of time. This can make managing your pain even harder.
Increased pain levels	Higher doses of opioids can make you become more sensitive to pain. This is due to changes in your nervous system that happen with long-term pain and long-term opioid use. Increasing the dose further will not make your pain improve and increases your risk of becoming dependent on the medicine and other harm from them.
Hormonal effects	Using opioid medication for more than six months can influence sex hormones, which can cause impotence in men and loss of libido in both men and women.
Tolerance, Dependence And Addiction	Opioids can become less effective with time (this is called tolerance) meaning your body has got used to the pain-relieving effect of the medicine. You can also become dependent on opioid medicines (dependence). This means that if you stop taking the drug suddenly, or lower the dose too quickly, you can get symptoms of withdrawal. In rare cases, patients can become addicted to opioids. People who are addicted to opioids can feel out of control about how much medicine they take or how often they take it. Some people are prone to opioid addition, specifically if they have a history of depression or mental health issues
Increased risk of falls and fractures	Long-term or high dose opioids increased your risk of falling and of developing osteoporosis, both of which can lead to bone fractures.
Dry mouth	Lack of saliva can increase your risk of dental caries and tooth loss

ARDENS OPIOID REDUCTION PLAN

(Version from Jul 24. Recommend it is accessed via **Ardens Opioid Template** on Primary Care Clinical System to ensure current version is used)

Patient Name:
Date of Birth:
NHS Number:
Today's date:

You are currently taking an Opioid called [insert drug, strength, formulation, and dose – include words "(Opioid Tapering) in directions].

We have arranged to begin a reduction plan.

- Please follow the dose reduction regime below which we have agreed together.
- We have discussed that we are trying to stop/reduce your opioid because of the benefits to you in avoiding long term harm and improving your ability to participate in self-management strategies.
- Medicines for pain can cause significant harm and many people find stopping their opioid doesn't increase their pain. They often feel better due to less side effects.
- You may wish to carry the information below and show it to any healthcare professional who gives you treatment.
- If the tapering trial doesn't work, we will review this and refer you to specialist services if appropriate.

Date	Duration	Dose	Tablets

Patient Information Leaflets

- British Pain Society: medicines: Managing your pain effectively using "Over the Counter" (OTC) Medicines
- MHRA: Opioid Medicines And The Risk Of Addiction
- British Pain Society: Managing Pain After Surgery
- Live well with pain: The Great Opioid Side-Effect Lottery
- Drugs and driving: the law www.gov.uk/drug-driving-law

Patient Resources - National and Charity Resources to Share with Patients/Carers

The experience of pain can be greatly reduced by engaging in daily activities, staying as fit as possible, reducing stress, and learning relaxation techniques to help with general well-being and mental health. Here are some resources which could help patients to self-manage their pain and improve their quality of life (some are registered charities). These are all free of charge. SY ICB is not responsible for their content. For medical advice always consult a doctor.

My Live Well with Pain website: Lots of resources to help you learn skills for managing your pain, including: Ten Footsteps towards supporting you to live well with pain. Visit: https://livewellwithpain.co.uk/. Ten Footsteps Programme (information on what it includes: https://livewellwithpain.co.uk/ten-footsteps-programme/) and available as an online interactive guide or a leaflet.

Flippin' Pain website: Flippin' Pain™ is a public health campaign with a clear goal: to change the way we think about, talk about and treat persistent pain. Flippin' your understanding of pain could change the lives of you and your loved ones forever. Visit: https://www.flippinpain.co.uk/

Pain Trainer: This is an online free Pain Management Programme from Australia that helps teach you effective strategies to manage your pain. Visit: https://www.paintrainer.org/login-to-paintrainer/

Pain Concern: This offers resources to support and inform people living with pain, including a: helpline; network forum; radio channel called Airing Pain; and a Self-Management Navigator Tool which can help you to recognise all the different ways in which pain affects you. Visit: https://painconcern.org.uk/

The Pain Toolkit: Pain self-management is about learning new and using old skills and trying them out to see what works for you. Visit: https://www.paintoolkit.org/

Retrain Pain: Short 1 min videos on pain, mind and goals, sleep, medication and relationships. Available in 23 different languages. Visit: https://www.retrainpain.org/

NHS Chronic Pain Self-management: Includes advice on importance of keeping active; links to different exercises (including chair exercises); pain medication; and a 20 minute guided meditation proven to help people cope with chronic pain. Visit: https://www.nhs.uk/live-well/pain/ways-to-manage-chronic-pain/ and https://www.nhs.uk/live-well/

NHS Fife Jigsaw: toolkit with information on specific areas of self-management https://www.nhsfife.org/media/0dhkipaz/pain-jigsaw-interactive3.pdf

ESCAPE-pain (https://escape-pain.org/) is a group rehabilitation programme for people with chronic joint pain that integrates educational self-management and coping strategies with an exercise regimen individualised for each participant. It is produced in the NHS and the programme can be accessed online: https://escape-pain.org/support-tools/escape-pain-online/

Social Prescribing: https://www.thejoyapp.com/

Videos Understanding Pain:

- Brainman: A five-minute explanation of chronic pain by the Hunter Integrated Pain Service in Australia. There is a follow up video called Brainman stops his opioids. https://www.tga.gov.au/chronic-pain-management-video-resource-brainman
- Tame the Beast. A good explanation of how your mood can affect pain: Tame the Beast

Podcasts: The Lorimer Moseley Podcast: Pain Matters

Apps:

- **Back Pain:** Chartered society of physiotherapy has a helpful video on back pain: https://www.csp.org.uk/publications/10-things-you-need-know-about-your-back

- **Advice About Sleep:** Sleepio is available free on the NHS for all adults nationwide. https://onboarding.sleepio.com/sleepio/nhs/391#1/1 and for anxiety: https://www.bighealth.co.uk/daylight.

Local Services and Resources

Pain Management Programme: A Pain Management Programme can make a huge difference to how well a patient manages the physical and emotional impact of living with chronic pain. Patients are referred by a clinician to the service. See below under each place for more details.

NHS Talking Therapies: This may be particularly helpful if mood and general mental health are affected by pain. Patients can self-refer. See below under each place for more details.

Sheffield Place:
- Sheffield Pain Clinic at STH: A-Z of Hospital Services (sth.nhs.uk) and information on their Treatments & Services including Pain Management Programme.
- Sheffield Aches and Pains Website (SAAP) https://www.sheffieldachesandpains.com/
- Sheffield Talking Therapies: NHS Sheffield Talking therapies access their: Living Well with Persistent Pain Course.
- Information on local support, groups, activities and development of skills: Sheffield Flourish and their Sheffield Mental Health Guide
- Ways to get active in Sheffield: Getting Sheffield Active — Move More Sheffield

Rotherham Place:
- Rotherhive has practical tips, national, local, and online services, organisations and groups that adults in Rotherham can access for expert advice to help you look after your mental health and well-being: Pain Management - RotherHive , Drugs – RotherHive
- Rotherham and Doncaster Talking therapies: https://talkingtherapies.rdash.nhs.uk/
- Directory of Exercise Groups and Volunteer Opportunities: https://rotherhamgismo.org.uk/
- Rotherham Healthwave – Get Active: Connect Healthcare Rotherham
- Directory of Help and Support: https://www.treacle.me/

Doncaster Place:
- Doncaster Pain Management unit in DBTH - https://www.dbth.nhs.uk/services/pain-management-2/
- Chronic pain peer group - https://welldoncaster.uk/for-me/peer-support/chronic-pain-peer-groups
- Rotherham and Doncaster Talking therapies: https://talkingtherapies.rdash.nhs.uk/
- NHS talking therapy, includes counselling, CBT support - https://www.yourlifedoncaster.co.uk/mental-health
- Health & wellbeing support - https://www.yourlifedoncaster.co.uk/wellbeing
- Get Doncaster moving - https://getdoncastermoving.org/

Barnsley Place:
- Barnsley Talking Therapies: https://barnsley-talkingtherapies.nhs.uk/
- Physical Activity opportunities are on our Wants Your Move Page. https://www.barnsley.gov.uk/whats-your-move/
- Barnsley Older People Physical Activity Alliance (BOPPAA): https://boppaa.ageukbarnsley.org.uk/
- Barnsley Recovery and Wellbeing College: What can we help you with today? - Barnsley Recovery College
- Barnsley campaign to support those with long-term health conditions be more active: We Are Undefeatable (barnsley.gov.uk)
- Barnsley PCN Social Prescribing Service: https://services.thejoyapp.com/

PrescQIPP

PrescQIPP has resources to support prescribing in chronic pain https://www.prescqipp.info/ (log in required):
All Primary Care Clinicians in SY can register for access:
- PrescQIPP Reducing opioid prescribing in chronic pain. Bulletin 218i. February 2019
- PrescQIPP: Chronic Pain. Bulletin 284i. January 2022
- Resources include patient video, sample text message and patient invite letter.

Codeine Tapering Plan

Indication:

- Codeine is licensed for acute moderate pain which is not considered to be relieved by other analgesics such as paracetamol or ibuprofen.[15]

Approximate Oral Morphine Equivalence:

- Although often classified as a 'weak opioid,' when codeine is taken at the maximum licenced adult dose of 240 mg in 24 hours, this is equivalent to approximately 24 mg of oral morphine per day.[5]

Formulation/Preparation to Use for Tapering:

- Codeine phosphate tablets are available as 15 mg, 30 mg, and 60 mg. It is suggested that the prescription is converted to the most appropriate tablet strength in the same total daily dose before tapering commences.
- If co-codamol is prescribed, change to paracetamol and codeine separately.
- Do not use codeine liquid.

Notes:

- Variation in metabolism: The capacity to metabolise codeine to morphine can vary considerably between individuals; there is a marked increase in morphine toxicity in patients who are ultra-rapid codeine metabolisers (CYP2D6 ultra-rapid metabolisers) and a reduced therapeutic effect in poor codeine metabolisers.[16]
- A suggested regime for a patient who is already taking codeine 60 mg QDS is included below.
- If the patient is taking a lower dose than 60 mg QDS then start the process further down the table and follow the suggested tapering guidance.
- There are no readily available codeine preparations to allow a maximum 10% reduction throughout the reducing regime. This leads to a larger reduction as the regime progresses.
- This may mean that some patients want to slow the speed of the reduction as the regime progresses.
- If intermittent use of codeine continues to be prescribed, prescribe separately to paracetamol to enable the lowest effective dose to be taken.
- **Please note that a similar reduction regime can be used for dihydrocodeine.**

Codeine Tapering Plan Example:

- Enter the table at the appropriate dose level.
- Consider using Ardens Opioid Template: Opioid Reduction Plan for sharing with patient. Recommend to access via clinical system or see here.

Change (Aim for a weekly dose reduction but can be faster e.g. every few days or slower e.g. every 2-4 weeks)	**Morning codeine dose**	**Midday codeine dose**	**Afternoon codeine dose**	**Evening codeine dose**	**Total codeine dose/24 hours**	**Notes**
1	60 mg	30 mg	60 mg	60 mg	210 mg	
2	60 mg	30 mg	30 mg	60 mg	180 mg	
3	30 mg	30 mg	30 mg	60 mg	150 mg	
4	30 mg	30 mg	30 mg	30 mg	120 mg	
5	30 mg	STOP	30 mg	30 mg	90 mg	Consider changing prescription to 15 mg tablets if a person is struggling with a 30 mg reduction at each change.
6	30 mg	STOP	STOP	30 mg	60 mg	
7	STOP	STOP	STOP	30 mg	30 mg	
8	STOP	STOP	STOP	STOP		

To keep withdrawal symptoms to a minimum:

- A decrease by 10% of original dose every 1-2 weeks is usually well tolerated. Individualise, and involve patient in decision. Can be slower or with smaller reductions. A decrease of 10% every 2-4 weeks may be better tolerated.
- Some patients will need space to acclimatise to the new dose so the dose change may be delayed.

Tramadol Tapering Plan

Indication:

- Tramadol Is licensed for moderate to severe pain.[15]
- It is a centrally acting opioid analgesic and a non-selective, partial agonist of μ-, δ- and κ-opioid receptors with a higher affinity for μ-receptors. Other mechanisms contributing to the analgesic effect are the inhibition of serotonin and noradrenaline reuptake, potentiating neurotransmission.
- The maximum licenced adult dose is 400 mg in 24 hours.

Approximate Oral Morphine Equivalence:

- 60-100 mg oral tramadol is equivalent to approximately 10 mg of oral morphine.[15,16]
- At the maximum licensed daily dose tramadol 400 mg is equivalent to approximately 40-66 mg oral morphine.

Formulation/Preparation to Use for Tapering:

- It is recommended to use tramadol IR available as 50 mg capsules.
- Tramadol MR (either MR twice daily or XL once daily) can be converted to tramadol 50 mg IR capsules to enable a more gradual reduction or consider reducing the MR preparation in a similar way to the suggested "see-saw" tapering regime for tapentadol (here). If MR preparation isn't available, convert to equivalent dose of 50 mg IR capsules and taper as per the table below.
- Tramadol MR preparations 12-hourly are available as 100 mg, 150 mg and 200 mg tablets.

Notes:

- When reducing, withdrawal effects with tramadol can be like other opioids. As well as acting on μ-opioid receptors, tramadol is a weak serotonin (SSRI) and noradrenaline (SNRI) reuptake inhibitor.
- Tramadol leads to an increased risk of serotonin syndrome when taken with other SSRIs or SNRIs.
- A suggested regime for a patient who is already taking tramadol 100 mg 4 times daily is shown below. It allows gradual discontinuation of tramadol over 8 weeks at a fast-tapering rate or slow tapering rate with a dose reduction every 2-4 weeks.
- If the patient is taking a lower dose than 100 mg QDS then start the process further down the table and follow the suggested tapering guidance.

Tramadol Tapering Plan Example:

- Enter the table at the appropriate dose level.
- Consider using Ardens Opioid Template: Opioid Reduction Plan for sharing with patient. Recommend to access via clinical system or see here.

Change (Aim for a weekly dose reduction but can be faster e.g. every few days or slower e.g. every 2-4 weeks)	**Morning tramadol dose**	**Midday tramadol dose**	**Afternoon tramadol dose**	**Evening tramadol dose**	**Total tramadol dose/24 hours**
1	100 mg	50 mg	100 mg	100 mg	350 mg
2	100 mg	50 mg	50 mg	100 mg	300 mg
3	50 mg	50 mg	50 mg	100 mg	250 mg
4	50 mg	50 mg	50 mg	50 mg	200 mg
5	50 mg	STOP	50 mg	50 mg	150 mg
6	50 mg	STOP	STOP	50 mg	100 mg
7	STOP	STOP	STOP	50 mg	50 mg
8	STOP	STOP	STOP	STOP	

To keep withdrawal symptoms to a minimum:

- A decrease by 10% of original dose every 1-2 weeks is usually well tolerated. Individualise, and involve patient in decision. Can be slower or with smaller reductions. A decrease of 10% every 2-4 weeks may be better tolerated.
- Some patients will need space to acclimatise to the new dose so the dose change may be delayed.

Morphine Tapering Plan

Indication:

- Morphine is licensed for severe chronic pain and/or pain resistant to other analgesics, in particular pain associated with cancer. [15]

Formulation/Preparation to Use for Tapering:

- If prescribed morphine MR continue with this (helps avoid peaks and troughs; and should minimise risk of withdrawal syndrome).
- If prescribed morphine IR consider changing to MR if there is a risk of fluctuating quantities consumed which could lead to overdose as tolerance is reduced or withdrawal syndrome being problematic. Monitor prescriptions issued.
- The tapering plan should have regular dosing (not PRN). Morphine MR (Zomorph® capsules) are the preferred MR 12-hour formulation and are available in the following strengths: 10 mg, 30 mg, 60 mg, and 100 mg. MST® is available as 5mg strength.
- Prescriptions should state the brand. See local formulary for preferred choice.
- Note MXL® brand which is a 24-hour formulation.

Morphine Oral Solution:

- Morphine oral solution should usually be changed to a solid oral formulation. Dispensing a fixed number of tablets allows the clinician more control over the patient's use and subsequent reduction.
- Patients can find it almost impossible to reduce the amount of morphine solution they take when there is a whole bottle available. This is particularly important when the patient describes unsafe behaviour such as 'swigging from the bottle.'
- Morphine solution contains 10% alcohol (oxycodone solution does not), so any patient who reports that morphine solution is much better than morphine tablets (e.g. Sevredol®) could be flagging an alcohol dependence (even if not conscious by the patient).
- A person may wish to avoid morphine solution if abstaining from alcohol for religious reasons or previous alcohol use disorder.
- Consider changing to an equivalent dose of solid oral morphine with fixed regular dosing e.g.:
  - Morphine MR (Zomorph®) as regular BD dosing or
  - Morphine IR tablets available as Sevredol® tablets (10 mg, 20 mg, 30 mg) or Actimorph® orodispersible tablets (1 mg, 2.5 mg, 5 mg, 10 mg, 20 mg, 30 mg).
- A solid oral preparation may be preferential if there is difficulty using an oral syringe e.g. dexterity issues or visual impairment.

Notes:

- In the UK there are no readily available MR Morphine preparations to allow 10% reduction throughout the reducing regime. This leads to a larger reduction as the regime progresses and so some patients may want to slow the speed of the reduction as the regime progresses.
- The table on the next page shows an example of a tapering plan for a person taking morphine MR 200 mg BD. If the person is taking a lower dose than this, then start the process further down the table.

To keep withdrawal symptoms to a minimum:

- A decrease by 10% of original dose every 1-2 weeks is usually well tolerated. Individualise, and involve patient in decision. Can be slower or with smaller reductions. A decrease of 10% every 2-4 weeks may be better tolerated.
- Some patients will need space to acclimatise to the new dose so the dose change may be delayed.

Morphine MR Tapering Plan Example:

- Aim for a fortnightly dose reduction, but this can be slower or faster depending on patient factors and choice.
- A monthly reduction may be better tolerated for those who have taken an opioid for ≥ 1 year.
- Enter the table at the appropriate dose level.
- Prescriptions should state the brand. See local formulary for preferred brand.
- Zomorph® MR capsules available as 10 mg, 30 mg, 60 mg, and 100 mg are the preferred brand across South Yorkshire ICB. MST® tablets are available as 5mg strength.
- Consider using Ardens Opioid Template: Opioid Reduction Plan for sharing with patient. Recommend to access via clinical system or see here.

Change (e.g minimum weekly, fortnightly or monthly)	**Morning morphine MR dose**	**Evening morphine MR dose**	**Total morphine dose/24 hours**	**Reduction in mg of the total daily dose of morphine at each change**
1	190 mg	190 mg	380 mg	Reduce the total daily dose by 20 mg at each change.
2	180 mg	180 mg	360 mg	
3	170 mg	170 mg	340 mg	
4	160 mg	160 mg	320 mg	
5	150 mg	150 mg	300 mg	
6	140 mg	140 mg	280 mg	
7	130 mg	130 mg	260 mg	
8	120 mg	120 mg	240 mg	
9	110 mg	110 mg	220 mg	
10	100 mg	100 mg	200 mg	
11	90 mg	100 mg	190 mg	Reduce the total daily dose by 10 mg at each change.
12	90 mg	90 mg	180 mg	
13	80 mg	90 mg	170 mg	
14	80 mg	80 mg	160 mg	
15	70 mg	80 mg	150 mg	
16	70 mg	70 mg	140 mg	
17	60 mg	70 mg	130 mg	
18	60 mg	60 mg	120 mg	
19	50 mg	60 mg	110 mg	
20	50 mg	50 mg	100 mg	
21	45 mg	50 mg	95 mg	Reduce the total daily dose by 5 mg at each change. Note: a person may prefer to continue with a larger reduction e.g. 10 mg at each change, and only drop to 5 mg towards the end. Some patients may not need to reduce to 5 mg doses at the end, and 10 mg changes may still be appropriate with increased time at each stage e.g. shifting to 4 week reduction as opposed to 2 week.
22	45 mg	45 mg	90 mg	
23	40 mg	45 mg	85 mg	
24	40 mg	40 mg	80 mg	
25	35 mg	40 mg	75 mg	
26	35 mg	35 mg	70 mg	
27	30 mg	35 mg	65 mg	
28	30 mg	30 mg	60 mg	
29	25 mg	30 mg	55 mg	
30	25 mg	25 mg	50 mg	
31	20 mg	25 mg	45 mg	
32	20 mg	20 mg	40 mg	
33	15 mg	20 mg	35 mg	
34	15 mg	15 mg	30 mg	
35	10 mg	15 mg	25 mg	
36	10 mg	10 mg	20 mg	
37	5 mg	10 mg	15 mg	
38	5 mg	5 mg	10 mg	
39	STOP	5 mg	5 mg	
40	STOP	STOP		
	Aim to stop opioid or towards the end change to low dose IR 'when required' for pain flare ups / improving function. IR is available in lower strengths and can aid tapering towards the end. If opioid continued, consider changing to codeine or dihydrocodeine 'PRN'. See codeine tapering plan			

Oxycodone Tapering Plan

Indication:
- Oxycodone is a synthetic opioid licenced for severe pain, postoperative pain, and pain control in terminal care.[15]

Approximate Oral Morphine Equivalence:
- Oxycodone is approximately 1.5–2x more potent than morphine.
- 100 mg of oral oxycodone is approximately equivalent to 150–200 mg of oral morphine.[15,16]

Formulation/Preparation to Use for Tapering:
- If prescribed oxycodone MR continue with this (helps avoid peaks and troughs; and should minimise risk of withdrawal syndrome).
- If prescribed oxycodone IR consider changing to MR if there is a risk of fluctuating quantities consumed which could lead to overdose as tolerance is reduced or withdrawal syndrome being problematic. Monitor prescriptions issued.
- The tapering plan should have regular dosing (not PRN). Oxycodone MR tablets are available in the following strengths: 5 mg, 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60 mg, and 80 mg.
- Prescriptions should state the brand. See local formulary for preferred choice.

Oxycodone Oral Solution:
- Oxycodone oral solution should usually be changed to a solid oral formulation. Dispensing a fixed number of tablets allows the clinician more control over the patient's use and subsequent reduction.
- Patients can find it almost impossible to reduce the amount of oxycodone solution they take when there is a whole bottle available. This is particularly important when the patient describes unsafe behaviour.
- Consider changing to an equivalent dose of oxycodone MR tablets or oxycodone IR capsules (available as 5 mg, 10 mg, and 20 mg) with fixed regular dosing.
- A solid oral preparation may be preferential if there is difficulty using an oral syringe e.g. dexterity issues or visual impairment.

Notes
- In the UK there are no readily available MR oxycodone preparations to allow 10% reduction throughout the reducing regime. This leads to a larger reduction as the regime progresses and so some patients may want to slow the speed of the reduction as the regime progresses.
- The table on the next page shows an example of dose reductions for a person taking oxycodone MR 100 mg BD. If the person is taking a lower dose than this, then start the process further down the table and follow the suggested tapering guidance.

Struggling with Tapering of Oxycodone:
- If the person struggles with tapering, particularly as the regimen progresses, hold the dose for longer before the next taper and if possible, taper in smaller doses.
- If this doesn't work, consider changing oxycodone MR to morphine MR capsules (Zomorph®) as this allows a smaller reduction at each taper. See FPM for advice on switching between opioids.
  - **It is recommended to seek specialist advice in this circumstance.** Switching from one opioid to another should only be recommended or supervised by a healthcare practitioner with adequate competence and sufficient experience. The calculated dose-equivalent of oral morphine must be reduced to ensure safety. The starting point for dose reduction from the calculated equivalent analgesic dose is around 25-50%. Individual patient factors should be taken into consideration.
  - A small quantity of IR morphine can be prescribed for breakthrough or withdrawal pain until they are on a stable dose and can be converted to the appropriate dose of morphine MR capsules, before tapering can commence.

To keep withdrawal symptoms to a minimum:
- A decrease by 10% of original dose every 1-2 weeks is usually well tolerated. Individualise, and involve patient in decision. Can be slower or with smaller reductions. A decrease of 10% every 2-4 weeks may be better tolerated.
- Some patients will need space to acclimatise to the new dose so the dose change may be delayed.

Oxycodone MR Tapering Plan Example

- Aim for a fortnightly dose reduction, but this can be slower or faster depending on patient factors and choice.
- A monthly reduction may be better tolerated for those who have taken an opioid for ≥ 1 year.
- Oxycodone is approximately 1.5 to 2x more potent than morphine. Therefore the rate of tapering may need to slow down more than with morphine.
- Enter the table at the appropriate dose level.
- Prescriptions should state the brand. See local formulary for preferred brand.
- Oxycodone MR tablets are available as: 5 mg, 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60 mg, and 80 mg.
- Consider using Ardens Opioid Template: Opioid Reduction Plan for sharing with patient. Recommend to access via clinical system or see here.

Change (e.g. minimum weekly, fortnightly or monthly)	**Morning oxycodone MR dose**	**Evening oxycodone MR dose**	**Total oxycodone dose/24 hours**	**Approximate oral morphine equivalence (based on x2 potency - see here)**	**Reduction in mg of the total daily dose of oxycodone at each change**
1	95 mg	95 mg	190 mg	380 mg	Reduce the total oxycodone daily dose by 10 mg at each change.
2	90 mg	90 mg	180 mg	360 mg	
3	85 mg	85 mg	170 mg	340 mg	
4	80 mg	80 mg	160 mg	320 mg	
5	75 mg	75 mg	150 mg	300 mg	
6	70 mg	70 mg	140 mg	280 mg	
7	65 mg	65 mg	130 mg	260 mg	
8	60 mg	60 mg	120 mg	240 mg	
9	55 mg	55 mg	110 mg	220 mg	
10	50 mg	50 mg	100 mg	200 mg	
11	45 mg	45 mg	90 mg	180 mg	
12	40 mg	45 mg	85 mg	170 mg	Reduce the total oxycodone daily dose by 5 mg at each change.
13	40 mg	40 mg	80 mg	160 mg	
14	35 mg	40 mg	75 mg	150 mg	
15	35 mg	35 mg	70 mg	140 mg	
16	30 mg	35 mg	65 mg	130 mg	
17	30 mg	30 mg	60 mg	120 mg	
18	25 mg	30 mg	55 mg	110 mg	
19	25 mg	25 mg	50 mg	100 mg	
20	20 mg	25 mg	45 mg	90 mg	
21	20 mg	20 mg	40 mg	80 mg	
22	15 mg	20 mg	35 mg	70 mg	
23	15 mg	15 mg	30 mg	60 mg	
24	10 mg	15 mg	25 mg	50 mg	
25	10 mg	10 mg	20 mg	40 mg	
26	5 mg	10 mg	15 mg	30 mg	
27	5 mg	5 mg	10 mg	20 mg	
28	STOP	5 mg	5 mg	10 mg	
29	STOP	STOP			
	Aim to stop opioid or towards the end change to low dose IR 'when required' for pain flare ups / improving function. If opioid continued, consider changing to morphine IR, dihydrocodeine or codeine. See codeine tapering plan.				

Tapentadol Tapering Plan

Note: tapentadol has not yet been placed on the SY TLDL. Currently it is Black on the Sheffield TLDL, Grey on the Barnsley TLDL, and not listed on the Rotherham TLDL. In Doncaster it is Amber on the TLDL for palliative care and chronic pain (3rd line as per formulary guidance). It has been included within this document as there is some primary care prescribing in all places in SY (see open prescribing).

Indication:

- Tapentadol MR is indicated for the management of severe chronic pain in adults, which can be adequately managed only with opioid analgesics.
- Tapentadol IR is indicated for the relief of moderate to severe acute pain in adults, which can be adequately managed only with opioid analgesics.[15]

Approximate Oral Morphine Equivalence:

- 25 mg of oral Tapentadol is equivalent to 10 mg of oral morphine.[5]

Formulation/Preparation to Use:

- Only tapentadol MR formulation is licensed for chronic pain.
- Tapentadol MR tablets should be taken at 12 hourly intervals (available in the following strengths 50 mg, 100 mg, 150 mg, 200 mg, and 250 mg).

Notes:

- Tapentadol has dual action as an opioid agonist and noradrenaline reuptake inhibitor.
- A suggested regime for a patient who is already taking tapentadol MR 250 mg twice daily is included below. If the patient is taking a lower dose than tapentadol MR 250 mg BD, then start the process further down the table and follow the suggested tapering guidance.
- It is suggested doses are "see-sawed" down i.e. different morning and evening doses in the reduction regime.
- There are no readily available tapentadol MR preparations to allow a 10% reduction throughout the reducing regime. This leads to a larger reduction as the regime progresses. This may mean that some patients want to slow the speed of the reduction as the regime progresses.

Tapentadol MR Tapering Plan Example

- Aim for a fortnightly dose reduction, but this can be slower or faster depending on patient factors and choice. A monthly reduction may be better tolerated for those who have taken an opioid for ≥ 1 year.
- Enter the table at the appropriate dose level.
- Consider using Ardens Opioid Template: Opioid Reduction Plan for sharing with patient. Recommend to access via clinical system or see here

Change (e.g. minimum weekly, fortnightly or monthly)	**Morning tapentadol MR dose**	**Evening tapentadol MR dose**	**Total tapentadol dose/24 hours**
1	200 mg	250 mg	450 mg
2	200 mg	200 mg	400 mg
3	150 mg	200 mg	350 mg
4	150 mg	150 mg	300 mg
5	100 mg	150 mg	250 mg
6	100 mg	100 mg	200 mg
7	50 mg	100 mg	150 mg
8	50 mg	50 mg	100 mg
9	STOP	50 mg	50 mg
10	STOP	STOP	

To keep withdrawal symptoms to a minimum:

- A decrease by 10% of original dose every 1-2 weeks is usually well tolerated. Individualise, and involve patient in decision. Can be slower or with smaller reductions. A decrease of 10% every 2-4 weeks may be better tolerated.
- Some patients will need space to acclimatise to the new dose so the dose change may be delayed.

Transdermal (TD) and Immediate Release (IR) Fentanyl Tapering Plan

Transdermal (TD) Fentanyl

Indication:
- Fentanyl patches are licensed for the management of severe chronic pain that requires continuous long-term opioid administration.[15]

Approximate Oral Morphine Equivalence
- A fentanyl 12 micrograms /hour patch is approximately equivalent to 30–44 mg of oral morphine per day.[15,16]

Formulation/Preparation to Use:
- Patches are available in the following strengths: 12 micrograms/hour, 25 micrograms/hour, 37.5 micrograms/hour (Mezolar® brand only), 50 micrograms/hour and 100 micrograms/hour.
- Patches provide 3 days of analgesia.

Notes:
- It is not recommended to change to another opioid as conversions are unreliable and may result in overdose.
- Tapering the dose by 12 micrograms/hour every 30 days is likely to be better tolerated than a faster taper.
- A suggested regime for a patient who is already using a fentanyl 100 micrograms/hour patch (changed every 3 days) is included on the next page. If the patient is taking a lower dose than this, then start the process further down the table and follow the suggested tapering guidance.
- In the UK there are no readily available preparations to allow a 10% reduction throughout the reducing regime. This leads to a larger reduction as the regime progresses. This may mean that some patients want to slow the speed of the reduction as the regime progresses.

Struggling With Breakthrough or Withdrawal Pain After TD Fentanyl Dose Reduction:
- Try slowing the rate of taper.
- If this does not work, consider providing a small quantity of immediate release (IR) morphine either as:
  - Morphine 10 mg/5 ml solution (2.5 ml up to a maximum of four times daily when required for severe breakthrough pain or withdrawal symptoms. Maximum 7 days use after patch reduction) or

  If there are concerns with issuing morphine solution e.g. closer monitoring required, possible unsafe behaviour ("glugging"), prescribe:
  - Morphine IR tablets as either Sevredol® tablets 5 mg (10mg tablets are scored) or Actimorph® orodispersible tablets.
    - Advise lowest effective dose for the shortest period of time. Elderly may require very small dose.

Changing From Fentanyl TD to Oral Morphine MR:
- **This is not usually recommended. Seek specialist advice, especially at higher doses.** See FPM for advice on switching between opioids and more information here.

MHRA Patient Information Leaflets for TD Fentanyl:
- Fentanyl skin patches: how to use and dispose of them safely: October 2018, see here and (Large Print).

To keep withdrawal symptoms to a minimum:
- As a guide reduce the fentanyl patch strength no more frequently than monthly but can go at a faster rate if needed.
- Some patients will need space to acclimatise to the new dose so the dose change may be delayed.

IR Fentanyl

- IR Fentanyl is GREY on the SY IMOC TLDL for patients not undergoing palliative care treatment as per NHSE guidelines. It is only licensed for cancer pain.[16] Any prescribing should have input from specialist palliative care team.
- If a patient is prescribed IR fentanyl for non-cancer pain and the plan is to taper, there is no recommended way of doing this. Consider seeking specialist advice.

TD Fentanyl Tapering Plan Example:

- Aim for a monthly dose reduction as it is likely to be better tolerated.
- Fentanyl patches provide 3 days of analgesia.
- Enter the table at the appropriate dose level.
- Prescriptions should state the brand. See local formulary for preferred brand.
- TD fentanyl is available as: 12 micrograms/hour, 25 micrograms/hour, 37.5 micrograms/hour, 50 micrograms/hour, 75 micrograms/hour and 100 micrograms/hour.
- Consider using Ardens Opioid Template: Opioid Reduction Plan for sharing with patient. Recommend to access via clinical system or see here.

Change in patch strength (e.g. minimum every 12, 18 or 30 days)	**Transdermal fentanyl dose**	**Patch combination to achieve this dose**	**Approximate oral morphine equivalence[16]**	**Severe breakthrough pain or withdrawal symptoms after a TD fentanyl dose reduction**
1	100 micrograms/hour	100 micrograms/hour	240 mg	If this could derail further tapering, see here for advice on providing a small quantity of morphine immediate release for a few days after each dose reduction.
2	87 micrograms/hour	75 + 12 micrograms/hour	210 mg	
3	75 micrograms/hour	75 micrograms/hour	180 mg	
4	62 micrograms/hour	50 + 12 micrograms/hour	150 mg	
5	50 micrograms/hour	50 micrograms/hour	120 mg	
6	37.5 micrograms/hour	25 + 12 micrograms/hour OR 1 x 37.5 micrograms/hour Mezolar®	90 mg	
7	25 micrograms/hour	25 micrograms/hour	60 mg	
8	12 micrograms/hour	12 micrograms/hour	30 mg	
9	STOP *Consider conversion to a lower strength opioid for more gradual tapering if needed e.g. morphine or buprenorphine patches			

*__Caution when switching to a different opioid__: The approximate oral morphine equivalence in the table above is taken from the BNF. Fentanyl is a potent opioid and there is wide variation in approximate morphine equivalence. The equivalent doses are an approximate guide and should be adjusted according to individual patient factors and response.[16] Monitor for signs of toxicity e.g. breathing difficulties, drowsiness, and breakthrough/withdrawal pain.

Caution: After removing a fentanyl patch, serum concentrations decrease gradually, taking 20 hours or more to fall by 50%.[15]

Remove fentanyl 12 micrograms/hour patch and consider either:

- **Morphine IR** e.g. morphine 10 mg/5 ml solution (2.5 ml up to a maximum of four times daily).
  - Consider solid oral morphine immediate release tablets (Sevredol® or Actimorph® orodispersible) if there is a concern with unsafe behaviour around morphine solution. See here
  - Aim to stop or titrate down to intermittent use for the management of flare ups.

OR

□ **If a patch is preferred, consider changing to TD buprenorphine** e.g buprenorphine 10 micrograms/hour patch (applied at the same time as removing the last fentanyl patch).
  - Buprenorphine 10 micrograms/hour is approximately equivalent to oral morphine 24 mg.
  - Fentanyl is a potent opioid and for some patients coming off this final dose can be the most challenging. A higher strength buprenorphine patch e.g. 15 micrograms/hour may be helpful for some patients, particularly those who have found tapering fentanyl difficult. Use buprenorphine 10 micrograms/hour, especially if frail and review.
  - Aim to titrate down / stop.

See **codeine tapering plan** if changed to this.

Transdermal (TD) Buprenorphine Tapering Plan

Indication:

- The lower strength 7-day buprenorphine patch is used for the treatment of non-malignant pain of moderate intensity when an opioid is necessary for obtaining adequate analgesia.
- The higher strength 3- or 4-day buprenorphine patch is used for moderate to severe cancer pain and severe pain which does not respond to non-opioid analgesics.
- Buprenorphine patches are not suitable for the treatment of acute pain.[15]

Approximate Oral Morphine Equivalence:

- A buprenorphine 5 micrograms/hour patch is approximately equivalent to 12 mg of oral morphine per day.[5]

Formulation/Preparation to Use:

Patches are available in the following strengths (prescribe as brand):

- 7-day patch: 5 micrograms/hour, 10 micrograms/hour, 15 micrograms/hour, 20 micrograms/hour
- 4-day patch: 35 micrograms/hour, 52.5 micrograms/hour, 70 micrograms/hour (note: 3-day Hapoctasin® patch).

Notes:

- Buprenorphine is an opioid partial agonist, acting at the μ-opioid receptor, with a ceiling effect. It also has antagonistic activity at κ- and δ-opioid receptors. Buprenorphine has a lower dependence liability than pure opioid agonists as result.
- Withdrawal reactions are uncommon with buprenorphine; but the manufacturer for the higher strength patches states *"after long-term use, withdrawal symptoms, similar to those occurring during opiate withdrawal, cannot be entirely excluded".*
- A suggested regime for a patient who is already using buprenorphine 122.5 micrograms/hour patches (changed every 4 days) is included below. If the patient is taking a lower dose than this, then start the process further down the table and follow the suggested tapering guidance.
- In the UK there are no readily available preparations to allow a 10% reduction throughout the reducing regime.

TD Buprenorphine Tapering Plan Example:

- Aim for around a fortnightly to monthly dose reduction, but this can be slower or faster depending on patient factors and choice.
- The higher strength patches provide 3 or 4 days of analgesia, whilst lower strength patches provide 7 days.
- Enter the table at the appropriate dose level. Prescriptions should state the brand. See local formulary.
- Consider using Ardens Opioid Template: Opioid Reduction Plan for sharing with patient. Recommend to access via clinical system or see here.

Change in patch strength (e.g. **- 4 -day patch** minimum every 8, 16 or 32 days **- 7-day patch** minimum every 7, 14 or 28 days)	**Transdermal buprenorphine dose**	**Patch combination to achieve this dose**
1	105 micrograms/hour	70 + 35 micrograms/hour (4-day patch)
2	87.5 micrograms/hour	52.5 + 35 micrograms/hour (4-day patch)
3	70 micrograms/hour	70 micrograms/hour (4-day patch)
4	52.5 micrograms/hour	52.5 micrograms/hour (4-day patch)
5	40 micrograms/hour	2 x 20 micrograms/hour (7-day patch)
6	35 micrograms/hour	20 + 15 micrograms/hour (7-day patch)
7	30 micrograms/hour	20 + 10 micrograms/hour (7-day patch)
8	25 micrograms/hour	25 micrograms/hour (7-day patch)
9	20 micrograms/hour	20 micrograms/hour (7-day patch)
10	15 micrograms/hour	15 micrograms/hour (7-day patch)
11	10 micrograms/hour	10 micrograms/hour (7-day patch)
12	5 micrograms/hour	5 micrograms/hour (7-day patch)
13	STOP	

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