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Abbreviated Drug Use Evaluation: Cough and Cold

Plain Language Summary:

- The common cold is caused by viruses, and symptoms include sore throat, nasal stuffiness and discharge, sneezing, and cough. The common cold usually resolves by itself within 1 to 2 weeks.
- The Oregon Health Plan covers several products that can be used for symptom management including antihistamines for sneezing, cough, and nasal discharge, decongestants for congestion, cough suppressants for persistent cough, and pain relievers for sore throat.
- An evaluation of Medicaid claims data indicated that most members who had prescriptions for a cough or cold medicine were prescribed treatment for less than a month. About 9% (n=76) of fee-for-service (FFS) or Open Card members and 4% (n=114) of members enrolled through Healthier Oregon had more than 30 calendar days covered by a cough or cold product.
- We recommend that the Oregon Health Plan only pay for a cough or cold medicine for more than 30 days after the provider has evaluated and treated common conditions that may be causing chronic cough.

Research Questions:

- Are cough and cold medications prescribed chronically for members enrolled in Open Card (or Fee-for-service) and Healthier Oregon?

Conclusions:

- Most members prescribed cough and cold products had prescriptions which lasted less than a month.
- About 9% (n=76) of fee-for-service (FFS) members and 4% (n=114) of coordinated care organization (CCO) members enrolled through Healthier Oregon had more than 30 calendar days covered by a cough or cold product. The most commonly prescribed products were benzonatate, pseudoephedrine, guaifenesin, codeine phosphate/guaifenesin, and guaifenesin/dextromethorphan.

Recommendations:

- Implement quantity limits to require prior authorization (PA) after use of more than 30 days every 6 months of a cough or cold medicine.

Background

Cough and cold medicines are most commonly prescribed for short-term symptomatic relief of the common cold. The common cold is caused by viruses resulting in symptoms of sore throat, nasal stuffiness and discharge, sneezing, and cough that usually last 1 to 2 weeks. There is no cure and treatment focuses on symptom management. The Oregon Health Plan covers several products that can be used for symptom management including antihistamines for sneezing, cough, and nasal discharge, decongestants for congestion, cough suppressants for persistent cough, and pain relievers for sore throat.

Chronic cough is typically defined as a cough lasting more than 8 weeks and can be caused by a variety of underlying comorbid conditions.[1] Common conditions include gastroesophageal reflux disease (GERD), asthma or bronchitis, chronic obstructive pulmonary disease (COPD), rhinosinus diseases like allergic rhinitis or

chronic sinusitis, active or passive smoking, and some medications like angiotensin-converting enzyme inhibitors.[1] Management typically involves ruling out comorbid symptoms that may be suggestive of potential life-threatening conditions, then identifying and treating the underlying disorder. Recommended first-line treatments for common conditions include antihistamines and intranasal corticosteroids for allergies, inhaled corticosteroids for asthma, bronchodilators for COPD, and proton pump inhibitors and lifestyle modifications for GERD.[1]

Recent systematic reviews have identified only limited and low quality evidence of benefit for cough and cold medicines for symptom relief, and effects on individual symptoms are probably too small to be clinically relevant.[2,3] In the past 10 years, the Food and Drug Administration (FDA) has issued several drug safety communications related to safety and efficacy of cough and cold products including a proposed order to remove oral phenylephrine from the market based on efficacy concerns,[4] risk for abuse and misuse of propylhexedrine leading to risk of heart and mental health problems,[5] and recommendations limiting the use of codeine and hydrocodone in children due to risk of adverse effects.[6] Before prescribing over-the-counter cough and cold products for symptom relief, the limited potential benefits must be weighed against the risk of adverse effects.

For treatment of cough, the Pharmacy and Therapeutics Committee previously recommended a minimum of 1 product with codeine and 1 with dextromethorphan preferred on the preferred drug list (PDL) for refractory cough as these have the strongest evidence of efficacy. The current preferred products include pseudoephedrine, guaifenesin, codeine phosphate/guaifenesin, and guaifenesin/dextromethorphan. Prior authorization is required for non-preferred products, for preferred products in children under 13 years of age, and for preferred products containing codeine or hydrocodone in people 13 to 18 years of age.

The goal of this analysis was to evaluate whether symptomatic treatment for cough and cold are prescribed chronically for members in the Oregon fee-for-service (Open Card) Medicaid program.

Methods:

Inclusion criteria:

1. Population 1: members with paid FFS claims from 2025-04-01 to 2026-03-31 for products in the Cough and Cold PDL class
2. Population 2: members enrolled through Healthier Oregon (identified by program eligibility resource codes [PERC] and benefit plan) with paid CCO claims from 2025-04-01 to 2026-03-31 for products in the Cough and Cold PDL class

Exclusion criteria: members with less than 2 months of Medicaid eligibility in the 12 months following the first paid claim for a cough/cold product in the evaluation period. Cough and cold products are generally expected to be prescribed for short treatment courses, so participants were required to be enrolled with Medicaid for a total of at least 2 months. This analysis did **not** exclude members with Medicare and other primary insurance because over the counter drugs like cough and cold products are not commonly covered by commercial insurance plans.

Outcome:

- Total calendar days covered by at least one cough/cold product in the 12 months following the first paid claim

Results:

Over a 1-year period, 799 patients in the FFS Open Card program and 2623 CCO members enrolled through Healthier Oregon had paid claims for a cough or cold medication. In the FFS program, all products require prior authorization when prescribed to members less than 13 years of age, and most products were prescribed for adults (**Table 1**). About 15% of FFS Open Card members were also eligible for Medicare where Medicaid would be the primary payer only for drugs

not covered by Medicare (such as over-the-counter products). Most members were prescribed only one agent and had only 1 claim for cough and cold medicine in the 12 months following the first paid claim. About 9% of FFS members and 4% of CCO members enrolled through Healthier Oregon had more than 30 calendar days covered by a cough or cold product (**Table 2**). The most commonly prescribed products were benzonatate, pseudoephedrine, guaifenesin, codeine phosphate/guaifenesin, and guaifenesin/dextromethorphan. Benzonatate was less common in FFS members than Healthier Oregon CCO members because it is non-preferred in the FFS program.

Table 1. Demographics identified at the time of the first paid claim in the evaluation window.

	FFS Open Card		Healthier Oregon	
	799	%	2,623	%
Average Age (Min-Max)	41.7	(6-97)	44.4	(4-99)
≤ 5 years	0	0.0%	5	0.2%
6-17 years	94	11.8%	72	2.7%
18-64 years	616	77.1%	2,331	88.9%
≥65 years	89	11.1%	215	8.2%
Race				
White	268	33.5%	98	3.7%
Hispanic or Latino	36	4.5%	1,730	66.0%
Native American	380	47.6%	64	2.4%
Unknown	93	11.6%	439	16.7%
Other	22	2.8%	292	11.1%
Benefit Plan				
Medicaid (BMH)	662	82.9%	2,623	100.0%
Bridge (BRG)	15	1.9%		
Medicare (BMD/BMM/MED)	122	15.3%		
Other	0	0.0%		
Number of covered drugs (by HSN) per member				
Members with 1 drug	742	92.9%	2,259	86.1%
Members with 2 drugs	54	6.8%	320	12.2%
Members with 3-5 drugs	3	0.4%	40	1.5%
Members with 6-10 drugs	0	0.0%	3	0.1%
Members with ≥ 11 drugs	0	0.0%	1	0.0%
Claims per member in the evaluation period				
Members with 1 claim	620	77.6%	2,012	76.7%
Members with 2 claims	108	13.5%	434	16.5%
Members with 3-5 claims	41	5.1%	151	5.8%

Members with 6-10 claims	21	2.6%	22	0.8%
Members with ≥11 claims	9	1.1%	4	0.2%

Table 2. Total Calendar Days Covered by a Cough or Cold Product in the evaluation period

	FFS Open Card		Healthier Oregon	
	799	%	2,623	%
Covered Days				
< 15 days	572	71.6%	2,101	80.1%
15-30 days	151	18.9%	408	15.6%
31-60 days	25	3.1%	86	3.3%
61-90 days	16	2.0%	16	0.6%
91-180 days	21	2.6%	9	0.3%
> 180 days	14	1.8%	3	0.1%

Figure 1. Covered days for cough and cold products in the evaluation period for Open Card Members

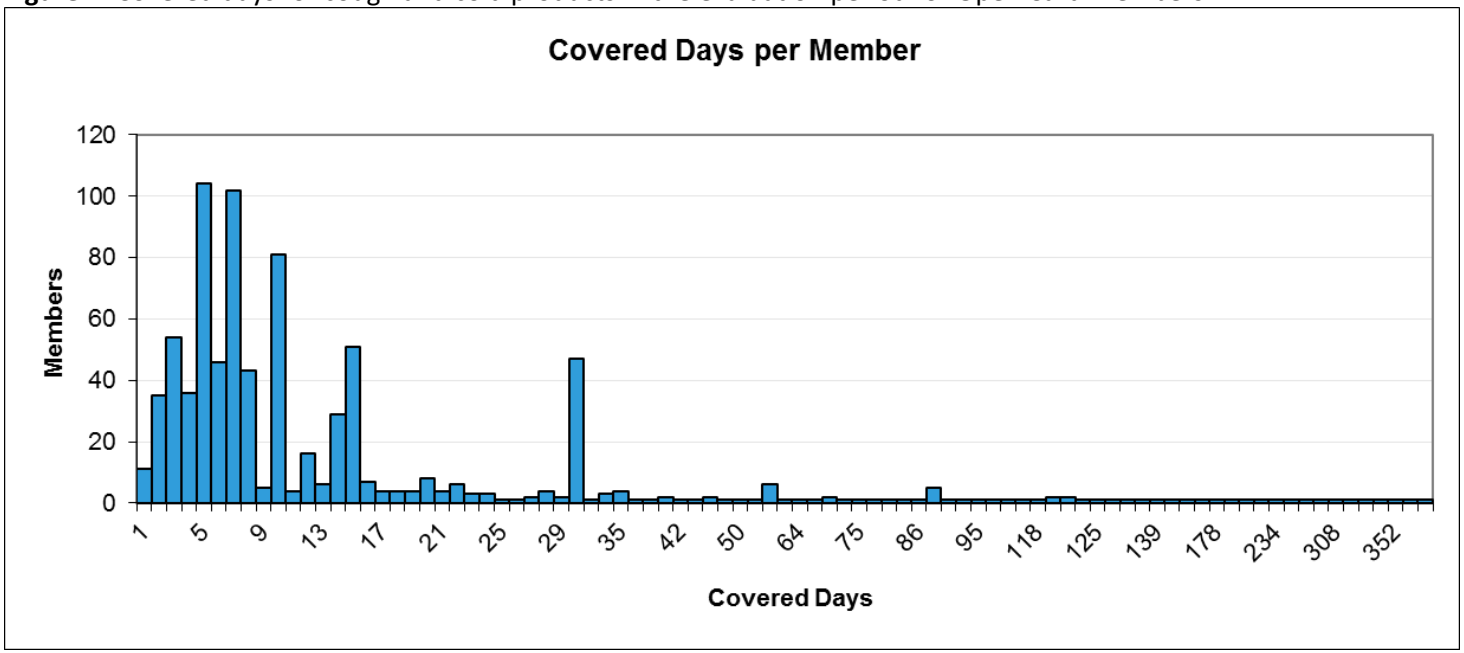


Figure 2. Covered days in the evaluation period for Healthier Oregon Members

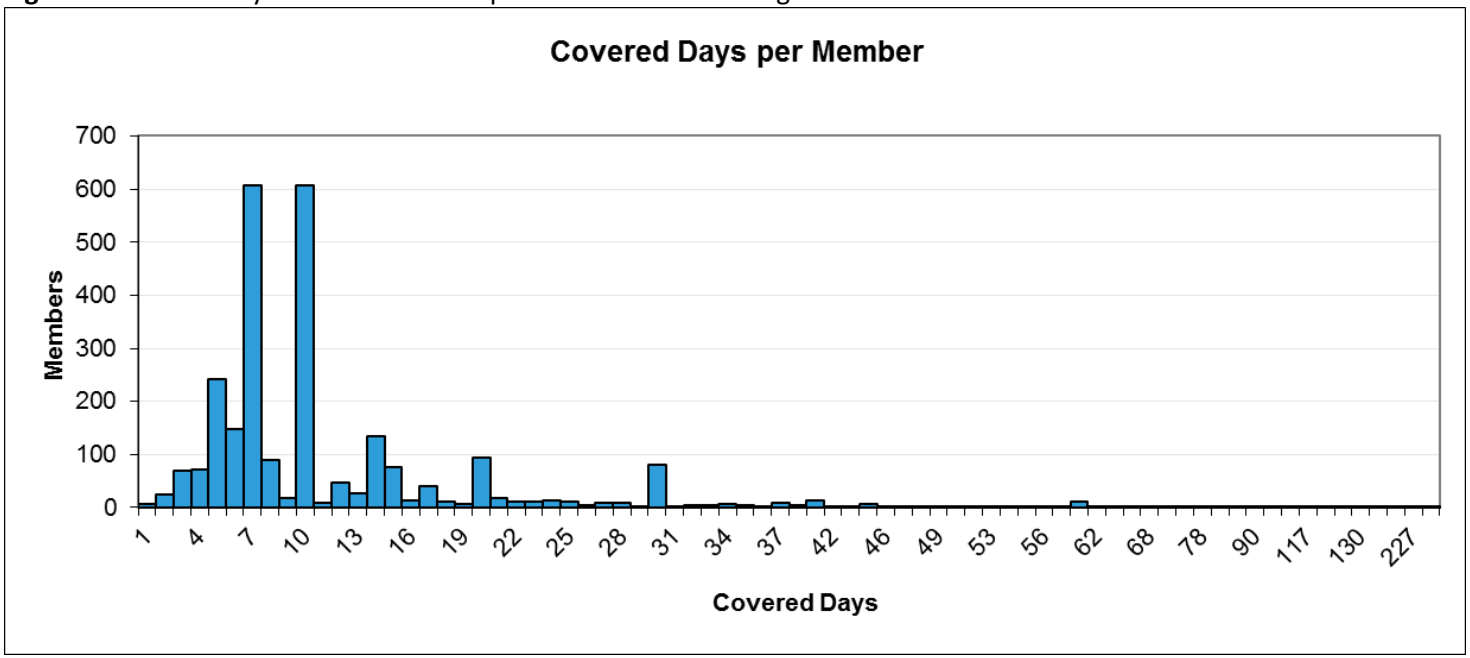


Table 3. Average and median covered days per member for the most commonly prescribed drugs

	FFS Open Card						Healthier Oregon					
	Patient Count		Covered Days per Member				Patient Count		Covered Days per Member			
	799	%	Average	Median	Min	Max	2,623	%	Average	Median	Min	Max
Top 10 Most Commonly Prescribed Agents (by HSN)												
1 benzonatate	58	7.3%	13	10	3	90	1,916	73.0%	12	10	1	227
2 pseudoephedrine HCl	326	40.8%	19	7	1	359	417	15.9%	12	8	1	117
3 guaifenesin	146	18.3%	45	15	2	358	97	3.7%	14	10	2	67
4 codeine phosphate/guaifenesin	149	18.6%	8	6	1	139	68	2.6%	11	8	2	58
5 guaifenesin/dextromethorphan	106	13.3%	13	7	1	168	70	2.7%	9	8	1	32
6 promethazine/dextromethorphan	12	1.5%	8	6	3	27	14	0.5%	11	9	6	32
7 oxymetazoline HCl							21	0.8%	40	30	3	242
8 hydrocodone bit/homatrop me-br	1	0.1%	6	6	6	6	8	0.3%	10	11	6	13
9 dextromethorphan polistirex							5	0.2%	9	4	4	25
10 loratadine/pseudoephedrine							4	0.2%	37	24	10	92
11 promethazine HCl/codeine	1	0.1%	4	4	4	4	2	0.1%	18	18	12	24
12 fexofenadine/pseudoephedrine							1	0.0%	30	30	30	30

Limitations:

- Claims history may not accurately reflect true medication use for members prescribed cough and cold medications.
- The evaluation period for this analysis ended on 2026-03-31 which was about 4 months prior to the analysis. All members had at least 2 months of eligibility following their first claim, but members with their first claim for a cough and cold product early in the evaluation period would have had a longer follow-up period compared to members who had their first claim near the end of the evaluation period.
- This analysis did not attempt to evaluate underlying diagnosis, comorbid conditions, or concomitant therapy prescribed to members with claims for cough and cold products.
- Members with other insurance or with Medicare were included in this analysis because many commercial insurance plans do not cover over-the-counter drugs. However, Medicaid data on legend prescription products for these populations (such as benzonatate) may be incomplete because Medicaid would not be the primary payer for legend drugs.

References:

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2. De Sutter AI, Eriksson L, van Driel ML. Oral antihistamine-decongestant-analgesic combinations for the common cold. Cochrane Database of Systematic Reviews. 1:CD004976. doi:https://dx.doi.org/10.1002/14651858.CD004976.pub4.
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5. FDA Drug Safety Communication. Abuse and Misuse of the Nasal Decongestant Propylhexedrine Causes Serious Harm. https://www.fda.gov/media/146936/download?attachment 3/25/2021. Accessed 8/11/2026. .
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Cough and Cold Preparations

Goal(s):

- Limit use of cough and cold preparations to evidence-supported durations

Length of Authorization:

- Up to 12 months

Requires PA:

All drugs (expectorants, antitussives, oral decongestants and combinations) in TC = 16, 17 except those listed below.
All products for patients under 13 years of age
All products prescribed for more than 30 days every 6 months.
All hydrocodone or codeine-containing products for patients under 19 years of age (see Short-acting Opioid PA criteria).

Covered Alternatives:

- Current PMPDP preferred drug list per OAR 410-121-0030 at www.orpdl.org
- Searchable site for Oregon FFS Drug Class listed at www.orpdl.org/drugs/

HSN	Generic Drug Name
000206	Guaifenesin/codeine
000223	Guaifenesin/Dextromethorphan
002091	Pseudoephedrine

Approval Criteria		
1. What diagnosis is being treated?	Record ICD10 code.	
2. Has the patient failed to have adequate benefit with, or have contraindications or intolerance to, one of the a preferred cough medication listed above?	**Yes:** Go to #3	**No:** Pass to RPh. Deny; medical appropriateness

Approval Criteria		
3. Is the request for acute treatment or intermittent use for acute symptoms (i.e., less than 30 days)? - Note: Intermittent use may be validated based on claims history.	**Yes:** Approve for requested duration (up to 30 days)	**No:** Go to #4
4. Has the provider documented an evaluation for underlying conditions including: - asthma or COPD - allergic rhinitis - gastroesophageal reflux - medication-related adverse effects (e.g., ACE inhibitors)	**Yes**: Go to #5	**No:** Pass to RPh. Deny; medical appropriateness
5. Have underlying conditions been treated as recommended when applicable (see Table 1)?	**Yes:** Initial requests: Approve for up to 3 months. Subsequent requests can be approved for up to 12 months if there is documented improvement in quality of life.	**No:** Pass to RPh. Deny; medical appropriateness.

Table 1. Recommended first-line treatment for common comorbid conditions

Comorbid condition	Recommended First-line Treatments
Asthma	Inhaled corticosteroid with a short or long-acting bronchodilator
Allergic Rhinitis	Nasal corticosteroids, Nasal antihistamines, and Second generation oral antihistamines
Chronic Obstructive Pulmonary Disease (COPD)	Bronchodilator (LABA or LAMA)
Gastroesophageal reflux	Lifestyle modifications and acid suppressive treatment (PPI or H2RA)
Medication-related adverse effects (e.g., ACE inhibitors)	Withdrawal of the medication

P&T Review: *10/26 (DM); 5/16 (KK); 5/13; 2/06*
Implementation: *1/1/27; 7/1/16; 1/10/08*

Opioid Analgesics, Short-acting

Goals:

- Restrict use of short-acting opioid analgesics for acute conditions where evidence of benefit outweighs risks.
- Encourage appropriate monitoring, risk mitigation, and concomitant therapy for chronic pain.
- Promote use of preferred short-acting opioid analgesics.

Length of Authorization:

- Initial: 7 to 30 days (except 12 months for end-of-life, sickle cell disease, severe burn injury, or cancer-related pain)
- Renewal: Up to 6 months

Covered Alternatives:

- Current PMPDP preferred drug list per OAR 410-121-0030 at www.orpdl.org
- Searchable site for Oregon FFS Drug Class listed at www.orpdl.org/drugs/

Requires a PA:

- Non-preferred short-acting opioids and opioid combination products.
- All short-acting products prescribed for more than 14 days. Each prescription is limited to 7 days in treatment-naïve patients. Patients may fill up to 2 prescriptions every 90 days without prior authorization.
- All codeine and tramadol products for patients under 19 years of age

Note:

- Patients on palliative care with a terminal diagnosis or with cancer-related pain or with pain associated with sickle cell disease or severe burn injury are exempt from this PA.

Table 1. Daily Dose Threshold (90 morphine milligram equivalents per day (MME/day) of Oral Opioid Products.

Opioid	90 MME/day Dose	Notes
Benzhydrocodone	73.5 mg	
Codeine	600 mg	Codeine is not recommended for pediatric use; codeine is a prodrug of morphine and is subject to different rates of metabolism, placing certain populations at risk for overdose.
Dihydrocodeine	360 mg	
Hydrocodone bitartrate	90 mg	
Hydromorphone	22.5 mg	
Levorphanol tartrate	8 mg	
Meperidine	900 mg	Meperidine is not recommended for management of chronic pain due to potential accumulation of toxic metabolites.
Morphine	90 mg	

Oxycodone	60 mg	
Oxymorphone	30 mg	
Tapentadol	225 mg	
Tramadol	400 mg	400 mg/day is max dose and is not equivalent to 90 MME/day. Tramadol is not recommended for pediatric use as it is subject to different rates of metabolism placing certain populations at risk for overdose.

Approval Criteria		
1. What is the patient's diagnosis?	Record ICD10	
2. Has the patient been prescribed any opioid analgesics (short or long-acting) for more than 6 weeks?	**Yes:** Go to **Renewal Criteria**	**No:** Go to #3
3. Is the request for fibromyalgia, TMJ, pelvic pain syndrome, neuropathy, or tension headache? Note: there is limited or insufficient evidence for opioid use in many pain conditions including fibromyalgia, TMJ, pelvic pain syndrome, neuropathy, and tension headache. Risks of opioid prescribing outweigh benefits.	**Yes:** Pass to RPh. Deny; medical appropriateness	**No:** Go to #4
4. Is the requested medication a preferred agent?	**Yes:** Go to #6	**No:** Go to #5

5. Does the patient have lack of benefit, intolerance, or contraindication to at least 2 preferred products? Note: Preferred opioids are reviewed and designated as preferred agents by the Oregon Pharmacy & Therapeutics Committee based on published medical evidence for safety and efficacy.	**Yes:** Go to #6	**No:** Pass to RPh. Deny; medical appropriateness
6. Is the patient being treated for pain associated with sickle cell disease, severe burn injury or cancer-related pain or under palliative care services with a life-threatening illness or severe advanced illness expected to progress toward dying?	**Yes:** Approve for up to 12 months.	**No:** Go to #7
7. Is the prescription for a product containing codeine or tramadol in a patient less than 19 years of age?	**Yes:** Deny for medical appropriateness	**No:** Go to #8
8. Is the prescription for a short-acting fentanyl product? Note: Short-acting transmucosal fentanyl products are designed for breakthrough cancer pain only. This PA does not apply to transdermal fentanyl patches.	**Yes:** Pass to RPh. Deny; medical appropriateness Note: Management of opioid dependence is funded by the OHP.	**No:** Go to #9
9. Is the opioid prescribed for pain related to migraine or other type of headache? Note: there is limited or insufficient evidence for opioid use for many pain conditions, including migraine or other types of headache.	**Yes:** Pass to RPh. Deny; medical appropriateness	**No:** Go to #10

10. Is the prescriber enrolled in the Oregon Prescription Drug Monitoring Program (www.orpdmp.com) and has the prescriber reviewed at least once in the past 1 month and verified that opioid prescribing is appropriate?	**Yes:** Go to #11	**No:** Pass to RPh. Deny; medical appropriateness.
11. Is the patient currently taking a benzodiazepine or other central nervous system (CNS) depressant? Note: All opioids have a black box warning about the risks of profound sedation, respiratory depression, coma or death associated with concomitant use of opioids with benzodiazepines or other CNS depressants.	**Yes:** Pass to RPh. Deny; medical appropriateness	**No:** Go to #12
12. Within the past 6 weeks, has a 5-day trial of at least one non-opioid analgesic (e.g., NSAID, acetaminophen, and/or muscle relaxant) been tried for this indication at its maximum effective dose and found to be ineffective or are contraindicated?	**Yes:** Go to #13	**No:** Pass to RPh. Deny; medical appropriateness
13. Has the patient already received more than 30 days of opioid therapy for this pain condition?	**Yes:** Go to #14	**No:** Approve for up to 7 days not to exceed 90 MME
14. Has the prescriber also developed a plan with the patient to stay active (home or prescribed exercise regimen) and with consideration of additional therapies such as behavioral health treatment (e.g., cognitive behavioral therapy), rehabilitative therapy (e.g., physical therapy, yoga, weight loss, massage), or interventional procedures (e.g., spinal manipulation or acupuncture)?	**Yes:** Go to #15	**No:** Pass to RPh. Deny; medical appropriateness

15. Can the prescriber provide documentation of sustained improvement in function of at least 30% compared to baseline with prior use of opioid analgesics (e.g., validated tools to assess function include: Oswestry, Neck Disability Index, SF-MPQ, 3-item PEG scale, and MSPQ)?	**Yes:** Go to #16	**No:** Pass to RPh. Deny; medical appropriateness.
16. Is there a plan to re-evaluate opioid therapy within 30 days?	**Yes:** Approve for up to 30 days	**No:** Pass to RPh. Deny; medical appropriateness.

Renewal Criteria		
1. What is the patient's diagnosis?	Record ICD10 code	
2. Is the request for a patient already established on opioid treatment for >6 weeks (long-term treatment)?	**Yes**: Go to #3	**No**: Go to **Approval Criteria**
3. Does the request document a taper plan for the patient?	**Yes:** Document taper plan and approve for duration of taper or 3 months whichever is less.	**No:** Go to #4
4. Has the patient been referred for alternative non-pharmacologic modalities of pain treatment (e.g., physical therapy, supervised exercise, spinal manipulation, yoga, or acupuncture) AND behavioral health treatment (e.g., cognitive behavioral therapy, acceptance and commitment therapy)?	**Yes:** Go to #5	**No:** Pass to RPh. Deny. Medical appropriateness
5. Is the patient currently prescribed an antidepressant OR is there documentation that the provider has evaluated antidepressant therapy for chronic pain in this patient?	**Yes:** Go to #6	**No:** Pass to RPh. Deny. Medical appropriateness

6. Can the prescriber provide documentation of sustained improvement of at least 30% in pain, function, or quality of life in the past 3 months compared to baseline? Note: Pain control, quality of life, and function can be quickly assessed using the 3-item PEG scale. *	**Yes:** Go to #8 Document tool used and score vs. baseline: _____	**No:** Go to #7
7. Is there documentation that the provider has assessed risks and benefits of tapering opioids within the past 3 months? Assessment should at minimum document 1) evaluation of patient concerns related to tapering, 2) factors which may contribute to increased risk of adverse events and 3) potential for pain improvement with a taper	**Yes:** Go to #8 Document provider attestation and rationale	**No:** Pass to RPh. Deny; medical appropriateness
8. Is the prescriber enrolled in the Oregon Prescription Drug Monitoring Program (www.orpdmp.com) and has the prescriber verified at least once in the past 1 month that opioid prescribing is appropriate?	**Yes:** Go to #9	**No:** Pass to RPh. Deny. Medical appropriateness
9. Has the patient had a urinary drug screen (UDS) within the past year to verify absence of illicit drugs and non-prescribed opioids?	**Yes:** Go to #10	**No:** Pass to RPh. Deny. Medical appropriateness
10. Has the member been prescribed or have access to naloxone?	**Yes:** Go to #11	**No:** Pass to RPh. Deny. Medical appropriateness
11. Does the patient have a pain contract on file with the prescriber?	**Yes:** Go to 12	**No:** Pass to RPh. Deny. Medical appropriateness
12. Is the request for an increased cumulative daily dose compared to previously approved therapy or average dose in the past 6 weeks?	**Yes:** Go to #13	**No:** Go to #15

13. Does the total cumulative daily opioid dose exceed 90 MME (see Table 1)?	**Yes:** Pass to RPh. Deny; medical appropriateness	**No:** Go to #14
14. Is there documented rationale (e.g., new acute injury) to support the increase in dose?	**Yes:** Go to #15	**No:** Pass to RPh; deny; medical appropriateness
15. Does the patient have any of the following risk factors for overdose? a. Concomitant CNS depressants (benzodiazepines, muscle relaxants, sedating antipsychotics, etc) b. Total daily opioid dose > 90 MME c. Recent urine drug screen indicating illicit or non-prescribed opioids d. Concurrent short- and long-acting opioid use e. Diagnosis of opioid use disorder	**Yes:** Approved duration is based on the number of identified risk factors for overdose or length of treatment (whichever is less): Risk factors: >=3: 2 month 1-2: 4 months	**No:** Approve for 6 months

*The PEG is freely available to the public http://www.agencymeddirectors.wa.gov/Files/AssessmentTools/1-PEG%203%20item%20pain%20scale.pdf.
Citation of the original publication:
Krebs EE, Lorenz KA, Bair MJ, Damush TA, Wu J, Sutherland JM, Asch SM, Kroenke K. Development and initial validation of the PEG, a 3-item scale assessing pain intensity and interference. *Journal of General Internal Medicine*. 2009 Jun; 24:733-738

Clinical Notes:

How to Discontinue Opioids.

Adapted from the following guidelines on opioid prescribing:

- The Washington State Interagency Guideline on Prescribing Opioids for Pain; Agency Medical Directors' Group, June 2015. Available at http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf.

Selecting the optimal timing and approach to tapering depends on multiple factors. The decision to taper should be based on shared decision making between the patient and provider based on risks and benefits of therapy. Involving the patient in the decision to taper helps establish trust with the patient, ensures patient-focused tapering, incorporates the patient's values into the taper plan, provides education on the risks of opioid use, and establishes realistic goals and expectations. Avoid insisting on opioid tapering or discontinuation when opioid use may be warranted. The rate of opioid taper should be based primarily on safety considerations, and special attention is needed for patients on high dose opioids or with significant long-term use, as too rapid a taper may precipitate withdrawal symptoms or drug-seeking behavior. In addition, behavioral issues or physical withdrawal symptoms can be a major obstacle during an opioid taper. Patients who feel overwhelmed or desperate may try to convince the provider to abandon the taper. Although there are no methods for preventing behavioral issues during taper, strategies implemented at the beginning of chronic opioid therapy such as setting clear expectations, allowing for pauses during the taper, and development of an exit strategy are most likely to prevent later behavioral problems if a taper becomes necessary.

1. Consider sequential tapers for patients who are on chronic benzodiazepines and opioids. Coordinate care with other prescribers (e.g. psychiatrist) as necessary. In general, taper off opioids first, then the benzodiazepines.

2. Do not use ultra-rapid detoxification or antagonist-induced withdrawal under heavy sedation or anesthesia (e.g. naloxone or naltrexone with propofol, methohexital, ketamine or midazolam).
3. Establish an individualized rate of taper based on safety considerations and patient history. Common tapers have a dose reduction of 5% to 20% per month:
    a. Assess for substance use disorder and transition to appropriate medication assisted treatment if there is diversion or non-medical use,
    b. Rapid taper (over a 2 to 3 week period) if the patient has had a severe adverse outcome such as overdose or substance use disorder, or
    c. Slow taper for patients with no acute safety concerns. May consider starting with a taper of ≤10% of the original dose per month and assess the patient's functional and pain status at each visit.
4. Adjust the rate, intensity, and duration of the taper according to the patient's response (e.g. emergence of opioid withdrawal symptoms (see Table below)).
5. Watch for signs of unmasked mental health disorders (e.g. depression, PTSD, panic disorder) during taper, especially in patients on prolonged or high dose opioids. Consult with specialists to facilitate a safe and effective taper. Use validated tools to assess conditions.
6. Consider the following factors when making a decision to continue, pause or discontinue the taper plan:
    a. Assess the patient behaviors that may be suggestive of a substance use disorder
    b. Address increased pain with use of non-opioid pharmacological and non-pharmacological options.
    c. Evaluate patient for mental health disorders.
    d. If the dose was tapered due to safety risk, once the dose has been lowered to an acceptable level of risk with no addiction behavior(s) present, consider maintaining at the established lower dose if there is a clinically meaningful improvement in function, reduced pain and no serious adverse outcomes.
7. Do not reverse the taper; it must be unidirectional. The rate may be slowed or paused while monitoring for and managing withdrawal symptoms.
8. Increase the taper rate when opioid doses reach a low level (e.g. <15 mg/day MED), since formulations of opioids may not be available to allow smaller decreases.
9. Use non-benzodiazepine adjunctive agents to treat opioid abstinence syndrome (withdrawal) if needed. Unlike benzodiazepine withdrawal, opioid withdrawal symptoms are rarely medically serious, although they may be extremely unpleasant. Symptoms of mild opioid withdrawal may persist for 6 months after opioids have been discontinued (see Table below).
10. Refer to a crisis intervention system if a patient expresses serious suicidal ideation with plan or intent, or transfer to an emergency room where the patient can be closely monitored.
11. Do not start or resume opioids or benzodiazepines once they have been discontinued, as they may trigger drug cravings and a return to use. Counsel the patient on the increased risk of overdose with abrupt return to a previously prescribed higher dose. Provide opioid overdose education and consider offering naloxone.
12. Consider inpatient withdrawal management if the taper is poorly tolerated.

Symptoms and Treatment of Opioid Withdrawal.

Adapted from the Washington State Interagency Guideline on Prescribing Opioids for Pain; Agency Medical Directors' Group, June 2015. Available at http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf)

Restlessness, sweating or tremors	Clonidine 0.1-0.2 mg orally every 6 hours or transdermal patch 0.1-0.2 mg weekly (If using the patch, oral medication may be needed for the first 72 hours) during taper. Monitor for significant hypotension and anticholinergic side effects.
Nausea	Anti-emetics such as ondansetron or prochlorperazine
Vomiting	Loperamide or anti-spasmodics such as dicyclomine
Muscle pain, neuropathic pain or myoclonus	NSAIDs, gabapentin or muscle relaxants such as cyclobenzaprine, tizanidine or methocarbamol
Insomnia	Sedating antidepressants (e.g. nortriptyline 25 mg at bedtime or mirtazapine 15 mg at bedtime or trazodone 50 mg at bedtime). Do not use benzodiazepines or sedative-hypnotics.

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