The prescriber needs to do a careful assessment of the risks and benefits of continued long-term opioid therapy. If your patient is doing well, engaging in activities, taking medication as prescribed, and has no other concerning risk factors, there may be no need to taper them off their current dose. But remember, the patient's subjective report is just one data point. Be sure to check other data points, such as collateral information from family, the Prescription Drug Monitoring Program, and urine drug screening. Document your assessment and monitor patients at least quarterly for any change in status. Remember patients can develop problems at any point in their opioid therapy. Review Broaching the Subject for advice on how to discuss tapering with your patient. For specific language on how to talk to your patients about opioid risks, see Weighing the Risks and Benefits of Chronic Opioid Therapy.

Consider tapering for the following reasons:

**Patient request** – If your patient requests reducing or eliminating opioids, you should initiate tapering. If pain is still a problem, offer alternatives. See Other Strategies for Coping with Pain.

**Pain and function not improved** – If your ongoing evaluation of the patient demonstrates that their pain and function are not meaningfully improved, then tapering is recommended.

**Adverse opioid effects** – Consider tapering if your patient is suffering adverse opioid side effects such as constipation, lethargy, sexual dysfunction, confusion, depression, increased risk for falls, immune suppression, or respiratory depression. Tolerance, dependence, and withdrawal can be adverse effects, and may themselves be indication for a taper.

**Co-occurring conditions (including mental health)** – Consider tapering if your patient has co-occurring health conditions such as lung disease, sleep apnea, liver disease, kidney disease, cardiac arrhythmias, obesity, or dementia. If your patient suffers from depression, anxiety, PTSD, or childhood trauma, they are at higher risk for developing opioid misuse or an opioid use disorder. Integrating mental health treatment alongside chronic pain treatment increases the odds of a successful and therapeutic opioid taper.

**Dose over 90 MED (Morphine Equivalent Dose)** – Morphine Equivalent Dosing (MED) is a patient’s cumulative intake of all opioids over 24 hours measured in morphine milligram equivalents. Adverse outcomes are dose and duration dependent. Some patients at higher doses may be fully adherent and functioning well with no other risk factors. However, the risks of overdose, addiction, and other serious side effects increase above 90 MED. At least quarterly, reassess the benefits versus the risks of continued opioid therapy at doses over 90 MED. MED Calculator

**Concurrent sedatives** – Consider tapering if your patient is prescribed benzodiazepines, carisoprodol, or other sedatives, or regularly drinking alcohol. You may want to taper the sedative before or instead of the opioid. Involve patients in the discussion of which to taper first. Check your state Prescription Drug Monitoring Program.

**Opioid Use Disorder** – Tapering is recommended if the patient meets criteria for a diagnosis of Opioid Use Disorder (OUD) (see Addiction and Dependence Happen). Also consider tapering opioids in patients at higher risk for developing an OUD, such patients on high doses, those with a personal or family history of addiction, a history of childhood trauma, co-occurring mental illness, or other psycho-social stressors that predict a poor response to opioids. DSM-5 OUD Criteria

**Opioid Overdose** – If your patient has had an overdose or other serious medical event (e.g., hospitalization, injury) due to opioids, immediate action is needed. It is likely that tapering will be necessary in conjunction with treatment of other conditions.