Nebraska Medicaid

DUR Matters

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Tapering Opioids and Withdrawal Management

In response to the national opioid crisis, Nebraska Medicaid will be implementing total daily dose limits of opioids. These limits are intended to enhance the safe use of opioids. Commonly prescribed opioids include buprenorphine, codeine, fentanyl, hydrocodone, hydromorphone, methadone, morphine, oxycodone, oxymorphone, tapentadol, and tramadol.

An initial daily limit of 300 Morphine Milligram Equivalents (MME) will be put in place in December 2018 for Nebraska Medicaid patients with pain, unless being treated for active cancer, enrolled in hospice, or receiving end of life care. Claims for total daily doses of more than 300 MME will reject beginning December 6, 2018 unless an approved prior authorization is on file.

Nebraska Medicaid plans to lower the maximum MME to:

- 300 MME in December 2018
- 250 MME in June 2019
- 200 MME in December 2019
- 150 MME in June 2020
- 120 MME in December 2020
- 90 MME in June 2021

According to the *Nebraska Pain Management Guidance Document*, patients should be weaned from chronic use of opioids (30 days or more) by tapering their dose, rather than abrupt discontinuation.[1] Patients who have taken opioids regularly are likely to be physically dependent, and possibly psychologically addicted. It is important to identify patients who have developed physical dependence but are using opioids as prescribed, and those who are deviating from their prescribed opioid regimen. Patients who have exhibited drug-seeking behaviors or taken more medication than prescribed may need to be treated for Opioid Use Disorder.[2]

Empowering patients in the tapering process is the key to success and patients should be involved in the planning from the start. In patients who have been taking opioids for a long period of time, psychosocial support is key to a successful taper. Patients may be fearful about the worsening of pain or experiencing the symptoms of opioid withdrawal.[1] The symptoms of opioid withdrawal include feeling sick or cold, stomach cramps, watery eyes, muscular spasms or twitching, aches, pounding heart, yawning, muscle tension, and problems sleeping.[3] Some patients may experience a transient, short-term increase in pain while tapering off of opioids. A slower taper will lessen this discomfort. In many cases, the patient will find relief from the side effects of the opioid, and improvement in function and quality of life.[1]

Plan to provide the patient with supportive treatment but be sure to set expectations that the opioid dose will not be increased or replaced with another opioid or a benzodiazepine. Where appropriate, a patient may be treated with antidepressants to decrease irritability. Trazodone may be used for sleep disturbances or hydroxyzine may be helpful for insomnia and reduction of anxiety. Anti-epileptics may be used for patients experiencing neuropathic pain. Clonidine may be helpful for autonomic withdrawal symptoms such as rhinorrhea, diarrhea, sweating, tachycardia, or hypertension. Consider using non-steroidal

anti-inflammatories such as ibuprofen for myalgia. Medications used for opioid-induced constipation may need to be reduced or discontinued. Loperamide may be helpful for patients experiencing diarrhea. Cognitive behavioral therapy and healthful activities will support patients as they go through the tapering process. Early symptoms of opioid withdrawal such as anxiety or restlessness, rapid breathing, runny nose, tearing eyes, sweating and insomnia usually resolve in five to ten days following a dose reduction.[4] The final stages of tapering are the most difficult for patients. It is important to remember that opioids have psychoactive effects. Slowing the taper at this stage and engaging other supports may be necessary to successfully finish the taper.[1] Nebraska Medicaid does provide coverage for Lucemyra (lofexidine hydrochloride) which is indicated for the mitigation of withdrawal symptoms to facilitate abrupt discontinuation of opioids in adults for up to 14 days.[5]

The patient should be involved in setting a taper completion date. Once the completion date is set, then the total daily MME should be calculated. In patients taking only short-acting opioids, the total daily MME can be tapered by 5–15% per week, which is more aggressive than patients on long-acting opioids. In patients taking long-acting opioids, the total daily MME should be decreased by 5–10% of initial dose per week. The progress of the taper should be monitored not only by patient response, but with urinary drug screening, utilization of pill counts, and verification of the prescription drug monitoring program.[1]

In patients with fibromyalgia and other central pain states, opiods are ineffective because the receptors which respond to opioids are not impacted by this type of pain. Therefore, opioid use in these patients is ineffective. There is evidence that opioid dose escalation in patients with central pain can become associated with Opioid Induced Hyperalgesia.[1]

Depression and Drop Out Rate

It is important to screen patients for depression, as it has been shown to be a risk factor in patients who stop the tapering process, as well as those who relapse to opioid use. Patients exhibiting signs of depression should be treated for depression and followed closely.[6]

Due to the growing concern about the use of opioids in the treatment of chronic, non-cancer pain, Nebraska Medicaid is implementing total daily dose limits incrementally to reach a goal of no more than 90 MME per day. Because no evidence exists to support long-term use of opioids, patients should be tapered down or off of opioids. With support, many patients may find improved quality of life and better health outcomes once opioids are discontinued.

References

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