## Pediatric Acute Care Opioid Weaning Guidelines

***The below dosing recommendations should be used as a general guide.***

<table>
<thead>
<tr>
<th>TIME EXPOSED</th>
<th>&lt; 5 DAYS</th>
<th>5-9 DAYS</th>
<th>≥ 10 DAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TAPER TEMPO</strong></td>
<td>No Taper</td>
<td>Rapid Taper</td>
<td>Slow Taper</td>
</tr>
</tbody>
</table>

- **Rapid Taper**: a decrease of 20-50% of the initial OME dose every 2-3 days
- **Slow Taper**: a decrease of 10% of the initial OME dose every 5-7 days

- Consider discontinuing the medication when it has reached 10-25% of the initial OME dose

**OME = Oral Morphine Equivalents**

### WAT SCORE

<table>
<thead>
<tr>
<th>WAT score below threshold for 2 consecutive time points OR &lt; 3 PRN's per 8h period</th>
<th>WAT score at or above threshold for 2 consecutive time points OR number of PRN's ≥ 3 per 8h period</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Slow</td>
</tr>
</tbody>
</table>

- **No Taper**: Continue current regimen.
- **Slow Taper**: May consider increased dose reduction and/or faster wean.
- **Consider rescue dosing PRN**: **See below for rescue dose recommendations.**
- **Consider delay in weaning schedule or stepping back to previous effective dose**

### General Weaning Information

- The rate at which patients are weaned off opioids is dependent on many factors and may include:
  - Reason for initiation of medications: sedation for intubation (CALM protocol), acute pain, acute on chronic pain
  - How long the patient has been on the medications
  - Presence of ongoing symptoms
  - Psychosocial factors
  - The risk of withdrawal increases with the duration and dosage of the opioid.
  - In general when weaning, decrease dose of opioid (ie 0.4mg to 0.3mg) before increasing dosing interval (ie q6h to q8h).
  - Generally, the longer the patient has been on medications, the slower the taper.
  - Symptoms associated with withdrawal can be caused by concurrent illnesses, and should be considered when weaning.

### Transition to Intermittent Dosing

- Whenever clinically appropriate, consider transition from PCA infusion to intermittent dosing (IV/PO).
- Longer acting agents (ie methadone) may be indicated for patients with long exposure.

### Rescue Dosing

- Prescribe the same dosage (or a lower dosage) as the previously prescribed PRN medication.
- If no previous PRN dose available, consider a rescue dose of 10% of the current OME

### ORAL MORPHINE EQUIVALENTS (OME)

- OMEs are calculated to find a patient’s daily opioid usage. Weaning parameters and dose reductions (as outlined above) are based off of the OME.
- Patients on > 60mg/day OME for at least 2 weeks are considered opioid tolerant and providers should consider exploring other pain intervention modalities.

**Oral Morphine Equivalents Calculations**

**STEP 1** Calculate Daily Use of Each and Every Opioid (including the as-needed doses in most cases).

**Example:** Patient is taking Oxycodone extended release PO 60mg/day and Hydromorphone PO 16mg/day

**STEP 2** Calculate equivalence by using the table located within the UCSF Opioid Equivalence Table document.

**Example:** Oxycodone PO extended release 60mg/day = Morphine PO 90mg/day
Hydromorphone PO 16mg/day = Morphine PO 64mg/day

**Table should only be utilized for opioid equivalence, NOT for opioid conversion.**

<table>
<thead>
<tr>
<th>Morphine</th>
<th>Oxycodone/Oxycodine</th>
<th>Hydromorphone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine 1mg IV = Morphine 3mg PO</td>
<td>Oxycodone/Oxycodine 2mg PO = Morphine 3mg PO</td>
<td>Hydromorphone 1mg IV = Hydromorphone 5mg PO</td>
</tr>
<tr>
<td>Morphine 1mg IV = Morphine 20 mg PO</td>
<td>Oxycodone/Oxycodine 1mg IV = Morphine 20 mg PO</td>
<td>Hydromorphone 1mg IV = Hydromorphone 4mg PO</td>
</tr>
</tbody>
</table>

**STEP 3** Add the total oral morphine equivalents.

**Example:** Morphine 90mg/day + Morphine 64mg/day >> 154mg/day Oral Morphine Equivalents (OME)

*****UCSF Opioid Equivalence Table found under Carelinks >> Medical Center Manuals >> Pharmacy >> Under Search (Opioid Equivalence Table). Please reference table for more thorough details.***

- No validated conversion factors exist for agents other than opioids.
- For patients that do not tolerate this conversion, the doses of intermittent medications may be adjusted based on withdrawal symptoms in order to continue transitioning.
- Adjuvant Medications should be considered for symptom management (ie: clonidine, anti emetics, anti agitation).

Consider IP3 consult for ANY opioid/benzodiazepine weaning or opioid conversion issues and questions (including initiation of methadone, or other rescue dose questions).