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Pediatric Acute Care Opioid Weaning Guidelines

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

TIME EXPOSED	< 5 DAYS	5-9 DAYS	≥ 10 DAYS
TAPER TEMPO **OME = Oral Morphine Equivalents	No Taper	FUd]X Taper • a decrease of 20-50% of the initial OME dose every 2-3 days Consider discontinuing the medication when it has reached 10-25% of the initial OME dose	Slow Taper • a decrease of 10% of the initial OME dose every 5-7 days
WAT SCORE	WAT scoring q shift, identify WAT Score Threshold (generally ≥ 4 indicates withdrawal, but may be adjusted upward to account for chronic symptoms)		
WAT SCORE and PRN NEED: TAPER TEMPO ADJUSTMENTS — WAT score below threshold for 2 consecutive time points OR < 3 PRN's per 8h period	NA	• Continue current regimen. • May consider increased dose reduction and/or faster wean	
WAT SCORE and PRN NEED: TAPER TEMPO ADJUSTMENTS — WAT score at or above threshold for 2 consecutive time points OR number of PRN's ≥ 3 per 8 h period	NA	• Consider rescue dosing PRN **See below for rescue dose recommedndations. • 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.

*** Some of the more commonly used opiates are listed below. See table for complete list.

Morphine
Morphine 1mg IV = Morphine 3mg PO
Oxycodone/Oxycontin
Oxycodone 2mg PO = Morphine 3mg PO

Hydromorphone
Hydromorphone 1mg IV = Hydromorphone 5mg PO
Hydromorphone 1mg IV = Morphine 20 mg PO
Hydromorphone 1mg PO = Morphine 4mg PO

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).