



# Tapering Opioid Pain Medication

2020 Update

The Functional Restoration/Chronic Pain Development Team developed these guidelines to assist providers with safe opioid tapering and to improve the quality of life of patients living with chronic pain. These guidelines were developed using the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain,<sup>UTA</sup> Washington’s Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain,<sup>JAV</sup> the CDC 2016 guideline for prescribing opioids for chronic pain,<sup>DOW</sup> and other peer-reviewed clinical guidelines.<sup>CDC, FSMB</sup>

## ► Why Focus ON TAPERING OPIOID MEDICATION?

Opioids may play a role for some patients in managing chronic pain. Tapering (lowering the dose or discontinuing) opioid medication may help minimize these inherent risks associated with opioid use:

- **Serious consequences** of long-term opioid use, which include respiratory depression and death, accidents, and increased disability. The CDC describes prescription pain medication overdose as an epidemic.<sup>DOW</sup>
- **Adverse effects** associated with opioid use, which include functional limitations, respiratory depression, disability, decreased cognitive function, constipation, and higher levels of overall pain.
- **Hyperalgesia**, which can result after opioid use. The long-term effectiveness of opioid pain medication is not clear,<sup>KRE</sup> and many patients report less pain when they discontinue opioids.
- **Opioid use disorder, unhealthy use (including dangerous aberrant behaviors), and diversion**, which represent significant and ongoing risks that increase in patients taking opioids for longer durations.

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## KEY POINTS IN THIS CPM

- Tapering is usually a slow process that requires preparation, planning, monitoring, and follow up. No single approach to tapering is appropriate for all patients.
- Although potentially unpleasant, many withdrawal symptoms associated with tapering can be reduced with symptomatic treatments.
- Consider referral to an addiction or pain specialist if:
  - Aberrant behavior is detected or suspected.
  - Dose equals or exceeds 90 MME/day.
  - Pain is uncontrolled.



## MEASURES & GOALS

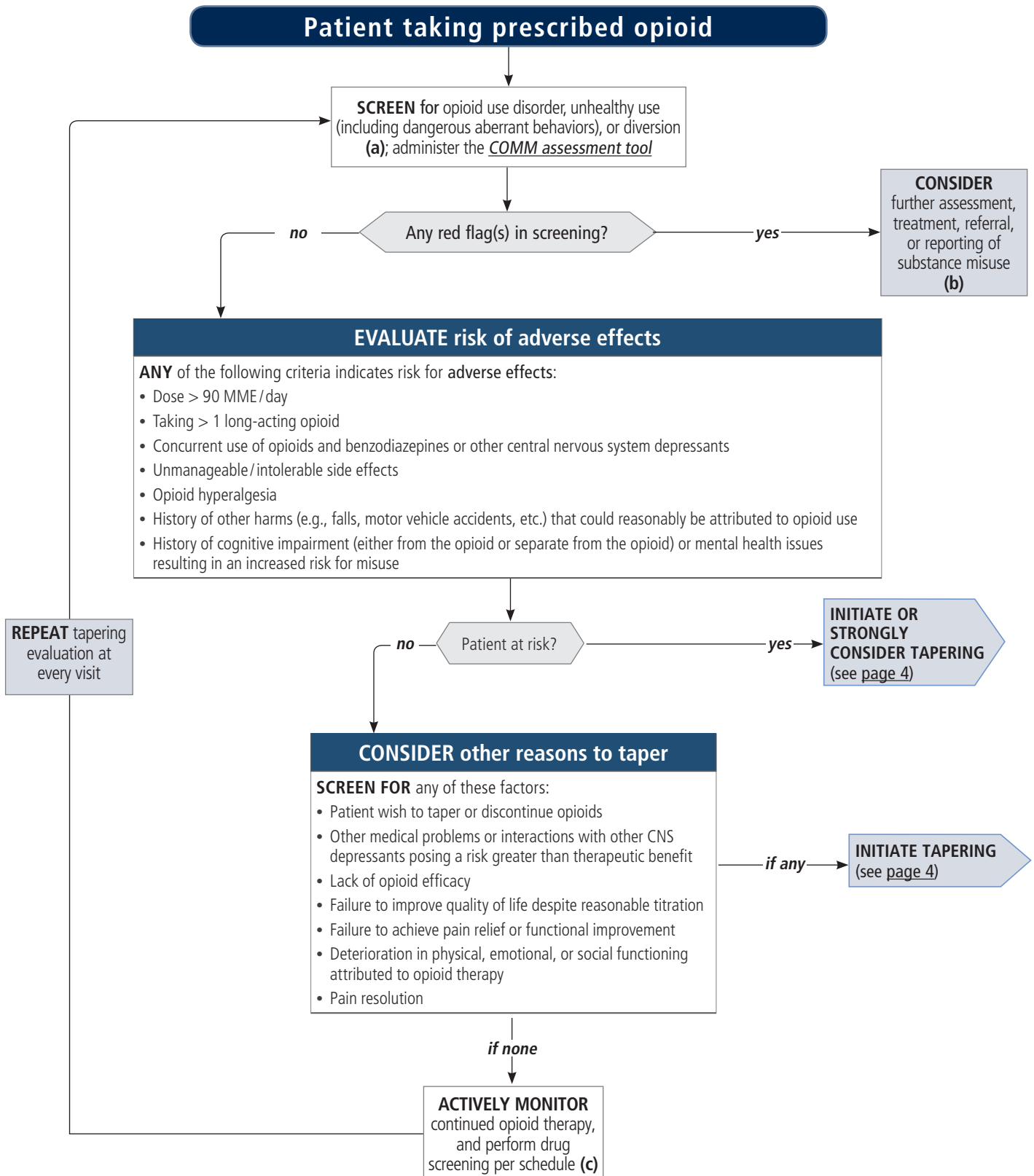
Intermountain goal to reduce adverse outcomes related to opioid use will focus on reducing the number of patients who are:

- Admitted for opioid overdose
- Taking opioids and benzodiazepines concurrently
- Taking a morphine equivalent dose  $\geq 90$  MME/day



Indicates an Intermountain measure

## ▶ ALGORITHM 1: TAPERING EVALUATION



## ALGORITHM NOTES

**(a) Screening for opioid use disorder, unhealthy use (including dangerous aberrant behavior), and diversion**

Evaluate whether patient exhibits **ANY** red flags:

- Aberrant results on a urine drug test or refusal to participate in screening (after excluding that the refusal is due to personal cost burden)
  - Note:** Positive screening results should be confirmed with testing that uses gas or liquid chromatography/mass spectrometry (GC/MS) to ensure accuracy. All results should be interpreted in the context of the clinical setting and discussed with patients to improve patient care.
- Inappropriate use (includes injecting/snorting oral or topical opioids)
- Selling prescription drugs, forging prescriptions, stealing or borrowing drugs
- Unsanctioned use of opioids
- Unsanctioned dose escalation (medication counts are helpful in this determination)
- Concurrent use of illicit drugs
- Presenting to the ED repeatedly for pain management
- Aggressively demanding opioid medication(s)
- Motor vehicle accident due to drug or alcohol impairment or DUI charge
- Hospital admission for overdose or drug abuse
- Concerning report in the *State of Utah Controlled Substance Database* (including obtaining obtaining opioid medication from multiple providers)
- Reports of frequently losing prescriptions or having prescriptions stolen
- Persistent nonadherence to the *Opioid MMA* or *Pain Management Plan*
- A score > 9 on the *Current Opioid Misuse Measure (COMM) assessment tool*, which indicates higher risk, suggesting a need to further evaluate the patient. A score < 9 suggests a lower risk, but does not rule out a need for concern.

**(b) Considerations for cases of opioid use disorder, unhealthy use (including dangerous aberrant behavior), or diversion**

Discuss your concerns with the patient. For opioid use disorder or dangerous aberrant behaviors, **tapering is likely not the best approach**. In the case of diversion, contact your facility's risk management or legal department. Depending on the situation, consider the following:

- Medication-assisted treatment, such as buprenorphine
- Consultation with an addiction specialist
- Admission for detoxification/discontinuation rather than tapering
- Performing or requesting a mental health assessment
- Alternatives to the shared decision-making approach, which may be inappropriate. If the patient resists recommendations, respectfully "agree to disagree" with the patient's perspective, and encourage compliance with recommendations.

See Intermountain's *Substance Use Disorder CPM*

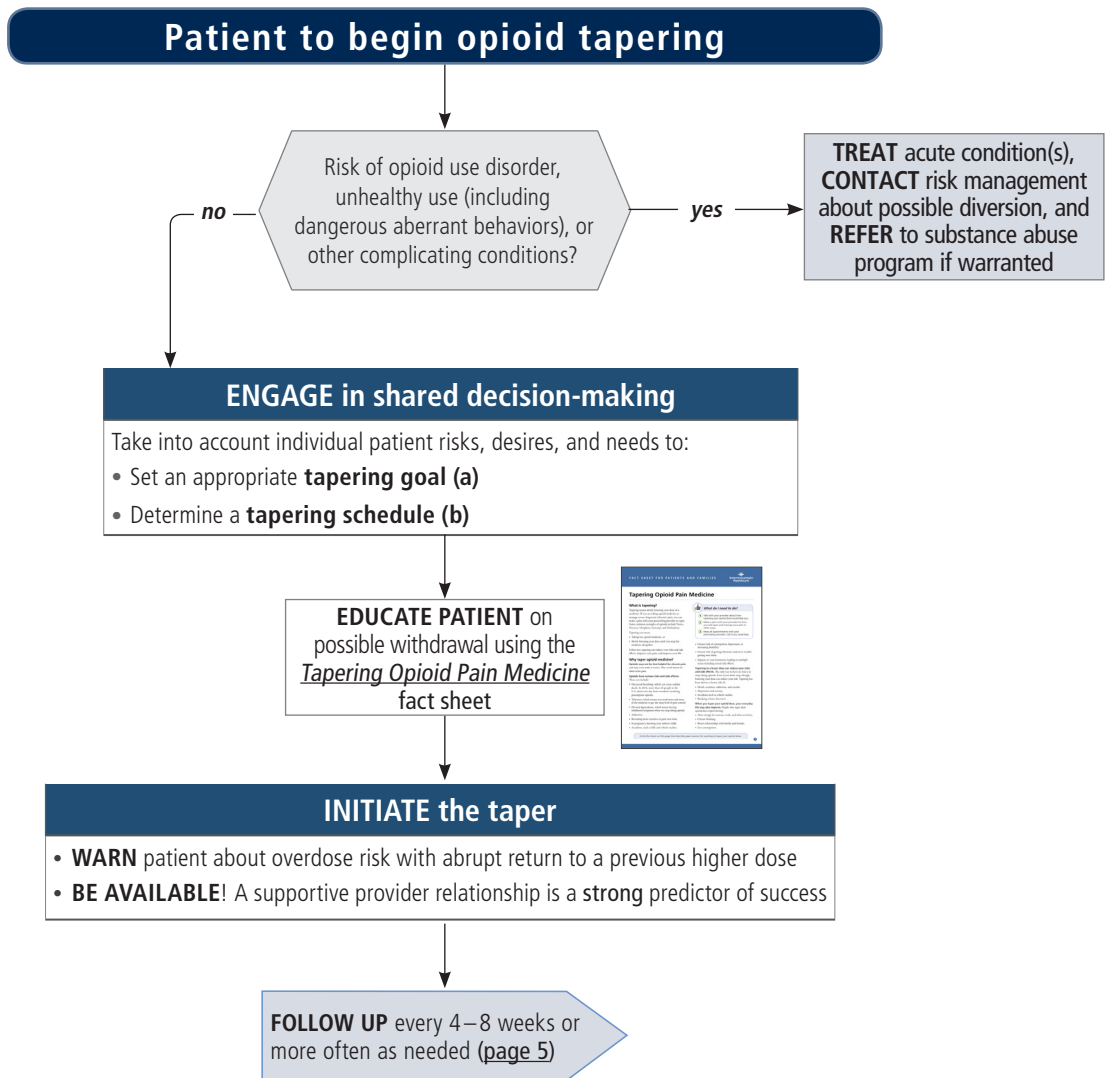
**(c) Opioid monitoring action plan**

If continuing opioids:

- **UPDATE** pain diagnosis on patient problem list.
- **REVIEW** the *Opioid MMA* annually, and update as needed.
- **REVIEW** the *Opioid Medication for Chronic Pain* fact sheet with patient.
- **DISCUSS** alternative pain treatments.
- **MONITOR** compliance with the pain management plan.
- **REASSESS** compliance **at every visit** as follows:
  - Check the **Utah Controlled Substance Database**.
  - Assess for overuse (e.g., medication counts, early refill requests, etc.). If medication counts are used, consider a pill identifier to ensure correct medication. If questions, call the pharmacy.
  - Perform unannounced urine drug screening (depending on patient's risk level and history) as follows:
    - Every month for high risk
    - Every 3–6 months for medium risk
    - Every year for low risk
- **REASSESS** risk of opioid use disorder, unhealthy use (including dangerous aberrant behaviors), or diversion, as well as **appropriateness of tapering, at every visit**.

**Note:** The risk of developing opioid use disorder increases with the duration of opioid use.

## ▶ ALGORITHM 2: TAPERING PLANNING AND INITIATION



### ALGORITHM NOTES

#### (a) Tapering goal

Always consider tapering from a higher dose to a lower dose (even if the current dose is substantially lower than 90 MME/day). The specific goal of the taper varies by patient, but a good starting goal is to achieve a daily dose of <90 MME/day. If possible, it is preferable to achieve a dose of <50 MME/day or in some cases, completely wean off opioid medications (see MME equivalents chart on page 9). Encourage patients to communicate their preferences about when to start, how quickly to taper, and when to schedule follow-up appointments.

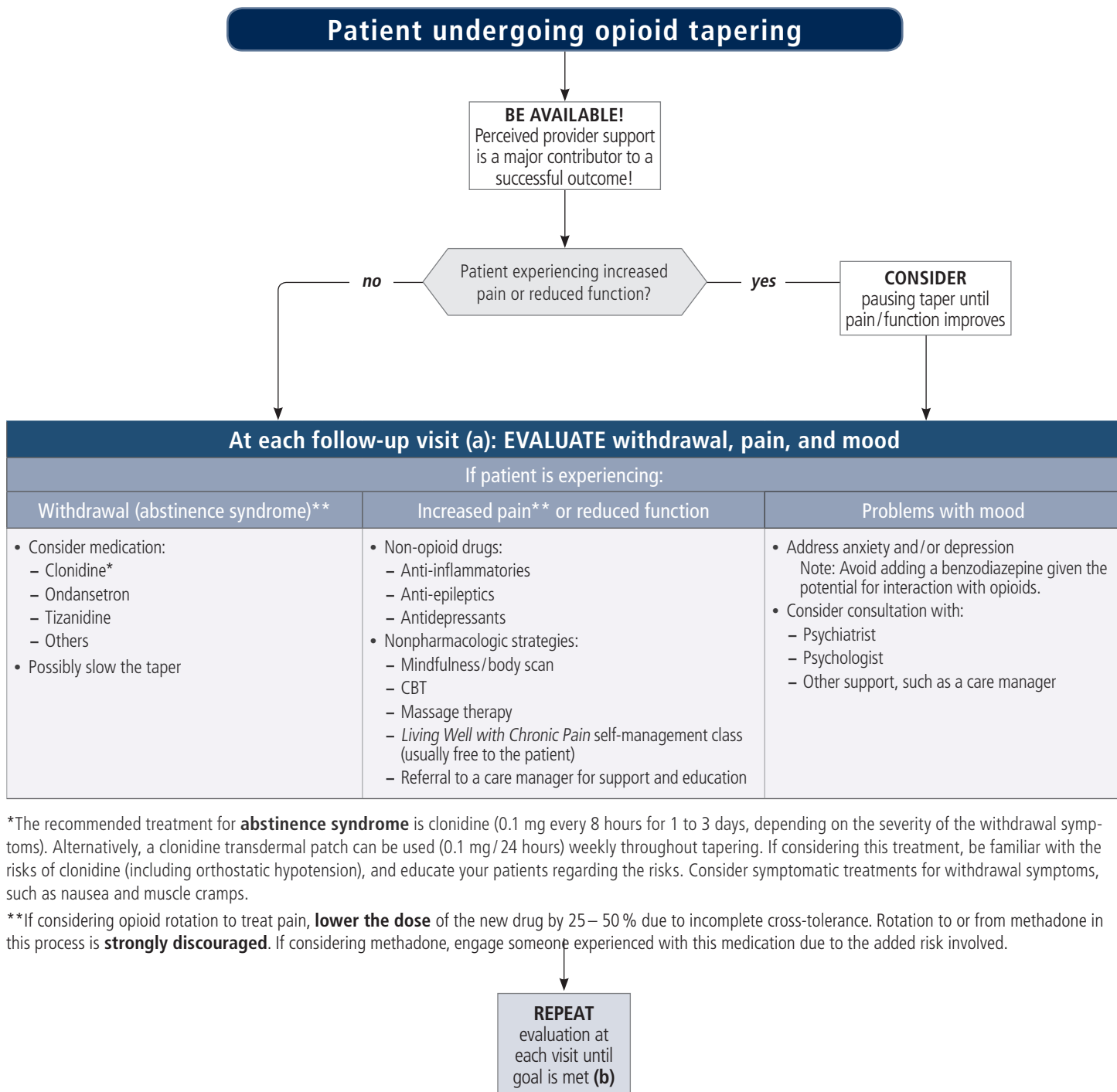
#### (b) Tapering schedule

A reasonable starting point for many patients is to decrease the original dose by 10% per week. Based on individual patient factors, tapering may be slowed or accelerated with respect to the following guidelines: <sup>DVA, DOW</sup>

- **Slowest taper** (over years). Reduce by 2–10% every 4–8 weeks with pauses in the taper as needed.
- **Slower taper** (over months or years). Reduce by 5–20% every 4 weeks with pauses in taper as needed.
- **Faster taper** (over weeks). Reduce by 10–20% every week.
- **Rapid taper** (over days). Reduce by 20–50% of first dose if needed; then, reduce by 10–20% every day.

See pages 6–7 for guidance on shared decision making and tapering schedules.

### ▶ ALGORITHM 3: TAPERING FOLLOW UP



\*The recommended treatment for **abstinence syndrome** is clonidine (0.1 mg every 8 hours for 1 to 3 days, depending on the severity of the withdrawal symptoms). Alternatively, a clonidine transdermal patch can be used (0.1 mg/24 hours) weekly throughout tapering. If considering this treatment, be familiar with the risks of clonidine (including orthostatic hypotension), and educate your patients regarding the risks. Consider symptomatic treatments for withdrawal symptoms, such as nausea and muscle cramps.

\*\*If considering opioid rotation to treat pain, **lower the dose** of the new drug by 25–50% due to incomplete cross-tolerance. Rotation to or from methadone in this process is **strongly discouraged**. If considering methadone, engage someone experienced with this medication due to the added risk involved.

#### ALGORITHM NOTES

##### (a) Follow up frequency

In general, follow up by phone or in office every 4–8 weeks or more often as needed. Consider frequent touchpoints during the weaning process with email, texts, and phone calls. Utilize support personnel, such as care managers or health advocates, in the weaning process.

##### (b) Tapering success

Patients who cannot complete tapering may continue on a reduced dose if compliant with treatment plan. Keep in mind that tapers may need to be slowed as patients reach lower doses and that tapers may be considered successful as long as the patient is making progress.<sup>DOW</sup> Once the smallest possible dose is reached, the interval between doses may be extended.

## ✓ KEY RECOMMENDATION

### Explain the risks of opioids.

Higher doses of opioids are associated with higher rates of **respiratory depression and death**.

Additional risks include:

- **Opioid use disorder**
- **Depression and suicide**
- **Fracture**
- **Car accidents**
- **Poorer function**
- **Higher levels of overall pain**

Explain that tapering may be necessary because **long-term use could do more harm** than good.

Remind the patient that people taking opioids are **at risk for addiction**, even if they have not had problems with drugs or alcohol in the past.

Focus on the patient's particular situation. If possible, **share specific examples** of why tapering is necessary.

## THE TAPERING TEAM APPROACH

Opioid tapering is usually best accomplished with a multidisciplinary team approach, involving:

- **Care managers**, who provide support, education and information.
- **Mental health providers, including MHI**, who offer counseling and education. Many patients who take opioids chronically have depression or anxiety as underlying health problems adding to their chronic pain.
- **Physical therapists**, who help reduce chronic pain symptoms through specific individual exercise plans.
- **Clinical pharmacists**, who help individualize a tapering plan and are also a valuable resource for education and information about opioids.

## ► EDUCATION AND GOAL SETTING

Most patients perceive tapering as difficult and anxiety-provoking. Often, they perceive a low risk of overdose and are more concerned about the more immediate risk of increased pain. A **shared decision making approach**, by which the patient's preferences and values are incorporated into the clinical decision-making process, is helpful in overcoming these barriers.

### The shared decision making (SDM) approach

Shared decision making (SDM) is a dynamic interplay between patient and provider about matching the best evidence and clinical experience with patient preferences and values. It implies a conversation between two experts, not a one-size-fits-all approach. SDM is highly effective tool in the tapering process because of the unique challenges and somewhat unpredictable nature of the opioid tapering process.

Part of the SDM exchange involves educational information given by the provider to the patient. Throughout this phase of the discussion, **focus on the particular patient** by tailoring information so that it is meaningful and relevant to the individual. The success of the SDM approach depends on the care provider's ability to elicit patient values and preferences.

Patients who have successfully tapered describe social support and a trusted healthcare professional as important to the process of tapering.

**Important factors for success** include:

- Accurate determination of patient's readiness and reason for wanting to taper
- A trusting relationship between patient and provider
- Maximal support, including psychological
- Engaged family members or loved ones
- Specific yet understandable educational resources

**During the SDM conversation, address these five specific points:**

1. **Explain the risks.** Communicate the risks listed in the sidebar at left, especially the higher rates of respiratory depression and death.
2. **Emphasize benefits.** Point out the possible benefits of tapering, such as improved day-to-day functioning, greater energy, and clearer thinking. Ask the patients about their personal goals, and discuss how tapering opioids could help achieve them. Identify and emphasize outcomes that patients care about.
3. **Outline alternatives.** Discuss non-opioid pain treatments, including alternative therapies that appeal to the patient. Explain that although you are recommending tapering, you are committed to caring for the patient and treating their pain. Reassure the patient that the tapering protocol will be tailored to their needs and can be modified if necessary.
4. **Set reasonable expectations.** Tell patients that pain might increase temporarily when the dose is reduced. Inform the patient that while discontinuing opioid pain medications might be uncomfortable, it is generally not dangerous. It is extremely important to warn the patient about the **potential for overdose** if they should return abruptly to a previous higher dose. Discuss **common withdrawal symptoms** and possible treatments. Encourage patients to call if withdrawal symptoms are bothersome.
5. **Provide support.** Acknowledge the patient's emotional distress, if appropriate. Discuss coping strategies, and offer referral to a behavioral health specialist. Assure the patient that you will try to be available to address concerns as they arise and will do your best to manage any withdrawal symptoms. If possible, identify potential **peer mentors** to support opioid tapering.

## ✓ KEY RECOMMENDATION

There are no high-quality studies comparing effectiveness of different tapering protocols. If the patient agrees to taper opioids to lower dosages, collaborate with the patient on a tapering plan.

For many patients, a reasonable starting point is to **decrease the original dose by 10% per week**.

Tapers may need to be slowed as patients reach lower doses and may be considered successful as long as the **patient is making progress**.<sup>DOW</sup>

Once the smallest possible dose is reached, the **interval between doses** may be extended.

## ▶ TAPERING SCHEDULES

### General points

The following considerations can be helpful when deciding whether a slower or faster taper is appropriate for a given patient.

### Slower tapering

Patients who have taken opioids for many years may require very slow tapers and/or pauses in the taper to allow for adaptation to lower doses. In general, slower tapering is suggested for patients who:

- Are dependent on opioids or anxious about tapering
- Have been on high doses and/or taking opioids for a longer time
- Have unstable cardiac disease
- Do not exhibit aberrant behavior
- Do not have comorbid conditions that necessitate a more rapid taper

### Faster tapering

Rapid tapering may be considered for patients when:

- They have been prescribed lower doses of opioids and/or taking opioids for a shorter time (i.e., < 1 month)
- Other situations dictate that the risks of continuing the opioid outweigh the risks of a rapid taper.
- They have comorbid medical conditions in which the risk of continuing opioids is considered to be high.
- They request a more rapid taper.

In situations of potential diversion or illegal activity, continuing to prescribe opioid medication is usually not appropriate. Contact risk management before considering to continue to prescribe opioid medications.

A rapid taper over 2–3 weeks has been recommended in the case of a severe adverse event such as an overdose.<sup>DOW</sup> Generally, rapid taper patients can be tapered more rapidly during the first 50% of dose reduction. The final 25% may be more challenging and require slower tapering.<sup>DVA</sup> Ultrarapid detoxification under anesthesia is associated with substantial risks (including death) and should not be used.<sup>DOW</sup>

### Specific tapering schedules

**See the box at left** for key recommendations about tapering schedules. A general guideline is included as note **(b)** in the algorithm on [page 4](#).

If patients take a long-acting and a short-acting opioid, make an individualized decision on which to taper first, keeping in mind that overdose risk is greater with long-acting preparations.<sup>DVA</sup> Decision criteria should include the patient's medical history, any mental health diagnoses, and personal preference(s).

## ✓ KEY RECOMMENDATION

### At follow-up visits, consider that:

- Most patients tolerate a **10 % dose reduction** per week. Faster or slower tapering may be indicated.
- Withdrawal symptoms may be treated with medications, such as oral or transdermal **clonidine**.
- Patients should be monitored regularly and referred to specialists as needed.
- Other pharmacological and non-pharmacological treatments, such as behavioral health, massage therapy, mindfulness, body scan, etc., should be considered when weaning.

## OVERDOSE DANGER

It takes as little as a week for opioid tolerance to decrease significantly. Warn all patients that there is **increased risk for overdose** with an abrupt return to a previously tolerated, higher dose.

## ► FOLLOW UP

In general, follow up during tapering by phone or in office **every 4–8 weeks** or more often as needed. Follow up more frequently for patients undergoing fast tapers and for those with complicating condition(s). Consider frequent touchpoints during the weaning process, using email, texts, and phone calls. Utilize support personnel, such as care managers or health advocates, in the weaning process. Some guidelines are as follows:

- **Be available.** Opioid tapering is a stressful experience, and for many patients, involves fear. Knowing that they have your support as a provider can make all the difference to their success.
- **Prescribe non-opioid adjunctive medications** as needed for pain. Many studies show these treatments to be equally as effective as opioids in treating chronic pain:
  - Anti-inflammatories, if appropriate
  - Antidepressants for irritability or sleep problems
  - Antiepileptics for neuropathic pain
- **Evaluate mental health status.** Refer patient to a counselor or other support program if behavioral problems develop during tapering.

**Consider temporarily holding the taper** if pain or functionality worsens during the taper. Implement alternative strategies for pain management. Educate the patient on the following points:

- There can be an **increase in pain** with tapering that may lead to a decrease in function (usually temporary).
- With time, patients frequently **acclimate to the lower dose**. Increased pain while tapering often diminishes and function returns. Interdisciplinary support from physical therapy and/or psychology can help in restoring and maintaining function.
- Before giving up on the taper, **consider other strategies** for pain, including symptomatic pharmacological therapies as well as non-pharmacological therapies, including mindfulness and body scan, cognitive behavioral therapy, and massage therapy.

**Consider stopping the taper** if pain worsens **and** functionality declines in conjunction with the taper. Make this decision on a case-by-case basis taking into account risks, side effects, aberrant behaviors, and benefits of opioid therapy.



## ORAL DOSE MME EQUIVALENTS

The following are equivalent to 90 mg/day of morphine (i.e., 90 MME, milligram morphine equivalent). Note that equianalgesic ratios are considered estimates and depend on age (use caution with elderly patients) and coexisting conditions, especially liver, renal, or pulmonary disease.

Use the following table to determine if a patient is receiving more than the recommended daily dosage of opioids.

Medication	90 MME
Codeine	600 mg/day
Fentanyl (transdermal)*	< 37.5 mcg/hr
Hydrocodone	90 mg/day
Hydromorphone	23 mg/day
Oxycodone	60 mg/day
Oxymorphone	30 mg/day

\*Variability in **transdermal fentanyl** absorption requires a heightened level of vigilance. When converting from a fentanyl patch, allow 12–24 hours after removal for absorption of residual drug before starting a new opioid. Monitor closely for several days after rotation.

## ► MEDICATIONS AND RELATED CONSIDERATIONS

### Methadone

Patients already on stable doses of methadone can be tapered using the guidelines in this CPM. However, methadone should be prescribed only by those who are familiar with its risks and are prepared to conduct necessary monitoring. It is not recommended that patients be rotated to methadone from another opioid as part of the process of tapering process. This is because there are many variables in use and risks to be weighed.

### Buprenorphine and combination buprenorphine / naloxone

Buprenorphine is a partial  $\mu$ -opioid receptor agonist and  $\kappa$ -receptor antagonist. Naloxone is an opioid antagonist and is minimally absorbed upon ingestion but is readily active in intravenous form (its purpose is to deter intravenous and intramuscular use of buprenorphine).

Some products combine both buprenorphine and naloxone (i.e., Suboxone, Zubsolv, and Bunavail). These products and the generic forms of Subutex (buprenorphine alone) are used in patients with opioid dependence. The combination products are used on label for maintenance therapy. The generic forms of Subutex are technically indicated for induction only, although some use it off label for maintenance therapy. Special licensure is required to prescribe it on label for opioid dependence.

The above products are also often used off label for chronic pain without special licensure. If opioids are used for chronic pain (despite weak evidence that opioids are helpful in chronic pain), the fact that buprenorphine is a partial  $\mu$ -opioid receptor agonist may be beneficial in some cases. This is because the partial  $\mu$ -receptor agonist characteristic of buprenorphine results in a “ceiling effect,” potentially decreasing the likelihood of opioid overdose relative to other opioid agonists. This could be particularly useful in treating chronic pain complicated by comorbid opioid use disorder.

The Butrans patch and the Belbuca buccal tablet are buprenorphine products that do not contain naloxone and are actually indicated for pain rather than opioid dependence. These can be prescribed without special licensure.

#### Note that buprenorphine:

- Does not eliminate the risk of opioid overdose (especially when combined with other central nervous system depressants, such as benzodiazepines).
- May interfere with the ability to obtain adequate analgesia in patients who require surgery and for patients with new-onset, severe acute pain superimposed on their chronic pain. This is because buprenorphine has a high binding affinity at the  $\mu$ -opioid receptor, dissociates slowly from the receptor, acts as a partial agonist, and has a relatively long half-life.

### Opioid rotation

If converting to a new opioid (rotation), remember that conversion tables may overestimate the morphine equivalent potency. Because of this and because of incomplete cross-tolerance, it is generally recommended to **lower the equianalgesic dose by 25–50 %**. **Close monitoring following rotation is crucial**, especially for the first several days after the change. However, rotation involving methadone is much more complex, and these recommendations would not apply. Consult a provider with appropriate expertise if considering rotation to or from methadone.

## ✓ KEY RECOMMENDATION

### Follow these guidelines on benzodiazepine tapering:

- Avoid concurrent use of benzodiazepines and opioids due to the risk of respiratory depression and death.
- Seek out **additional information** about patient's medical and psychological state.
- **Taper benzodiazepines gradually.** A commonly used schedule is to reduce benzodiazepine dose by 25 % every 1–2 weeks.
- Consider concurrent CBT to increase tapering success rate.
- Offer other pharmacological therapies (e.g., antidepressants, other non-benzodiazepine medications) when patient requires treatment for anxiety.

Note that there is significant patient **variability in transdermal drug delivery**. Even when considering a specific patient, variables can affect the delivery of fentanyl. For example, an elevated body temperature increases fentanyl absorption significantly. A heightened level of vigilance / monitoring when rotating to / from transdermal fentanyl products is required, though caution / monitoring is particularly important at times of opioid rotation involving any opioid.

## Opoids and benzodiazepines

Avoid combining opioids and benzodiazepines due to the risk of respiratory depression and death in patients who take these concurrently. However, the risks of benzodiazepine withdrawal are generally greater relative to opioid withdrawal, and tapering opioids can cause increased anxiety. The safe and more practical choice is often to taper opioids first.<sup>DOW</sup> However, the choice depends on the relative importance of anxiety vs. pain to the patient's well-being.

In addition to discussions with the patient, obtain additional information on the patient's medical and psychological situation from other providers, attending physicians, etc. This holistic approach can help determine which medication should be tapered first. Psychological support may be helpful to this end and is strongly encouraged.

Follow the principles below and in the sidebar at left if tapering benzodiazepines:<sup>DOW</sup>

- **Taper benzodiazepines gradually.** Abrupt withdrawal can be associated with rebound anxiety, hallucinations, seizures, delirium tremens, and, in rare cases, death.
- **A schedule that is considered safe** and moderately successful and that is commonly used is to reduce benzodiazepine dose by 25 % every 1–2 weeks.
- **Cognitive behavioral therapy (CBT)** increases tapering success rates. Consider for patients struggling with a benzodiazepine taper.
- **Offer antidepressants** and / or other non-benzodiazepine medications approved for the treatment of anxiety when appropriate.

## ► SPECIAL POPULATIONS

Certain populations of chronic pain patients require extra care when managing tapering, including:

- **Pregnant patients.** Babies born to mothers who are chronic opioid users often develop neonatal abstinence syndrome. However, tapering should be approached with caution as acute withdrawal symptoms can trigger premature labor and spontaneous abortion in pregnant patients and may also exacerbate some medical and psychiatric conditions. Consult with OB/GYN if considering tapering during pregnancy.
- **Pre-operative patients.** Control of post-operative pain is often a challenge for patients who take opioids on an ongoing basis. Using the tapering guidelines found here and planning ahead, it may be possible to taper prior to surgery, leading to better post-operative pain management.
- **Patients taking multiple opioids.** When a patient takes both long- and short-acting opioids, make an individualized judgement on which to taper first. The decision should include considerations of medical history (and especially mental health diagnoses) as well as patient preference. Consider that overdose risk is greater for long-acting than short-acting formulations.

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This CPM presents a model of best care based on the best available scientific evidence at the time of publication. It is not a prescription for every physician or every patient, nor does it replace clinical judgment. All statements, protocols, and recommendations herein are viewed as transitory and iterative. Although physicians are encouraged to follow the CPM to help focus on and measure quality, deviations are a means for discovering improvements in patient care and expanding the knowledge base. Send feedback to Cara Camiolo Reddy, MD, Intermountain Healthcare, ([CaraCamiolo.Reddy@imail.org](mailto:CaraCamiolo.Reddy@imail.org)).

## ► RESOURCES

### Provider resources

To find this CPM, clinicians can go to [intermountainphysician.org/clinicalprograms](http://intermountainphysician.org/clinicalprograms), and click on “Clinical Topics A - Z” on the left side of the screen. Then, select “Opioid Tapering” under “O.” Or, go to [intermountain.net](http://intermountain.net), and click on the “Clinical” banner on the top. Select “Care Processes Models” under Clinical Programs. Open the “Pain Services CPMs and Related Tools” menu, and select “Opioid Tapering.”

Also see provider [Best Practice Flash cards](#) related to this CPM.

### Patient resources

Clinicians can order Intermountain patient education booklets and fact sheets for distribution to their patients from Intermountain’s Online Library and Print Store, [iprintstore.org](http://iprintstore.org). Call 801-442-3186 for ordering information.

[Addiction](#)

[Buprenorphine for opioid use disorder](#)

[Fentanyl \(Duragesic\): Safe use](#)

[Illegal opioids: How to protect yourself and others](#)

[Leftover medications: How to dispose of them safely](#)

[Managing chronic pain: Treatment options](#)

[Naloxone for opioid overdose](#)

[Opioid medicine in pregnancy](#)

[Opioid medicine for chronic pain Prescription opioids: What you need to know](#)

[Tapering opioid pain medication](#)

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