| **FAIRCHILD MEDICAL CLINICS** | **Implemented:** | **08/2018** |
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| **Prescribing of Benzodiazepines** | **Reviewed:** | **08/2018** |
| | **Revised:** | |
| | **Responsibility:** | **FMC Providers, Nursing staff** |
| | **Reference:** | **See List of References** |

**POLICY:** The use of benzodiazepines has grown over time and evidence has shown that long term use of these drugs has very little benefit with many risks involved. This is an evidence based guideline for the use of benzodiazepines and related drugs in clinical office practice. A multidisciplinary work group was formed to develop this guideline for use in an outpatient setting.

## PROCEDURE(S):

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## Indications for Short-Term Benzodiazepine use:

Benzodiazepine use is for short-term treatment (2-6 weeks) of anxiety disorders. These conditions include generalized anxiety disorder, phobias, PTSD with panic disorder, and severe anxiety associated depression, while waiting for the full effect of the antidepressant.

Benzodiazepines are **NOT** first line therapy agents

***Insomnia****:* there is evidence for the effectiveness of benzodiazepines and other hypnotics in the relief of short-term (1-2 weeks), but not long-term insomnia.

***Muscle relaxant***: benzodiazepines are indicated for the short-term relief (1-2 weeks) of muscular discomfort associated with acute injuries or flare-ups of chronic musculoskeletal pain. Benzodiazepines may be combined with analgesics and non-drug therapies, but not with other sedatives, hypnotics, or other muscle relaxants.

***Other indications****:* benzodiazepines are indicated for urgent treatment of acute psychosis with agitation; as part of a protocol for treating alcohol withdrawal (Librium); adjunctive treatment of withdrawal from other addictions (less accepted); single dose treatments of phobias, such as flying phobia; sedation for office procedures; for seizures and a limited number of other neurological disorders.

## Indications for long-term treatment with Benzodiazepines:

Benzodiazepines may be used for longer than 6 weeks in the terminally ill, in the severely handicapped patient, and in certain neurological disorders.

Benzodiazepines may be used for restless leg syndrome

For some patients, e.g., those who are intolerant of/or non-responsive to alternative pharmacotherapy, long term use of benzodiazepines may be clinically prudent.

## Contraindications to Benzodiazepine use:

**Pregnancy and the Patient at Risk for Pregnancy:** Benzodiazepines are category D. If a hypnotic is necessary, Zolpidem (Ambien), which is category B, is preferred. Patients who conceive while on benzodiazepines should be tapered off completely or to the lowest possible dose.

**Substance Abuse:** Active substance abuse, including alcohol.

**Medical and Mental Health:** Medical and mental health problems that may be aggravated by benzodiazepines. These include fibromyalgia, chronic fatigue syndrome, other somatization disorders, depression (except for short-term use to treat anxiety), bipolar disorder (except for urgent sedation in acute mania), ADHD, kleptomania, and other impulse control disorders.

Benzodiazepines may worsen hypoxia and hypoventilation in asthma, sleep apnea, COPD, CHF, and other cardiopulmonary disorders.

**Chronic Pain:** Patients being treated with opioids for chronic pain or replacement therapy for narcotic addiction.

**Grief Reactions:** Benzodiazepines are often used for short-term treatment for insomnia in acute grief but should otherwise be avoided in treating grief reactions, as they may suppress and prolong the grieving process. Likewise, in PTSD, although relieving acute stress symptoms, longer-term use of these agents compromise the needed exposure and cognitive processing of the trauma, which is known to result in symptom amelioration.

Long-term use of benzodiazepines is generally not recommended. However, there are some patients that may require long term PRN doses in limited quantities.

## New Prescriptions for Benzodiazepines

Benzodiazepines generally are to be used for the short-treatment of severe anxiety or insomnia (anxiety for a maximum of 4-8 weeks; insomnia for a maximum 10 nights). The duration should be as short as possible. The risk of dependence increases with dose and duration.

Patients should be educated on short-term use.

Providers should ensure all new prescriptions are **NOT** entered onto a repeat prescribing system.

Discharge medications from a hospital must **NOT** be repeated, unless the patient was previously receiving benzodiazepines.

It should properly be recorded that a patient receiving a prescription for a benzodiazepine has been advised on non-drug therapies for anxiety or insomnia. Non-drug strategies can be effective in the management of anxiety and insomnia and may address the underlying cause, rather than just relieving symptoms.

It should properly be recorded that the patient has been given appropriate advice on the risks of treatment, including potential for addiction. Chronic use may lead to the development of physical and psychological dependence.

Patients should be provided information on behavioral strategies for anxiety reduction (supplement with sleep guides, diaries and leaflets e.g.: relaxation techniques, biofeedback, etc.).

Only one provider should prescribe the benzodiazepine and should be agreed upon when treated across specialties.

Providers should calculate exactly how many pills the patient will need and give only one prescription with no refills.

## Long Term  Users

It must be recorded annually the prescribed indication and that advice has been given on non-drug therapies for anxiety and insomnia.

It must be documented that advice has been given on the risks, including potential dependence, drowsiness, falls, reduction of coping skills, promotion of identification with the sick role, impairment of judgment and dexterity.

Patients must be reviewed regularly, at least every 90 days. Response to treatment should be assessed and non-drug treatment(s) re-enforced at the discretion of the clinician.

As these agents become absorbed by adipose tissue in long-term users, be aware that GABA agents may persist in the vascular system, to continue to affect GABA receptors for long periods after tapering or discontinuation. Clinicians should always keep this in mind.

## Do Not Prescribe – No Effectiveness For:

- Tinnitus
- Chronic Tension Headache
- Essential Tremor
- Meniere's
- Post-Traumatic Stress Disorder
- Concussion
- Evidence of Substance Abuse

## Special Considerations

Prescribing of benzodiazepines should be avoided for the elderly, as the increased risk of becoming ataxic and confused leads to falls and injuries, in particular hip fractures.

It should be recorded in notes that the patient or caregiver has been given advice on non-drug therapies for anxiety and insomnia and the risks of benzodiazepine use.
If prescribing to elderly or medically compromised individual, use doses less than half of those normally recommended.

The elderly are particularly vulnerable to adverse drug reactions because of the declining renal function, changes to hepatic metabolism, and increased sensitivity to certain drugs.

The elderly often experience trouble-swallowing medicines. The following are available in liquid format: Temazepam and Diazepam.

## Pregnancy and Breast Feeding

Benzodiazepines should generally be avoided in pregnancy and lactation.

Non-Drug treatments are preferred. Pharmacological intervention may be required in severe circumstances and specialist consultation should be sought.

Seek specialist opinion for the management of pregnant or breastfeeding patients who are currently taking benzodiazepines.

## Tapering Benzodiazepines

## Basic Principles:

The precise rate of withdrawal is an individual matter. It depends on many factors including the dose and type of benzodiazepine used, duration of use, personality, lifestyle, previous experiences, specific vulnerabilities, and (perhaps genetically determined) speed of recovery systems,

If they do not succeed on the first attempt encourage the person to try again. Emphasize that any reduction in use is beneficial. Treat any underlying problem before trying again.

Tapering should be guided by severity of withdrawal symptoms. Drug discontinuation may take 3 months to a year or longer. Some people may be able to discontinue the drug in less time.

Sometimes holding the taper for a month might be necessary if circumstantial stressors arrive. Patient education and support are very important.

The slower the taper, the better the change is tolerated. Abrupt withdrawal is not recommended as risk of seizures and/or delirium increases with abrupt withdrawal.

Review the patient's progress frequently to detect and manage problems early and to provide advice and encouragement during and after tapering.

Drug testing/random pill counts will be left to the discretion of the provider if aberrant behavior is suspected.

## TAPER METHOD EXAMPLES

**Direct/Fast Taper: Decrease the total daily dose of the benzodiazepine by 25% the first week and then decrease by 5%-10% each subsequent week and adjust based on patient response**

Alprazolam (Xanax) note: care should be taken not to taper alprazolam too rapidly or to switch to another benzodiazepine too abruptly, as withdrawal seizures are more prone to occur with alprazolam than with other benzodiazepines. If difficulty tapering the last 1–2 mg of alprazolam: taper more gradually (0.25 mg/week) or substitute diazepam gradually over 1 week and taper as usual.

## Direct/Slow Taper:

**For those patients that may require a longer taper or have been on the benzodiazepine for greater than a year:**

Generally speaking, the rate of withdrawal, as long as it is slow enough, is not critical. Whether it takes 6 months, 12 months, or 18 months is of little significance if benzodiazepines have been taken for a matter of years.

**Incremental dose cuts at later stages of tapering may be more difficult to tolerate and result in increased withdrawal symptoms, and a slower titration may be required.**

Consider an adjunctive agent to help with symptoms or to replace the benzodiazepine such as buspirone, clonidine, hydroxazine, SSRI's, and/or sleeping aids.

Educate patient on non-drug therapies available to assist with symptoms such as: relaxation techniques, deep breathing, exercise, psychotherapy, etc.

## Substitution Taper:

**Substituting the patient's current short-acting benzodiazepine with a long-acting benzodiazepine before starting the taper significantly reduces inter dose withdrawal effects, especially in those benzodiazepines with short terminal half-lives.**

**The most commonly selected long-acting benzodiazepine for substitution taper is diazepam.**

Switching to diazepam is sometimes recommended for individuals who are:

- Using the short- to intermediate-acting potent benzodiazepines (e.g., alprazolam and lorazepam)
- Using preparations that do not easily allow for small reductions in dose (e.g., alprazolam or flurazepam)
- Experiencing difficulty or who are likely to experience difficulty withdrawing directly from temazepam due to a high degree of dependency (associated with long duration of treatment, high doses, or history of anxiety problems)

For more specific examples please reference: **Ashton, H (2002) *Benzodiazepines: How They Work and How to Withdraw* https://www.benzo.org.uk/manual/bzsched.htm**

## Substitution Taper example:

Use an equivalent dose to replace with Diazepam two times daily for 1-2 weeks.

- **Convert total daily dose of current benzodiazepine dose into an equivalent diazepam dose.**
- **Tapering schedule should include a 25% reduction the first 1-2 weeks and 25% the 3rd week.**
- **Subsequent decreases should be 12.5% every seven days as tolerated.**
- **Doses should be rounded up or down for easier administration**

## Substitution in patients 65 and older:

Switching to diazepam in patients aged 65 and over is not recommended, as case reports suggest that it may be associated with delirium.

For older adults, lorazepam, oxazepam, and temazepam are 8 the safest options because they don't have metabolites that can accumulate.

Of these, lorazepam is the best in terms of dosing options—available as 0.5, 1, and 2 mg tabs, and as 2 mg/mL oral solution.

## Approximate Equivalent Doses of Benzodiazepines:

**Alprazolam 0.5mg = Chlordiazepoxide 25mg = Clonazepam 0.5mg = Diazepam 10mg Lorazepam 1mg = Temazepam 20mg**

## Alternatives to Benzodiazepines:

- Hydroxazine 25mg-50mg TID
- Propranolol 10mg-20mg TID
- Buspirone 5mg-20mg TID
- Lyrica 50mg-150mg TID (off label use)
- Gabapentin 100mg-300mg TID (off label use)

## Informed Consent of Treatment with Benzodiazepine Medication

I, _____, have received a copy of the **Informed Consent of Treatment with Benzodiazepines**. I understand that I am prescribed a benzodiazepine medication. I understand this medication can help me cope with a short period of extreme stress or insomnia. I understand this medication is not intended for long-term treatment and can be habit-forming. I realize I must not consume alcohol, opioids, or use illicit drugs, such as marijuana, cocaine, heroin, or methamphetamine while using benzodiazepines. I understand that long-term use of benzodiazepines may worsen my anxiety or insomnia. I agree I will not drive or operate machinery while under effects of these medications. I understand that I must not share my mediation with others.

By signing this agreement, I _____ agree:

_____ I will use my medications exactly as prescribed.

_____ I will request refills of my medications at least 3 business days before they are due.

_____ I understand there are no same day refills, unless I have an appointment.

_____ I understand lost or stolen medications may not be replaced and may result in a request for a police report or may result in monitoring and modifying the medication.

_____ I acknowledge no “same day” appointments will be granted for medication refills.

_____ I understand that my medications cannot be filled by a mail order pharmacy.

**CONTINUED ON NEXT PAGE**

Violation of, but not limited to, any of the following will result in rapid reduction of benzodiazepines:

1. ***Use of other substances, such as alcohol, marijuana, prescription pain killers, heroin, methamphetamine, or other illicit substances while receiving benzodiazepines.***
2. ***Failure to keep all of my medical appointments (if a missed appointment occurs, or patient does not show for an appointment, medication may not be refilled).***
3. ***Failure to submit to randomized drug testing and/or pill counts, when prescribing provider requests it. Patients have 24 hours to comply with the provider's request. Failure to comply may lead to automatic rapid tapering and discontinuation of medications.***
4. ***Failure to keep medications locked in a safe place, away from others.***
5. ***Failure to report any change in condition, side effects, or problematic use behavior (cravings, shaking, excessive sleepiness) to the provider immediately.***
6. ***Sharing of medications with any other person, including family members.***
7. ***Medications become lost or stolen.***

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

***NOTE: A copy of the Informed Consent of Treatment with Benzodiazepine Medication will be kept in your chart***

# Long Term Use Discontinuation Letter

Dear _____,

I am writing to you because I note from our records that you have been taking _____ for some time now. Recently, the medical community has become concerned about this kind of medication when it's taken over long periods. Our concern is that the body can get used to these medications so that they no longer work properly (tolerance) If you stop taking the medication suddenly, you may experience unpleasant, and possibly life threatening withdrawal symptoms. For these reasons, repeated use of this medication over a long period of time is *no longer* recommended. More importantly, these medications may actually cause anxiety and sleepiness, and they can be addictive.

At our next appointment we will evaluate your current prescription and the short and long term goals of treatment with _____.

It is important to work with me in the tapering or discontinuation of this medicine. Please do not discontinue this medication until we have an opportunity to discuss a plan. Any change in the medication would involve a plan to prevent and/or reduce the likelihood of significant withdrawal symptoms.

We can discuss your prescription of _____ and alternate options that may be a good fit for your condition.

Sincerely,

_____ _____

*Provider's Signature* *Date*

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