While F329 of the new CMS guidance document emphasizes the importance of seeking an appropriate dose and duration for each medication, gradual dose reduction/GDR tapering is still mentioned for specific classes of medications. Below is a summary of the gradual dose reduction/tapering guidelines along with a comparison of the previous and new guidance documents.

**ANTIPSYCHOTICS**

**Applicable medications:**

**OLD:**
- First Generation Agents:
  - chlorpromazine
  - fluphenazine
  - haloperidol
  - loxapine
  - mesoridazine
  - molindone
  - perphenazine
  - promazine
  - thioridazine
  - thiothixene
  - trifluoperazine
  - triflupromazine

- Removed with new regs:
  - acetophenazine (-)
  - chlorprothixene (-)
  - prochlorperazine (-)

- Second Generation Agents:
  - clozapine
  - olanzapine
  - quetiapine
  - risperidone

**NEW:**
- First Generation Agents:
  - chlorpromazine
  - fluphenazine
  - haloperidol
  - loxapine
  - mesoridazine
  - molindone
  - perphenazine
  - promazine
  - thioridazine
  - thiothixene
  - trifluoperazine
  - triflupromazine

- Removed with new regs:
  - acetophenazine (+)
  - chlorprothixene (+)
  - prochlorperazine (+)

- Second Generation Agents:
  - clozapine
  - olanzapine
  - quetiapine
  - risperidone

- Added with new regs:
  - aripiprazole (+)
  - ziprasidone (+)

**Conditions that must be present before GDR/tapering attempt required:**

**OLD:**
- Undefined, but length of time after initiation/admission when first GDR is attempted should be consistent with condition

**NEW:**
- Undefined

**Indications requiring GDR/tapering:**

**OLD:**
- Organic Mental Syndrome (Dementia-related behaviors)

**NEW:**
- When used to manage behavior, stabilize mood, or treat a psychiatric disorder - so virtually ALL indications/purposes

**Indications EXEMPTED from GDR/tapering:**

**OLD:**
- Schizophrenia
- Schizoaffective disorder
- Delusional disorder
- Psychotic mood disorders (including mania and depression with psychotic features)
- Acute psychotic episodes
- Brief reactive psychosis
- Schizophreniform disorder
- Atypical psychosis
- Tourette’s disorder
- Huntington’s disease

**NEW:**
- None

**Frequency of GDR/tapering:**

**OLD:**
- Twice per year

**NEW:**
- Within 1st year, twice in 2 separate quarters with at least 1 month between attempts; After 1st year, once per year

**Clinical contraindication:**

**OLD:**
- Failed 2 previous attempts

**NEW:**
- Failed previous attempt AND physician documents clinical rationale

**Length of time clinical contraindication is valid:**

**OLD:**
- Undefined

**NEW:**
- Undefined
SUMMARY OF GRADUAL DOSE REDUCTION / TAPERING

SEDATIVES / HYPNOTICS
Applicable medications:

OLD:
• benzodiazepines
• chloral hydrate
• zolpidem
• diphenhydramine
• hydroxyzine

NEW:
• benzodiazepines
• chloral hydrate
• zolpidem
• sedating antihistamines
  (e.g., diphenhydramine, hydroxyzine)
• eszopiclone (+)
• zaleplon (+)
• ramelteon (+)
• sedating antidepressants (e.g., trazodone) (+)

Conditions that must be present before GDR/tapering attempt required:

OLD: 10 days of continuous use

NEW: Routine use during previous quarter

Indications requiring GDR/tapering:

OLD: All

NEW: All

Indications EXEMPTED from GDR/tapering:

OLD: Not Applicable

NEW: Not Applicable

Frequency of GDR/tapering:

OLD: 3 times within 6 months (approximately every 2 months)

NEW: Quarterly (approximately every 3 months)

Clinical contraindication:

OLD: Failed 3 attempts within past 6 months

NEW: Failed 3 attempts during previous 3 quarters

Length of time clinical contraindication is valid:

OLD: Undefined

NEW: Remainder of the year after failed attempts

PSYCHOPHARMACOLOGICAL MEDICATIONS

Applicable medications: (Depends on how the medication is used or what condition the medication is used to treat)

OLD:
Anxiolytics
• benzodiazepines

Removed from Regs:
• chloral hydrate (-)
• diphenhydramine (-)*
• hydroxyzine (-) *

NEW:
Anxiolytics *
• benzodiazepines

Added to Regs:
• buspirone (+)
Antidepressants (+)
Anticonvulsants (+)
Cognitive enhancers (+)

* New F329 states that diphenhydramine and hydroxyzine are not appropriate for use as anxiolytics

Conditions that must be present before GDR/tapering attempt required:

OLD: For benzodiazepines and other anxiolytics, 4 months of continuous use

NEW: Undefined
SUMMARY OF GRADUAL DOSE REDUCTION / TAPERING

Indications requiring GDR/tapering:
OLD:
• Generalized anxiety disorder
• Organic mental syndromes with associated agitated behaviors, which are quantitatively and objectively documented
• Panic disorder
• Symptomatic anxiety that occurs in residents with another diagnosed psychiatric disorder

NEW:
When used to manage behavior, stabilize mood or treat a psychiatric disorder

Indications EXEMPTED from GDR/tapering:
OLD:
• Diazepam used for neuromuscular syndromes (e.g., cerebral palsy, tardive dyskinesia or seizure disorder)
• Long-Acting benzodiazepines used to withdraw residents from short-acting benzodiazepines
• Clonazepam used in bipolar disorders, management of tardive dyskinesia, nocturnal myoclonus or seizure disorder

NEW:
• Used for neuromuscular syndromes (e.g., cerebral palsy, tardive dyskinesia, restless leg syndrome or seizure disorders)
• Short-acting benzodiazepine used to withdraw a resident from a long-acting benzodiazepine
• Symptom relief in end-of-life situations

Frequency of GDR/tapering:
OLD:
For Benzodiazepines and other anxiolytics, twice per year

NEW:
Within 1st year, twice in 2 separate quarters with at least 1 month between attempts; After 1st year, once per year

Clinical contraindication:
OLD:
For Benzodiazepines and other anxiolytics, failed 3 attempts within past 6 months

NEW:
Failed previous attempt AND physician documents clinical rationale

Length of time clinical contraindication is valid:
OLD:
Undefined

NEW:
Undefined

(+)= Medication was NOT in previous guidelines but was ADDED to the new guidelines,
(-)= Medication was included in previous guidelines but has been REMOVED in the new guidelines.