

San Mateo County Health and BHRS Guidelines for the Use of Benzodiazepines (BZDs) and Z-Drugs

PURPOSE: To present updated practice standards that minimize practice variation, maximize evidence-based treatment, improve patient safety and increase patient and provider satisfaction.

BACKGROUND: BZDs are lipid-soluble, gamma-aminobutyric acid (GABA) receptor agonists that quickly cross the blood-brain barrier producing CNS depression and have hypnotic, anxiolytic, muscle relaxant, anticonvulsant, and amnesic properties. Short-acting BZDs (half-life <12hrs) include midazolam, oxazepam, triazolam. Intermediate-acting (half-life 12-24hrs) includes alprazolam, lorazepam, and temazepam. Long-acting (half-life >24hrs) include diazepam, clonazepam, clorazepate, chlordiazepoxide, and flurazepam.

BZDs have been associated with increased falls, accidents, cognitive decline, delirium, aggressive behaviors, suicide risk, overdose mortality, premature birth and low birth weight, harmful psychological and physical dependence, misuse, withdrawal, and death, particularly when used with CNS depressants such as alcohol or opioids. Since 2000, fatal overdoses involving BZDs have increased nearly tenfold, often involving the combination of opioids and BZDs. Despite the known risks, BZDs and Z-drugs (zaleplon, zolpidem, eszopiclone) are overprescribed, often as part of treatment plans that are supported by neither scientific evidence nor published guidelines. In 2017 the DEA reported 45 million alprazolam, 26.4 million lorazepam, 29.2 clonazepam, 12.6 million diazepam, and 7 million temazepam prescriptions in the US. Between 1996 and 2013 the number of adults filling BZD prescriptions increased 67% from 8.1 million to 13.5 million and the percentage of adults filling BZD prescriptions increased from 4.1% to 5.6%. BZDs are involved in approximately 1/3 of overdose deaths in the US.

In a 2020 study of a Community Mental Health Setting, 19.9% of patients were prescribed at least one BZD, and among them, 35.1% had a substance use disorder (SUD) diagnosis. Of those with an SUD diagnosis, the odds of receiving a prescription was significantly increased for older patients (age 55 and older), non-Hispanic whites, and women. A study by Agarwal et al published in 2019 found that PCPs accounted for 52.3% of visits involving BZDs in 2015. They also found that BZDs were co-prescribed with opioids in 19% of visits, and that women, middle aged adults (45-64), White patients, and those with public insurance were significantly more likely to be prescribed BZDs. In 2018, ~50% of patients dispensed oral BZDs received them for ≥ 2 months. Long-term prescribing remains common in older adults, despite recommendations to avoid BZDs in this population. In 2023, nearly 24 million individuals in the US reported BZD use.

INDICATIONS

Short-Term (2-4 weeks) Use

- Urgent treatment of acute agitation, psychosis, or mania. Treatment of Catatonia.
- Urgent medical treatment. Sedation for office procedures or imaging.
- Seizures, spasticity, and a limited number of neurologic disorders.
- Management of alcohol and BZD withdrawal.
- Insomnia (Only if not contraindicated and non-pharmacological and non-controlled pharmacological options have been exhausted. It should not exceed 2 weeks. Sleep

studies have shown that sleep patterns return to pre-treatment levels after only a few weeks of regular use. Temazepam is the only BZD with an indication for insomnia).

- Anxiety (only if not contraindicated and only as a bridge to non-controlled medication and non-pharmacological treatment options. Continuing beyond 2 weeks will result in loss of effectiveness, development of tolerance or dependence, potential for withdrawal symptoms, persistent adverse side effects, and interference with the effectiveness of definitive medications and counseling).

Long-Term (2 months or more) Use: BZDs and Z-drugs are NOT recommended for long-term use except in exceptional circumstances (e.g., terminally ill).

CONTRAINDICATIONS

Note: These guidelines apply to outpatient mental health practice. In outpatient care, some conditions make the risk-benefit profile unfavorable for benzodiazepines and should generally be treated as functional contraindications. The risk-benefit profile may shift depending on acuity and treatment setting.

Please refer to the contraindications table in the appendix for the drug specific list. Examples of agent specific contraindications include:

- Diazepam: severe respiratory impairment, severe hepatic impairment, sleep apnea, acute narrow-angle glaucoma, untreated open-angle glaucoma, myasthenia gravis
- Clonazepam: significant liver disease, hypersensitivity to benzodiazepines, acute narrow-angle glaucoma
- Certain agents: contraindicated with strong CYP3A inhibitors (e.g. alprazolam, triazolam)

High-Risk Conditions (strong caution)

These require a documented risk-benefit discussion, shared decision making, and closer monitoring. In some cases, outpatient prescribing should be strongly discouraged.

- Active or history of substance use disorder (including alcohol or sedative use)
- Currently taking opioids, stimulants, another benzodiazepine, Z drug, muscle relaxants, or other CNS depressants
- Poly sedative regimens (e.g. another benzodiazepine, Z drug, muscle relaxant, alcohol)
- Age 65 and older (higher risk of falls, adverse effects, and drug interactions; may develop confusion & ataxia, increasing fall and fracture risk)
- Medical or mental health problems that may be worsened by benzodiazepines, including cardiopulmonary disease (e.g. asthma, sleep apnea, COPD, CHF) when not a drug-specific contraindication, as benzodiazepines may worsen hypoxia and hypoventilation
- Cognitive impairment, history of traumatic brain injury, or falls
- Pregnancy or lactation (coordinate with prenatal care, consider consultation)
- PTSD (benzodiazepines not recommended as routine treatment, prioritize alternatives)
- High interaction burden or complex polypharmacy

RECOMMENDATIONS

New Prescriptions

- Avoid starting new BZD and Z-Drugs whenever possible.
- Z-drugs are not “safer” than BZDs. Patients on BZDs should not be switched to Z-drugs.
- Confirm no contraindications. Confirm that all appropriate non-pharmacologic and non-controlled pharmacologic options have been exhausted. Consult as appropriate for additional alternatives and Wellness Resources.
- For insomnia, provide psychoeducation that Cognitive Behavioral Therapy for Insomnia is more effective than hypnotics with no side effects. The CBT-i Coach guides the patient through a structured program, to be used with their health provider. Provide Sleep Hygiene information, Insomnia Coach App, and handout on Important Facts about Sleep Medications. Consider alternatives (melatonin, trazodone) (refer to Table 3).
- Check CURES.
- Complete Controlled Medication Agreement with clients.
- Always prescribe the lowest dose of BZD for the shortest time possible.
- Advise the patient regarding the anticipated duration of treatment. Use of BZDs beyond 2 weeks is not recommended. Discuss with the patient in advance, so they agree to a discontinuation plan.
- Many patients will have difficulty discontinuing. Have a plan in place to discontinue the BZD in your work with the patient.
- Review the potential risks, benefits and alternatives of BZDs, Z-drugs, and document discussion.
- Caution patients about risk of respiratory depression with alcohol, sedatives, and opioids and document education provided. Consider Narcan prescription and training as appropriate.
- If it is necessary to prescribe BZDs to adults older than 65, consider initiating the medication at half the adult dose. Avoid diazepam (case reports it may be associated with delirium). For older adults, BZDs that don’t accumulate metabolites are safest (lorazepam, oxazepam, temazepam). Lorazepam is typically best in this population based on available dosing options (0.5, 1, 2 mg tabs, or 2 mg/mL oral solution).

Managing Existing Prescriptions

- Given the frequency of BZD prescriptions, clinicians may encounter patients who have been prescribed BZDs or Z-Drugs on a long-term basis. Many may be unwilling and/or afraid to discontinue them.
- Assess risks and benefits of continued BZD use regularly, including CURES (PDMP) review. Reassess ideally every 3 months and at minimum with each new prescription or renewal, per ASAM guidelines. Health plan guidance recommends checking CURES at least every 4 months or with each prescription, whichever is more frequent (HPSM), while the state required minimum is prior to initial prescribing and at least every 6 months thereafter (CA HSC §11165.4).
- Review risks and benefits of BZD prescribing for clients co-prescribed opioids and BZDs at least every 3 months, or at every related encounter or prescription renewal, whichever is sooner. Conduct more frequent assessments in clients with additional risk factors for adverse events. The Risk Index for Overdose or Serious Opioid-Induced Respiratory

Depression (RIOSORD) tool may be used; key factors include SUD, bipolar disorder, schizophrenia, other conditions, and use of higher-risk opioids such as fentanyl or methadone. Use the lowest effective doses, optimize non-opioid pain treatments including exercise, mindfulness-based interventions, and CBT; consider safer options like buprenorphine when appropriate, and provide naloxone to clients at risk for overdose.

- Provide education on your concerns of chronic BZD or Z drug use in the first meeting.
- Physical dependence can develop within weeks even when used as prescribed and is heterogeneous across clients (refer to Table 1 to estimate the risk of clinically significant withdrawal).
- Complete Controlled Medication Agreement with clients. Patients receive all BZD prescriptions from one designated prescriber and one pharmacy (whenever possible).
- That one prescriber should also be responsible for prescribing other medications with abuse potential, specifically central nervous system (CNS) stimulants and narcotics; if not possible, the prescriber of BZDs should closely coordinate with those prescribing other controlled medications.
- Establish regular monitoring visits that occur at a frequency based on the patient's risk.
- Check a Urine Drug Screen: Discuss with the patient before the UDS about the purpose of testing, what will be screened for and how the UDS result will affect the medications they are prescribed.
- Urine immunoassays can help detect substances use but have limitations
- High false-negative risk; use gas chromatography-mass spectrometry (GCMS) for confirmation, highly specific/sensitive, but may still miss some BZDs.
- Do not use results punitively, use them to engage patients and inform treatment plans.

Discontinuing Existing Prescriptions

- Any patient taking BZDs or Z-Drugs for longer than a month should be encouraged to discontinue use unless there are compelling reasons for continuation. Prioritize the following situations:
 - 65 years or older
 - Taking multiple BZDs, at supratherapeutic doses or combined with opioids.
 - Cognitive disorder or history of traumatic brain injury.
 - Current or prior history of substance use disorder.
 - Patients who are having falls.
- Each patient's taper will need to be tailored to the individual's needs based on acute versus chronic medical or psychiatric conditions. Plan to taper slowly and provide supportive resources as necessary. Create a treatment plan or schedule to help the patient with this process.
- Physiologic dependence will occur for most clients with chronic BZD use. It is important to distinguish physical dependence from addiction. Avoid abrupt discontinuation in clients with likely physical dependence and risk of withdrawal.
- Assess the patient's underlying condition for which the drugs were originally prescribed. Discuss alternative treatments which may include:
 - Psychotherapy (e.g., CBT, acceptance commitment therapy); Relaxation and Wellness.
 - Antidepressant medications (e.g., SSRIs, SNRIs, tricyclic antidepressants, buspirone)

- Sleep Hygiene, Insomnia Coach, CBT-i Coach, melatonin, trazodone.
- Monitor sleep closely during BZD tapering in clients with mood or psychotic disorders as sleep disturbances can trigger episodes of mania.
- For clients reluctant to stop BZDs, discuss the benefits of tapering to a lower dose. Set the expectation of revisiting the topic at least annually, and more frequently when there are changes in the patient's care plan or based on provider or patient concerns.
- Determining Level of Care: Assess to determine the level of care the client will need when discontinuing or tapering BZDs. Consider inpatient or medically managed residential care when appropriate, if:
 - Imminent risk of significant harm from continued BZD use (interaction, overdose, falls, self-harm) is unlikely to be rapidly reduced by initial taper.
 - Symptoms or conditions likely to complicate BZD taper, unsafe for outpatient management.
 - Severe or complicated BZD withdrawal is expected.
- Offer treatment for co-occurring physical or psychiatric conditions that could interfere with taper

Tapering Process

- The goal of tapering is to discontinue or reduce BZD use to the lowest effective dose.
- These guidelines refer to the 2025 ASAM Joint Clinical Practice Guideline on Benzodiazepine Tapering. Refer to the latest ASAM Guidelines for the most current recommendations.
- BZD tapers should take place over several weeks to months; sometimes it can be up to years (depending on the person's ability to tolerate the taper, dose, underlying diagnosis, etc.).
- The initial taper should be between 5% and 10% of the total daily dose, then individualized based on the patient's response and tolerability. Typically, the taper should not exceed 25% every 2 weeks. Tapers faster than 25% increase risk of BZD withdrawal.
 - Consider first 5% reduction to assess response, unless imminent safety concerns.
 - For patients with likely strong physical dependence (eg, high dose BZD use >1 year), use a slower taper: start with ~5% reduction, adjust based on response, then reduce 5-10% every 6-8 weeks or slower as needed.
 - May consider 10-25% reduction for patients unlikely to have significant dependence (eg, lower dose <3 months) but still requiring taper.
- Many patients on BZDs <1 month can stop without taper, but consider a short taper if risk factors (BZD pharmacology, age, comorbidities, other substance use, withdrawal history) or if the pt is concerned about discontinuation.
- Consider pausing or slowing the taper if patients develop symptoms that significantly interfere with progress (eg, sleep disturbance, anxiety). Behavioral support is the first line adjuncts (CBT/CBT-I, sleep hygiene, peer support), which improve discontinuation rates compared with taper alone. Evidence for pharmacologic adjuncts is limited, but their use may be considered in select cases.
- Consider week at a time dispensing to prevent self-escalation.
- Monitor withdrawal symptoms with each dose reduction and for 2-4 weeks after full discontinuation.

- May consider adding an antiepileptic and using a slower taper when there is concern for serious withdrawal. Management of seizure risk should align with clinical standards and may vary by specialty. See "Assessing and Managing Seizure Risk" in the 2025 ASAM guidelines (p. 51) for further detail.
 - Screen for past seizures, as these significantly increase BZD withdrawal risk.
 - Use PDMPs to identify concurrent controlled substances or meds that lower the seizure threshold.
 - For high-risk clients, utilize a slower taper rate and establish a clear emergency response plan, including immediate response with appropriate medication.
- Maintaining a 50% dose for 1-2 months may be warranted before proceeding further with the taper.
- The last 25% of BZD will often require slower, more gradual taper.
- The decision to switch to a longer-acting BZD should be patient-specific.
 - Dose conversions are approximate, use patient experience and response to guide therapy.
 - Cross-taper slowly over 1-2 weeks rather than 1-2 days.
 - Alprazolam is difficult to taper (short acting, no metabolites, higher cross-tolerance). Consider transitioning to a longer-acting BZD, however, some clients may experience challenges due to cross-tolerance.
 - Typically transition back to the original BZD if a switch results in significant withdrawal.
 - Consider switching clients
 - Using short to intermediate acting BZDs (eg. alprazolam)
 - Likely to experience difficulty tapering directly due to high physical/psychological dependence
 - With SUD or uncertain daily BZD dose, unless contraindicated.
 - Switching may not be appropriate for
 - Older adults (increased sensitivity, reduced clearance, polypharmacy).
 - Patients with significant hepatic impairment or high DDI/polypharmacy risk
 - In significant hepatic dysfunction, prefer lorazepam (no active metabolites); avoid diazepam, clonazepam, chlordiazepoxide.
- Care should be taken not to taper alprazolam too rapidly or switch abruptly to another BZD, as withdrawal seizures are more likely to occur than with other BZDs. Tapering may be needed even after short term daily use (2-4 weeks), since alprazolam is associated with faster onset of physical dependence due to short half-life, rapid onset, and no active metabolites.
- Strongly consider tapering BZDs in patients with PTSD

Acute Withdrawal Signs and Symptoms:

- Anxiety-related withdrawal symptoms are common, and include restlessness, agitation, tremors, dizziness, panic attacks, palpitations, shortness of breath, sweating, flushing, shakiness, difficulty swallowing, poor sleep, sensation of choking, and chest pain.
- Other less common acute withdrawal symptoms include seizures, bowel/bladder problems, changes in appetite, tiredness, faintness, poor concentration, tinnitus, and delirium.

Post-Acute Withdrawal Syndrome (PAWS):

- Some withdrawal symptoms can persist and may take months or years to resolve, including anxiety, agitation, hallucination, dizziness, fatigue, depression, poor memory and cognition, motor symptoms (pain, weakness, muscle twitches, jerks, seizures), depersonalization, psychosis, paranoid delusions, rebound insomnia, and abnormal perception of movement.

Rapid Tapers

Use only when there is a clear, imminent safety concern (e.g., misuse, overdose risk, or serious adverse effects) that cannot be managed with closer monitoring, limited dispensing, or coordination with other prescribers. In many cases, the situations that create urgency also increase withdrawal risk, so a slower, structured taper is often safer. See pages 15, 16, 41-44, 55, 77, and 91 of the [2025 ASAM guidelines](#) for additional details.

- Rapid tapers are generally discouraged due to increased risk of withdrawal symptoms and complications.
- The taper rate should generally not exceed 25% dose reduction every 2 weeks. Slow or pause if withdrawal symptoms become clinically significant.
- When significant withdrawal risk or safety concerns are anticipated, consider whether a higher level of care (e.g., medically managed residential settings or inpatient care) may be appropriate.
- If more rapid tapering is indicated, such as with imminent safety risks or failed alternative treatments, clinicians may consider very long-acting agents.
- Inadequate tapering may drive patients to the illicit market, where counterfeit pills containing fentanyl and other potent synthetic opioids increase overdose risk.
- Refer to the latest ASAM Joint Clinical Practice Guideline on Benzodiazepine Tapering for the most current recommendations.

BZD Interactions

- Screen for non-prescription BZD use and other substances that may interact with BZDs or complicate tapering.
- Additive sedation occurs with antihistamines, antipsychotics, opioids, and gabapentinoids.
- Concomitant opioid use increases risk of CNS depression and adverse events. Assess the risks and benefits at every clinical encounter or prescription renewal, and at least every 3 months.
 - Offer/provide naloxone
 - Use the lowest effective dose and optimize non-opioid alternatives.
- CYP3A4 inhibitors, such as antibiotics like clarithromycin and erythromycin, may lead to excessive sedation.
- Alcohol potentiates CNS depressant effects.

Pregnancy and Lactation

- Weigh maternal-fetal risks/benefits when prescribing or tapering BZDs, monitor closely, and coordinate with prenatal care.
- 20-40% exposed neonates during late pregnancy develop withdrawal, floppy infant syndrome possible in third trimester exposure.
- Lorazepam preferred (no active metabolites, low relevant infant dose). If stable on another BZD, not typically necessary to switch, consider transitioning to lorazepam if taking alprazolam.
- Encourage breastfeeding in infants at risk for neonatal withdrawal (can reduce withdrawal symptoms) and communicate BZD exposure to the infant's healthcare provider (with parental consent).
- Consider consulting the [UCSF Reproductive Health Hotline \(ReproHH\)](#) for free guidance from specialists in sexual & reproductive health, if needed.

Harm Reduction

- Provide/offer naloxone to all clients at risk of opioid overdose.
- Harm reduction is important even if clients decline SUD treatment
- Do not use BZD prescribing or tapering considerations as a reason to stop or disrupt medications for SUD treatment (e.g., buprenorphine, methadone)
- Educate on risks of contamination (eg. fentanyl in heroin, counterfeit BZDs) and safe use practices (avoid using alone, test dose first).
- Connect clients to harm reduction services (education, drug checking, fentanyl/xylazine test strips, sterile syringes).

APPENDIX A: TIPS on conversation with patient our concern about chronic BZDs or Z-Drugs:

- Validate the patient's concerns.
- Keep a positive and encouraging attitude with patients to foster a non-judgmental compassionate approach. Instill hope that clients can get off BZD with the goal to improve their quality of life.
- Reassure patients that support will be provided throughout the taper.
- Provide psychoeducation of side effects and risks of BZDs and discuss no evidence of benefit for BZDs taken for more than 2-4 weeks for any psychiatric condition.
- Provide additional resources (e.g. Resources, Peer Support and Groups, Additional Information).
- Educate the patient about the tapering process and symptoms of withdrawal.
- Recommend non-pharmacological therapies such as cognitive-behavioral therapy, motivational interventions, and development of coping skills and sleep hygiene.
- Involve the patient's family and friends for support and encouragement when appropriate.
- Advise that each person's taper will be unique.
- Advise them that the taper will never go backwards to avoid going through withdrawal again.
- Set expectation with patient that with each step down they likely will have some BZD withdrawal that will likely resolve within 1-2 weeks.

Example script on starting discussion about BZD taper:

Explore treatment history of BZD:

I want to understand your history of being on BZDs or Z drugs. I am curious about when you started taking it, what symptoms were the BZD prescribed to treat, and how those symptoms have changed over time? What treatment (medication and therapies) have you tried for X symptoms (try to non-judgmentally understand their story and history. Then affirm, reflect on what you heard).

Ask permission to provide education on physical dependence:

Would it be okay if I share with you some of my concerns regarding long-term use of this medication? [If they say, yes, and then proceed, if no offer to discuss with them at their next appt.] Overtime, people can develop physical tolerance to the BZD (meaning the desired effect needs more medication over time) and physical dependence (meaning the body will have withdrawal symptoms when the BZD is discontinued).

Validate their concerns about not having the BZD and why they rely on them:

For many people, there is a lot of concern about getting off these drugs/medications and understandably because you've been taking it to help _____ symptom(s).

Provide information and discuss treatment options:

My approach is to help people get off BZDs in a safe and personalized manner and you will be involved with the decision making throughout the process. When you were started on this medication it was probably unknown that there are long-term safety concerns, we now know that long-term use can cause harm for many people. I've helped individuals with successful discontinuation of BZDs and they describe having less anxiety and/or insomnia over time and feel a sense of freedom with no longer feeling the need to take it.

Gauge their interest in tapering:

Here is some information on BZDs [review side effects], have you experienced any of these? What are your thoughts about considering lowering or discontinuing your dose so we can keep you safe? I can offer you safer meds for anxiety or sleep that do not cause physical dependence.

Would you be interested in starting a safer medication? [Provider can reference healthcare system recommendation for tapering due to long-term effects of chronic BZD use].

**Table 1: Risk for Clinically Significant BZD Withdrawal
Estimated Risk Depending on Dose, Duration, and Frequency of BZD Use**

Duration of BZD Use	Frequency of BZD Use	Total Daily BZD Dose	Risk for Clinically Significant Withdrawal†
Any	<3 days per week	Any	Rare
<1 month	≥4 days per week	Any	Lower risk, but possible
1–3 months	≥4 days per week	Low‡	Lower risk, but possible
1–3 months	≥4 days per week	Moderate§ to high**	Yes, with greater risk with increasing dose and duration
≥3 months	≥4 days per week	Any	Yes, with greater risk with increasing dose and duration

† Clinical Consensus; risk increases with higher doses, longer duration, and greater frequency of use. ‡ Low: below typical therapeutic dose range. § Moderate: within therapeutic range. ** High: above typical therapeutic range.

Table 2: Approximate BZD Dose Equivalents to 10 mg Oral Diazepam for Tapering[†]

Benzodiazepine	ATC Therapeutic Class	VA/DoD SUD CPG (2021)	Ashton Manual (2002) [‡]
Alprazolam	Anxiolytic	1	0.5
Chlordiazepoxide	Anxiolytic	25	25
Clonazepam	Antiepileptic	1	0.5
Clorazepate	Anxiolytic	15	15
Diazepam	Anxiolytic	10	10
Estazolam	Sedative–Hypnotic	1	1–2
Flurazepam	Sedative–Hypnotic	15	15–30
Lorazepam	Anxiolytic	2	1
Oxazepam	Anxiolytic	30	20
Quazepam	Sedative–Hypnotic	10	20
Temazepam	Sedative–Hypnotic	15	20
Triazolam	Sedative–Hypnotic	0.25	0.5

[†] For guidance only as determined by the VA/DoD SUD guideline and *The Ashton Manual*. Clinical decisions should be individualized based on patient response. **ATC:** Anatomical Therapeutic Chemical classification system, **CPG:** clinical practice guideline, **DoD:** US Department of Defense, **SUD:** substance use disorder, **VA:** US Department of Veterans Affairs, [‡] Same equivalents in Ashton, H. *Benzodiazepine Equivalence Table* [Online]. Revised April 2007. <https://www.benzo.org.uk/bzequiv.htm> and Ashton CH. *The diagnosis and management of benzodiazepine dependence. Curr Opin Psychiatry.* 2005;18(3):249–255. doi:10.1097/01.yco.0000165594.60434.84

Table 3: Medications for Insomnia-Related Symptoms

Drugs that can be considered as adjuncts for managing insomnia during BZD tapering

Medication*	Class	Considerations for Use [†]	Patient Population Considerations
Doxepin[‡]	Antihistaminic TCA	-AASM approved for sleep maintenance insomnia -Avoid in pts with suicidal ideation & behavior due to risk for overdose	Caution in older adults, coronary artery disease, arrhythmia
Diphenhydramine[§]	Antihistamine	AASM does not recommend for sleep onset or sleep maintenance insomnia	Avoid in older adults, may have paradoxical effects in children
Doxylamine[§]	Antihistamine		Avoid in older adults, may have paradoxical effects in children
Hydroxyzine^{**}	Antihistamine	Avoid in pts with h/o of QTc prolongation	Avoid in older adults
Melatonin[§]	Sedative Hypnotic	AASM does not recommend for sleep onset or sleep maintenance insomnia	Avoid during pregnancy & breastfeeding, insufficient safety evidence
Ramelteon[‡]	Melatonin receptors 1 & 2 agonist	-AASM approved for sleep onset insomnia -Prone to significant interactions with CYP inhibitors & inducers	
Trazodone^{**}	Antidepressant	-Start with lower doses to avoid orthostasis in older adults -AASM does not recommend for sleep onset or sleep maintenance insomnia	Use with caution in older adults

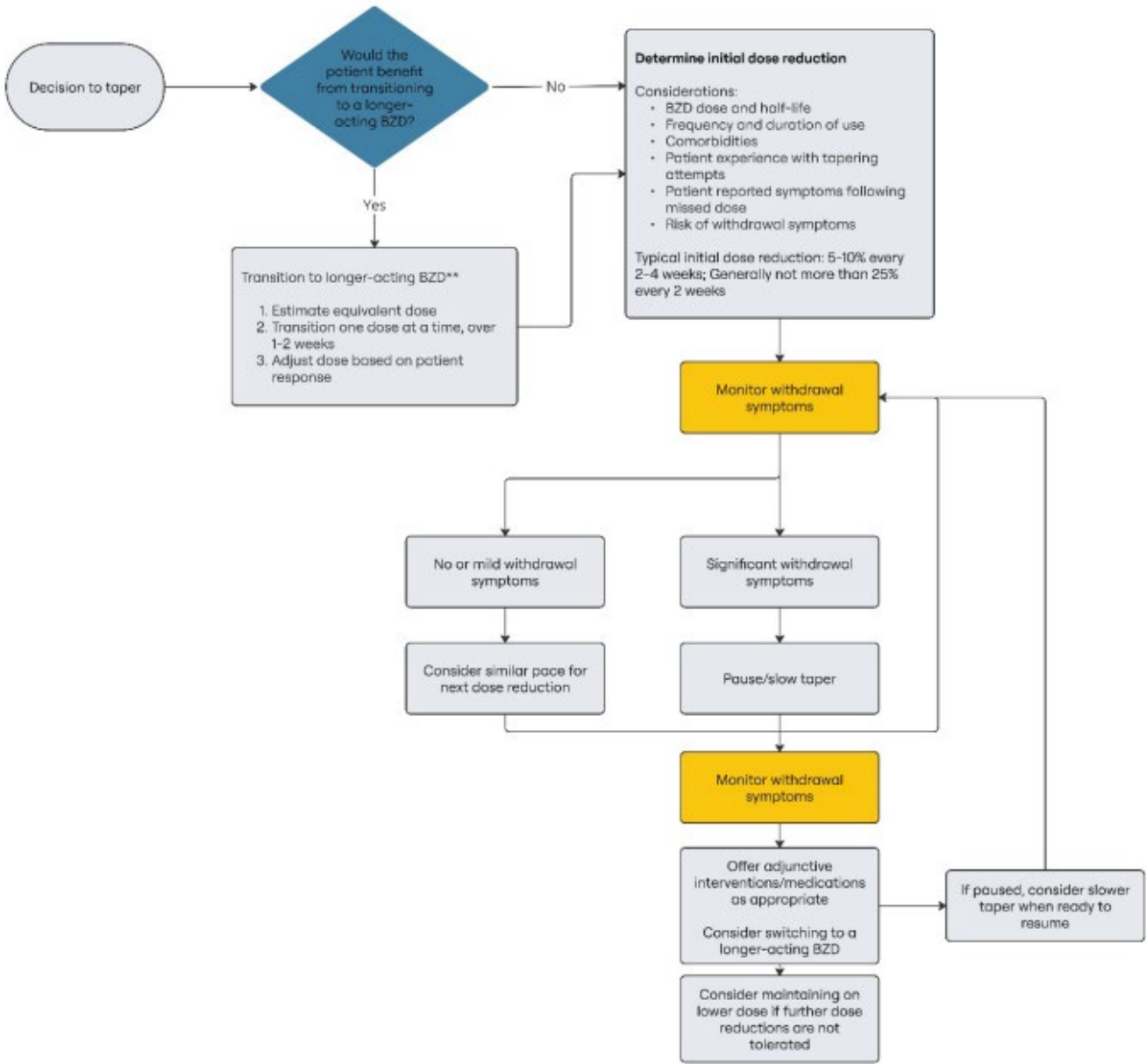
* Non-BZD sedative–hypnotics (eg, Z-drugs) are not recommended for patients with sleep issues who are undergoing BZD taper due to similar receptor action. Further information on adjunctive medications may be found on UpToDate, which has topics on benzodiazepine withdrawal and complementary and alternative treatments for anxiety symptoms and disorders: herbs and medications. Pts: Patients, h/o: History of

[†] Use in individual patients should always include review of medical and medication history and individual prescribing information to assess for any relative/absolute contraindications. [‡] FDA approved. [§] FDA approved, available over the counter. ^{**} Not FDA approved for insomnia.

Resources and References

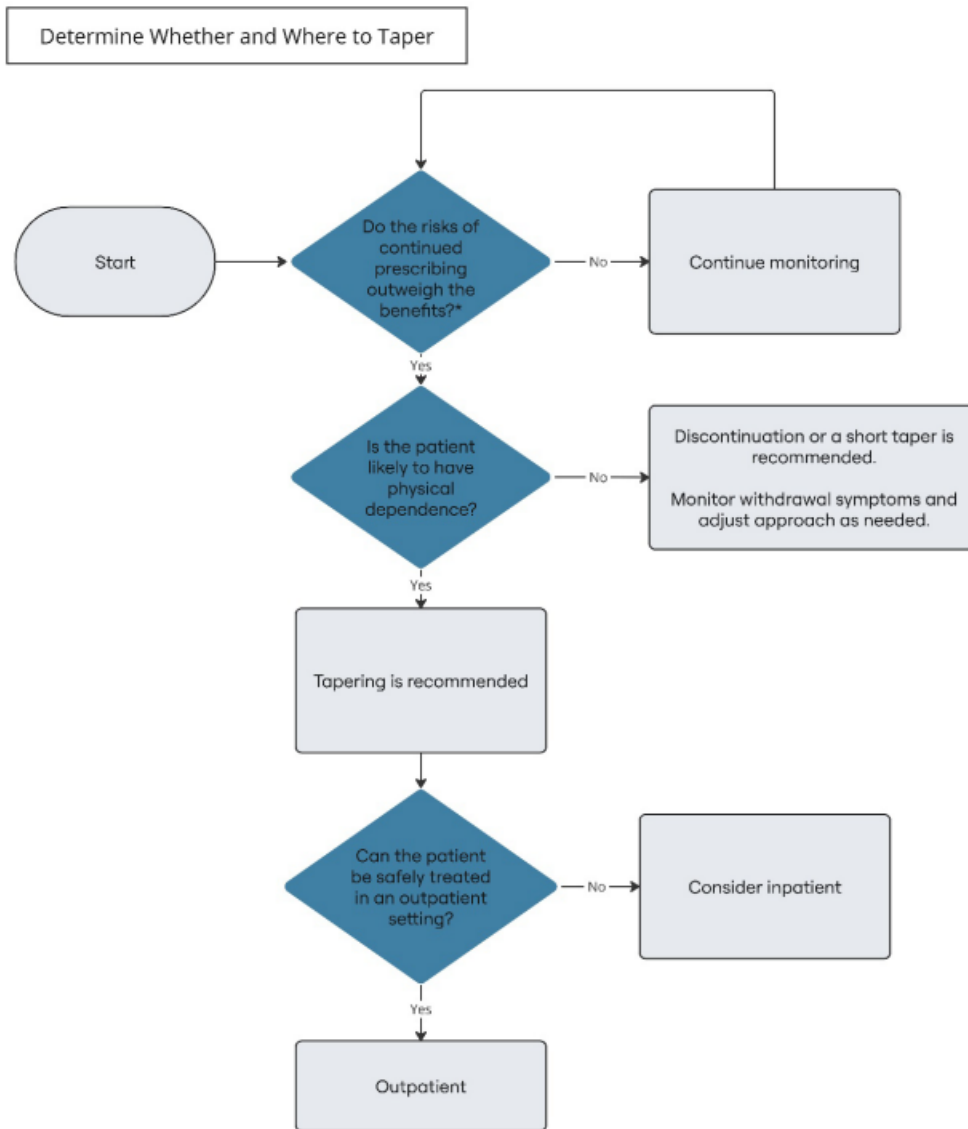
1. Agarwal SD & Landon BE (2019) Patterns in Outpatient Benzodiazepine Prescribing in the United States, JAMA network open, 2(1), 1-11.
2. American Geriatrics Society 2019 Updated AGS Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. Journal of American Geriatrics Society. 00:1-21, 2019.
3. Bachhuber MA, Hennessy S, Cunningham CO, & Starrels JL (2016). Increasing Benzodiazepine prescriptions and Overdose Mortality in the United States, 1996-2013. American Journal of Public Health, 106(4), 686-688.
4. California Legislative Information. California Health and Safety Code §11165.4. State of California, https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC§ionNum=11165.4
5. Drug Enforcement Administration, Benzodiazepine Factsheet 12/2019.
6. Effective Treatment for PTSD: Helping Patients Taper from Benzodiazepines, National Center for PTSD 2015.
7. Genentech USA, Inc. (2010). *Klonopin® tablets (clonazepam) and Klonopin® wafers (clonazepam orally disintegrating tablets) [Package insert]*. South San Francisco, CA.
8. Health Plan of San Mateo. Prescribing Controlled Substances Guideline. Health Plan of San Mateo, <https://www.hpsm.org/provider/resources/guidelines/prescribing-controlled-substances>.
9. Jassell et al (2020). Factors Associated with Benzodiazepine Prescribing in Community Health Settings. J Subst Abuse Treat, Feb 109: 56-60.
10. Kaiser's Benzodiazepine and Z-drug safety Guidelines Jan 2019.
11. Lembke (2019). Benzodiazepines: The Hidden Epidemic. YouTube Video. Lembke (2019).
12. Lembke (2019). Benzodiazepines: Dependence and Withdrawal. YouTube Video. Lembke (2019).
13. Lexicomp Online, accessed 10/8/25
14. Osteopathic Medical Board of California. CURES FAQ. State of California, <https://www.ombc.ca.gov/faqs/cures.shtml>
15. Overdose Death Rates, National Institute on Drug Abuse.
16. Team, A. S. A. M. "Joint Clinical Practice Guideline on Benzodiazepine Tapering: Considerations when Benzodiazepine Risks Outweigh Benefits." Accessed Online 9/26/25
17. The ASAM Essential of Addiction Medicine Second Edition 2015; Chapter 44 "Management of Sedative Hypnotic Intoxication and Withdrawal" p 262-266
18. The Ashton Manual, The Institute of Neuroscience, Newcastle University.
19. University of California San Francisco. (n.d.). Center for Reproductive Health. Retrieved October 24, 2025, from <https://reprohh.ucsf.edu/>
20. VA Clinical Practice Guidelines for the Management of PTSD (2017).

Taper Management - Outpatient



Engage in shared decision making process with the patient (and care partner(s)) whenever possible

**See *Transitioning to a Longer-Acting Benzodiazepine*



*Risks associated with BZD tapering should also be considered

Table 4: Benzodiazepines - Contraindications

Medication	Contraindications	Additional Contraindications (Canadian labeling)
All Benzos	Hypersensitivity to the medication or any component of the formulation	
Alprazolam (Xanax [®])	<ul style="list-style-type: none"> • Cross-sensitivity with other benzos may exist • Concurrent therapy with strong CYP3A inhibitors (eg, itraconazole, ketoconazole), except ritonavir • Acute narrow angle glaucoma. • Significant DDIs may require dose/frequency adjustment or avoidance. Consult drug interactions database 	<ul style="list-style-type: none"> • Myasthenia gravis • Severe hepatic insufficiency • Severe respiratory insufficiency • Sleep apnea
Chlordiazepoxide (Librium [®])		
Clobazam (Onfi [®])		<ul style="list-style-type: none"> • Myasthenia gravis • Narrow-angle glaucoma • Severe hepatic or respiratory disease • Sleep apnea • H/o substance abuse • Pregnancy (1st trimester) • Breast feeding
Clonazepam (Klonopin [®])	<ul style="list-style-type: none"> • Hypersensitivity to other benzos • Significant liver disease • Acute narrow-angle glaucoma (may be used in treated open angle glaucoma) 	<ul style="list-style-type: none"> • Severe respiratory insufficiency • Sleep apnea syndrome • Myasthenia gravis
Clorazepate (Tranxene [®])	<ul style="list-style-type: none"> • Acute narrow-angle glaucoma 	<ul style="list-style-type: none"> • Myasthenia gravis
Diazepam (Valium [®])	<ul style="list-style-type: none"> • Acute narrow-angle glaucoma • Untreated open-angle glaucoma • Myasthenia gravis • Severe respiratory impairment • Severe hepatic impairment • Sleep apnea 	
Flurazepam (Dalmane [®])	<ul style="list-style-type: none"> • Hypersensitivity to other benzos • Pregnancy 	<ul style="list-style-type: none"> • Severe respiratory function impairment • Myasthenia gravis • Severe hepatic impairment
Lorazepam (Ativan [®])	<ul style="list-style-type: none"> • Cross-sensitivity with other benzos may exist • Acute narrow-angle glaucoma 	<ul style="list-style-type: none"> • Myasthenia gravis
Oxazepam (Serax [®])		<ul style="list-style-type: none"> • H/o Glaucoma • Myasthenia gravis
Temazepam (Restoril [®])		<ul style="list-style-type: none"> • Hypersensitivity to other benzos • Myasthenia gravis • Sleep apnea • Prior paradoxical reactions to ethanol and/or sedatives
Triazolam (Halcion [®])	<ul style="list-style-type: none"> • Hypersensitivity to other benzos • Concurrent therapy with strong CYP 3A inhibitors (eg, itraconazole, ketoconazole, nefazodone, lopinavir, ritonavir) • Significant DDIs may require dose/frequency adjustment or avoidance. Consult drug interactions database 	<ul style="list-style-type: none"> • H/o paradoxical reactions to alcohol and/or sedatives • H/o substance or alcohol abuse • Myasthenia gravis • Narrow-angle glaucoma • Pregnancy

This table applies to oral formulations & adults only

DDI: Drug drug interactions, Benzos: Benzodiazepines, H/o: History of