POCKET GUIDE

MEDICATION-ASSISTED TREATMENT OF OPIOID USE DISORDER

Substance Abuse and Mental Health Services Administration

SAMHSA

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Nearly 80 percent of individuals with an opioid use disorder do not receive treatment. In the 2014 National Survey on Drug Use and Health (NSDUH), 435,000 respondents ages 12 or older reported current use of heroin. Nonmedical use of pain relievers continues to be more widespread than heroin use—4.3 million NSDUH respondents reported nonmedical use of pain relievers in the past month. Medication-assisted treatment (MAT) is an effective response to opioid use disorder. It is the use of medications, in combination with behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Individuals receiving MAT often demonstrate dramatic improvement in addiction-related behaviors and psychosocial functioning.

The first barrier to accessing treatment is failure to recognize substance use disorder. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an approach in which screening is followed up as appropriate with brief intervention to promote healthy behavior change and with referral to treatment for those needing more extensive care. (www.samhsa.gov/sbirt)

Produced by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Checklist for Prescribing Medication for the Treatment of Opioid Use Disorder

Assess the need for treatment

For persons diagnosed with an opioid use disorder, first determine the severity of patient's substance use disorder. Then identify any underlying or co-occurring diseases or conditions, the effect of opioid use on the patient's physical and psychological functioning, and the outcomes of past treatment episodes.

Your assessment should include:

A patient history

- Ensure that the assessment includes a medical and psychiatric history, a substance use history, and an evaluation of family and psychosocial supports.
- Access the patient's prescription drug use history through the state's prescription drug monitoring program (PDMP), where available, to detect unreported use of other medications, such as sedative-hypnotics or alcohol, that may interact adversely with the treatment medications.

- A physical examination that focuses on physical findings related to addiction and its complications.
- Laboratory testing to assess recent opioid use and to screen for use of other drugs. Useful tests include a urine drug screen or other toxicology screen, urine test for alcohol (ethyl glucuronide), liver enzymes, serum bilirubin, serum creatinine, as well as tests for hepatitis B and C and HIV.

Educate the patient about how the medication works and the associated risks and benefits; obtain informed consent; and educate on overdose prevention.

There is a potential for relapse and overdose on discontinuation of the medication. Patients should be educated about the effects of using opioids and other drugs while taking the prescribed medication and the potential for overdose if opioid use is resumed after tolerance is lost.

Evaluate the need for medically managed withdrawal from opioid

Naltrexone patients must first be medically withdrawn from opioids.

Address co-occurring disorders

Have an integrated treatment approach to meet the substance use, medical and mental health, and social needs of a patient.

Integrate pharmacologic and nonpharmacologic therapies

All medications for the treatment of the opioid use disorder should be prescribed as part of a comprehensive individualized treatment plan that includes counseling and other psychosocial therapies, as well as social support through participation in Narcotics Anonymous and other mutual-help programs.

Refer patients for higher levels of care, if necessary

Refer the patient for more intensive or specialized services if office-based treatment with buprenorphine or naltrexone is not effective or the clinician does not have the resources to meet a particular patient's needs, Providers can find programs in their areas or throughout the United States by using SAMHSA's Behavioral Health Treatment Services Locator at www.findtreatment.samhsa.gov.

Medications Approved in the Treatment of Opioid Use Disorder*

▶ Frequency of Administration

Extended Release Injectable Naltrexone	Methadone	Buprenorphine
Monthly†	Daily	Daily (also alternative dosing regimens)

▶ Route of Administration

Extended Release Injectable Naltrexone	Methadone	Buprenorphine
Intramuscular (IM) injection into the gluteal muscle by a physician or other health care professional.†	Orally as liquid concentrate, tablet or oral solution of diskette or powder.	Oral tablet or film is dissolved under the tongue.

Who May Prescribe or Dispense

Extended Release Injectable Naltrexone	Methadone	Buprenorphine
Any individual who is licensed to prescribe medicines (e.g., physician, physician assistant, nurse practitioner) may prescribe and/or order administration by qualified staff.	SAMHSA-certified Opioid Treatment Programs dispense methadone for daily administration either on site or, for stable patients, at home.	Physicians must have board certification in addiction medicine or addiction psychiatry and/or complete special training to qualify for the federal waiver to prescribe buprenorphine, but any pharmacy can fill the prescription. There are no special requirements for staff members who dispense buprenorphine under the supervision of a waivered physician.

*Table highlights some properties of each medication. It does not provide complete information and is not intended as a substitute for the package inserts or other drug reference sources used by clinicians (see www.dailymed.nlm.nih.gov for current package inserts). For patient information about these and other drugs, visit the National Library of Medicine's MedlinePlus (www.medlineplus.gov). Whether a medication should be prescribed and in what amount are matters to be discussed between an individual and his or her health care provider. The prescribing information provided here is not a substitute for the clinician's judgment, and the National Institutes of Health and SAMHSA accept no liability or responsibility for use of the information in the care of individual patients.

†Naltrexone hydrochloride tablets (50 mg each) are also available for daily dosing.

Pharmacologic Category

Extended Release Injectable Naltrexone	Methadone	Buprenorphine
Opioid antagonist Naltrexone displaces opioids from receptors to which they have bound. This can precipitate severe, acute withdrawal symptoms if administered in persons who have not completely cleared opioid from their system. Patients who have been treated with extended-release injectable naltrexone will have reduced tolerance to opioids. Subsequent exposure to previously tolerated or even smaller amounts of opioids may result in overdose.	Opioid agonist Patients starting methadone should be educated about the risk of overdose during induction onto methadone, if relapse occurs, or substances such as benzodiazepines or alcohol are consumed. During induction, a dose that seems initially inadequate can be toxic a few days later because of accumulation in body tissues. For guidance on methadone dosing for all phases of MAT consult: TIP 43 (http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214)	Opioid partial agonist Buprenorphine's partial agonist effect relieves withdrawal symptoms resulting from cessation of opioids. This same property will induce a syndrome of acute withdrawal in the presence of long-acting opioids or sufficient amounts of receptor-bound full agonists. Naloxone, an opioid antagonist, is sometimes added to buprenorphine to make the product less likely to be abused by injection.

Clinical Uses/Ideal Candidates

Extended Release Injectable Naltrexone	Methadone	Buprenorphine
Prevention of relapse to opioid use disorder following opioid detoxification; studies suggest benefits for patients who are experiencing increased stress or other relapse risks (e.g., visiting places of previous drug use, loss of spouse, loss of job). Appropriate for patients who have been detoxified from opioids and who are being treated for a co-occurring alcohol use disorder. Extended-release naltrexone should be part of a comprehensive management program that includes psychosocial support. Other good candidates include persons with a short or less severe addiction history or who must demonstrate to professional licensing boards or criminal justice officials that their risk of opioid use is low.	Detoxification and maintenance treatment of opioid addiction. Patients who are motivated to adhere to the treatment plan and who have no contraindications to methadone therapy. Methadone should be part of a comprehensive management program that includes psychosocial support.	Treatment of opioid dependence. Patients who are motivated to adhere to the treatment plan and who have no contraindications to buprenorphine therapy. Buprenorphine should be part of a comprehensive management program that includes psychosocial support.

Contraindications

Extended Release Injectable Naltrexone	Methadone	Buprenorphine
Contraindicated in patients receiving long-term opioid therapy. Contraindicated in patients who are engaged in current opioid use (as indicated by self-report or a positive urine drug screen) or who are on buprenorphine or methadone maintenance therapy, as well as in those currently undergoing opioid withdrawal. Contraindicated in patients with a history of sensitivity to polylactide-co-glycolide, carboxymethylcellulose, or any components of the diluent. Should not be given to patients whose body mass precludes IM injection with the 2-inch needle provided; inadvertent subcutaneous injection may cause a severe injection site reaction. Should not be given to anyone allergic to naltrexone.	Contraindicated in patients who are hypersensitive to methadone hydrochloride or any other ingredient in methadone hydrochloride tablets, diskettes, powder or liquid concentrate. Contraindicated in patients with respiratory depression (in the absence of resuscitative equipment or in unmonitored settings) and in patients with acute bronchial asthma or hypercarbia. Contraindicated in any patient who has or is suspected of having a paralytic ileus.	Contraindicated in patients who are hypersensitive to buprenorphine or naloxone.

Warnings

Extended Release Injectable Naltrexone	Methadone	Buprenorphine
Use with caution in patients with active liver disease, moderate to severe renal impairment, and women of childbearing age. Discontinue in the event of symptoms or signs of acute hepatitis. As with any IM injection, extended-release injectable naltrexone should be used with caution in patients with thrombocytopenia or any coagulation disorder (e.g., hemophilia, severe hepatic failure); such patients should be closely monitored for 24 hours after naltrexone is administered. Patients may become sensitive to lower doses of opioids after treatment with extended-release injectable naltrexone. This could result in potentially life-threatening opioid intoxication and overdose if previously tolerated larger doses are administered. Clinicians should warn patients that overdose may result from trying to overcome the opioid blockade effects of naltrexone.	Methadone should be used with caution in elderly and debilitated patients; patients with head injury or increased intracranial pressure; patients who are known to be sensitive to central nervous system depressants, such as those with cardiovascular, pulmonary, renal, or hepatic disease; and patients with comorbid conditions or concomitant medications that may predispose to dysrhythmia or reduced ventilatory drive. Methadone should be administered with caution to patients already at risk for development of prolonged QT interval or serious arrhythmia. The label includes a warning about somnolence that may preclude driving or operating equipment.	Caution is required in prescribing buprenorphine to patients with polysubstance use and those who have severe hepatic impairment, compromised respiratory function, or head injury. Significant respiratory depression and death have occurred in association with buprenorphine, particularly administered intravenously or in combination with benzodiazepines or other central nervous system depressants (including alcohol). Buprenorphine may precipitate withdrawal if initiated before patient is in opioid withdrawal, particularly in patients being transferred from methadone. The label includes a warning about somnolence that may preclude driving or operating equipment.

Use in Pregnant and Postpartum Women

Extended Release Injectable Naltrexone	Methadone	Buprenorphine
Pregnancy: FDA pregnancy category C‡ ***Nursing:*** Transfer of naltrexone and 6ß-naltrexol into human milk has been reported with oral naltrexone. Because animal studies have shown that naltrexone has a potential for tumorigenicity and other serious adverse reactions in nursing infants, an individualized treatment decision should be made whether a nursing mother will need to discontinue breastfeeding or discontinue naltrexone.	***Pregnancy:*** FDA pregnancy category C‡ Methadone has been used during pregnancy to promote healthy pregnancy outcomes for more than 40 years. Neonatal abstinence syndrome may occur in newborn infants of mothers who received medication-assisted treatment with methadone during pregnancy. No lasting harm to the fetus has been recognized as a result of this therapy but individualized treatment decisions balancing the risk and benefits of therapy should be made with each pregnant patient. ***Nursing:*** Mothers maintained on methadone can breastfeed if they are not HIV positive, are not abusing substances, and do not have a disease or infection in which breastfeeding is otherwise contraindicated.	***Pregnancy:*** FDA pregnancy category C‡ Neonatal abstinence syndrome may occur in newborn infants of mothers who received medication-assisted treatment with buprenorphine during pregnancy. No lasting harm to the fetus has been recognized as a result of this therapy but individualized treatment decisions balancing the risk and benefits of therapy should be made with each pregnant patient. ***Nursing:*** Buprenorphine and its metabolite norbuprenorphine are present in low levels in human milk and infant urine. Available data are limited but have not shown adverse reactions in breastfed infants.

Potential for Abuse and Diversion

Extended Release Injectable Naltrexone	Methadone	Buprenorphine
No	Yes	Yes

‡Animal studies have shown an adverse effect on the fetus and there are no adequate, well-controlled studies in humans, but potential benefits may warrant use of the drug in some pregnant women despite potential risks.

Clinical Opiate Withdrawal Scale

This tool can be used in both inpatient and outpatient settings to reproducibly rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time.

Resting Pulse Rate: _____ beats/minute

Measured after patient is sitting or lying for one minute.

0 pulse rate 80 or below
1 pulse rate 81-100
2 pulse rate 101-120
4 pulse rate greater than 120

GI (Gastrointestinal) Upset: *Over last 1/2 hour.*

0 no GI symptoms
1 stomach cramps
2 nausea or loose stool
3 vomiting or diarrhea
5 multiple episodes of diarrhea or vomiting

Sweating: *Over past 1/2 hour not accounted for by room temperature or patient activity.*

0 no report of chills or flushing
1 subjective report of chills or flushing
2 flushed or observable moistness on face
3 beads of sweat on brow or face
4 sweat streaming off face

Tremor: *Observation of outstretched hands.*

0 no tremor
1 tremor can be felt, but not observed
2 slight tremor observable
4 gross tremor or muscle twitching

Restlessness: *Observation during assessment.*

0 able to sit still
1 reports difficulty sitting still, but is able to do so
3 frequent shifting or extraneous movements of legs/arms
5 unable to sit still for more than a few seconds

Yawning: *Observation during assessment.*

0 no yawning
1 yawning once or twice during assessment
2 yawning three or more times during assessment
4 yawning several times/minute

Pupil Size:

0 pupils pinned or normal size for room light
1 pupils possibly larger than normal for room light
2 pupils moderately dilated
5 pupils so dilated that only the rim of the iris is visible

Bone or Joint Aches: *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored.*

0 not present
1 mild diffuse discomfort
2 patient reports severe diffuse aching of joints/muscles
4 patient is rubbing joints or muscles and is unable to sit still because of discomfort

Runny Nose or Tearing: *Not accounted for by cold symptoms or allergies.*

0 not present
1 nasal stuffiness or unusually moist eyes
2 nose running or tearing
4 nose constantly running or tears streaming down cheeks

Anxiety or Irritability:

0 none
1 patient reports increasing irritability or anxiousness
2 patient obviously irritable or anxious
4 patient so irritable or anxious that participation in the assessment is difficult

Gooseflesh Skin:

0 skin is smooth
3 piloerrection of skin can be felt or hairs standing upon arms
5 prominent piloerrection

TOTAL SCORE: _____

The total score is the sum of all 11 items.

▶ ***SCORE:*** **5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal**

Initials of person completing assessment: _____

http://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf
Source: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). J Psychoactive Drugs, 35(2), 253–9.

Disclaimer

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This publication may be downloaded or ordered at store.samhsa.gov. Or call SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

Information contained in this guide is condensed from the SAMHSA publication *Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide* (SMA14-4892R), which is available at http://store.samhsa.gov.

For more information visit:
http://www.samhsa.gov

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