HIV CLINICAL RESOURCE ¼-FOLDED GUIDE

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TREATMENT OF OPIOID USE DISORDER

NYSDOH AIDS INSTITUTE HIV CLINICAL GUIDELINE AUGUST 2019

ALL RECOMMENDATIONS: HARM REDUCTION APPROACH IN SUBSTANCE USE DISORDER (SUD) TREATMENT *See full guideline for additional information*

Harm Reduction Approach in Treatment of All SUDs

- For patients who use substances, whether or not they are engaging in SUD treatment, clinicians should continue to offer medical care and offer or refer for harm reduction services and counseling on safer substance use. (A3)
- For patients who inject drugs, clinicians should: Provide patient education on the risks of sharing injection equipment (A3); offer to prescribe needles and syringes (B3); discuss other options for accessing sterile needles and syringes, including use of the *NYS Expanded Syringe Access Program and Syringe Exchange Programs*. (A2)

Implementing a Harm Reduction Treatment Plan

- Clinicians should collaborate with patients to set specific treatment goals (A3); goals other than full abstinence are acceptable, e.g., changes in use resulting in increased well-being and decreased harm or potential harm. (A3)
- To assist patients in planning and reaching treatment goals, clinicians should ask them about the role and effects of substance use in their daily lives. (A3)
- Clinicians and patients should decide on an appropriate level of care (e.g., venue and/or intensity) based on: Medically recommended treatment for the patient's SUD(s); the patient's need for other support and services, such as medical or mental health care and psychosocial support; availability of care; patient preference. (B3)
- For patients with an SUD, clinicians should offer pharmacologic treatment when it is indicated. (A3)
- Clinicians should not discontinue SUD treatment due solely to recurrences or continuation of use. (A3)

Reducing Stigma

- Clinicians should examine their assumptions and decisions for any biases that may affect their ability to provide effective care for individuals who use substances. (A3)
- Clinicians and other staff interacting with patients should use neutral terms to describe all aspects of substance use and avoid language that perpetuates stigma. (A2)

ALL RECOMMENDATIONS: TREATMENT OF OPIOID USE DISORDER (OUD) *Please see full guideline for additional information* P.1

Pharmacologic Treatment

- Clinicians should offer pharmacologic treatment to all patients with OUD. (A1)
- Clinicians should *not* exclude patients from pharmacologic treatment due to lack of participation in structured psychosocial therapy, such as general counseling, cognitive behavioral therapy, or contingency management. (A1)
  - Note: If a patient is court-ordered to participate in psychosocial therapy, the clinician who is providing pharmacologic treatment should partner with the patient to ensure compliance with the court order.
- Clinicians should not exclude patients from pharmacologic treatment solely due to co-occurring SUDs or other substance use. (A2)
- Because OUD is a chronic condition, clinicians should recommend long-term pharmacologic treatment, which, in some cases, may be lifelong. (A1)
- Clinicians should offer pharmacologic treatment to patients with OUD who are not actively using opioids but are at risk of relapse or overdose. (B3)
- Before a patient with OUD who has been treated for an opioid overdose or a complication related to opioid use leaves an acute care setting, clinicians should initiate or recommend pharmacologic treatment. (A1)
- Clinicians should provide or prescribe naloxone (NLX) to all patients with OUD so they are prepared in case of an opioid overdose (A2) and should encourage patients to have their partners, families, and household or other close contacts trained to use NLX. (A3)

Treatment Options

- Clinicians should inform patients with OUD about all available pharmacologic options (BUP, methadone, and extended-release injectable naltrexone) and all formulations. (A3)

Choosing a Treatment Option

- Clinicians should recommend coformulated BUP/NLX or methadone as the preferred treatments for individuals with OUD. (A3) See *Table 1*, inside.
- Clinicians and patients should choose the pharmacologic medication for OUD based on: The patient's opioid tolerance and prior treatment experiences; available formulations and adverse effects; evidence of effectiveness of the different treatment options; ease of access; presence of other medical conditions; insurance coverage; and patient preference. (A3)
- If individuals who are treated for OUD with BUP/NLX or XR naltrexone require opioid analgesics for pain management, clinicians should refer patients to methadone treatment; if methadone treatment is not available, consult or refer patients to an experienced substance use treatment or pain management provider. (B3)

ALL RECOMMENDATIONS: TREATMENT OF OPIOID USE DISORDER (OUD), CONTINUED P.2

Choosing a Treatment Option, continued

- Clinicians should refer patients who have continued symptoms of opioid withdrawal or cravings on a maximum dose of BUP/NLX 24 mg/6 mg per day, taken as 1 dose or split into 2 doses, to methadone treatment. If methadone treatment is not available, clinicians should consult or refer patients to an experienced substance use treatment provider. (A3)
- Clinicians should offer XR naltrexone to patients who prefer naltrexone for treatment, or who are not able to access treatment with or not able to meet their treatment goals with methadone or BUP/NLX. (A3)

BUP/NLX (Preferred Treatment Regimen)

- Because initiation of BUP/NLX treatment may induce precipitated withdrawal, clinicians should verify—by observation or patient report—that a patient is already experiencing signs and symptoms of opioid withdrawal before starting treatment. (A2)
- Clinicians should titrate a patient's dose of BUP/NLX to the dose needed to control the patient's opioid cravings, reduce or prevent withdrawal symptoms, and support the individual's treatment goals. (A3)
- Because home-based, unobserved BUP/NLX induction and office-based, observed induction are equally effective, clinicians should choose an induction approach based on patient and healthcare provider experience, comfort, and preferences. (B2)
- If tapering BUP/NLX treatment, clinicians should inform patients about the risks of relapse, reduced tolerance, and opioid overdose (A3) and should offer patients a slow tapering schedule to minimize withdrawal symptoms (B3).

Methadone (Preferred Treatment Regimen)

- Because methadone cannot be prescribed in an office-based setting for treatment of OUD, clinicians should recommend and refer a patient to a methadone maintenance treatment program if the patient prefers methadone treatment, cannot access BUP/NLX, or has continued symptoms of opioid withdrawal or cravings while on the maximum dose of BUP/NLX 24 mg/6 mg daily. (A3)

XR Naltrexone (Alternative Regimen)

- When informing patients about XR naltrexone as a treatment option, clinicians should emphasize the strong motivation and adherence required for success. (B1)
- Before administering XR naltrexone, clinicians should administer a NLX challenge and confirm that the patient has no reaction to ensure that opioids have been cleared from the system. (A2)

KEY POINTS

- **Alternative treatment goals:** Long-term cessation of opioid use, a traditional goal of SUD treatment, is not achievable for many patients, and alternative goals can lead to substantial improvements in the health and lives of those with OUD.
  - Alternative goals include: 1) Staying engaged in care, which can also facilitate prevention, diagnosis, and treatment of other conditions; 2) reducing opioid use; 3) reducing high-risk behaviors, such as injection drug use and sharing of injection equipment, and reducing related complications, such as infection and overdose; and 4) improving quality of life and other social indicators, such as employment, stable housing, and risk of incarceration.
  - SUD treatment medications and other treatments should not be denied or discontinued in individuals with SUDs because they continue or return to use; individuals who continue to use can benefit from treatment.
- **Support:** Ongoing, regular follow-up is essential for support, encouragement, and modification of the treatment plan as needed.
  - Follow-up within 2 weeks of treatment initiation allows tailoring of the treatment plan (e.g., change in dose of pharmacologic treatment, addition of support services) according to individual needs.
  - As individuals stabilize on treatment, monthly or at least quarterly follow-up allows for ongoing evaluation to ensure that the patient's goals are being met.
- **Before prescribing BUP/NLX:** The NYS prescription drug monitoring program (PDMP) tracks a patient's history of dispensed controlled substances and must be consulted before providing each prescription for BUP/NLX (see *New York State I-STOP/PMP – Internet System for Tracking Over-Prescribing – Prescription Monitoring Program*). However, medications dispensed in opioid treatment programs (OTPs) are not included in the PDMP.

← Use this code with your phone's QR code reader to go directly to a mobile-friendly version of the guideline.

This ¼-Folded Guide is a companion to the New York State Department of Health AIDS Institute guideline *Treatment of Opioid Use Disorder*. The full guideline is available at www.hivguidelines.org.

TABLE 1: MEDICATIONS FOR TREATMENT OF OPIOID USE DISORDER IN NONPREGNANT ADULTS [a]

MEDICATION [b]	DOSE	CONSIDERATIONS FOR USE
PREFERRED MEDICATIONS		
Buprenorphine/naloxone (BUP/NLX) sublingual and buccal, film and tablet (multiple brands) **Mechanism:** Partial opioid agonist	· **Initial:** Individualized; BUP/NLX 2 mg/0.5 mg to BUP/NLX 8 mg/4 mg. · **Titration:** Adjust dose in increments or decrements of BUP/NLX 2 mg/0.5 mg or BUP/NLX 4 mg/1 mg to reach a level that will control the patient's opioid cravings and withdrawal symptoms and support treatment goals. · **Maximum dose:** BUP/NLX 24 mg/6 mg taken once per day or split into 2 doses per day.	· By observation and/or patient report, confirm that the patient is experiencing signs and symptoms of opioid withdrawal [c]. · Under the *Drug Addiction Treatment Act*, physicians must qualify for a waiver to prescribe BUP. Physicians must complete 8 hours of required training and an application for the waiver, and nurse practitioners, certified nurse midwives, nurse anesthetists, other advanced practice nurses, and physician assistants must complete an additional 16 hours of training (24 hours total of training) – **New York State:** To contact qualified clinicians, call the NYS HOPEline at 1-877-8-HOPENY or use the Substance Abuse and Mental Health Services Administration (SAMHSA) national *Buprenorphine Practitioner Locator*. – **New York City:** To contact qualified clinicians, see *Opioid Addiction Treatment with Buprenorphine or Methadone: How to Find Treatment.* – For information on applying for a waiver, contact SAMHSA or the American Society of Addiction Medicine's *Provider's Clinical Support System (PCSS)*.
Methadone, oral liquid (multiple brands) **Mechanism:** Full opioid agonist	· **Initial:** Individualized dose based on opioid treatment program (OTP) evaluation. · **Titration:** Individualized to reach a dose that will control the patient's opioid cravings and withdrawal symptoms and support treatment goals.	· For a list of certified OTPs in NYS, contact the *Office of Alcoholism and Substance Abuse Services*.
ALTERNATIVE MEDICATIONS		
· BUP monotherapy sublingual tablet (multiple brands) · BUP subdermal implants (Probuphine) [d] · BUP subcutaneous (abdominal) injection (Sublocade) [d] **Mechanism:** Partial opioid agonist	**Tablets:** · **Initial:** Individualized, 2 mg to 8 mg. · **Titration:** Increase dose by increments of 2 mg to 4 mg daily over 3 to 4 days to reach a dose that will that will control the patient's opioid cravings and withdrawal symptoms. **Implants:** 4 upper-arm subdermal implants lasting 6 months. **Injection:** · **Initial:** 300 mg every 4 weeks. · **Maintenance:** 100 mg to 300 mg every 4 weeks.	· Under the *Drug Addiction Treatment Act*, physicians must qualify a waiver to prescribe buprenorphine. Physicians must complete 8 hours of training and an application for the waiver, and nurse practitioners and physician assistants must complete an additional 16 hours of training – **New York State:** To contact qualified clinicians, call the NYS HOPEline at 1-877-8-HOPENY or use the Substance Abuse and Mental Health Services Administration (SAMHSA) national *Buprenorphine Practitioner Locator*. – **New York City:** To contact qualified clinicians, see *Opioid Addiction Treatment with Buprenorphine or Methadone: How to Find Treatment.* – For information on applying for a waiver, contact SAMHSA or the American Society of Addiction Medicine's *Provider's Clinical Support System (PCSS)*.
Naltrexone long-acting injectable (XR naltrexone) (Vivitrol) **Mechanism:** Opioid antagonist	· 380 mg intragluteal injections every 28 days.	· Inform patients of the risk of precipitated and protracted opioid withdrawal [e] if opioids are used prior to taking naltrexone. · Emphasize the strong motivation and adherence needed for treatment success. · Warn patients of increased risk of opioid overdose after discontinuing naltrexone, due to increased sensitivity. · Confirm the length of time since last opioid use with an NLX challenge: Administer a single intranasal dose (2.0 mg/0.1 cc) of NLX and observe the patient's reaction. In individuals with recent opioid use, this may precipitate opioid withdrawal. · Prescribe a short course of oral naltrexone to confirm the patient can tolerate the medication. · Contraindications: Acute hepatitis or liver failure; concomitant use of opioid analgesics or opioid agonists (e.g., methadone or BUP); acute opioid withdrawal; positive urine test result for opioids; failure of the opioid antagonist challenge test.

a. For OUD treatment in pregnant individuals, see the *American College of Obstetrics and Gynecology (ACOG) Opioid Use and Opioid Use Disorder in Pregnancy*.

b.Consult full prescribing information for each drug before prescribing.

c. Opioid withdrawal symptoms include increased heart rate, chills, insomnia, bone or joint aches, gastrointestinal symptoms (cramping, diarrhea, nausea, vomiting), anxiety/irritability, "goosebumps" on skin, increased sweating, restlessness, dilated pupils, runny nose or tearing, tremor, and yawning.

d. Use for maintenance after treatment initiation with transmucosal buprenorphine and adjustment to optimal dose.

e When withdrawal is precipitated abruptly by the administration of an opioid antagonist to an opioid-dependent patient, the resulting withdrawal syndrome can be severe enough to require hospitalization. Symptoms of withdrawal usually appear within 5 minutes of ingestion of naltrexone and can last for up to 48 hours. Changes in mental status include confusion, somnolence, and visual hallucinations, and patients can experience significant fluid losses from vomiting and diarrhea requiring intravenous fluid administration.

KEY POINTS

- The harm of not treating OUD outweighs the risk of adverse events that may be associated with concurrent use of alcohol or benzodiazepines and methadone or BUP.
- Patients who are seen in EDs or other acute care settings for opioid overdose or complications related to opioid use are at risk of a fatal overdose. Pharmacologic treatment for OUD should be initiated or recommended before the patient leaves the acute care setting. In addition, NLX should be dispensed or prescribed.
- Medical settings should offer all pharmacologic OUD treatment options allowed under state and federal regulations.
- Pharmacologic treatment for OUD with BUP/NLX, other formulations of BUP, and XR naltrexone does not require specialized substance use care or clinics. These medications can be prescribed by medical providers in nonspecialized settings and, ideally, integrated into primary care practice.
- Fentanyl is a common and often unidentified additive to heroin and other drugs. In New York City, it has been found in samples of cocaine, methamphetamine, and in counterfeit pills that look like various opioid analgesics and benzodiazepines. Because fentanyl is much more potent than heroin, it can increase the likelihood of a fatal overdose. It is important to advise individuals who use drugs how to avoid a fentanyl overdose: start with a small amount of a drug, carry NLX to reverse an opioid overdose if it occurs, and avoid mixing drugs.