Before prescribing BUP/NLX:

Alternative treatment goals

- Alternative goals include: 1) Staying engaged in care, which can also facilitate modification of the treatment plan as needed. 2) Stopping drug use; individuals who continue to use can benefit from treatment. 3) Minimizing signs and symptoms of withdrawal or cravings on a maximum dose of BUP/NLX 24 mg/6 mg per day, taken as needed. 4) If tapering BUP/NLX treatment, clinicians should inform patients about the risks of relapse, reduced tolerance, and opioid overdose (A3) and should offer patients continued care to prevent overdose. (A3)

- Clinicians should advise patients of the potential for withdrawal or craving as a result of stopping BUP/NLX treatment and recommend treatment to prevent withdrawal. (A2)

- Clinicians should refer patients who have continued symptoms of opioid withdrawal to a substance use treatment provider. (A3)

- If tapering BUP/NLX treatment, clinicians should inform patients about the risks of relapse, reduced tolerance, and opioid overdose (A3) and should offer patients continued care to prevent overdose. (A3)

- Ongoing, regular follow-up is essential for support, encouragement, and modification of the treatment plan as needed. (A2)

- 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. (A2)

- 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. (A3)

- 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.

- Note: If a patient is court-ordered to participate in psychosocial therapy, the clinician should refer the patient for treatment in accordance with the court order. (A3)

- Clinicians and patients should discuss pharmacotherapies that are appropriate for the patient’s needs. (A3)

- To assist patients in planning treatment goals, clinicians should ask patients about their goals and willingness to remain on treatment; if methadone treatment is not available, consult or refer patients to an experienced substance use treatment or pain management provider. (B3)

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TABLE 1: MEDICATIONS FOR TREATMENT OF OPIOID USE DISORDER IN NONPREGNANT ADULTS \(^{[a]}\)

<table>
<thead>
<tr>
<th>MEDICATION [b]</th>
<th>DOSE</th>
<th>CONSIDERATIONS FOR USE</th>
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<tbody>
<tr>
<td><strong>PREFERRED MEDICATIONS</strong></td>
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</table>
| 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/2 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  
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| 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. |

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**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 opioid 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.

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[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.

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