ALL RECOMMENDATIONS (continued from P.2) P.3

Initiating Pharmacologic Treatment, continued

- ALTERNATIVE: Disulfiram: For use if patients have the treatment goal of abstinence from alcohol use.
  - Clinicians should consider disulfiram for individuals with AUD who have not responded to or are intolerant of naltrexone or acamprosate, or who may prefer disulfiram. (A3)
  - Clinicians should advise patients that they should not take disulfiram until they have been abstinent from alcohol for 12 hours or longer. (A3)
  - Clinicians should emphasize the importance of avoiding alcohol consumption in all forms to patients taking disulfiram. (A3)
  - Clinicians should discontinue disulfiram treatment in any individual with symptoms of acute hepatitis or acute liver failure. (A3)
  - Contraindications: Clinicians should not prescribe disulfiram for patients who have recent or concomitant use of metronidazole, paraldehyde, alcohol, or alcohol-containing preparations (e.g., cough syrups, tonics; coronary artery disease; recent myocardial infarction; psychoses; or signs or symptoms of acute hepatitis or acute liver failure. (A3)
  - ALTERNATIVES: Gabapentin or Topiramate: For use if patients have the treatment goal of reducing or abstaining from alcohol use. Clinicians should consider gabapentin or topiramate for individuals with AUD who have not responded to or are intolerant of naltrexone or acamprosate, or who may prefer gabapentin or topiramate. (A3)

Initiating Pharmacologic Treatment

- PREFERRED: Oral or injectable Long-Acting Extended-Release (XR) naltrexone: If the treatment goal is reduction of or abstinence from alcohol use.
  - Contraindication: Clinicians should not prescribe naltrexone for individuals with acute hepatitis or liver failure; individuals taking opioid analgesics; individuals currently physically dependent on opioids, including those currently maintained on opioid agonists (e.g., methadone) or partial agonists (e.g., buprenorphine); or individuals in treatment for opioid use disorder who require treatment with opioids.
  - For patients with AUD who also use opioids, clinicians should administer naltrexone before initiating treatment with injectable XR naltrexone. (A3)
  - Before initiating treatment with injectable XR naltrexone, clinicians should recommend XR naltrexone if adherence to an oral regimen is a concern. (B3)
  - Because active alcohol use is not a contraindication to naltrexone, clinicians should initiate naltrexone even if patients continue to use alcohol. (A1)
  - Naltrexone: For use if patients have the treatment goal of either reduction of or abstinence from alcohol use.

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**SELECTED GOOD PRACTICES**

- Emphasize that consumption of ANY alcohol during treatment with disulfiram can result in flushing, throbbing in head and neck, respiratory difficulty, nausea, copious vomiting, sweating, thirst, chest pain, palpitations, dyspnea, hypertention, tachycardia, hypotension, syncope, marked uneasiness, weakness, vertigo, blurred vision, and confusion.
- Inform patients that adverse reactions to alcohol ingestion may occur for up to 14 days after stopping disulfiram treatment.
- Advise patients to carry a wallet card or wear a medication bracelet that states they are taking disulfiram so this information will be available to emergency personnel in case of a severe adverse reaction [NIAAA 2005].
- Educate patients taking disulfiram that alcohol may be found in cough and cold medicines, mouthwashes, tonics, sauces, vinegars, and other food or skin products.

**KEY POINTS**

- Because gabapentin can induce a sense of euphoria [Mersfelder and Nichols 2016; Smith, et al. 2016] when taken in combination with other substances, especially opioids, benzodiazepines, or alcohol, there is the potential for misuse.
- Individuals may take gabapentin for recreational purposes, to control mood or anxiety, to intensify the effects of substance use disorder medication, or for intentional self-harm.
- If a strong concern about gabapentin misuse or diversion, clinicians may want to schedule monthly or more frequent follow-up visits and medication counts [Mersfelder and Nichols 2016; Smith, et al. 2016].

**ALL RECOMMENDATIONS: HARM REDUCTION APPROACH TO TREATMENT OF ALL SUBSTANCE USE DISORDERS (SUDs)**

Harm Reduction in Treatment of Substance Use Disorders

- 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 Expanded Syringe Access Program and Syringe Exchange Programs, NYS’s syringe access initiatives. (A2)
  - Follow the recommendations on providing naloxone in the NYSDOH AI guideline Treatment of Opioid Use Disorder.

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 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: (B3)
  - Medically recommended treatment for the patient’s SUDs.
  - The patient’s need for support and other services, such as medical and mental health care and psychosocial support.
  - Availability of care.
  - Patient preference.
- 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 personal 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 (see Box A: Changing the Language of Substance Use: Use Neutral Terms in the NYSDOH AI guideline, Harm Reduction Approach to Treatment of All Substance Use Disorders). (A2)

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**Table 1: Pharmacologic Treatment of Alcohol Use Disorder in Nonpregnant Adults [a]**

<table>
<thead>
<tr>
<th>Medication [b]</th>
<th>Dosage</th>
<th>Considerations for Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acamprosate oral (Brand name: Campral)</td>
<td>Initial and maintenance: 666 mg 3 times per day.</td>
<td>CONTRAINDICATION: Patients with CrCl ≤50 mL/min or eGFR ≤50 mL/min/1.73 m2. See package insert for dose adjustments based on CrCl.</td>
</tr>
<tr>
<td>Naltrexone oral (Brand name: Revia)</td>
<td>Initial and maintenance: 50 mg once daily.</td>
<td>CONTRAINDICATION: Acute hepatitis or liver failure, concomitant use of opioid analogs or opioid agonists (e.g., methadone or buprenorphine), acute opioid withdrawal.</td>
</tr>
<tr>
<td>XR Naltrexone, long-acting injectable (Brand name: Vivitrol)</td>
<td>Initial: 50 mg oral naltrexone once daily for at least 3 days. Maintenance: 380 mg intragluteal injection every 28 days.</td>
<td>CONTRAINDICATION: Acute hepatitis or liver failure, concomitant use of opioid analogs or opioid agonists (e.g., methadone or buprenorphine), acute opioid withdrawal.</td>
</tr>
<tr>
<td>Disulfiram oral (Brand name: Antabuse)</td>
<td>Initial and maintenance: 500 mg once daily for 1 to 2 weeks. Reduce to 250 mg once daily.</td>
<td>CONTRAINDICATION: Recent or concomitant use of metronidazole, paroxetine, alcohol, or alcohol-containing preparations (e.g., cough syrups, tonics); coronary artery disease; recent myocardial infarction; psychoses or signs or symptoms of acute hepatitis or acute liver failure. For all contraindications, see package insert.</td>
</tr>
<tr>
<td>Gabapentin oral (multiple brands)</td>
<td>Initial: 300 mg once daily. Titrate: Increase in increments of 300 mg. Maintenance: Up to 3,600 mg daily, divided in 3 doses; dose is based on response and tolerance.</td>
<td>A dose reduction by half is recommended for adult patients with CrCl ≤50 mL/min or eGFR ≤50 mL/min/1.73 m2. See package insert for full prescribing information.</td>
</tr>
<tr>
<td>Topiramate oral (multiple brands)</td>
<td>Initial: 25 mg once daily. Titrate: Increase dose by 50 mg increments each week to a maximum of 400 mg daily administered in 2 divided doses. Maintenance: 200 to 400 mg daily divided into 2 doses.</td>
<td>A dose reduction by half is recommended for adult patients with CrCl ≤50 mL/min or eGFR ≤50 mL/min/1.73 m2. See package insert for full prescribing information.</td>
</tr>
</tbody>
</table>

**Abbreviation key:** AST/ALT, aspartate aminotransferase/alanine aminotransferase; CrCl, creatinine clearance; eGFR, estimated glomerular filtration rate.

**a.** For treatment of pregnant individuals with AUD, see American Psychiatric Association Practice Guideline for the Pharmacological Treatment of Patients With Alcohol Use Disorder, Statement 14: Pharmacotherapy in Pregnant or Breastfeeding Women.

**b.** Consult package insert for full prescribing information for each medication.

**c.** Concomitant use of disulfiram and alcohol, even small amounts, can result in the following adverse effects: flushing, throbbing in head and neck, respiratory difficulty, nausea, copious vomiting, sweating, thirst, chest pain, palpitations, dyspnea, hypertention, tachycardia, hypotension, syncope, marked uneasiness, weakness, vertigo, blurred vision, and confusion. Severe reactions may result in respiratory depression, cardiovascular collapse, arrhythmias, myocardial infarction, acute congestive heart failure, unconsciousness, convulsions, and death.