Prescribing Medications for Addiction Treatment

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No disclosures

Before We Jump In

- Introductions
- What are your top questions about integrating medications for opioid use disorder into your behavioral health programs?

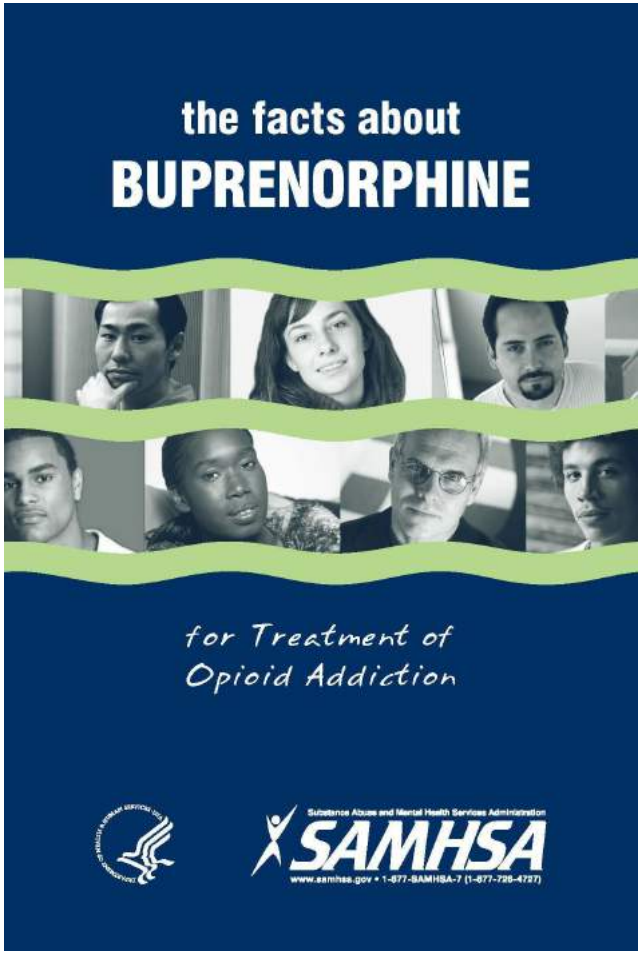
Treatment Goals

- Range of treatment goals

Minimization of harms from ongoing use

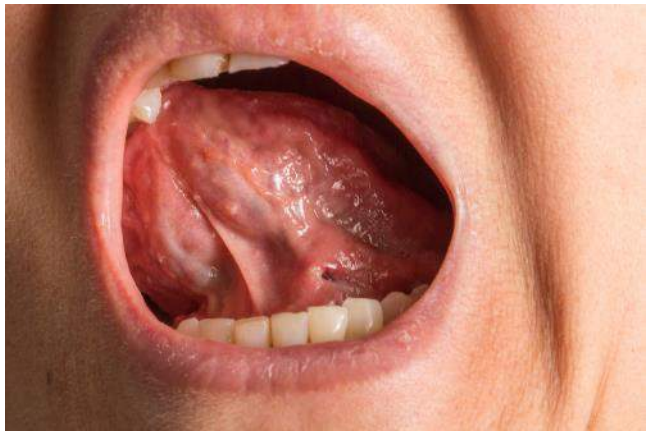
Sustained recovery with abstinence from all substances

- Treatment Options; Federations of State Medical Boards 2013
  - Buprenorphine / Methadone / Naltrexone
  - Simple detoxification and no other treatment
  - Counseling and/or peer support without MAT
  - Referral to short or long term residential treatment


the facts about
BUPRENORPHINE
for Treatment of
Opioid Addiction
Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

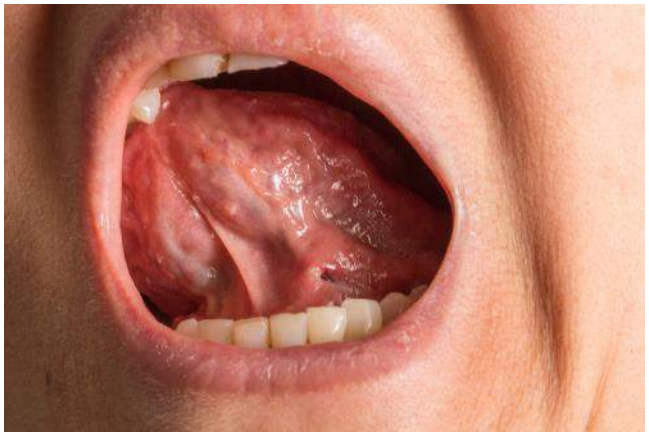
Bup/Nlx – How to Start

- How to start buprenorphine/naloxone?
  - Instruct the patient to stop using opioids, wait until they're in withdrawal, then have them take sublingual buprenorphine and up-titrate until they're not longer in withdrawal.



Bup/Nlx – How to Start

- Usual dose:
- 8mg/2mg q1H prn
- FDA max is 32mg/8mg daily - not every patient needs this dose



- Common initial Rx: Buprenorphine/Naloxone 8mg/2mg, take 2 SL daily, #56, 1 refill (if close follow-up is uncertain)

Health Services
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Buprenorphine-naloxone (Suboxone) to help with opioid withdrawal

You should receive a supply of 28 tablets or films. Begin taking them once you are feeling seriously dope-sick / in opioid withdrawal. If you are no longer in withdrawal, but want to use this medication for opioid cravings, start by taking a ½ to one full tablet or film. Let the staff know on the third day how much you have been taking each day and when you need a refill.

HOW to take buprenorphine-naloxone?

To start- 3 steps:

1. If you have used another opiate recently, WAIT until you feel AT LEAST 3 of the following:




Yawning	Sweating or chills
Enlarged pupils	Restless/Can't sit still
Joint and bone aches	Anxiety, irritable, fast heart beat
Shaking or twitches	Bumpy skin (Gooseflesh)
Watery eyes/Runny Nose	Lost Appetite, Stomach cramps
Nausea, vomiting or Diarrhea	

- *These are known as withdrawal symptoms/ you might know them as being dope sick*
- *Before you start you should be about ½ way to the worst dope sickness you have had*
- *For many people this means 12 hours after heroin, or morphine, Vicodin, Norco or oxycodone.*
- *If you took a long acting like Oxycontin or MSContin it will likely take 16-24 hours*
- *Methadone is unpredictable and can take 24-72 hours*
- *Rely on what you feel*

Health Services
LOS ANGELES COUNTY

2. Put the tablet / film under your tongue and let it dissolve [don't swallow, don't chew]

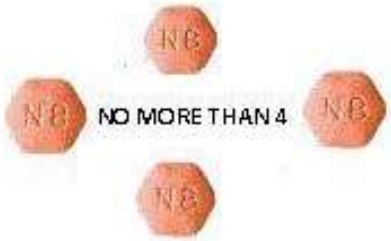
3. After 1 hour, how are you feeling?
   - o IF GOOD: nothing more to do
   - o IF still having the withdrawal symptoms or feeling worse:
     put another tablet under your tongue

Day 2:

- IF you feel good the next day, take the <u>same</u> number of total pills you took the day before
- during the day: if you feel withdrawal symptoms or feel cravings you can take another tablet under your tongue

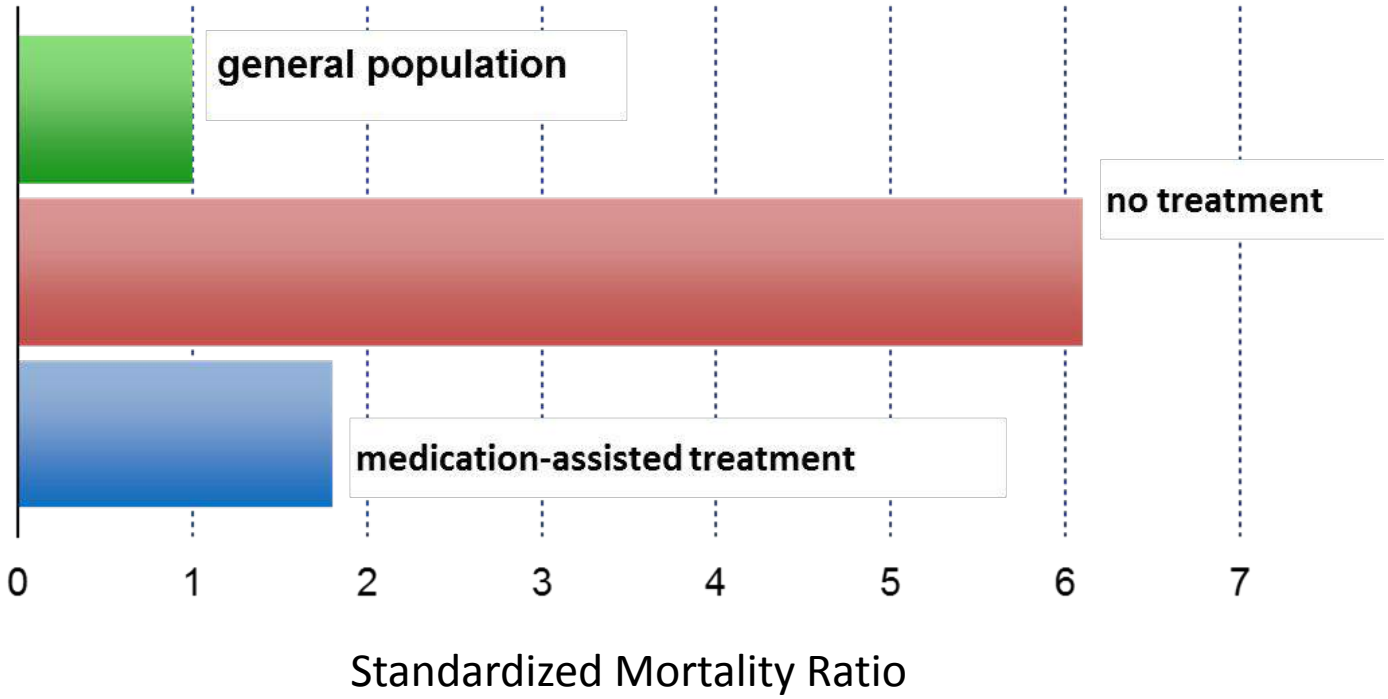
Day 3:

- IF you feel good, you can take the same number of pills you took the day before or split it however you want throughout the day.
- If you are taking LESS than 4 tablets AND you have cravings later in the day, you can take yourself the 4th tablet whatever time of the day you want.



Benefits of MAT: Decreased Mortality

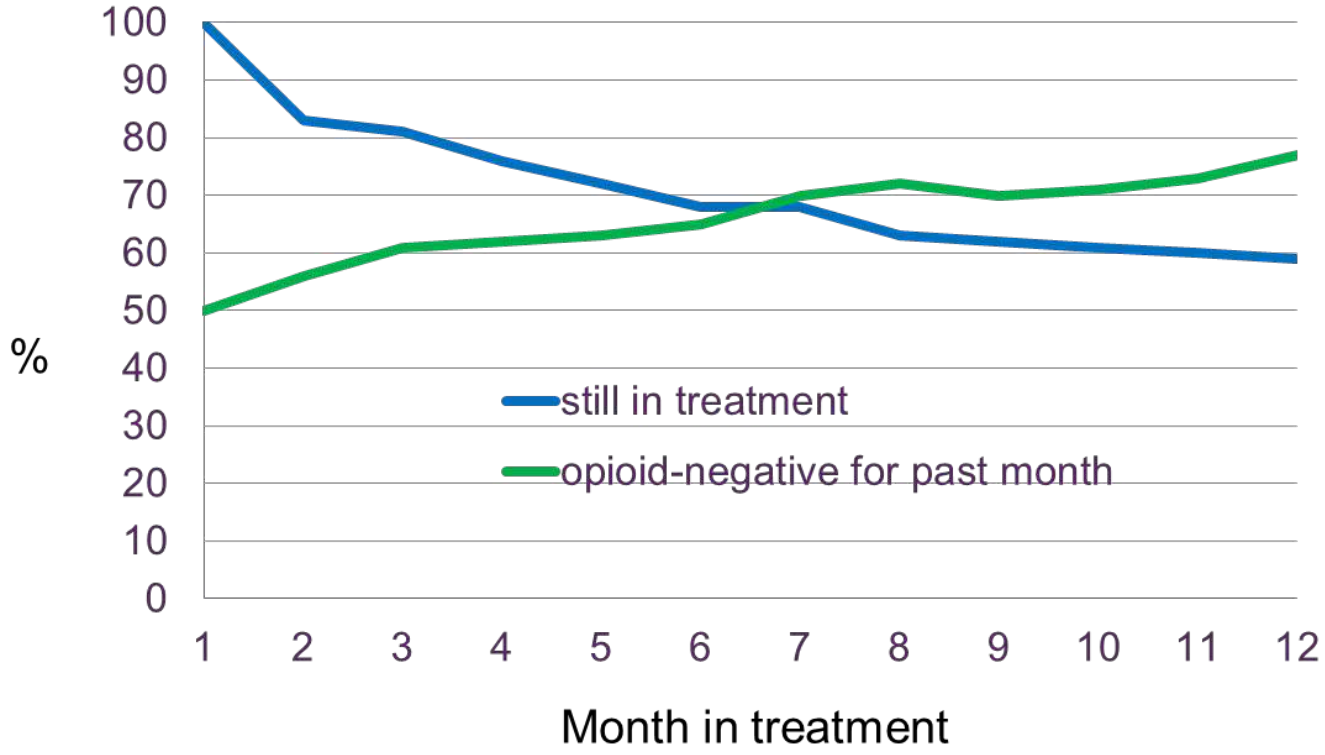
Death rates:



Dupouy et al., 2017
Evans et al., 2015
Sordo et al., 2017

Treatment Retention and Decreased Illicit Opioid Use on MAT

- Buprenorphine promotes retention, and those who remain in treatment become more likely over time to abstain from other opioids



Kakko et al, 2003
Soeffing et al., 2009

Medication FIRST Model

- People with OUD receive pharmacotherapy treatment as quickly as possible, prior to lengthy assessments or treatments planning sessions;
- Maintenance pharmacotherapy is delivered without arbitrary tapering or time limits;
- Individualized psychosocial services are continually offered but not required as a condition of pharmacotherapy;
- Pharmacotherapy is discontinued only if it is worsening the person's condition.

http://www.nomodeaths.org/medication-first-implementation

Medication FIRST Model

- Medication *first* ***does not mean*** Medication *only*
- Medication is contingent upon the pt's benefit, not based upon a timeframe, patient's participation in counseling, an unexpectedly positive test result, etc

http://www.nomodeaths.org/medication-first-implementation

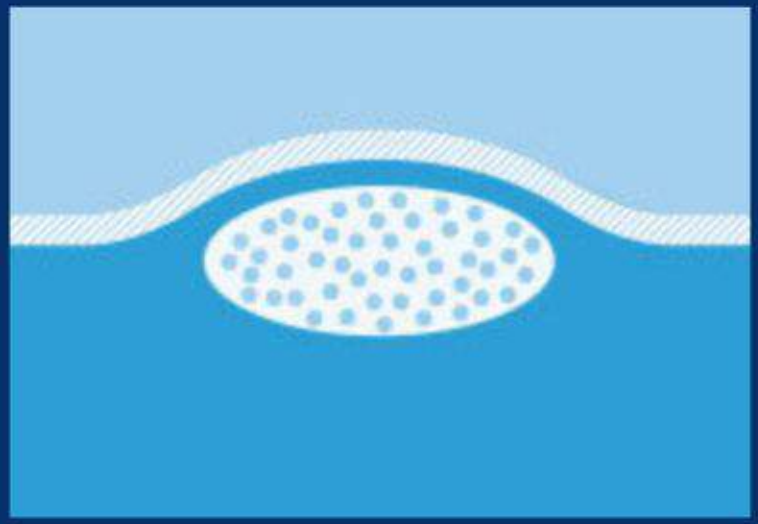
In Opioid Use Disorder:
Adding psychosocial support does not change the effectiveness of retention in treatment and opiate use during treatment.

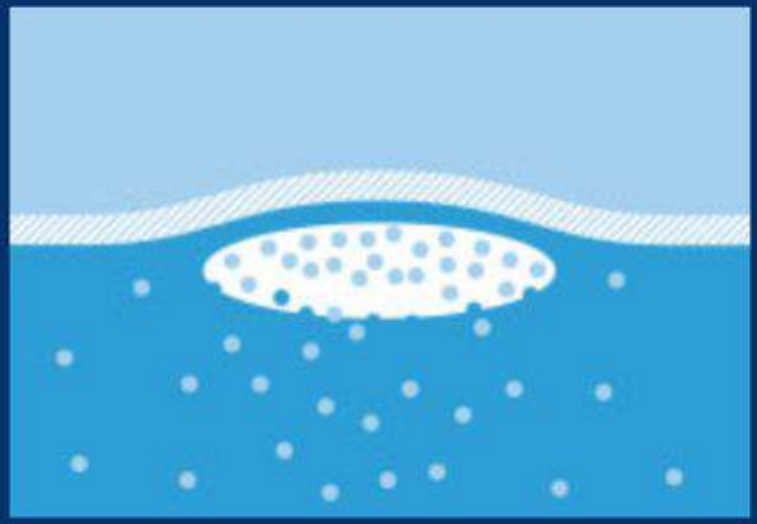
Amato L, Minozzi S, Davoli M, Vecchi S. Psychosocial combined with agonist maintenance treatments versus agonist maintenance treatments alone for treatment of opioid dependence. Cochrane Database of Systematic Reviews 2011, Issue 10. Art. No.: CD004147. DOI: 10.1002/14651858.CD004147.pub4

Buprenorphine XR Injection

- Five day transmucosal lead-in
- Equivalent of 8 to 24 mg of buprenorphine daily

OVER THE COURSE OF A MONTH





Images are used for illustrative purposes only and may not accurately depict the subject matter.

Medication will be gradually released into the body over time.

What About Pregnant Patients?

- Same process
- No need to switch to buprenorphine monotherapy
- Continue after delivery while breastfeeding
- Caution the patient about pre-term labor from opioid withdrawal

Home Vs. Office Starts

What About Patients In Controlled Settings?

- Can Start with 2mg/0.5mg – 4mg/1mg BID to TID as tolerated, increase each day as necessary

Naltrexone Extended Release Injection

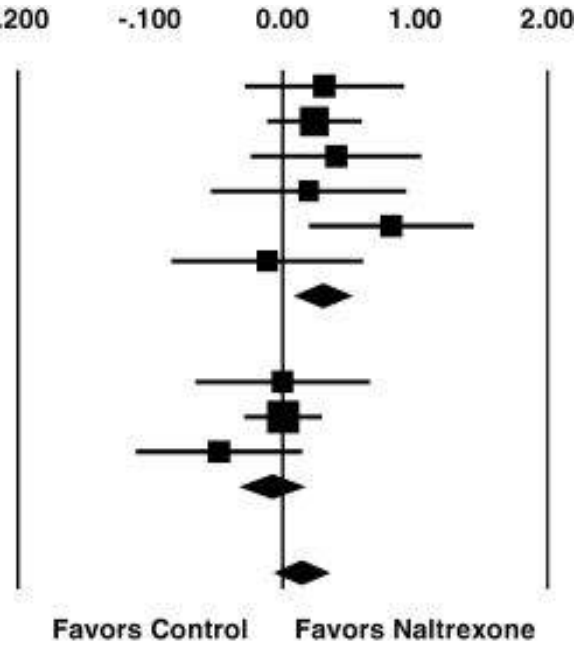
Adherence is key to naltrexone being effective

Oral naltrexone is worse than placebo for patients with opioid use disorder in usual outpatient settings

Oral Naltrexone for OUD

Outcome: Treatment Retention

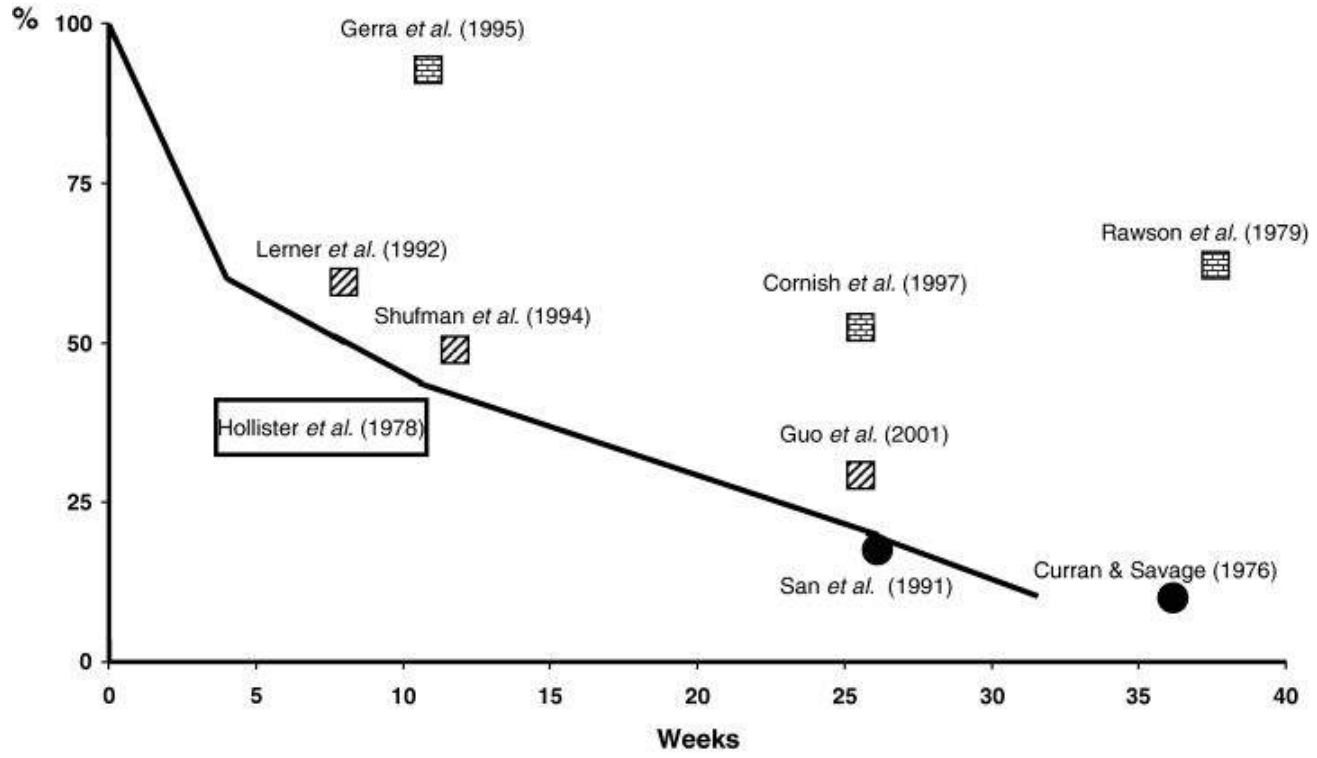
	Retention	Citation	NTotal	Effect	Lower	Upper
	High	Cornish *et al.* 1997	51	.32	-.29	.92
	High	Gerra *et al.* 1995	142	.24	-.12	.60
	High	Guo *et al.* 2001	49	.40	-24	.105
	High	Lerner *et al.* 1992	31	.19	-54	.93
	High	Rawson *et al.* 1979	58	.82	.20	.144
	High	Shufman *et al.* 1994	32	-.12	-.84	.61
Random	**High (6)**		**363**	**.31**	**.08**	**.53**
	Low	Curran & Savage 1976	38	.00	-.66	.66
	Low	Hollister *et al.* 1978	183	.00	-.29	.29
	Low	San *et al.* 1991	43	-.48	-.111	.15
Random	**Low (3)**		**264**	**-.08**	**-.32**	**.17**
Random	**Combined (9)**		**627**	**.15**	**-.07**	**.36**



Johansson, B. A., Berglund, M., & Lindgren, A. (2006). Efficacy of maintenance treatment with naltrexone for opioid dependence: a meta-analytical review. *Addiction*, *101*(4), 491-503.

Oral Naltrexone for OUD

Outcome: Treatment Retention



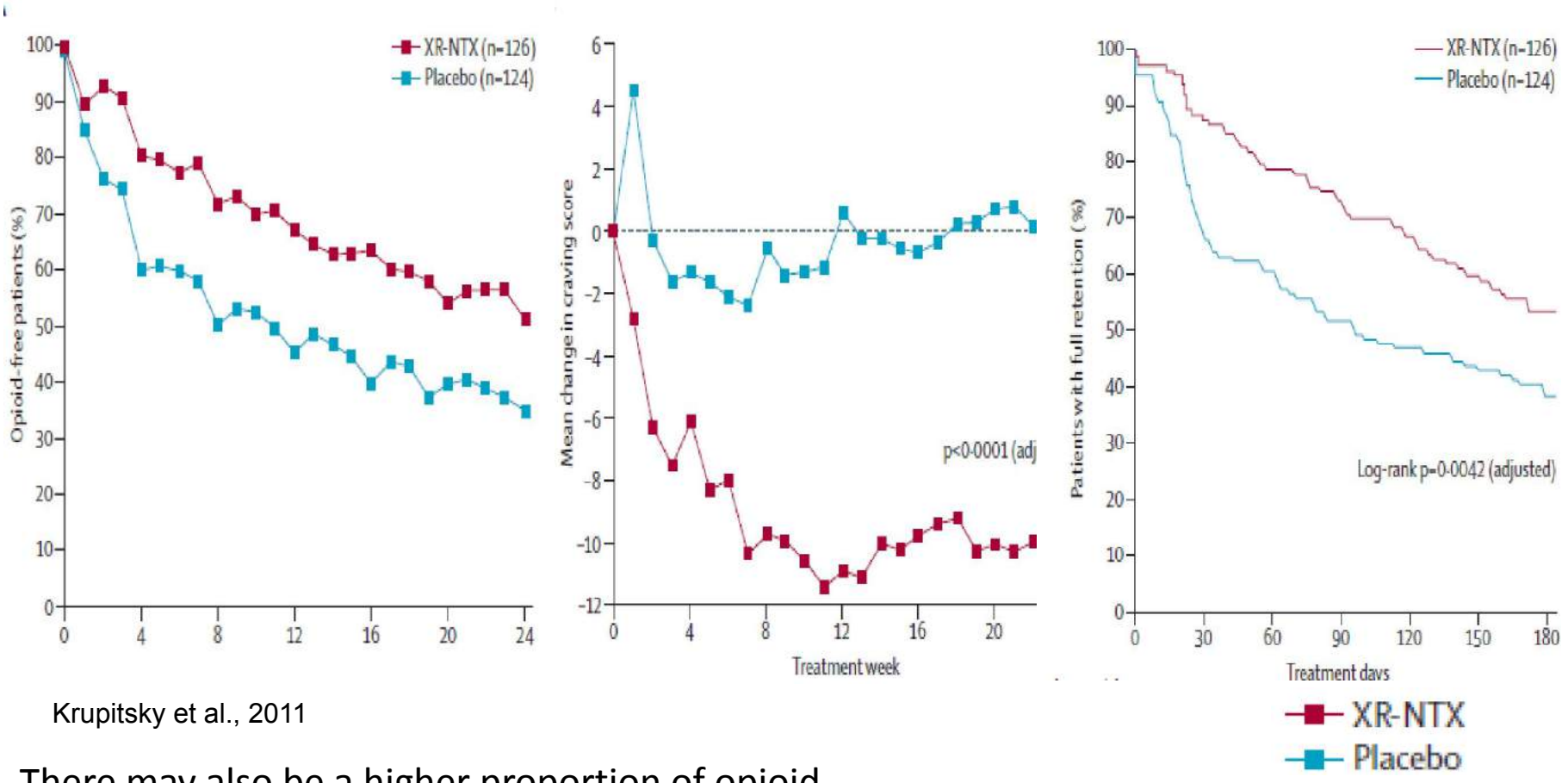
Johansson, B. A., Berglund, M., & Lindgren, A. (2006). Efficacy of maintenance treatment with naltrexone for opioid dependence: a meta-analytical review. *Addiction*, *101*(4), 491-503.

Oral Naltrexone

- Comparing naltrexone versus placebo or no pharmacological treatments, no statistically significant difference were noted.

Minozzi, S., Amato, L., Vecchi, S., Davoli, M., Kirchmayer, U., & Verster, A. (2011). Oral naltrexone maintenance treatment for opioid dependence. *Cochrane Database of Systematic Reviews*, (4).

Naltrexone LAI: Efficacy

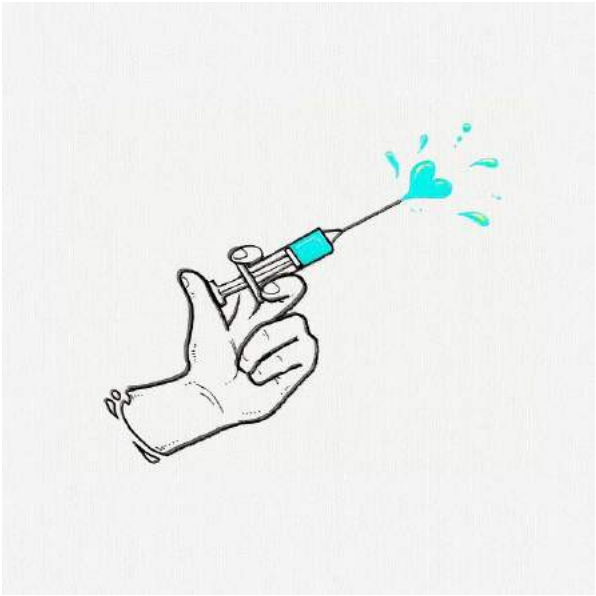


Krupitsky et al., 2011

There may also be a higher proportion of opioid, cocaine, benzodiazepine, cannabinoids, amphetamine - free patients.

Naltrexone LAI – How to Start

- How to start naltrexone long acting injection?
  - Window period is biggest factor
  - Doesn't require oral lead-in
  - Doesn't require recent LFTs



Naltrexone Long Acting Injection

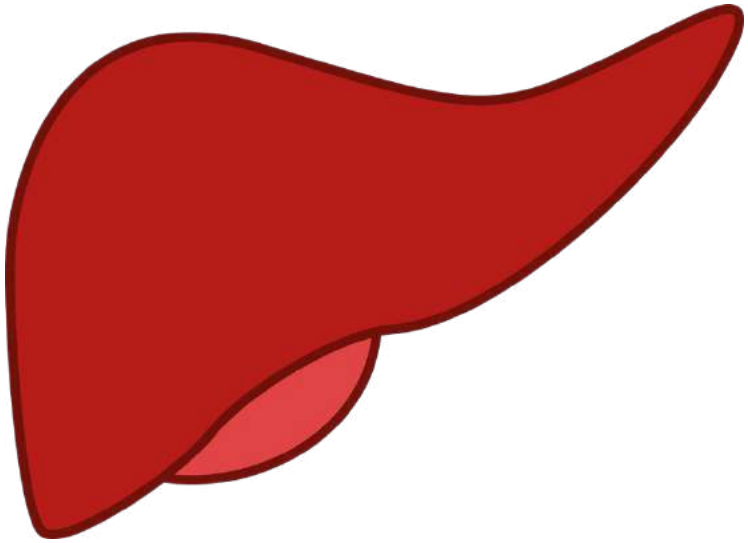
- <u>Window period</u>
  - 7 days from heroin and other short acting opioids (i.e. oxycodone / hydrocodone)
  - 10 days from extended release opioids (oxycodone-CR, or morphine sulfate-CR)
  - 14 days from buprenorphine or methadone

Naltrexone Long Acting Injection

- <u>Window Period</u> - how to be sure?
  - Toxicology information is the usual standard
  - History
  - Collateral
  - CURES
  - *Naloxone challenge administered in the office – rare for primary care settings*

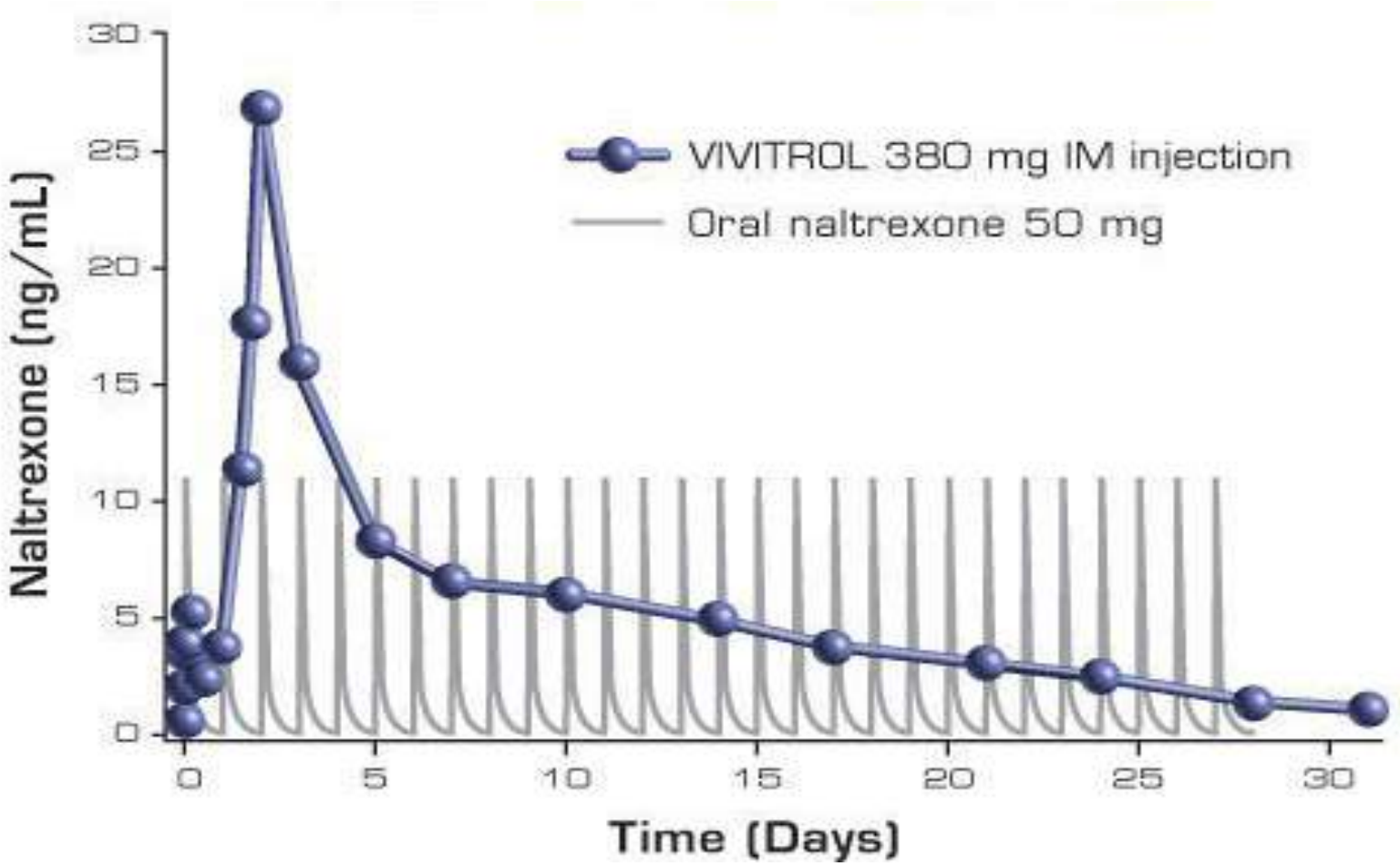
Naltrexone Long Acting Injection

- <u>Monitoring?</u>
  - Liver monitoring only absolutely required if there are signs of liver disease (jaundice, abdominal pain, nausea, vomiting)

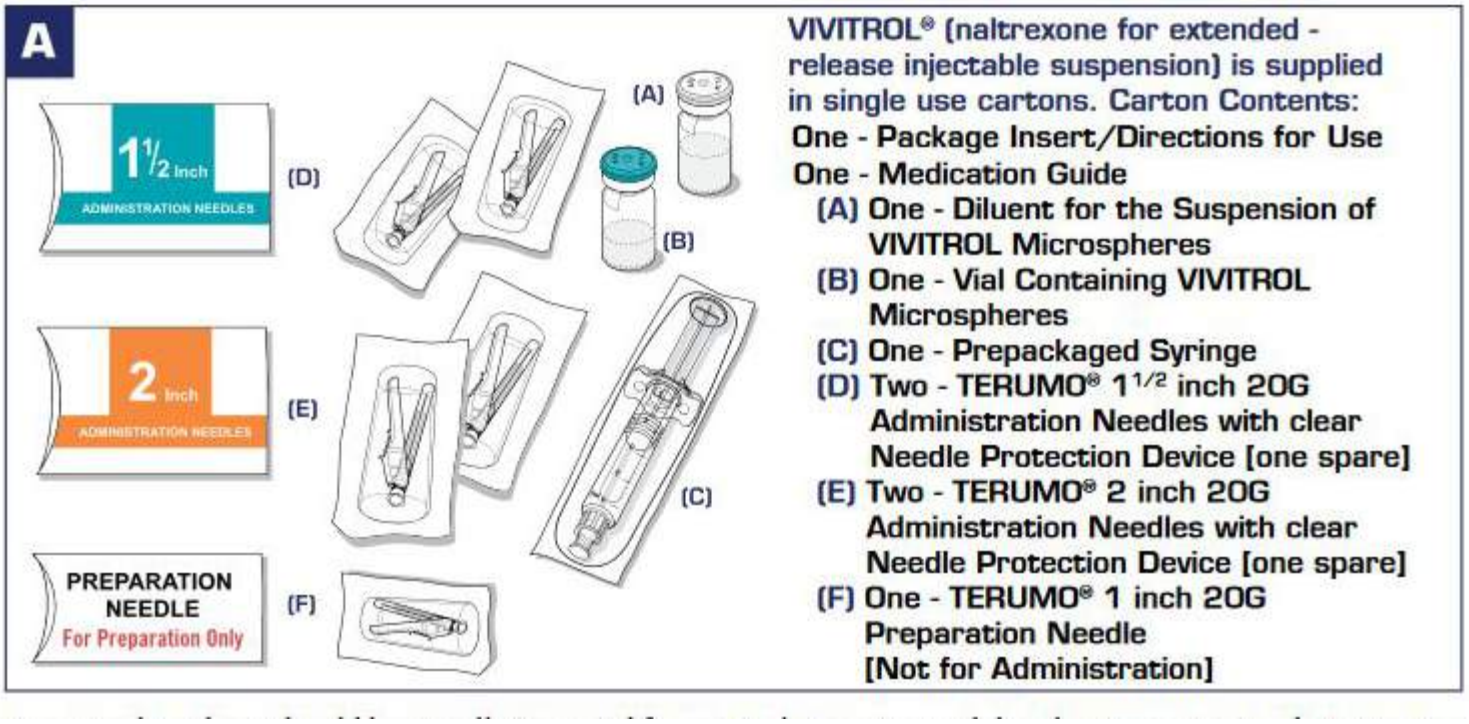


- Generally good practice to obtain quarterly LFTs, but <u>do not withhold naltrexone</u> if liver function testing has not yet been obtained *if patient is without signs or symptoms of active liver disease*

Naltrexone Long Acting Injection

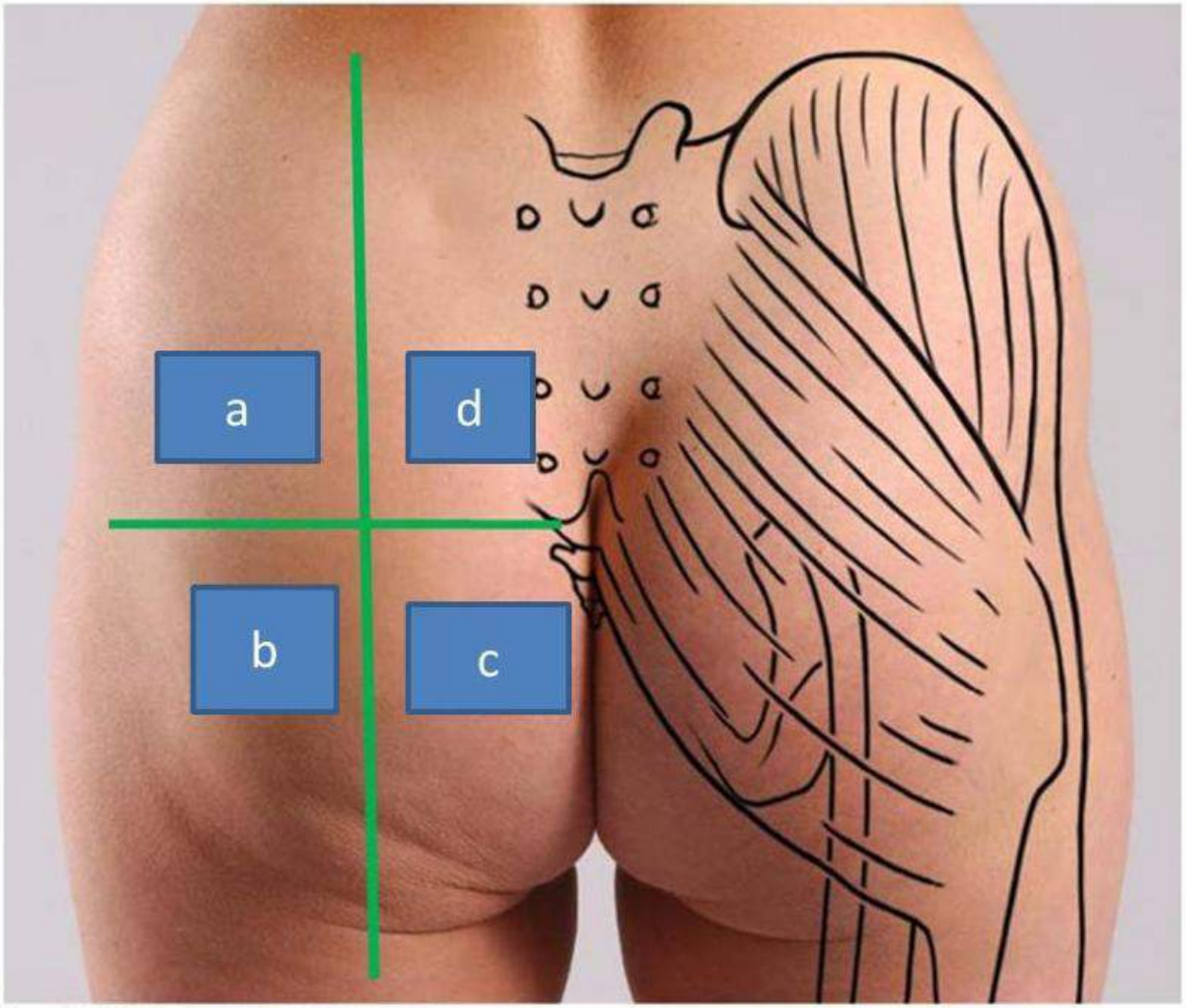


Naltrexone Long Acting Injection

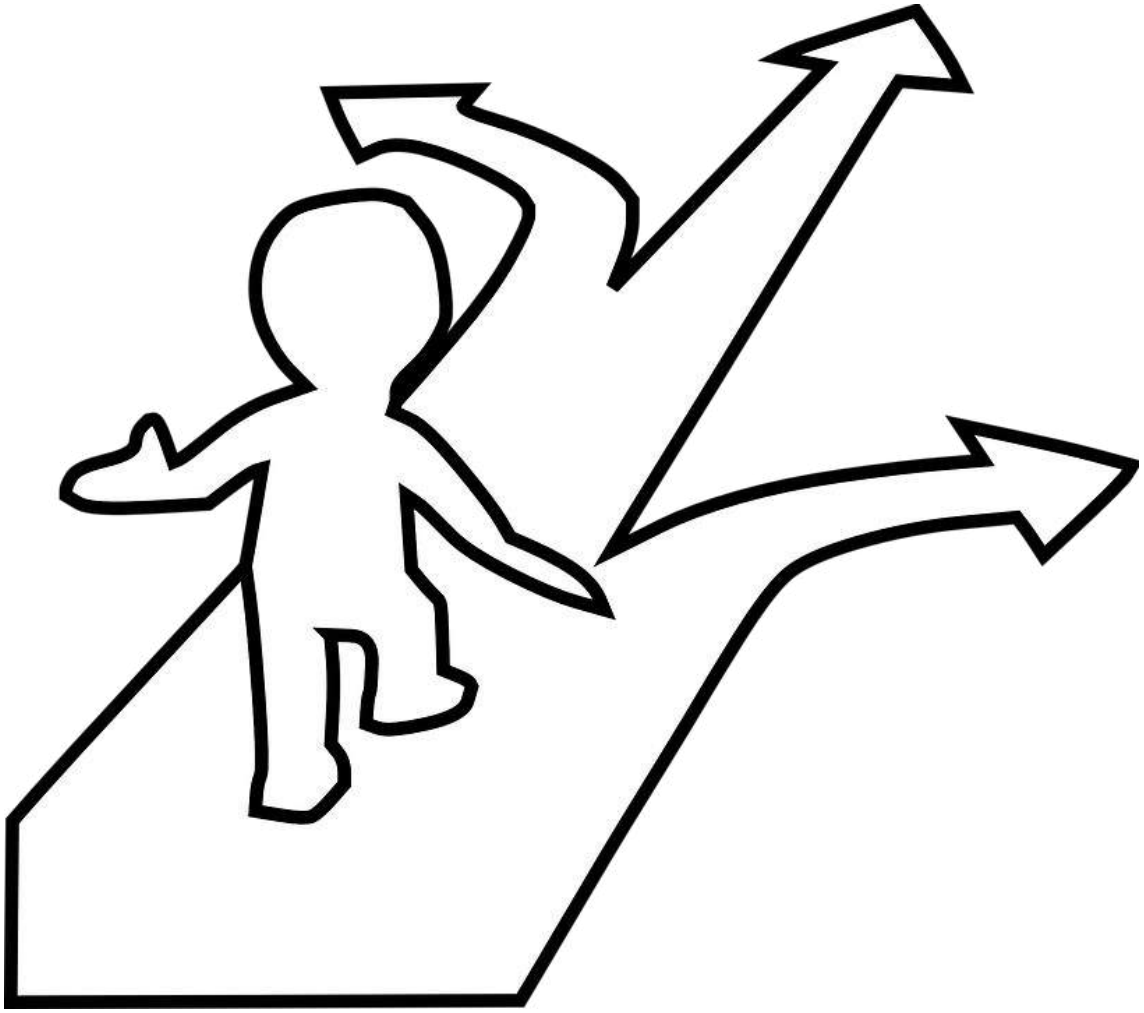


https://www.youtube.com/watch?v=lZBaDCIWSwg

Naltrexone Long Acting Injection



Which Medication to Select?



Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X:BOT): a multicentre, open-label, randomised controlled trial

Ease of induction is a limitation of naltrexone and an advantage of buprenorphine.

Once successfully inducted to either naltrexone LAI or buprenorphine / naloxone similar outcomes:

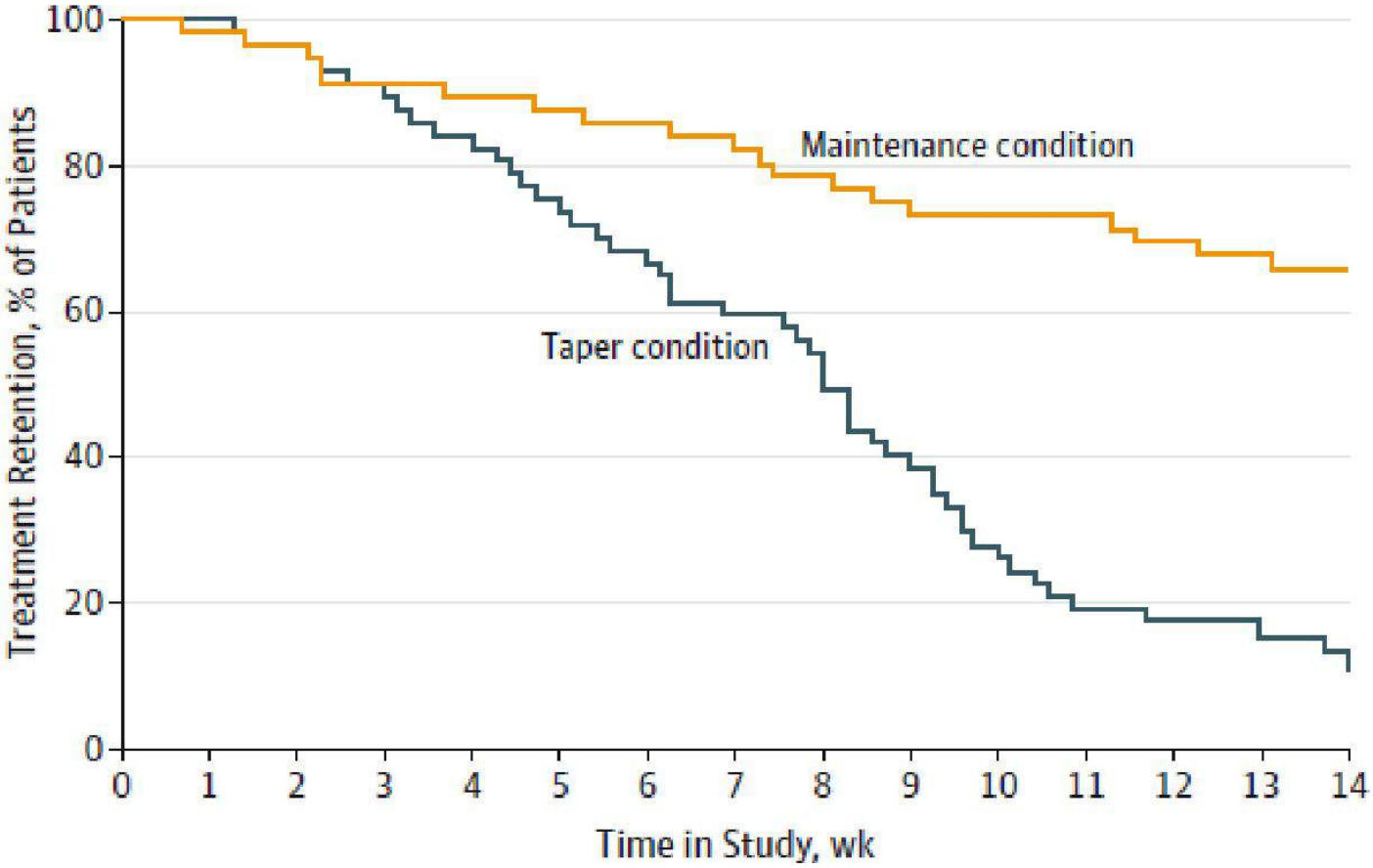
- relapse-free survival
- overall relapse
- retention in treatment
- negative urine samples
- days of opioid abstinence
- self-reported cravings

Lee, J. D., Nunes, E. V., Novo, P., Bachrach, K., Bailey, G. L., Bhatt, S., ... & King, J. (2017). Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X: BOT): a multicentre, open-label, randomised controlled trial. *The Lancet*.

Payer Questions

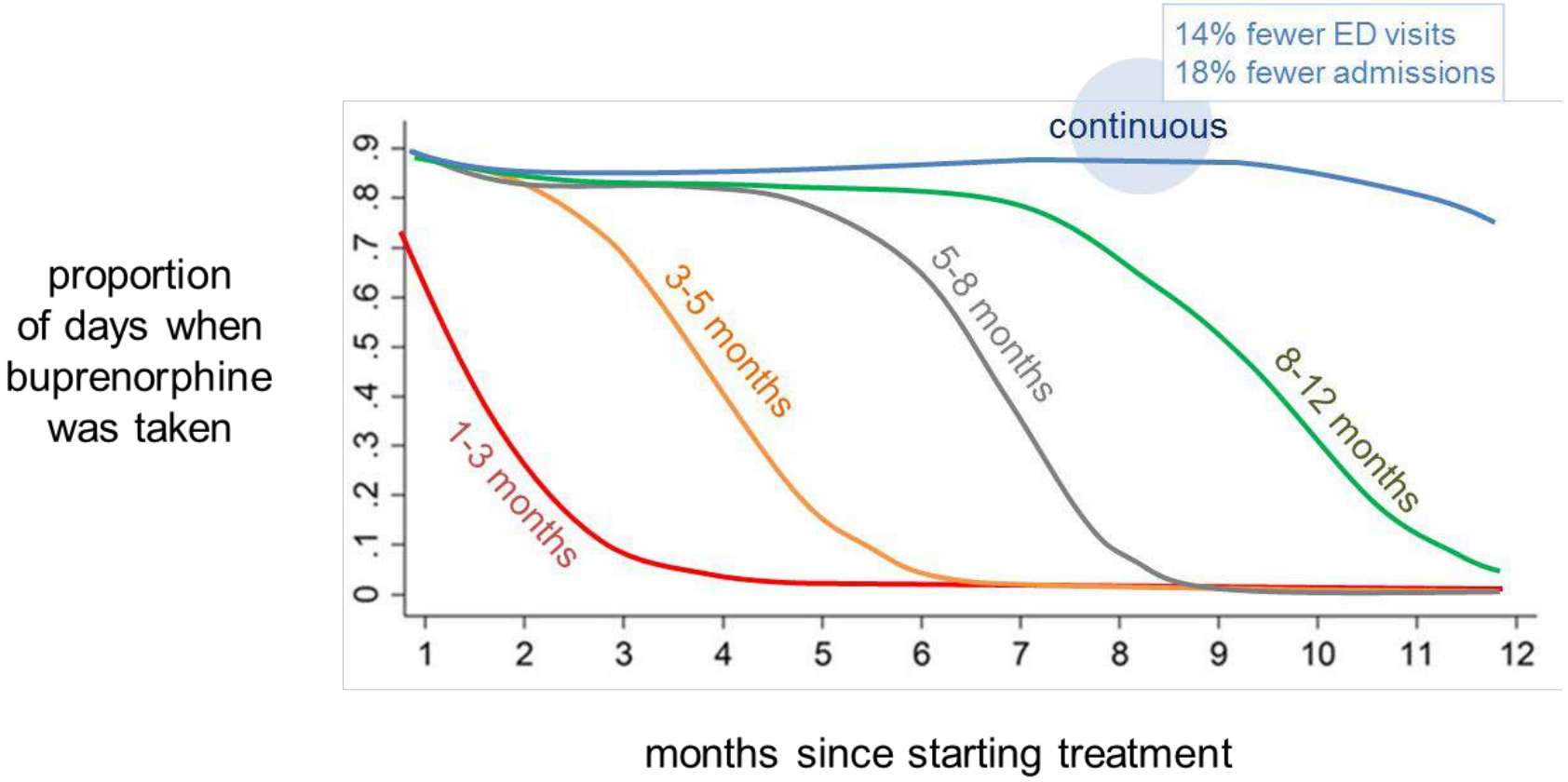
- Medi-Cal covers with no TAR / PA:
  - Buprenorphine/Naloxone tablets (generic)
  - Buprenorphine/Naloxone film (Suboxone®)
  - Buprenorphine/Naloxone tablets (Zubsolv®)
  - Buprenorphine tablets (generic)
  - Naltrexone Extended Release Injection (Vivitrol)
  - Buprenorphine Extended Release Injection (Sublocade)

How Long to Continue Treatment?



Fiellin et al., 2014

How Long to Continue Treatment?



Lo-Ciganic et al., 2016

What Else?

Questions / Feedback

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Come to the

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- CSAM Annual Meeting: http://csam-asam.org
- AAAP Annual Meeting: http://www.aaap.org