“I’m Ready to Prescribe”
A Primer to Medication Assisted Treatment
For Opioid Use Disorder

Spotting Opioid Use Disorder

Warning Signs that your patient might have an Opioid Use Disorder (OUD):

- Use more drug than is prescribed or has transitioned from pain pills to heroin.
- Spend more and more time seeking opioids.
- Choose drug use over social obligations and responsibilities.
- Have powerful cravings.
- Suffer negative consequences as result of their drug use.
- When they try to stop, or cut back and can’t.
- Periods of abstinence cause withdrawal symptoms.

Once diagnosed with OUD providers are encouraged to proceed with
offering or referring for medicated assisted treatment (MAT).

- Buprenorphine/Naloxone or Methadone increase retention in treatment and decrease opioid misuse.
- Protects the patient from overdose and health consequences such as Hepatitis and HIV.
It’s not about getting high!

Once tolerance develops the euphoric highs disappears and the person must use just to feel normal and avoid painful withdrawal. This graph illustrates what it feels like to be opioid dependent.

It’s not Substitution Therapy

- This graph illustrates why MAT is not substitution therapy. It does not get the patient “high” but keeps the patient feeling normal “straight”.
- Methadone or buprenorphine keeps the patient feeling normal for most of the time, as opposed to feeling either “high” or “sick”.

Diagrammatic summary of functional state of typical “mainline” heroin user. Arrows show the repetitive injection of heroin in uncertain dose, usually 10 to 30 mg but sometimes much more. Note that addict is hardly ever in a state of normal function (“straight”).

Stabilization of patient in state of normal function by blockade treatment. A single daily oral dose of methadone prevents him from feeling symptoms of abstinence (itch’s or euphoria “high”), even if he takes a shot of heroin. Dotted line indicates course if methadone is omitted.
NIDA’s Research Based Rules for Effective Addiction Treatment

Principles of Effective Treatment

- Addiction is a complex but treatable disease that affects brain function and behavior.
- No single treatment is appropriate for everyone.
- Treatment needs to be readily available.
- Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.
- Remaining in treatment for an adequate period of time is critical.
- Behavioral therapies—including individual, family, or group counseling—are the most commonly used forms of drug abuse treatment.

NIDA’s Research Based Rules for Effective Addiction Treatment

Principles of Effective Treatment

- Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
- An individual’s treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.
- Many drug-addicted individuals also have other mental disorders.
- Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.
NIDA’s Research Based Rules for Effective Addiction Treatment

Principles of Effective Treatment

• Treatment does not need to be voluntary to be effective.
• Drug use during treatment must be monitored continuously, as lapses during treatment do occur.
• Treatment programs should test patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counseling, linking patients to treatment if necessary.

Menu of Treatment Options

Medication Assisted Treatments (FDA-Approved Drugs for the Treatment of Opioid Use Disorder)

<table>
<thead>
<tr>
<th>Medication</th>
<th>MOA</th>
<th>Formulations</th>
<th>Dosing Frequency</th>
<th>As an APRN Can I Prescribe?</th>
<th>Special Considerations</th>
<th>Covered Under Medicaid?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buprenorphine with Naloxone</td>
<td>Partial agonist</td>
<td>Pills, dissolving film, implant</td>
<td>Daily for pills and file. Every six months for implant</td>
<td>YES</td>
<td>Requires special training and waiver. Subutex=Monotherapy product. Used in pregnancy, higher risk for diversion. Suboxone=Buprenorphine + Naloxone product, prevents diversion. Recommended product for most clients. Naloxone activated only if injected.</td>
<td>YES</td>
</tr>
<tr>
<td>Methadone</td>
<td>Full agonist</td>
<td>Pill, liquid, and water forms</td>
<td>Daily</td>
<td>NO</td>
<td>Client must have reliable transportation to Opioid Treatment Center.</td>
<td>YES</td>
</tr>
<tr>
<td>Naltrexone</td>
<td>Antagonist</td>
<td>Pill or extended release injection</td>
<td>Daily for pill Monthly for IM injection</td>
<td>YES-No special waiver required</td>
<td>Client requires med alert bracelet or dog tags.</td>
<td>YES</td>
</tr>
</tbody>
</table>
So many choices, where do I start?

- Opioid agonist treatment is preferred (Methadone or Buprenorphine).
- Meta-analyses for both drugs confirm superiority compared to placebo in two areas:
  - Retention in treatment
  - Reductions in illicit opioid use.
  - Both drugs are equivalent in terms of reducing illicit use.
- Flex dose Methadone shows a slight edge as compared to Buprenorphine in overall treatment retention rates.
- Naltrexone still has a place.
  - Patients that cannot have synthetic opioids due to strict employment policies: DOT, nurses, doctors, etc.
  - Does block cravings and effects of use.
  - For patients with an allergy to Methadone or Buprenorphine
  - Client preference
  - Pill has poor compliance over the injection

Opioid Maintenance Therapy

Methadone  Buprenorphine pills  Buprenorphine film
Risk and Benefits Buprenorphine

### Risks
- Higher attrition rates as compared to Methadone
- Client may return heroin use.
- Client may receive less support in outpatient setting, which can improve recovery rates.
- More difficult induction with risk of precipitated withdrawal.
- Bup treatment caps. Difficulty accessing treatment.
- Risk of hepatic dysfunction.
- In pregnancy Bup without naloxone required. Higher risk for abuse. Tablet and film preparation has greater risk for injection and diversion.

### Benefits
- Treatment provided outpatient. Less restricting for patient.
- Less abuse potential than Methadone. Ceiling effect risk for respiratory depression.
- Fewer drug-drug interactions than MMT.
- Effective at treating withdrawal. Lasts for 36-48 hours.
- Affordable—covered under Medicaid.
- Potentially less stigma.
- L2 Rating for Breastfeeding, lower RID 0.9%-1.9%
- May improve abstinence in 3rd and 4th trimester as compared with MMT.
- Less severe NAS, improved neurobehavioral and biometric outcomes for infants.

---

When Buprenorphine/Naloxone may be preferred over Methadone

- **Patient preference**
- **Transportation issues and can’t get to the Methadone clinic**
- **QT Risks**
- **Worried about drug interactions**
- **Employed full time and cannot comply with strict Methadone visit schedule**
- **Allergy to Methadone**
- **History of over sedation on methadone or sexual side effects**
- **Past success with Buprenorphine**
Where Can Buprenorphine be Prescribed and by Whom?

- **Outpatient settings**
  - Several studies demonstrate that buprenorphine can be used as effectively and safely in primary care settings as compared to specialty settings.

- **Opioid treatment Programs (OTPs)**

- **Waivered Physicians, Nurse Practitioners, and Physician Assistants can prescribe this medication**

---

Phases of Buprenorphine Treatment

**Dose induction and stabilization**

- COWS is used to measure withdrawal before medication administered
- Typically conducted in office

**Maintenance**

- For some patients, the medication will be a lifelong treatment

**Medically Supervised Withdrawal**
Risk and Benefits Methadone

### Risks
- Continued use of illicit opioids while on Methadone. More abuse potential with no protective overdose factor
- Strict protocol requires daily visits, transportation, may make client feel that she has less control over treatment
- Shows up in urine drug screens may be barrier to employment
- Prolongs QTC interval
- Methadone has significant drug to drug interactions, psychiatric medication and antiretroviral agents.
- Stigma of going to Methadone clinic
- Less favorable NAS and nonbehavioral outcomes as compared to Bup for infants.

### Benefits
- Less risk for attrition as compared to Bup. More effective for severe dependence
- Oral liquid less risk of injection
- Daily visits may provide much needed structure. OTPs offer comprehensive care such as counseling, group support, prenatal, nutrition, navigation services.
- No patient treatment limits for OTPs with methadone may be more accessible than Bup.
- Effective at treating withdrawal. Lasts for 24 hours.
- Affordable—covered under Medicaid.
- L2 rating for Breastfeeding
- Gold standard of treatment of OUD in pregnancy. 30+ of experience

---

When Methadone may be preferred over Buprenorphine/Naloxone

- **Patient preference**
- **Patient needs the support provided by the OTPs**
- **If induction withdrawal is dangerous to patient**
- **History of injecting buprenorphine**
- **Failure to stabilize on buprenorphine**
- **Buprenorphine inaccessible. Treatment caps create waitlists**
- **Considered gold standard for pregnancy**
- **Severe dry mouth or Sjogren’s syndrome**
- **Previous success with Methadone**
Where Can Methadone be Prescribed and by Whom?

- Federal laws require that only certified clinics dispense Methadone
- Opioid Treatment Programs (OTPs) can be located on the SAMSHA website for patient referrals
- Only physicians can prescribe Methadone

How do I treat my Patient Population?

**Special Populations (Adapted from ASAM guidelines)**

- **Pregnancy:** Methadone or Buprenorphine monoprodct ONLY. Encourage breastfeeding. Both Methadone and Buprenorphine have an L2 rating for breastfeeding.
- **Adolescents:** Methadone, Buprenorphine/naloxone combination product, oral or LAI Naltrexone.
- **Psychiatric Disorders:** Methadone, Buprenorphine/naloxone combination product, oral or LAI Naltrexone. Manage drug interactions and stabilize patient before initiating treatment.
- **Incarceration:** Methadone, Buprenorphine/naloxone combination product, LAI Naltrexone (Initiate RX ≥ 30 days before release)

Warn your patients that while taking this medication they will lose their tolerance. What they use to take could now cause an overdose and kill them.
Combined Treatment for Works Best

- Studies show that combining opioid agonist therapy with behavioral interventions improves treatment retention.
  - Cognitive Behavioral Therapy (CBT)
  - Narcotics Anonymous
  - SMART Recovery
  - SOS

References

- Reference 1
- Reference 2
- reference 3