PURPOSE:

The purpose of this policy is to increase access to Medications for Addiction Treatment (MAT) therapies for patients with an active diagnosis of Opioid Use Disorder (OUD) including MAT stabilization and induction with buprenorphine in an Office Based Opioid Treatment (OBOT). Medication Assisted Treatment has been shown to be more effective than detoxification and abstinence in reducing the frequency and quantity of opioid use as well as the risk of overdose, improving social functioning, and decreasing criminal activity and disease rates. Treatment programs that include both the medication and psychosocial components are more effective than programs without both types of interventions and are associated with better treatment retention. [1] Active use of other illicit substances in pregnant women or patients does not necessarily disqualify the patient from eligibility for medication assisted treatment for opioid use disorder. Medication Assisted Treatment for opioid use disorder during pregnancy has been shown to increase prenatal care utilization, reduce illicit drug use, reduce exposure to sexually transmitted infections, improve maternal nutrition, improve infant birth weight, and improve outcomes associated with Neonatal Opioid Withdrawal Syndrome. [2]

POLICY:

Facility name will promote access to MAT, in an integrated care setting, for stabilization of life-threatening OUD for patients that are appropriate outpatient treatment candidates. Specifically, facility name will increase access to MAT in the below situations:

- When a DATA waived provider is available and on-duty in the facility name;
- When the patient has completed appropriate screenings, assessments, intakes, and informed consent;
- When the patient is deemed a candidate for OBOT with buprenorphine or naltrexone and an option for continuation of chronic maintenance therapy is available;

PROCEDURE:

A. Complete and Accurate Patient Assessment. Patients diagnosed with OUD will be screened for alcohol, tobacco, and other substance misuse using validated tools and symptom surveys. When patients screen positive for risk of harm from substance use, practitioners should assess them using tools that determine whether substance use meets diagnostic criteria for a substance use disorder (SUD). A thorough patient assessment should address patients' medical, psychosocial, chemical dependency, and family history. Laboratory tests can inform treatment planning, however, should not be used as the primary assessment tool when evaluating substance use disorder. Treatment plans should consider assessment findings and appropriately match the patient to the recommended level of care. Informed consent should be obtained prior to initiating treatment.

The below procedures should be followed to stabilize patients and engage clients in recovery.

1. Patients should be screened for alcohol use using the AUDIT-C tool. 4Ps should be used for pregnant patients. The DAST, NIDA quick screen, and CRAFFT may be considered for screening for Substance Use Disorder (SUD). All results should be documented in the patient record.
2. Conduct chemical dependency intake and patient needs assessment.
3. Patient must have a *DSM-5* diagnosis of Opioid Use Disorder or Alcohol Use Disorder.
4. Patient should not be actively using other illicit substances.
5. Patients actively using other illicit substances must be willing to engage in treatment or detox for these substances.
6. Obtain laboratory tests to include the following if clinically needed:
   All: complete blood count, basic metabolic panel, hepatitis screening (Heb B sAb& sAg, Hep C Ab), pregnancy test (required on all females of child- bearing age, unless not clinically indicated), HIV, and immunoassay urine drug screen with follow-on confirmatory pain clinic urine drug

screen
- If sexually active get RPR, GC/Chlamydia, trichomoniasis, gonorrhea, syphilis

7. Patient treatment plan should be coordinated and include bio, psycho, social, and spiritual considerations. Referral for traditional or cultural medicine may be considered as requested and available.
8. Providers should explain the components and goals of the MAT treatment plan and patients must be willing to sign an informed consent explaining the risks and benefits of MAT treatment. Patients will need to be candidates for OBOT and should not be in need of higher levels of care with more intense management. Buprenorphine may be initiated in patients that need a higher level of care while awaiting placement upon consultation with attending provider at accepting facility.
9. Collect signed release of information for other recent medical, psychiatric, and substance use treatment providers. Request releases of information to speak with facility name, significant others, supportive individuals, or collateral informants.
10. Care team should assist the patient with understanding treatment plan requirements as well as to assist with coordination of care and referrals for continuation therapy. This may include providing assistance with transportation as well as maintaining and updated phone number.
See also Appendix A for screening flow-chart.

B. <u>Patient Education & Care Coordination.</u> Patient education, care coordination, and warm-handoffs should be practiced health-system wide for patients with a known or suspected OUD. Staff will have opioid related training to reduce health-care worker stigma and practice trauma-responsive approaches to health care delivery.

Patients will be educated by the Nurse Care Manager or Pharmacist on the below elements during the initial visit:

1. Review clinic hours and times available for scheduling visits.
2. Explain clinic policy regarding medication refills.
3. Discuss relapse prevention and support.
4. Describe treatment planning and review process, including the potential types of people who may be involved including clinic administrators, counselors, medical and psychiatric professionals, social services, recovery support professionals, and family.
5. Describe the referral process to facility name and what to expect for chronic maintenance therapy.
6. Review and educate patient on: expected adverse events including potential for withdrawal, precipitated withdrawal, opioid antagonism and other side effects.
7. Review and educate patient on: safe storage, responsibilities for medication storage and lost/stolen policies handling, and use of medication, including pediatric exposure concerns.
8. Inform the patient that the initial interview is not a guarantee of treatment. Following the interview, each case may need additional review, including lab results, before determining whether buprenorphine/naloxone or naltrexone treatment is an appropriate option for the patient in this outpatient treatment setting.

The patient will be expected to:

1. Present to scheduled appointments with clinic staff.
2. Adhere to counseling requirement and psychiatric assessment and follow-up, if part of the treatment plan.
3. Provide their own urine or appropriate bodily fluid for drug testing, as appropriate upon clinic request.
4. Call if medical issues arise that may require opioid management, and not ask for early refills due to misuse or overuse.

5. Follow through on recommendations for enhanced treatment as required.
6. Continue involvement with their primary medical team.
7. Follow-up with facility name referral for ongoing treatment and recovery support.

Patient Welcome Packet Will Include:

1. Treatment Agreement and Informed Consent
2. Return to Use Brochure
3. Naloxone Brochure
4. COWS and SOWS assessments
5. Chemical Dependency Intake Sheet (ASAM Assessment)
6. Release of Information Forms (IHS and Chemical Health)
7. NOWS brochure, Opioid Use/MAT in pregnancy brochure for pregnant women and women of child-bearing age

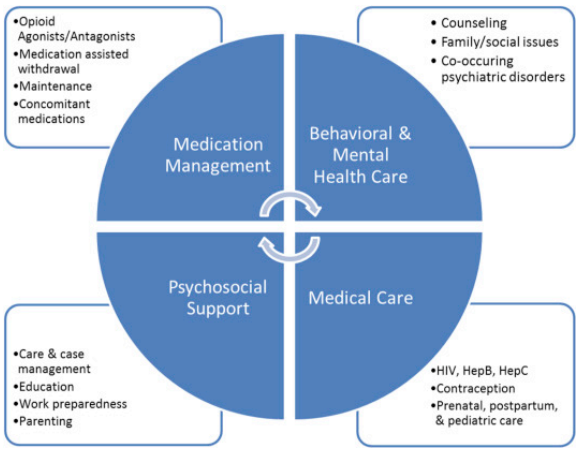
C. <u>Integrated Care & Treatment Initiation.</u> Facility name utilizes team-based care provided in the IHS Improved Patient Care model. Patients may be requested to follow-up with Primary Care Provider extenders to ensure on-going patient assessments and optimized treatment planning. The decision to initiate buprenorphine or naltrexone will be a mutual shared decision between the prescriber and the patient. Follow-up care may be coordinated within a team-based model.

See Appendix for sample check-lists

D. <u>Opioid Overdose Education</u>. ALL patients entering into the MAT stabilization program will be provided naloxone and instructions for use for the reversal of opioid overdose. Patients will also be educated on naloxone storage and resupply.

E. <u>Special Populations</u>.

- **Pregnancy:** Most pregnant women can be induced on an outpatient basis, but it may be necessary to conduct an inpatient induction for a select group of pregnant women. This may be considered when there are concerns of relapse or return to use, when the pregnant woman does not have access to a stable home environment and additional care coordination is needed, and when co-occurring psychiatric condition that may present a danger to self or others. [2,6]



F. <u>Discharge/Referral to a higher level of care.</u> Tapering/discharge from office-based clinic or initiation of more intensive treatment plan should be considered for the following cases: ongoing opioid use or use of other illicit drugs; three or more positive urine toxicology results in a row for opioids or other illicit drugs; or, the risk of continuing treatment outweighs the benefit. If a patient is discharged

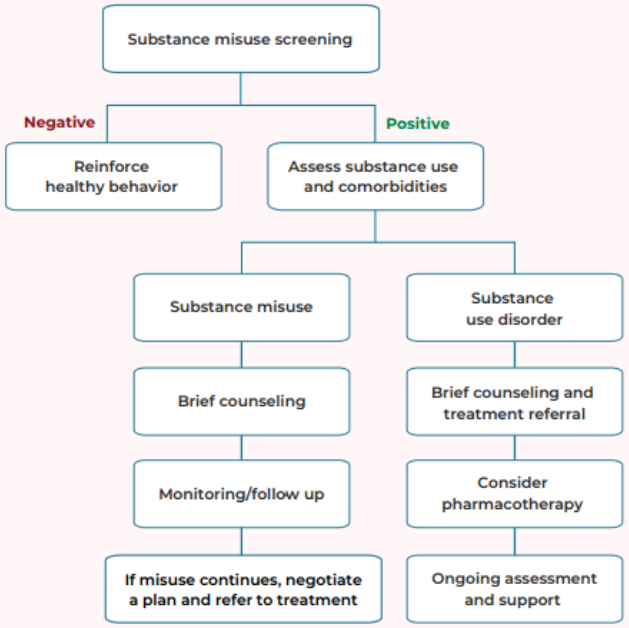
from OBOT they are welcome to re-engage, except if there are administrative or safety concerns connected with the discharge. Examples of administrative and safety issues: violence or criminal activity on hospital grounds, police report or other documentation of patient selling prescribed medication, inappropriate behavior in a clinic setting, threatening safety of staff or other patients.

G. REFERENCES

1. Center for Substance Abuse Treatment. Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. SAMHSA/CSAT Treatment Improvement Protocol (TIP) Series, No. 43. HHS Publication No. (SMA) 12-4214. Rockville, MD. 2005. https://store.samhsa.gov/system/files/sma18-5063pt2.pdf
2. Indian Health Service. Recommendations to the Indian Health Service on AI/AN Pregnant Women and Women of Childberaing Age with Opioid Use Disorder.' Accessed September 5, 2019. https://www.ihs.gov/sites/opioids/themes/responsive2017/display_objects/documents/acogguidelines2018.pdf
3. https://docs.clinicaltools.com/sites/clinicalencounter/buppractice/pdf/6-Induction.pdf
4. http://pcsspodcast.org/episode-3-buprenorphine-induction
5. https://www.ihs.gov/opioids/maternalchild/
6. https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co711.pdf?dmc=1

Appendix A. Patient Screening Algorithm

EXHIBIT 2.2. Substance Misuse and SUD Screening



Adapted with permission.[15]

DSM V Opioid Use Disorder Diagnostic Criteria

DSM-5 Criteria for Diagnosis of Opioid Use Disorder

Diagnostic Criteria*

These criteria not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Check all that apply

	Opioids are often taken in larger amounts or over a longer period of time than intended.
	There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
	Craving, or a strong desire to use opioids.
	Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.
	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
	Important social, occupational or recreational activities are given up or reduced because of opioid use.
	Recurrent opioid use in situations in which it is physically hazardous
	Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
	*Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid
	*Withdrawal, as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms

Total Number Boxes Checked: _____

Severity: **Mild**: 2-3 symptoms. **Moderate**: 4-5 symptoms. **Severe**: 6 or more symptoms

*Criteria from American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,. Washington, DC, American Psychiatric Association page 541. For use outside of IT MATTTRs Colorado, please contact ITMATTTRsColorado@ucdenver.edu

https://www.asam.org/docs/default-source/education-docs/dsm-5-dx-oud-8-28-2017.pdf?sfvrsn=70540c2_2

Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:_____ Date and Time ____/____/____:_____

Reason for this assessment:_____

Resting Pulse Rate: _____beats/minute
Measured after patient is sitting or lying for one minute
0 pulse rate 80 or below
1 pulse rate 81-100
2 pulse rate 101-120
4 pulse rate greater than 120

GI Upset: *over last 1/2 hour*
0 no GI symptoms
1 stomach cramps
2 nausea or loose stool
3 vomiting or diarrhea
5 multiple episodes of diarrhea or vomiting

Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.*
0 no report of chills or flushing
1 subjective report of chills or flushing
2 flushed or observable moistness on face
3 beads of sweat on brow or face
4 sweat streaming off face

Tremor *observation of outstretched hands*
0 no tremor
1 tremor can be felt, but not observed
2 slight tremor observable
4 gross tremor or muscle twitching

Restlessness *Observation during assessment*
0 able to sit still
1 reports difficulty sitting still, but is able to do so
3 frequent shifting or extraneous movements of legs/arms
5 unable to sit still for more than a few seconds

Yawning *Observation during assessment*
0 no yawning
1 yawning once or twice during assessment
2 yawning three or more times during assessment
4 yawning several times/minute

Pupil size
0 pupils pinned or normal size for room light
1 pupils possibly larger than normal for room light
2 pupils moderately dilated
5 pupils so dilated that only the rim of the iris is visible

Anxiety or Irritability
0 none
1 patient reports increasing irritability or anxiousness
2 patient obviously irritable or anxious
4 patient so irritable or anxious that participation in the assessment is difficult

Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored*
0 not present
1 mild diffuse discomfort
2 patient reports severe diffuse aching of joints/muscles
4 patient is rubbing joints or muscles and is unable to sit still because of discomfort

Gooseflesh skin
0 skin is smooth
3 piloerrection of skin can be felt or hairs standing up on arms
5 prominent piloerrection

Runny nose or tearing *Not accounted for by cold symptoms or allergies*
0 not present
1 nasal stuffiness or unusually moist eyes
2 nose running or tearing
4 nose constantly running or tears streaming down cheeks

Total Score _____
The total score is the sum of all 11 items

Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

This version may be copied and used clinically.

https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf

Name: _____

DOB: _____

IT ATTTRs Colorado

Subjective Opiate Withdrawal Scale (SOWS)

Instructions: We want to know how you're feeling. In the column below today's date and time, use the scale to write in a number from 0-4 about how you feel about each symptom right now.

Scale: **0 = not at all** **1 = a little** **2 = moderately** **3 = quite a bit** **4 = extremely**

DATE						
TIME						
SYMPTOM		**SCORE**	**SCORE**	**SCORE**	**SCORE**	**SCORE**
1	I feel anxious					
2	I feel like yawning					
3	I am perspiring					
4	My eyes are tearing					
5	My nose is running					
6	I have goosebumps					
7	I am shaking					
8	I have hot flushes					
9	I have cold flushes					
10	My bones and muscles ache					
11	I feel restless					
12	I feel nauseous					
13	I feel like vomiting					
14	My muscles twitch					
15	I have stomach cramps					
16	I feel like using now					
TOTAL						

Mild Withdrawal = score of 1 – 10
Moderate withdrawal = 11 – 20
Severe withdrawal = 21 – 30

https://www.asam.org/docs/default-source/education-docs/sows_8-28-2017.pdf?sfvrsn=f30540c2_2

APPENDIX B:

CONSENT FOR TREATMENT WITH BUPRENORPHINE

INDICATION
Buprenorphine (Suboxone/Subutex) is prescribed for treatment of opioid use disorder.

DESCRIPTION
Buprenorphine is a partial opioid. Suboxone is the commercial name for buprenorphine combined with a short-acting opiate blocker (naloxone). Buprenorphine is not as strong as heroin or morphine, but does result in physical dependence. Buprenorphine withdrawal is generally less intense than heroin or methadone withdrawal. To minimize the possibility of withdrawal, buprenorphine should be discontinued slowly under your doctor's supervision.

HOW IT IS TAKEN
If you are dependent on opioids, you must be in moderate withdrawal when you take the first dose of buprenorphine.

Tablets or strips must be held under the tongue until they dissolve completely through the mucous membranes. Do not swallow the saliva that accumulates in your mouth for 5-10 minutes, whether you take the film or tab. You should begin to feel better within 30 minutes. It will take 30 to 120 minutes for full absorption. Buprenorphine is not absorbed adequately if swallowed. After you become stabilized on buprenorphine, it will have a blocking effect if you use other opioids. **Attempts to override buprenorphine by taking more opiates put you at risk for an opioid overdose.**

ALTERNATIVES TO BUPRENORPHINE
Facility name coordinates with department for intensive outpatient drug abuse treatment services and aftercare (which may include group therapy). You may seek a referral to in-patient detoxification or treatment in a residential program that provides a medication-free treatment focus. In addition, Naltrexone or Vivitrol are medications that block the effect of opiates, but have no opiate effect of their own.

Buprenorphine medication-assisted treatment (MAT) is designed to provide clients the opportunity to stabilize from opiate dependency and further engage in the recovery process

Eligibility for the program includes
Completion of a clinical work-up at the facility name lab tests, and the ability to engage in treatment and comply with facility standards, rules and expectations. Patients should also have a willingness to transition services to the facility's Medication Assisted Recovery program.

Day One of Induction—What to Expect
If you have recently used opiates, it is important you be in withdrawal at time of evaluation. If you are not in withdrawal and have recently used opioids, you will be at risk for precipitated withdrawal (see page 1) and may have to postpone starting medication-assisted treatment. You need to stop short acting opiates such as heroin, oxycodone, or hydrocodone a minimum of 12 hours before your appointment, unprescribed Suboxone a minimum of 24 hours before appointment and stop use of methadone at least 48 hours before your appointment.

- The nurse will assess your withdrawal symptoms
- A provider will meet with you to do assessment
- A nurse or care team member supervises initial dose of medication and provides medication education

Day Two of Induction
You will attend a 30-minute morning appointment with the provider or care team to review the past 24 hours and determine appropriate *maintenance* dosage.

Contact: To reach facility's MAT services, please call (phone numbers). If you are experiencing a life-threatening emergency call 911 or go to your nearest emergency department for help.

Facility name

Medications In Support of Recovery Treatment Agreement and Informed Consent

My Indian Health Service provider, _____, has prescribed _____ to treat my Opioid Use Disorder. This agreement is to outline our understanding of our roles and responsibilities regarding this treatment plan.

We here at facility name are making a commitment to work with you in your efforts to engage in treatment, recovery and overall wellness. To help you in this work, we agree:

1. We will treat you with courtesy and respect. This includes making sure we discuss all medication concerns in private. We do not give out information about your medication without consent.
2. We will work with you to create a treatment plan that includes coordination with other service providers as well as regular appointments for follow-up visits for general wellness or special conditions.
3. We will take the time to make sure you understand how to safely take your medication.
4. We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects.
5. You will get clear instructions about how to contact your primary care team to discuss side effects, dosage change, or to report other prescriptions.
6. If we stop these medications because you have not followed this agreement we will:
    a. Explain to you why your medications are being stopped
    b. Continue to treat you and help you with your chronic condition in other ways.
    c. Treat you with the best medications in an emergency or for another problem.

I understand that:

____ (If take-home doses are prescribed) **I agree not to sell, share, or give my medication to another person.** Selling/sharing/ or giving my medications with others will result in immediate termination of my medications.

____(If take-home doses are prescribed) **I agree to comply with required film/pill counts and urine drug screens the day I am called, and to notify facility name immediately in case of lost, stolen or damaged medication.** Refills will not be prescribed earlier than scheduled. I will promptly report and bring in the pill bottle of any prescribed opioid and will dispose any unused medication.

_____I will comply with Urine Drug Testing. Refusing or tampering with a urine drug screen will result in discharge from treatment.

____ **I will keep facility name informed of my current phone number** and notify my provider of any plan to be out of town.

____ **I agree to safely manage my prescriptions.** It is recommended I use a locked safe. Buprenorphine can cause death to children, other adults, or pets. I will call the poison control center or 911 immediately if anyone besides me takes the medication. I will report stolen medication to the police and bring in a police report. However, stolen medication will not be replaced.

____ **I agree to take my medications only as prescribed.** I will not adjust the dose on my own.

____ **I agree to discuss with my physician my prescribed medications including benzodiazepines (such as Valium, Klonopin, Ativan or Xanax), stimulants (such as Ritalin, Concerta, Adderall or Vyvanse) or other opioids. I may be asked to reduce or discontinue these medications.** Mixing buprenorphine with some of the drugs listed above or with alcohol can be life threatening.

____ **I agree to notify the clinic immediately in case of return to drug use, which can be life threatening.** I will notify my doctor or counselor before any urine test shows drug use

___**I agree to attend treatment sessions, complete assignments and show progress towards goals** I will follow

recommendations from my treatment team that will assist in my recovery.

My initials and signature below show that I have reviewed the following documents with staff, asked questions, and had my questions explained to me in terms I understand.

_____ The purpose, side effects, and risks and benefits of buprenorphine.
_____ My responsibilities while a client of medication-assisted treatment

By signing this Medications in Support of Recovery Treatment Agreement, I agree to abide by the terms of the agreement.

_____	_____	_____
Patient signature	*Provider/Case Manager signature*	*Date*

Return signed Agreement and Informed Consent to HIM for upload to VistaImaging

Appendix C. MAT Check Lists

1. Checklist prior to Buprenorphine/Naloxone Induction

- ☐ Patient Treatment Information reviewed with patient verbally and in writing. Obtain signature on treatment agreement and informed consent.
- ☐ Reinforce to the patient the need for frequent appointment adherence and confirm that this is realistic and manageable.
- ☐ Discuss counseling services that are available and expectations of the patient and provider.
- ☐ Review lab test results.
- ☐ Offer vaccination for Hepatitis A and B if appropriate.
- ☐ Negative pregnancy test for women of childbearing age.
    - If positive HCG immediately assist with patient engagement with OB providers. Also consider screening for other secondary complications.
- ☐ Women of childbearing age should be counseled on contraception methods and on the increase in fertility resulting from effective OUD treatment.
- ☐ Release of information (ROI) on file and documents related to recent past treatment in detox, OTP, or other treatment facility or office based treatment reviewed.
- ☐ Determine if patient is most appropriate for office based or home induction.
    - For office based induction: date, time prescription are set-up with patient.
    - For home induction standard process is reviewed with the patient.
- ☐ Medication education with focus on appropriate administration technique is completed.
- ☐ Patient is given information on f/u plan, clinic contact info, on what to do in case of questions after hours.

2. Buprenorphine/Naloxone Office Induction

Day 0:

- ☐ The decision to do office induction may be based on the following criteria at the point of nurse comprehensive intake or first visit with provider:
    - Intolerant of withdrawal syndrome
    - Patient-reported adverse events during in-home induction
    - Homeless on street or in shelter
    - Patient request
- ☐ If provider sees patient and determines an in-clinic induction is appropriate, then the provider will write a buprenorphine prescription to be administered during the next clinic appointment.

Day 1:

Patient arrives at clinic in early withdrawal, if previously seen by provider

- ☐ The nurse or provider will assess symptoms with Clinical Opioid Withdrawal Scale (COWS), if the COWS score is >6-12 continue with induction.
- ☐ *If the buprenorphine is ordered for in-clinic administration*, then the order is placed, the pharmacy called and buprenorphine/naloxone 2-4mg initial dose is sent to the clinic. The RN then gives the medication to the patient for sublingual administration, monitoring for appropriate administration, and waits 10-30 minutes until medication dissolved.
- ☐ Reassess after 30-60 minutes, and instruct patient to then take their second dose of 2-8mg sublingually if needed, again observed and supervised by the RN or provider for proper administration.
- ☐ Dosage is titrated per prescription instructions and until patient symptoms stabilize.

Provide support and ongoing education. Typically patients will titrate to 8mg by the end of day 1, however, this dose may be less or more depending on patient circumstances.

Day 2 through Day 7:

- Patient is instructed to take total dose equivalent from day one upon awakening. Patient is asked to check in with the RN or prescriber by phone during business hours with any questions, as needed. If increased symptoms throughout the day, the patient may increase by pre-specified amount daily up to 16mg. Daily check-in with a phone note as needed; patient to return to clinic within one week or sooner as indicated.
- Provider may elect office-based administration on days 2-7 if desired.

3. **Buprenorphine/Naloxone Home Induction**

Day 1:

- Patient checks in by telephone, as needed, during that day. Dosage is titrated per prescription instructions and until patient symptoms stabilize. Provide support and ongoing education; update Nurse Care Manager, prescriber, or associated care team member as needed. Typically patients will titrate to **8mg by the end of day 1**, however, this dose may be less or more depending on patient circumstances.

Day 2 through Day 7:

- Patient is instructed to take total dose equivalent from day one upon awakening. Patient is asked to check in with the Nurse Care Manager, prescriber, or associated care team member by phone during business hours with any questions, as needed. If increased symptoms throughout the day, the patient may increase by pre-specified amount daily up to **16mg**. Daily check-in with a phone note as needed; patient to return to clinic within one week or sooner as indicated.

4. **Buprenorphine/Naloxone Stabilization and Maintenance**

When facility's MARS program or other MAT program is unavailable

Goal: stabilization of dosing. Target buprenorphine/naloxone dose = 8-16 mg/day (maximum of 24mg/day) or less. May be taken in divided doses.

  - Divided dosing is especially helpful for patients with chronic pain for dual effectiveness and avoidance of narcotic medications.

- Patient sees Nurse Care Manager or Provider weekly until stable, then every other week, and progresses to monthly as clinically indicated. If a patient requires more support they may present in person for more frequent visits.
- Clinic visits to include
  - Collection of urine sample or oral swab for toxicology.
  - Review of current buprenorphine/naloxone dose, adherence, and correct administration techniques
  - Review of treatment plan: (counseling, meetings), need for further psychiatric treatment, difficulties with obtaining or using buprenorphine/naloxone, incidence of side effects, presence of cravings or withdrawal, instances of drug use.
  - Lab testing: if LFTs were elevated at induction, consider re-check within 1-2 months or sooner and regularly monitored thereafter. Elevations are more common in patients with hepatitis C and HIV infection.
  - Discussion of other substance use disorders and other comorbid conditions (e.g., insomnia, depression, etc.). Referrals may be made and/or prescriptions signed, by protocol as appropriate, for appropriate treatment modalities.
  - Medical case management with brief counseling support.

- Review contact information, including pharmacy at each visit.

- Visits with care team provider or prescriber provider at every visit, with review of medical record, lab test results, recovery status and UDS results.
- Care team provider performs telephone contact for support, monitors medical issues, pregnancy status, medication changes, any pending needs for surgery, acute/chronic pain management, and need for psychiatric assessment.

5. Buprenorphine/Naloxone Tapering

Buprenorphine is a partial mu-opioid agonist that results in physical adaptations (i.e., dependence) when used chronically. Accordingly, abrupt discontinuation will result in a withdrawal syndrome. In patients with a history of chronic IV opioid misuse, studies have consistently demonstrated a persistent relapse risk of >80% regardless of duration of opioid agonist therapy. While the evidence describing relapse rates in people who used alternative forms of non-heroin administration suggests there may be a somewhat decreased rate of relapse, abstinence from illicit opioids is consistently better among people on buprenorphine long-term. That said, for a variety of reasons patients may want to discontinue their buprenorphine therapy.

- Withdrawal symptoms begin within the first 3 days, peak between 3 and 5 days, and return to baseline usually within 10 to 14 days (may be longer).
  - Subjective withdrawal signs include: restless leg, insomnia, anxiety, nausea, chills, abdominal distress
  - Objective withdrawal signs include: lacrimation, rhinorrhea, tremors, vomiting, diarrhea, gooseflesh.
- Protracted abstinence syndrome can occur and persist for months or years following discontinuation of the medication. It is important to respond to patient's protracted withdrawal symptoms (anxiety, insomnia, depression) to support their recovery process and avoid relapse.

  Buprenorphine/naloxone should be tapered over days, weeks, or months, depending on patient's tolerance of withdrawal symptoms, rise of cravings, and other risks of return to use.
    - The prescriber should continue to support tapering patients, offer assistance with dose decreases and associated management of withdrawal symptoms and cravings.
    - Rapid taper example for a patient on 16mg buprenorphine daily
      - 10-day taper: 12mg x3 days, 8mg x3 days, 4mg x3 days, then stop
      - 7-day taper: 12mg x1 day, 8mg x2 days, 4mg x2 days, 2mg x2 days, then stop
      - For all cases, offer adjunctive therapy for withdrawal symptoms including medications such as ondansetron (nausea); loperamide (diarrhea); hydroxyzine (anxiety); ibuprofen (myalgias); and, clonidine 0.1mg q8h prn (anxiety/agitation) holding if patient is lightheaded, describes orthostatic symptoms, or presents with hypotension

6. Naltrexone Checklist

Checklist prior to Naltrexone Initiation

- ☐ Patient Treatment Information reviewed with patient verbally, in writing or both.
- ☐ Reinforce to the patient the need for frequent appointment adherence and confirm that this is realistic and manageable.
- ☐ Discuss counseling services that are available and expectations of the patient and provider.
- ☐ Review UDS, pregnancy test, and confirm that transaminases are < 5x normal and there is no sign of decompensated cirrhosis
- ☐ Detoxification from opioids should be completed prior to the administration of naltrexone to prevent precipitated or spontaneous withdrawal. The patient should be off short-acting opioids 5-7 days. If taking long-acting opioids such as methadone or buprenorphine, the patient should be off for at least 7-10 days.
- ☐ Detoxification from alcohol should occur prior to naltrexone initiation if a patient has a history of alcohol-related seizures, DTs, presence of moderate-severe withdrawal signs or symptoms, or as otherwise clinically indicated.
- ☐ Release of information (ROI) on file and documents related to recent past treatment in detox, Opioid Treatment Program (i.e., methadone program), or other treatment facility or office based treatment reviewed.
- ☐ Medication education with focus on adverse effects such as injection site reactions and vulnerability to opioid overdose
- ☐ Patient is given information on f/u plan, clinic contact info, on what to do in case of questions after hours.
- ☐ Consider low dose oral naltrexone challenge for at risk patients whom you suspect may not have disclosed recent opioid use to avoid precipitated withdrawal

Naltrexone Maintenance

- ☐ Once stable, clinic visits required every 4 weeks if on Vivitrol (IM depot naltrexone) or earlier for supportive therapy.
- ☐ Refer to pharmacy for on-going maintenance therapy.
- ☐ Goal: Clinic visits every 28 days, occurring on the date of the patient's extended-release naltrexone injection.

Appendix D: Intake Questionnaire

Intake Questions (EHR Documentation Template)

1) What is your substance of choice:
2) Patient use of substances:
3) Age of first use:
4) Duration of use (months years)
5) Peak use:
6) History of CD treatment(location, type, and year)
7) Anti-relapse medications + how did it go:
8) Last period of sobriety + perception of what led to relapse:

Assessments

1) Mood (PhQ-9)
2) Anxiety (GAD-7)
3) Trauma—Tool?
4) Sleep (Epworth =/- Insomnia severity)
5) Seizures (from what?)
6) CNS infections
7) Learning disabilities
8) Cognitive Deficits

Past Psych History

1) Diagnosed with a psychiatric illness (who diagnosed? Formal testing done?)
2) History of admission for psychiatric illness
3) Suicide attempts (how long ago)
4) Psych Medications

Family History (document in Family History)

1) Family use of drugs/ETOH
2) Family history of mental health issues
3) History of abuse in the family

Social History (document in Social History)

1) Living situation (with family, alone, friends, pets)
2) Safety at home
3) Food insecurity (enough to eat)
4) Sober supports