evidence based guidelines

MEDICATIONS for OPIOID USE DISORDER

GENERAL

Medication for Opioid Use Disorder (MOUD): reduces illicit opioid use, retains people in treatment, and reduces the risk of opioid overdose death better than treatment with placebo or no medication.

MOUD should be part of a comprehensive rehabilitation program – see "Substance Use Disorder" guideline

Preventive naloxone (Narcan) available by prescription, through hospital pharmacy, or FREE community distribution centers:

Fridays 1PM -4 PM at Skip's Pharmacy; 700 Michigan Ave Holland
Fridays 10AM-12PM at Grand Haven Community Mental Health; 1111 Fulton St #1
FREE mail order at naloxoneforall.org/michigan

NALTREXONE

Full opioid antagonist – Patient must be off all opioids for 7-14 days prior to initiating
Dosing: 50mg oral once daily or 380mg IM (e.g. Vivitrol) every 4 weeks

BUPRENORPHINE

Partial opioid agonist with a higher receptor affinity than other opioids

May precipitate withdrawal symptoms in those actively using other opioids
At low doses each 1mg gives similar analgesia as 20-30mg of morphine
Has a "ceiling" effect for higher doses with no further benefit/harm above 24mg/day
Can give euphoria and over-sedation especially with IV form or in opioid naïve patients
Can cause fatal overdose in children or if co-administered with alcohol/benzodiazepines

Formulations:

Combination with naloxone sublingual strips (e.g Suboxone)
Combination with naloxone sublingual tablets (e.g Suboxone, Zubsolv)
- Naloxone is NOT absorbed sublingually, but WILL inactivate opioid effect intravenously
- Combination is preferred if clinically appropriate to prevent diversion to IV use

Stand-alone buprenorphine sublingual tablets (e.g Subutex)
Injectable -SC/IM/IV (e.g. Sublocade, Brixadi)

Induction:

Starting moderate or high dose buprenorphine for the first time while a patient is actively using other opioids may cause precipitated withdrawal. To prevent this uncomfortable reaction, various induction methods are used. See: A practical guide for buprenorphine initiation in the primary care setting (Cleveland Clinic Journal of Medicine Sep 2023, 90 (9) 557-564)

Be cautious to avoid over-sedation especially if patient has also been abusing sedatives or Etoh
The majority of patients will receive relief with 8mg or 16mg of buprenorphine/day
Treat withdrawal symptoms if necessary.

Nausea: ondansetron, promethazine, prochlorperazine
Insomnia: trazodone, melatonin, gabapentin, quetiapine
Shakes/sweats, hypertension: clonidine 0.1 q4hrs prn
Anxiety: hydroxyzine, buspirone, gabapentin, SSRIs

Maintenance:

Begin with frequent visits, routine point of care drug testing, and small supplies of medications.
Relax oversight as patient demonstrates successful recovery.
Instead of dismissal for evidence of relapse or diversion, increase oversight (shorter f/u, random testing/med count, supervised administration, monthly SC treatment) or refer to a higher level of care

METHADONE

Must be prescribed at a federal regulated treatment center

- Western Michigan Comprehensive Treat. Ctr.: 833-919-2179 western-michigan-comprehensive-treatment-center/
- Muskegon Recovery Center: 231-767-1921 cherryhealth.org/locations/muskegon-recovery-center/

RESOURCES

OPEN (Overdose Prevention Engagement Network): michigan-open.org/programs/request-a-consultation/
SAMHSA (Substance Abuse and Mental Health Serv. Admin): samhsa.gov/medications-opioid-use-disorder

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