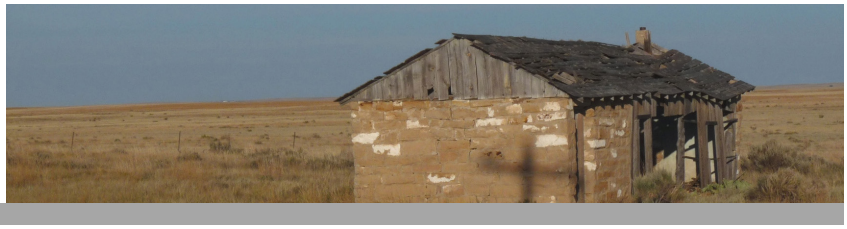
IT ATTTRs™

Implementing Technology, Medication Assisted Treatment Team Training, and Resources



Alternatives to Buprenorphine

INJECTABLE NALTREXONE (XR-NTX)*

- Multicenter (13 sites in Russia)
  - DB RPCT, 24 wks, n=250 w/ opioid dependence
  - XR-NTX vs placebo, all offered biweekly individual drug counseling
  - Increased weeks of confirmed abstinence (90% vs 35%)
  - Increased patients with confirmed abstinence (36% vs 23%)
  - Decreased craving (-10 vs +0.7)
- Two recent studies showed similar effectiveness for XR-NTX and daily buprenorphine-naloxone (BUP-NX)
  - More difficult to start patients on XR-NTX than BUP-NX

Benefits

- Good for patients who do no want agonist or partial agonist therapy
- No risk of diversion (not a controlled substance)
- No risk of overdose by drug itself
- Can be administered in any setting (OBOT or OTP)
- Long-acting formulation
- Treats both opioid use disorder and alcohol use disorder

Potential Candidates

- Occupational Obstacles: e.g, HCPs
- Not Interested/Failed Agonists
- High Motivation for AA Model of Recovery
- Currently Abstinent: High Risk for Relapse
- Younger, Lower Duration of OUD
- Don't want to be Physically Dependent
- Tired of regulations, stigma, and SO pressure

Limitations

- Ease of starting—must be fully withdrawn from opioids
  - short-acting (6 days)
  - long-acting opioids (7-10 days)
- Not recommended for pregnant women
  - Pregnant women who are physically dependent on opioids should receive treatment using methadone or buprenorphine monopro
- Diminished tolerance to opioids, unaware of consequent increased sensitivity to opioids if they stop taking naltrexone
- Head to Head Studies Buprenorphine versus IM Naltrexone equally effective if able to start IM Naltrexone

*No Black Box LFTs Warning Label for IM Formulation

METHADONE HYDROCHLORIDE

- Full opioid agonist
- Oral - 80-90% oral bioavailability
- Tablets, Liquid Solution, Parenteral (50%)
- PO onset of action 30-60 minutes
- Duration of action
  - 24-36 hours to treat opioid use disorders (OUD)
  - 6-8 hours to treat pain
- Proper dosing for OUD
  - 20-40 mg for acute withdrawal
  - > 80 mg for craving, "opioid blockade"

Methadone Maintenance Treatment

- Highly regulated - Narcotic Addict Treatment Act 1974
  - Created Opioid Treatment Programs (OTPs)
  - Separate system not involving primary care or pharmacists
- Treatment (methadone dispensing) for opioid use disorder limited to licensed OTPs
- It is illegal for a physician to prescribe methadone for the treatment of opioid use disorders in an office-based practice

Methadone Maintenance in OTP

- Highly Structured
  - Daily nursing assessment
  - Weekly individual and/or group counseling
  - Random supervised drug testing
  - Psychiatric services
  - Medical services
- Methadone dosing
  - Observed daily "take homes" based on stability and time in treatment. Max: 27 take homes. Varies by state, county and individual clinics

Benefits

- Increases overall survival
- Increases treatment retention
- Decreases illicit opioid use
- Decreases hepatitis and HIV sero conversion
- Decreases criminal activity
- Increases employment
- Improves birth outcomes

Limitations

- Limited access
- Inconvenient and highly punitive
- Mixes stable and unstable patients
- Lack of privacy
- No ability to "graduate" from program
- Stigma