Medications for Opioid Use Disorder

Leslie Dabovich Dempsey, MD
Southern Colorado Family Medicine
Faculty & Director of Obstetrics
NEW
ICWB Co-clinical Lead

OBJECTIVES

Update our understanding of common terms

Review 3 major categories of treatment medications:

- MOA
- Risks/Benefits
- Dosing Strategies

A quick look at supportive medications

A Brief word on treatment settings

Followup Care Basics

A ROSE BY ANY OTHER NAME . . .

- OUD – Opioid Use Disorder
- Dependence
- MOUD – Medications for Opioid Use Disorder
- MAT – Medication-Assisted Treatment
- NAS – Neonatal Abstinence Syndrome

DSM V CRITERIA FOR DX OF OUD

Loss of Control	1 – More and for longer than intended
	2 – Unable to cut back or control use
	3 – A lot of time spent obtaining, use, recovering
	4 – Craving, or a strong desire to use
Social Impairment	5 – Causing failure of obligations at work, school, or home
	6 – Contributing to social/interpersonal problems
	7 – Important social, occupation or recreation activities given up to use
Risky Use	8- Use in physically hazardous situations
	9- Use w/ knowledge that it is contributing to physical and psychological problems
Tol & WD	10 – tolerance
	11 – withdrawal

Mild (1-3), Moderate (4-5), Severe (6+)

MEDICATIONS FOR OPIOID OVERDOSE, WITHDRAWAL, & ADDICTION

Medications for opioid overdose, withdrawal, and addiction are safe, effective and save lives.

The National Institute on Drug Abuse supports research to develop new medicines and delivery systems to treat opioid use disorder and other substance use disorders, as well as other complications of substance use (including withdrawal and overdose), to help people choose treatments that are right for them.

FDA-approved medications for opioid addiction, overdose, and withdrawal work in various ways.

Opioid Receptor Agonist
Medications attach to opioid receptors in the brain to block withdrawal symptoms and cravings.

Opioid Receptor Partial Agonist
Medications attach to and partially activate opioid receptors in the brain to ease withdrawal symptoms and cravings.

Opioid Receptor Antagonist
Medications block activity of opioid receptors in the brain to prevent euphoric effects (the high) of opioids and alcohol and help reduce cravings.

Adrenergic Receptor Agonist
A medication that attaches to and activates adrenergic receptors in the brain and helps alleviate withdrawal symptoms.

REDUCES OPIOID USE AND CRAVINGS

Methadone
Daily liquid or tablet

Dolophine®, Methadose®
Generics available

Naltrexone
Monthly injection

Vivitrol®

Buprenorphine
Daily tablet
Monthly injection

Sublocade®
Generic tablets available

Buprenorphine/ Naloxone
Daily film under the tongue or tablet

Zubsolv®, Suboxone®
Generics available

TREATS WITHDRAWAL SYMPTOMS

Lofexidine
As-needed tablet

Lucemyra®

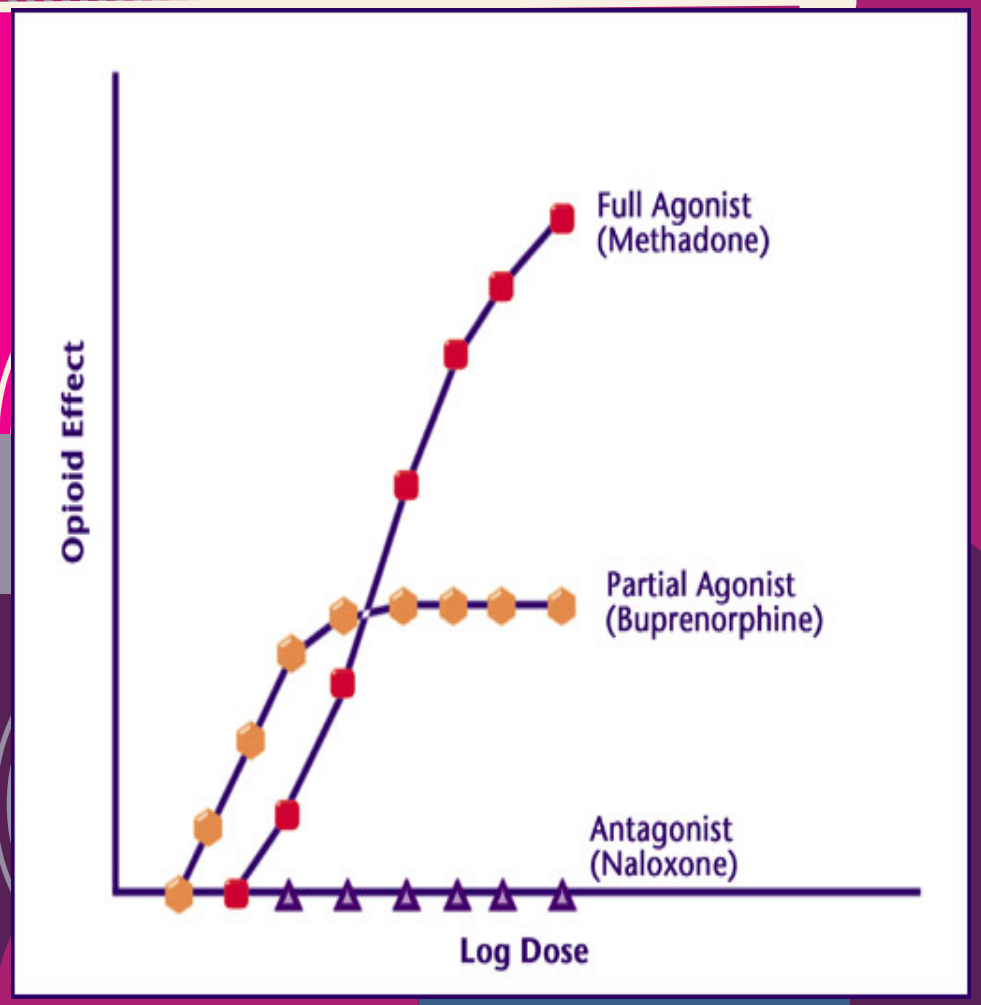
REVERSES OVERDOSE

Naloxone
Emergency nasal spray or injection

Kloxxado®, Narcan®, Zimhi™
Generics available

METHADONE

The "gold standard" or the "OG"

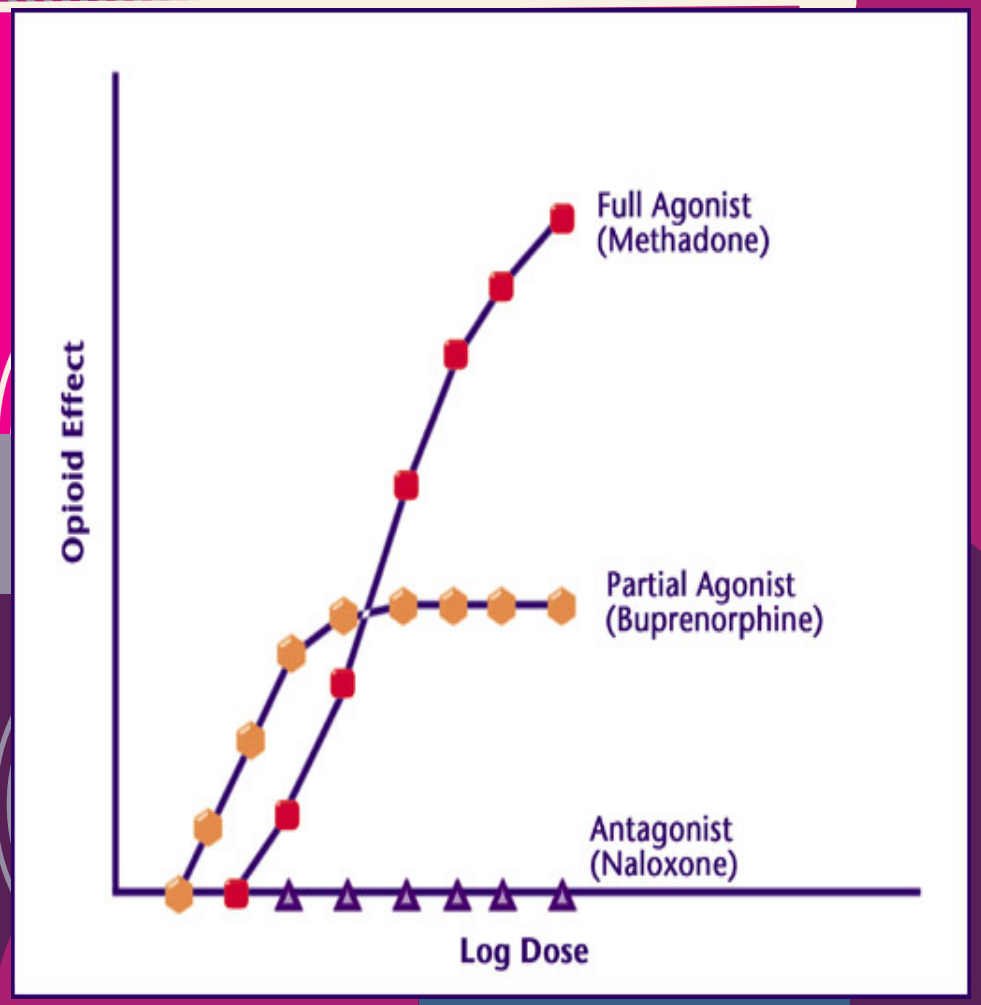


Formulations: tablets (pain), liquid (OUD trt), wafer (rare)

+ Full agonist, pain control, no "max" dose, easy to start, no risk or precipitated withdrawal, long half life (15-60 h → 5d to ss)

- for OUD treat need to pick up daily*, sedation, stigma, QTc prolongation, medication interactions (a lot of abx), overdose due to long half life

METHADONE



Dosing:

Start at 30-40mg typically

Average therapeutic dose often 80-120mg/d*

Inpatient: Start at 30mg, add 10mg every 4 hours that pt not sedated to max of 50mg on 1st day

Outpatient: OTP required

BUPRENORPHINE

PARTIAL AGONIST

Formulations: tablet (SL), film (B), injectable (SQ, IV)

+

accessible to any prescriber in CO* (no OTP needed)

decreased risk of sedation and respiratory depression

pain control

long acting (24-26h)

high affinity for mu receptor

-

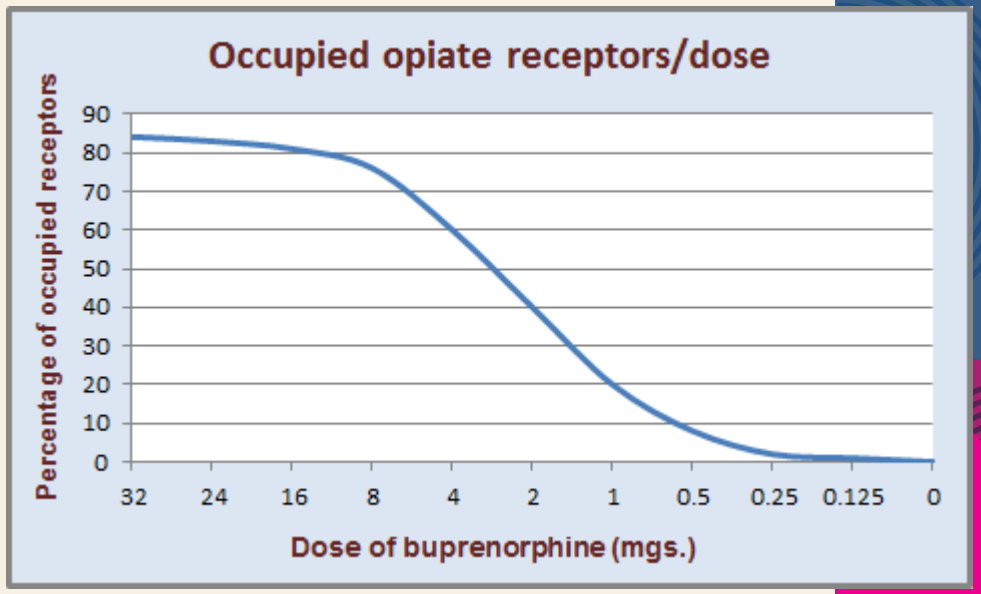
Max dose of 24mg *

Taste?

Nausea/headaches

w/ and w/o precipitated withdrawal

Less effective w/ fentanyl due to ceiling effect?



BUPRENORPHINE

PARTIAL AGONIST

Low – *small and gradually increasing doses while CONTINUING/TAPERING full agonist over 2-7 days*

Traditional *

Start 2-4mg when COWS score 12 and above

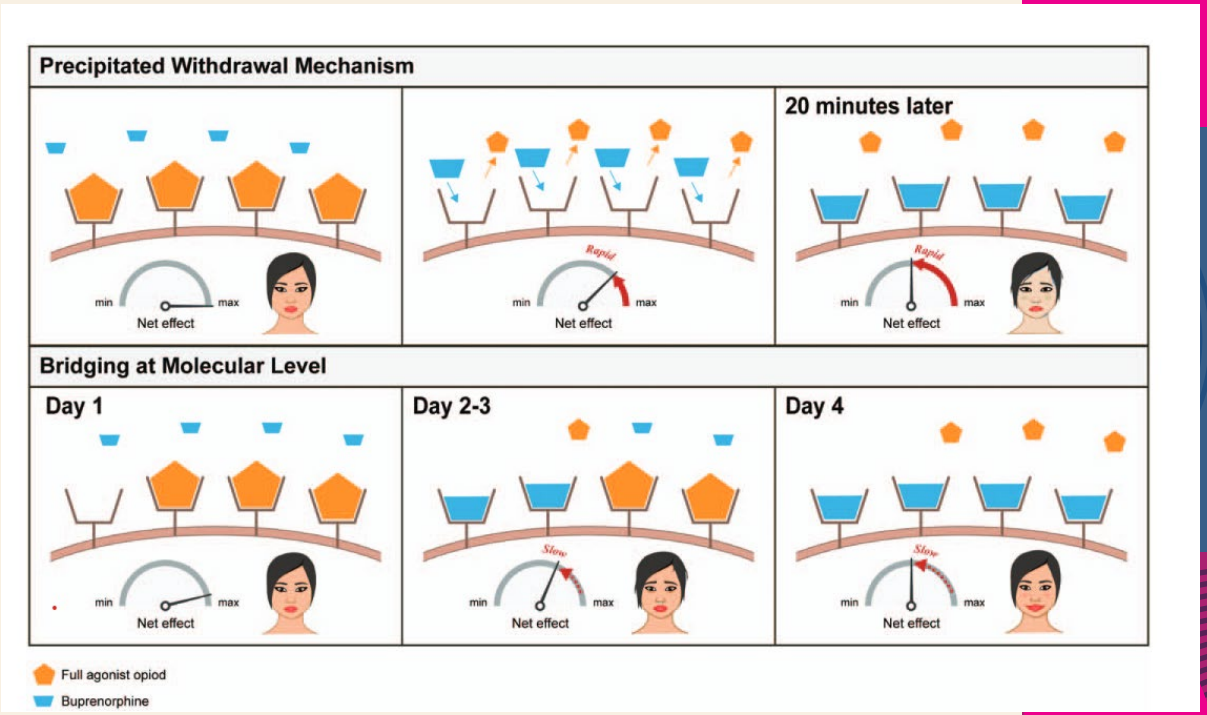
Re-dose with 2mg every 2-4 hours until COWS score < 5, to max of 24mg*

Day 2 – dive total used on day 1 and give BID

Increase prn

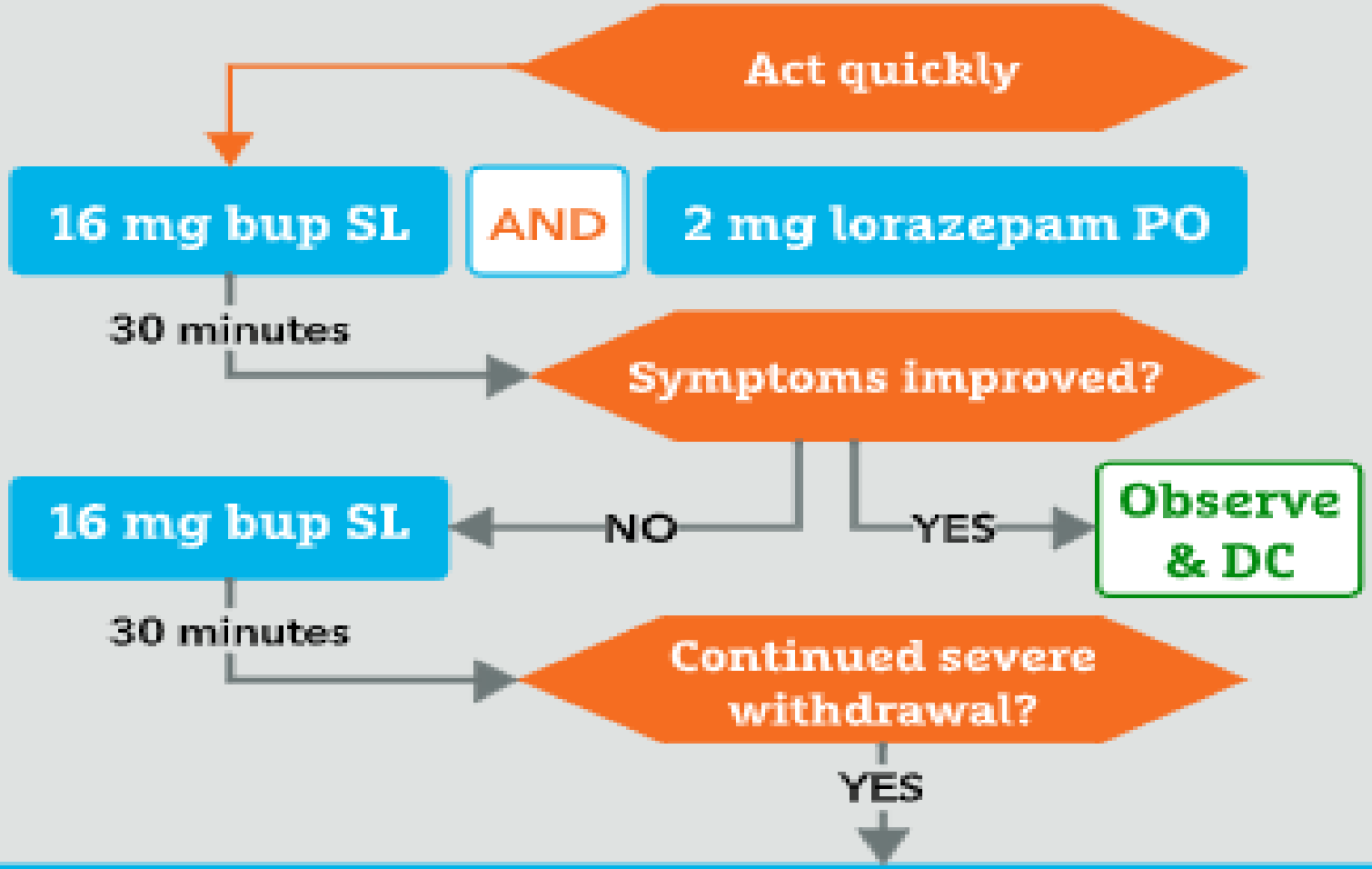
High –*not ideal in pregnancy. Mostly seen in ED*

Wait for severe w/d, start 16mg SL, redoes if slight improvement in 1 hour, reassess if no improvement



Treatment of bup precipitated withdrawal

(Sudden, significant worsening of withdrawal soon after bup administration.)



Adjuvants:
OK but should not delay or replace bup. Use sparingly with appropriate caution.

Benzodiazepines:

- Lorazepam 2 mg PO/IV

Antipsychotics:

- Olanzapine 5 mg PO/IM

Alpha-agonists:

- Clonidine 0.1-0.3 mg PO

D2/D3 agonists:

- Pramipexole 0.25 mg PO

Gabapentinoids:

- Pregabalin 150 mg PO

Escalate level of care to manage potential moderate to deep sedation including cardiac, pulse oximetry, and end tidal CO2 monitoring:

1. Ketamine (0.3 mg/kg IV slow push q 15 minutes and/or infusion).
2. Fentanyl 200 mcg IV q10 minutes. Total dose of > 2000 mcg has been reported.

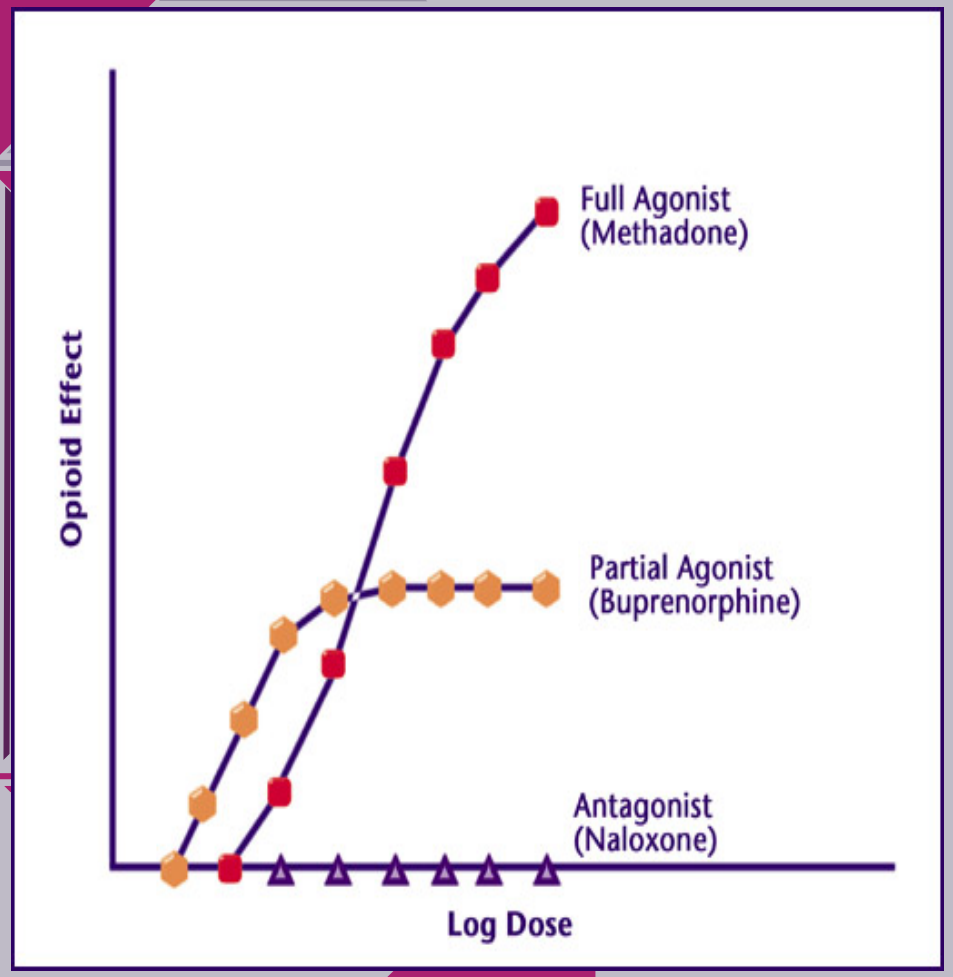
BUPRENORPHINE

PARTIAL AGONIST

SLOW **BUPRENORPHINE MICROINDUCTION RECOMMENDATION[4]**			
DAY	**DATE**	**SUBOXONE DOSE**	**CURRENT SUBSTANCE RECOMMENDATIONS**
Day 1		¼ film once daily	Continue current dose/use
Day 2		¼ film twice daily	Continue current dose/use
Day 3		½ film twice daily	Continue current dose/use
Day 4		1 film twice daily	Reduce dose/use by 25%
Day 5		1 ½ films twice daily	Reduce dose/use by 25%
Day 6		2 film's twice daily	Reduce dose/use by 25%
Day 7		3 film's twice daily	Reduce dose/use by 50%
Day 8 and beyond dosing to be filled in by provider at follow up appointments			
Day 8			Reduce dose/use by 50%
Day 9			Reduce dose/use by 50%
Day 10			Reduce dose/use by 50-75%
Day 11			Reduce dose/use by 50-75%
Day 12			Reduce dose/use by 75%
Day 13			Reduce dose/use by 75%
Day 14			STOP
Days 15 – beyond			STOP

https://www.momsplus.us/resources-1

NALTREXONE



ANTAGONIST

Formulaton: IM inj (for OUD), daily tablet (AUD)

+ no physical dependence as antagonist (blocks receptor)

HIGH affinity and competitive binding

Accessible

- Need 7-10d opioid free prior before starting, intolerance due to nausea/HAs, pain management issues when indicated

ADJUNCT TREATMENTS (+/-)

- [ ] Clonidine 0.1 mg orally q4h PRN restlessness, hot/cold flashes or anxiety
- [ ] Hydroxyzine 25-50 mg orally q6h PRN anxiety or insomnia
- [ ] Ondansetron 4 mg orally q6h PRN nausea
- [ ] Dicyclomine 10 mg orally TID PRN abdominal cramping
- [ ] Trazodone 50-100 mg orally qHS PRN insomnia
- [ ] Acetaminophen 500-1000 mg orally q6h PRN headache, pain
- [ ] Gabapentin 300 mg orally TID PRN restless legs, anxiety, agitation
- [ ] Promethazine 12.5-25 mg orally q6H PRN nausea (if preferred to ondansetron, or not having success with ondansetron)

TO BE OR NOT TO BE

In the hospital

There is no universally accepted protocol for where buprenorphine initiations should occur for pregnant women:

Home

Clinic

OTP

ER/OB Triage

L&D

Med/Psych Units

Other?

Hybrid Clinic/Home

FOLLOWUP CARE

Medication:

- Buprenorphine – apt in 5-7 days, enough medication to get to apt
- Methadone: coordinate with OTP for next day dose, weekends/holidays *

Post Partum Appointments – increased intensity rec'd

Peer Support

Social work

OUD/SUD in patient's problem list

NALOXONE !

THANK YOU

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- To all those listening for being my 1st audience in this new role!

Leslie Dabovich Dempsey, MD

Leslie.Dempsey@commonspirit.org

QUESTIONS?