Overdose Reversal

Naloxone, the antidote for opioid overdose, was reclassified as an over-the-counter medication to make it widely accessible to people at risk of overdosing from opioids. A prescription for naloxone will no longer be needed for the purchase of this medication. For more information on obtaining and administering naloxone, please visit: ***http://www.getnaloxonenow.org/***

Medications: naloxone (Narcan®, Evzio®, RiVive®)

Administration: injection, auto injection, intramuscular, or intranasal spray

Mechanism: Reverses opioid overdose by removing opioids from receptor. Only effective at reversing overdose for 20-90 minutes. Patients should receive medical attention after naloxone is administered, in case an additional dose of naloxone is needed.

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Southwest Interdisciplinary Research Center
Arizona State University

AHCCCS
Arizona Health Care Cost Containment System

MOUD

Medications for Opioid Use Disorder

A Pocket Guide

Southwest Interdisciplinary Research Center
Arizona State University

Medications for Opioid Use Disorder (MOUD) is an **evidence-based approach** that is often combined with counseling, therapy, and psychosocial support to provide comprehensive care for individuals seeking recovery from opioid addiction. A related term is Medication Assisted Treatment or MAT, which refers to a combination of MOUD, counseling and behavioral therapies.

The Evidence

Research on medications for opioid use disorder shows:

- Half of patients participating in treatment for a substance use disorder (SUD), with behavioral therapies alone, will be lost to attrition.
- Patients who participate in abstinence-based behavioral treatment programs that do not use medication have an increased rate of overdose death due to loss of tolerance when patients restart illicit opioid use.
- Treatment, which combines medication with behavioral therapies, has been shown to be more effective than treatment with behavioral therapies alone.
- MOUD can be an effective treatment on its own when access to behavioral health intervention is limited.
- MOUD has been found to improve treatment retention, reduce illicit opioid use, decrease cravings, and improve overall functioning.
- MOUD has demonstrated significant reductions in mortality and premature death.
- MOUD has been linked to reduced healthcare costs, fewer ER visits, and shorter inpatient stays.

Frequently Asked Questions

How do I know if my patient needs MOUD?

All patients with an Opioid Use Disorder (OUD) are candidates for MOUD. Patients who have struggled to maintain abstinence from opioids, through traditional forms of treatment alone, may benefit from the addition of pharmacotherapy to behavioral therapies.

Is one form of medication better than another?

The best medication is the one that works for the patient. A patient's response to a medication is affected by their prior use patterns, drugs used, dose, length of use, and routes of administration, as well as genetic factors. These considerations as well as prior treatment responses can be used in deciding the most appropriate medication. The table included herein briefly compares the three (3) medications that are FDA approved for treating OUD.

How long should my patient remain on MOUD?

MOUD medications have no significant long-term organ toxicity, and there is no medical urgency to stop them in someone who is receiving benefit. Some patients may utilize MOUD to stabilize in their recovery for a period of time, while others may remain on their medications for their lifetime. Research suggests brief courses of MOUD may not be sufficient and a minimum of 12-month courses or longer may be optimal.

My patient is currently abstaining from opioids. Do they really need MOUD?

Patients who are currently abstinent, but at risk for relapse, may be good candidates for MOUD. Patients are most at risk for overdose when they have a reduced tolerance for opioids, which may occur after a period of abstinence, incarceration, or detoxification services. This may be a critical time for MOUD treatment.

Isn't treating my patient's opioid use disorder with medication just replacing one addiction for another?

Addiction differs from physical dependence, in that addiction involves using a substance compulsively, using a substance despite negative consequences, and using it to reach a state of euphoria. With medications to treat substance use, a patient may become physiologically dependent on the substance, but the dosage of medication used does not produce euphoria or a "high" Medication helps reduce cravings and withdrawal. Medications, such as methadone, actually have greater chemical similarities to the brain's natural hormones (e.g., endorphins) than to other opioids.

Patients on MOUD improve in multiple domains: less use of illicit drugs, better social function, and less risk of overdose. Patients on MOUD are more likely to be employed, have stable housing, improved family relationships, and better health. MOUD is far from "replacing one addiction for another." It is the standard of care for helping those struggling with an opioid addiction stay alive and improve their lives.

I work with pregnant women. What are the standards of care for this population?

The American College of Obstetricians and Gynecologists and American Society of Addiction Medicine have published a joint statement that endorses methadone and buprenorphine (mono-product), accompanied by behavioral therapy, as the standard of care for pregnant women with opioid use disorders.

Are methadone overdoses common? Would I be putting my patient at risk?

A federal panel of national experts, through an extensive review of the research literature and national data, determined the majority of methadone overdoses occur when methadone is used as an analgesic, not when methadone is dispensed in Opioid Treatment Programs (OTPs). Methadone and other forms of MOUD are some of the most heavily regulated and monitored forms of medication in the healthcare system.

Arizona Opioid Assistance & Referral Line

This free 24/7 hotline gives providers information about safe prescribing limits, potentially dangerous drug combinations, chronic pain treatment options, and caring for patients who are suffering from opioid use disorder.

1-888-688-4222

Patients at Risk for Overdose:

- **Individuals receiving rotating opioid medication regimens**
- **Individuals who inject opioids**
- **Individuals with reduced tolerance who have:**
  - Recently been released from incarceration and have used opiods in the past
  - Recently been released from emergency medical care following opioid intoxication or poisoning
  - Completed opioid detoxification or have been abstinent for a period of time

Opioid Withdrawal Symptoms

If your patient experiences withdrawal symptoms when they attempt to stop their opioid use, they may be a good candidate for MOUD. Opioid withdrawal symptoms include:

- Anxiety
- Dilated pupils
- Watery eyes
- Diarrhea
- Vomiting
- Sweating
- Cramping/abdominal pain
- Rapid heart rate
- Excessive yawning
- Nausea
- Restlessness
- Insomnia
- Tremors
- "Goose bumps"

A Message from SAMHSA

As overdose deaths involving opioids, particularly illicitly manufactured fentanyl, continue to remain extremely high across the country, we are pleased that the opportunity to treat people with safe and effective medications for opioid use disorder (OUD), such as buprenorphine, has increased with the passage of Section 1262 of the Consolidated Appropriations Act, 2023. This section of the Act removes the requirement that a health care practitioner apply for a separate waiver to dispense certain controlled medications, including buprenorphine. Medication treatment saves lives, and we encourage colleagues in the field to screen for OUD and to initiate or refer for treatment as indicated.

Need to refer your patient for substance use disorder services?

Visit: ***https://www.samhsa.gov/medications-substance-use-disorders/find-treatment***

Need to locate Opioid Treatment Programs (OTPs)?

Visit: ***www.samhsa.gov/medication-assisted-treatment*** (click on "Opioid Treatment Program Directory")

You can locate psychosocial substance use treatment services in Arizona using the Arizona Substance Abuse Treatment Provider Locator: ***http://substanceabuse.az.gov/*** (search by zip code)

Evidence-based Practices used in Treatment for Substance Use Disorder

Treatment Modality	Motivation Enhancement/ Motivational Interviewing	Cognitive Behavioral Therapy	Contingency Management
Psychological Mechanism	Enhance internal motivation through a strong working alliance/ therapeutic alliance and eliciting "change talk" from the patient	Patient changes maladaptive thinking and behaviors through structured exercises and activities	Reinforces desired behaviors through an incentive-based system
Treatment Frequency and Duration	Can be utilized for brief interventions or longer interactions; useful for initial treatment engagement	Short to long term therapy (approximately 10-20 sessions)	Several months (8-16 weeks), 1-2 times weekly
Considerations	Patients are encouraged to identify measurable target behavior Some patients may be in a pre-contemplative state and may take time to engage in changing their behavior	Patients may require a high level of cognitive functioning and ability to work independently to participate in this treatment	Should be used to augment other forms of treatment the patient is receiving, not the sole treatment

Consult with a licensed treatment provider, as not one behavioral treatment is right for everyone. For an overview of treatment best practices, see: National Institute on Drug Abuse (2018, January 17). *Principles of Drug Addiction Treatment: A Research-Based Guide* (3rd ed.). Washington, DC: Author.

MOUD Medications

	methadone (Methadose®, Dolophine®) FDA Approval: 1964	**buprenorphine/naloxone (Suboxone®, Sublocade®, Zubsolv®, Brixadi®) FDA Approval: 2002, 2017, 2022, 2023**	**naltrexone (Vivitrol®, Revia®, or Depade®) FDA Approval: 1984**
Pharmacologic Mechanism	Full Agonist - Activates opioid receptors	Partial Agonist - Acts on and blocks opioid receptors	Antagonist - Blocks opioid receptors
Administration Route	Liquid or oral tablet	Suboxone: Sublingual tablet or film Sublocade: Once a month injection Zubsolv: Sublingual tablet Brixadi: Weekly or monthly injection	Take-home daily oral medication* or long term injectable *Oral medication is approved to treat alcohol use disorder but not FDA approved to treat OUD
Administration Frequency	Daily administration; take home doses for stable patients	Take home doses permitted; initial weekly visits then monthly	Weekly visits or once monthly injection
Prescriber Requirements	Must be administered at an Opioid Treatment Program (OTP)	Practitioners who have a current DEA registration, that includes Schedule III authority, may now prescribe buprenorphine in their practice if permitted by applicable state law.	Any licensed prescriber
Pros	Economical/ low cost Long half-life (24-36 hours allows for daily dose in clinic) Good control of cravings and withdrawal symptoms Acts an analgesic for pain patients 50-80% 1 year retention rates No abstinence required prior to commencing treatment	Improved safety profile compared to methadone Patient convenience (take home dosing available) Naloxone combination discourages misuse Acts an analgesic for pain patients 40-50% year 1 retention rates	Does not cause physical dependence Injectable can prevent diversion & noncompliance
Cons	Risk for respiratory depression when combined w/opioids, alcohol, benzodiazepines Less accessible than other forms of MOUD due to in-clinic dosing	May provide poor craving control in long-term opioid users due to ceiling effect May cause precipitated withdrawal on initial dosing especially for patients using fentanyl To avoid precipitated withdrawal, patients should wait at least 24 hours after their last dose of another opioid before starting buprenorphine However, in some cases, such as when patients are using fentanyl, precipitated withdrawal can still occur even after 24 hours; In these cases, microdosing with buprenorphine may be an option	Does not decrease overdose risk Does not provide analgesia Higher cost Extended abstinence (10-14 days) required prior to commencing treatment
Patient Considerations	May provide better control of withdrawal symptoms and cravings for long term opioid users FDA approved for pregnant women	Patients with high motivation towards compliance and strong social supports may be best suited for this treatment Not currently FDA-approved to treat pregnant women with OUD, but often prescribed off-label; consider risks and benefits when prescribing off-label	Most appropriate for patients who decline MOUDs with agonist therapies or those who have recently tapered off of methadone or buprenorphine

Effective treatment for OUD includes medication prescribed in conjunction with behavioral therapies. However, medication should not be withheld when patients are unable or unwilling to engage in behavioral treatments.