

Medication Treatment for Opioid Use Disorder

February 26th, 2018

12:00pm – 1:00pm

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Disclosures

The speakers do not have relevant financial relationships with commercial interests.

Objectives

- Specify the three medications to treat opioid use disorders
- Describe at least three (3) benefits for using medication assisted treatment.
- Describe at least three (3) strategies to prevent opioid overdose.
- Demonstrate two (2) lessons learned from case discussion.

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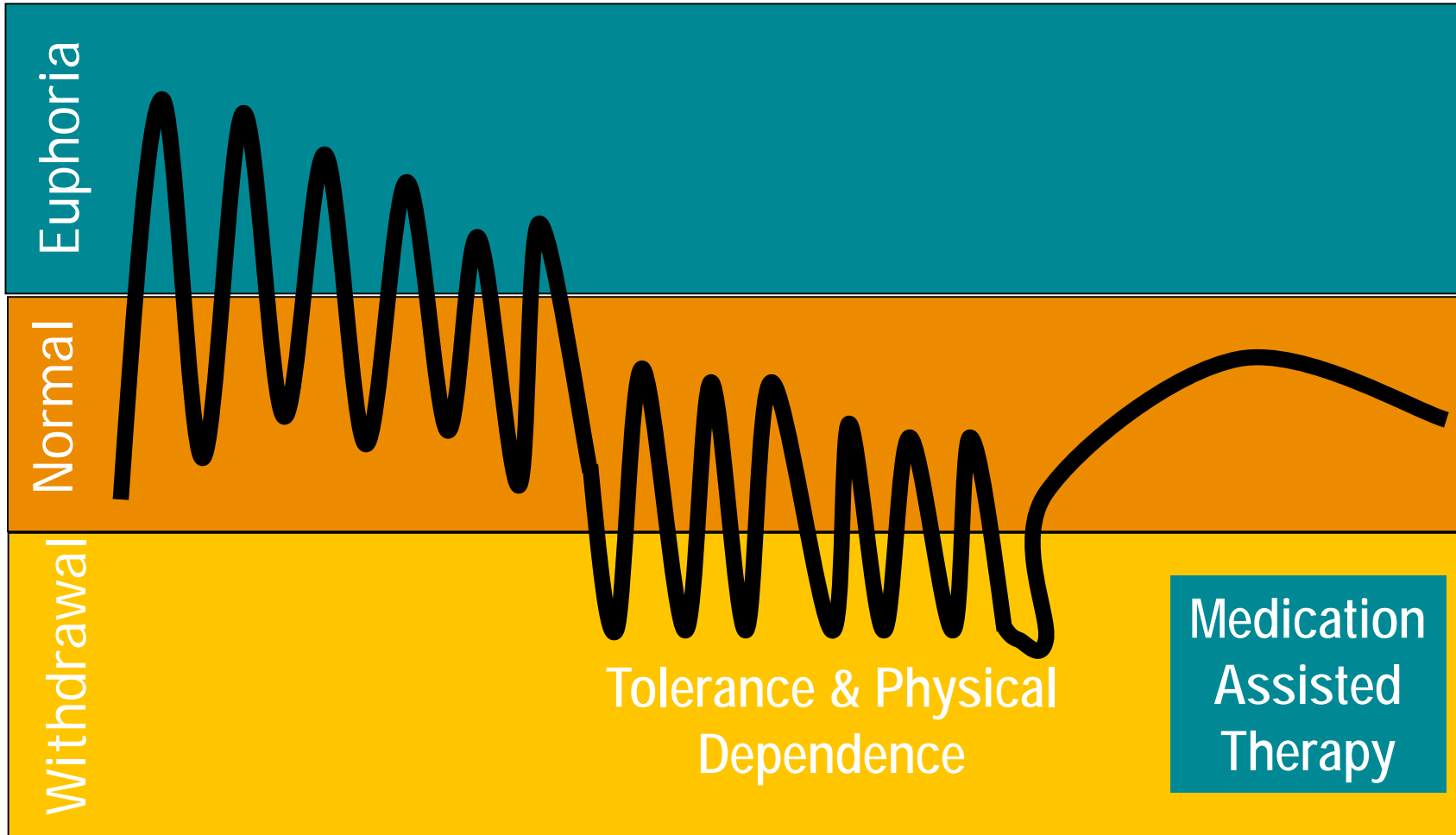
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Medications for Opioid Use Disorder

- ▶ Buprenorphine (sublingual and implantable)
- ▶ Naltrexone (oral and extended release injectable)
- ▶ Methadone

“Detox” has no long-term effect on outcomes; it is medication maintenance that saves lives and reduces relapse





Acute Use

Chronic Use

Alford, Boston
University, 2012



Pharmacotherapy for Opioid Addiction: **Methadone**

- Most effective
 -  survival, treatment retention, employment
 -  illicit opioid use, hepatitis and HIV infections, criminal activity
- Highly regulated, dispensed at Opioid Treatment Programs (OTP)
 - Supervised daily dosing with take-home doses if stable
 - Counseling, urine testing
 - Psychiatric, medical services often not provided
 - **Illegal** to prescribe methadone for addiction in general practice
- Cost-effective
 - Every dollar invested generates \$4-5 in savings

Pharmacotherapy for Opioid Addiction: Methadone

Daily, observed dosing

- ▶ Full opioid agonist
- ▶ Onset within 30-60 minutes
- ▶ Long-acting: Daily dosing effective for addiction
- ▶ Dose 20-40 mg for acute withdrawal
- ▶ >80 mg for craving and “blockade”
- ▶ To evaluate stability, ask about take-home doses
- ▶ **Multiple** medication interactions

Advise staying in treatment until social, medical, psychiatric, legal, and family issues are stable.

- ▶ “Detox” therapy has no long-term effect on outcomes
- ▶ Longer duration, higher dose treatment most effective
- ▶ For some patients methadone therapy should be lifelong, as risk of relapse is high after cessation

METHADONE...

DECREASES RISK OF HIV AND HEPATITIS C INFECTION

Highly effective

FACTS

Reduces relapse

One of the WHO list of 100 essential meds that should be available worldwide

Improves pregnancy outcomes

MYTHS

Always sedated

Can't drive

BAD FOR YOUR BABY

Rots your teeth

Still addicted

Can't nurse your baby

Gets in the bones



Pharmacotherapy for Opioid Addiction: Buprenorphine

- 2000 Federal Drug Addiction Treatment Act (“DATA-2000”):
 - Made office-based addiction treatment by physicians legal
 - Must complete 8-hour training and obtain federal waiver
- 2002: Suboxone (buprenorphine/naloxone) FDA approved
 - Outcomes much superior to psychosocial treatment alone
 - Longer treatment duration is more effective
- Compared to methadone:
 - Similar abstinence from illicit opioids and decreased craving
 - Lower retention in treatment
 - Can be prescribed in general practice, lowering barriers to treatment

Pharmacotherapy for Opioid Addiction: **Buprenorphine**

- Partial opioid agonist, so safer than methadone
- High mu receptor affinity, so blocks other opioids
- Formulated with naloxone - abuse deterrent
- Sublingual dosing and newer implant (Probuphine)
- Can precipitate withdrawal in tolerant patients
- Requires induction after patient enters mild-moderate withdrawal
- Home induction appears to be safe and effective, widely adopted
- Induction from methadone more difficult (taper to ~30 mg)
- Implant approved for stable patients on ≤ 8 mg buprenorphine

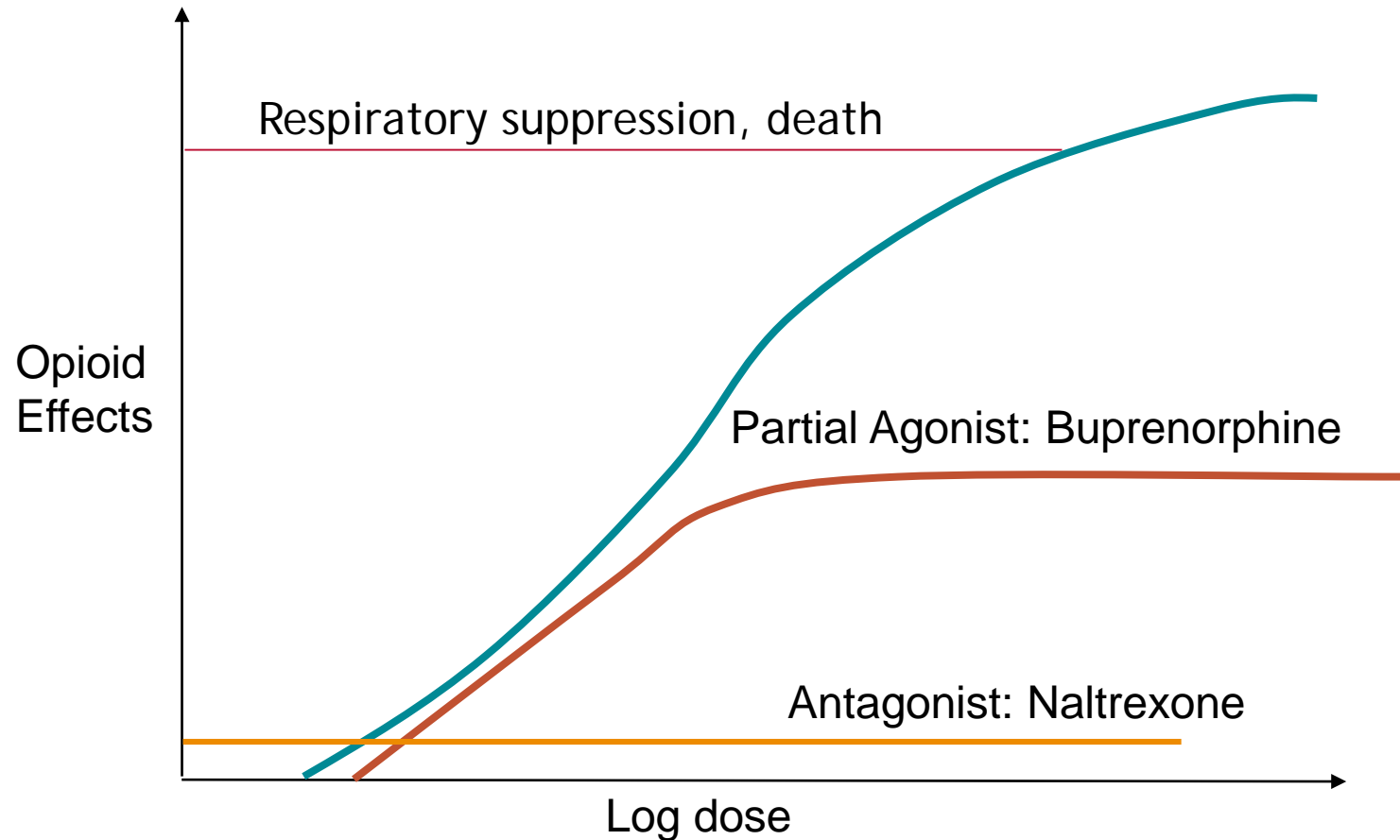


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Why is Overdose Potential Low with Buprenorphine?



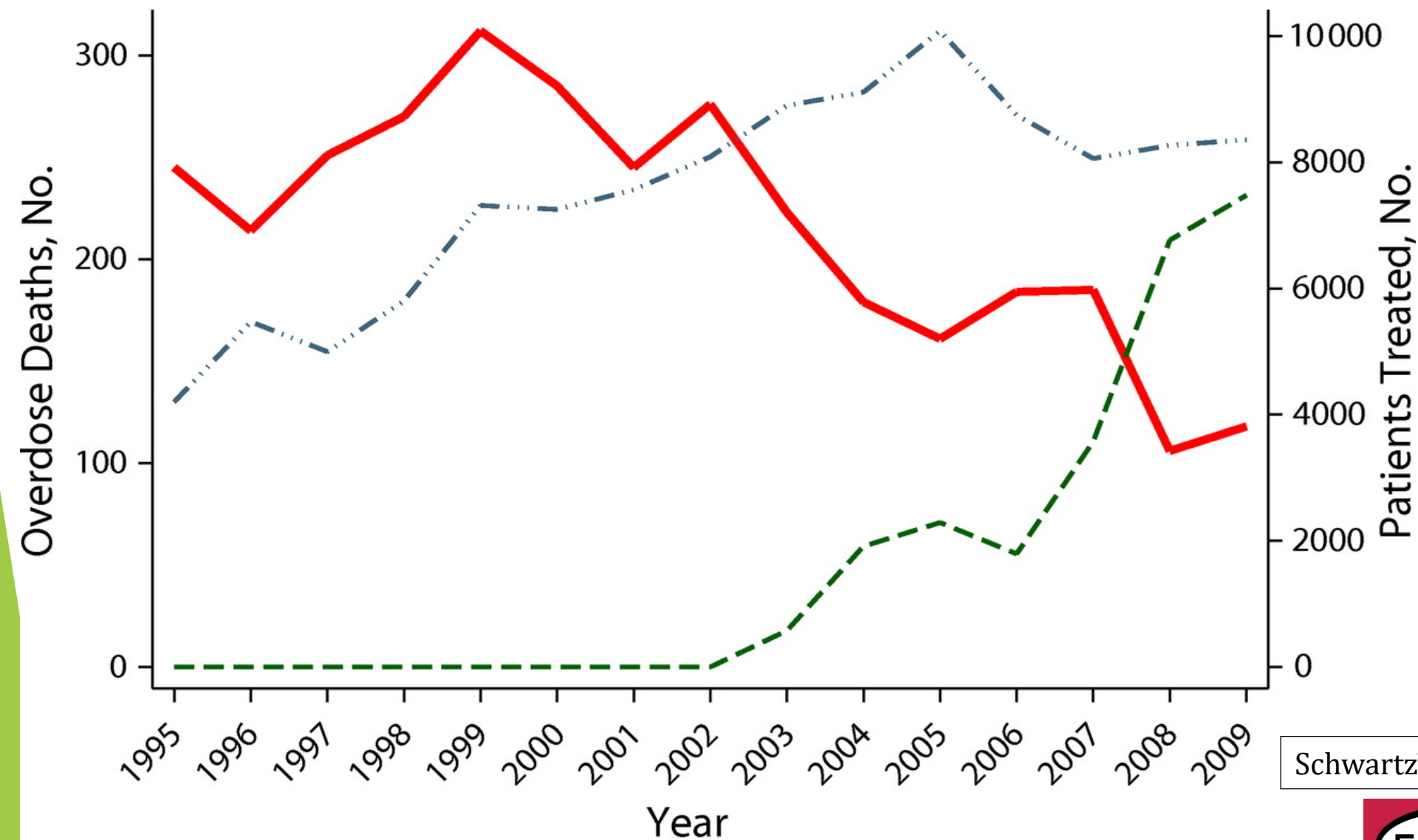
Agonist: Methadone,
Heroin, etc.

Trial of Buprenorphine

40 people addicted to heroin
Buprenorphine 16 mg/day vs taper + placebo
All received indiv counseling + therapy groups
Followed for 1 year

	Buprenorphine 16 mg per day	Placebo
Retained at 1 yr	75%	0
% died	0	20%

Kakko et al, Lancet 2003



Schwartz, AJPH, 2012

— Heroin overdoses
 - - - Buprenorphine patients
 - · - · - Methadone patients



Buprenorphine in Primary Care

- ▶ Not widely used in primary care
- ▶ Most prescribers treat few patients, so poor access
- ▶ Barriers in primary care include:
 - ▶ Urgency of scheduling
 - ▶ Induction visit and frequent early follow up (consider home induction)
 - ▶ Urine testing and prescription logistics
 - ▶ Linkages to psychosocial services
 - ▶ Difficult decisions about when to stop or refer
- ▶ Some physicians restrict prescribing to patients who were already in their own practice

Buprenorphine in Primary Care

- Advantages of buprenorphine in primary care:
 - Setting built for chronic disease management
 - Reduces the stigma of addiction treatment
 - Reduced contact with active drug users
 - Facilitates management of mental health and medical co-morbidities and preventive care
 - Important tool when problems arise during chronic opioid therapy
 - Public health benefit: increases local access to lifesaving care
- Highly gratifying form of treatment!

Emerging Models of Buprenorphine Care

- Massachusetts Nurse Care Manager Model
 - Full time RN and Program Manager can screen and assess, perform induction and follow closely
 - Prescriber time leveraged
 - Regular team meetings aid in decision-making
 - Allows primary care practices to involve multiple prescribers
 - RN can follow 100-125 patients
- Hub and Spoke Model (Vermont, California)
 - Centralized screening, assessment, stabilization
 - Transfer to primary care sites for ongoing treatment

Naltrexone

- ▶ Opioid antagonist that blocks other opioids
- ▶ Does not lead to physical dependence, or to withdrawal when stopped
- ▶ Causes acute withdrawal in opioid-dependent patients
- ▶ Can be used in office-based settings without added training
- ▶ Effective in alcohol use disorder treatment
- ▶ Two formulations available:
 - ▶ Oral ReVia 50 mg PO daily
 - ▶ Injectable Vivitrol 360 mg IM monthly

Naltrexone for Opioid Use Disorder

- Requires opioid abstinence prior to initiation, a major barrier since most treatment-seeking patients are actively using opioids
- Difficult to compare with methadone or buprenorphine (trial underway)
- Russian studies show benefit in population where opioid substitution therapy is not available
- Mixed results in US populations (Cochrane reviews)
- Recent study (Lee, NEJM) in criminal justice population showed short term reduction in opioid relapse compared with “usual care” (not buprenorphine or methadone), and reduction in overdose compared with no medication

Overdose Prevention

- Naloxone (“Narcan”) reverses opioid overdose
- Overdose education and naloxone is an effective harm reduction strategy
- For those at high risk of overdose and their friends or family
- Populations: syringe exchange, exit from jail, in drug treatment, high risk prescribed opioids
- Prescribe to Prevent educational modules:
http://www.opioidprescribing.com/naloxone_module_1-landing

Summary:

Medications for Opioid Use Disorder

- Prescription opioid and heroin epidemics are major public health problems
- Medications are an essential component of evidence-based treatment
- Methadone and buprenorphine are the most effective pharmacotherapies for opioid use disorder
- Naltrexone can also be used, but only in patients who are not currently physically dependent on opioids
- Primary care teams can play an important role in treatment of opioid use disorders and prevention of overdose

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