FDA-approved medications for the treatment of Opioid Use Disorder (OUD)

Full agonist (methadone) *For the treatment of opioid dependence*
- For withdrawal and maintenance
- From a specialized, certified, and licensed methadone practice in an Opioid Treatment Program (OTP)
- Brand names: Methadone, Dolophine

Partial agonist (buprenorphine/BUP) *For the treatment of opioid dependence*
- For withdrawal or maintenance
- Available in tablets, sublingual films, buccal films, and now implant Brand names: Suboxone, Zubsolv, Bunavail, Probuphine (implant)
- Can be proscribed by any DATA 2000 waivered physician, physician assistant, and nurse practitioner in any health care setting

Antagonist (Naltrexone oral-ReVia, Naltrexone ER IM-Vivitrol) *For relapse prevention to opioid dependence, after being opioid free (including methadone and buprenorphine) for 7 to 14 days*
- Can be proscribed by any physician, physician assistant, and nurse practitioner in any health care setting

The Effect of Medications for OUD on the Brain

Key Ingredients

Patients with OUD seeking treatment

Waivered prescribers
- Having completed DATA 2000 waiver training and obtaining special DEA number for prescription of buprenorphine

Clinical Support Staff
- Key role in accepting referrals and scheduling with physicians/ prescribers
- Get brief history, vitals, urine/salivary drug screen and COWS/ assess for opioid withdrawal
- Remain the point of contact for patients in between physician/ prescriber visits
- Make phone calls to check on patients between physician visits

Behavioral Treatment, including but not limited to combinations below:
- On-site medication support groups, Craving management groups, 12 Step groups (AA, NA, others), SMART Recovery, Refuge Recovery, Referral to IOP or other treatment program (if needed, due to risk of relapse), Individual Therapy, Trauma related groups Skill building groups (parenting, job seeking etc.)

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Additional References:

1. Weiss, RD et al. Long term outcomes from NIDA CTN Prescription Opioid Addiction Treatment Study (POATS). Drug Alcohol Depend (2015) 150: 112-119.
2. Waiver training curricula for NPs/PAs through PCSS-MAT—http://pcssmat.org or ASAM—http://elearning.asam.org.
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Adapted from presentations by Jeff Watts, MD: The original presentation, *Recipe Book for Medication-Assisted Treatment (MAT) Integration,* can be found at: **PCSS-MAT (the Providers' Clinical Support System for Medication Assisted Treatment)** http://www.attcnetwork.org/userfiles/file/GreatLakes/Webinars/2017%20Webinars/Watts%20Webinar%20Final.pdf

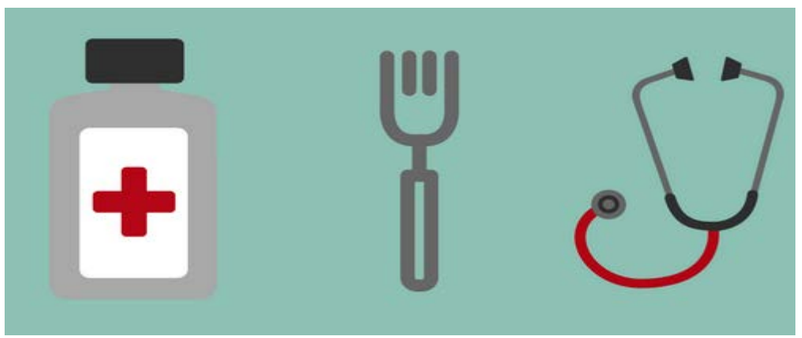
Missouri Opioid State Targeted Response

Recipe Book for the Medical Treatment of Opioid Use Disorders

Missouri Edition

"We can use a cookbook metaphor to imagine the effective delivery of Opioid Use Disorder (OUD) services."

In the kitchen:	In clinical practice:
Key ingredients	*Patients, prescribers, support staff, support services*
Appliances needed	*Clinical space and tools, pharmacy, toxicology testing*
Culinary skills	*Direct care, procedures, logistics*
Serving the food	*Frame the dialogue, start seeing and treating patients*
Making changes for the next time	*Adjust dosing and supportive services*
Share recipe with friends	*Program, lunch-n-learn, e-consult*



Appliances

Clinical Space: No specific requirements for buprenorphine (BUP) or naltrexone/Vivitrol, but, here are some suggestions:

- Nearby bathroom for urine toxicology screens and gastrointestinal issues in opioid withdrawal
- Ideal to have 2 patient rooms so that prescriber (MD, DO, NP, PA) can be monitoring an induction while seeing other patients simultaneously
- Small conference room on weekly basis (if on-site medical treatment for OUD groups are provided)
- Note: No unusual emergency equipment is needed

Clinical Tools

- Screening and assessment tools: Clinical Opiate Withdrawal Scale (COWS) only requires phone/watch (for pulse) and pen light (for pupil dilation)
- Patient-centered educational materials (including overdose education and naloxone training), patient-provider agreement (if required by treatment agency)
- Other helpful documents—sample induction, notes/progress notes, policy/procedures, FAQs for covering physicians, billing information, protocol/algorithm, implementation checklist
- Prescription monitoring website/database

Pharmacy

- Most insurers have Suboxone, Zubsolv, and/or Bunavail on their formularies as well (varying prior authorization requirements)
- Immediate availability of BUP & naltrexone will dictate induction model
- Partnering with on-site or nearby pharmacy is helpful to, for example, ensure BUP and naltrexone are always stocked, arrange for daily (or more frequent) delivery services, coordinate invoicing agreements
- Naltrexone XR (Vivitrol) is being added to more formularies but prior authorization is often required. Can be expensive
- If stocking/storing Naltrexone XR, practice will need refrigerator

Toxicology Testing

- Urine vs. Saliva—ease of use, cost, detection window
- Send-out lab—know what is tested for
- Point of Care (POC) testing—likely need assay with high detection of opiates (e.g., 300 ng/dl) - need separate methadone, BUP, oxycodone, maybe fentanyl

Culinary Skills: Master as you go!

Models of Induction/Care Delivery: Patient already inducted at another site. You need to evaluate the patient to see if they are on the correct dose or need an adjustment.

- Comes to your clinic already on inducted on medication [1,2]
- From hospital ER or inpatient ward [3]
- From correctional setting [4]
- From induction center (hub-and-spoke model)
- From substance use treatment program

Made from Scratch: Initiate on-site assessment, induction, monitoring. (This approach can be difficult because stocking BUP requires a lot of paperwork for the medical practice. Most providers who take this approach have patients pick up BUP at a local pharmacy and bring it in for office induction. Vivitrol and naltrexone can be stocked—if Vivitrol is refrigerated).

- Traditional "made from scratch" model taught in waiver training [5]
- Inductions are on-site and observed (using the COWS Instrument)
- Requires prep time (pre-assessment), space for extended period (on induction day), medication availability, and more staff time than the "Delivery" or "Out of a Box" models
- Ensures BUP and naltrexone are taken correctly and allows for direct monitoring of potential precipitated withdrawal [6]

Out of the Box: Initiate on-site instructions with "home" non-observed induction for BUP. (This is the simplest process for the prescribing provider and the medical team).

- Patients are given a prescription and instructions—written, online, video—on when and how to take BUP or naltrexone
- Patients have to assess timing of their last use and severity of withdrawal before taking medication (Subjective Opiate Withdrawal Scale [SOWS] instrument)
- Does not require extended clinic visit or space occupation
- Does not require on-site medication [7]
- A very good option in patients who have been previously prescribed (or otherwise have experience with) the treatment medication
- Screening tools are available to determine is patient is a good candidate for home induction

Serving the Food: Patient Flow / Scheduling

- Three phases of treatment—induction, stabilization, and maintenance
- After induction, a follow-up visit or call the next day is recommended. Consider role of team members to make these calls and document results.
- For example, at Dr. Watts' clinic, (see Additional References) they provide:
  - A one-week prescription for 4-6 weeks
  - Two week prescription for the following 6-8 weeks, then
  - Monthly thereafter
  - Issues with lost prescriptions, diversion, problematic toxicology results, etc., resets the process
- As in cooking, medical treatment clinic flow and scheduling is often dictated by the shape in which it was prepared. Your management may differ based upon staffing, space, capacity, etc., within your clinic.

Making Changes for Next Time

- Administrative support staff keeps tracking log to know when prescriptions are due, most recent toxicology results, current schedule (weekly, biweekly, monthly), other tasks as needed
- Utilize quality improvement methods such as lunch-n-learns and e-consultations
- Anticipate / Plan for Common Issues
  - Urine toxicology positive for opiates, methadone, fentanyl
  - Urine toxicology negative for BUP (a problem when BUP is prescribed)
  - Urine toxicology repeatedly + for THC, benzodiazepines, cocaine, PCP, amphetamine
  - Patient seeking benzodiazepines or prescription opiates / tramadol
  - Lost/stolen prescriptions
  - Missed/late appointments—policy around walk-ins
  - Patient seeking benzodiazepines