tipSC | Timely Information for Providers in South Carolina

An outreach service for Medicaid providers to help identify and prevent potential gaps in evidence-based care, as well as detect fraud, abuse, overuse or inappropriate use.

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NALOXONE AND NALTREXONE – WHAT'S THE DIFFERENCE?

https://msp.scdhhs.gov/tipsc/

NALOXONE

Quick-acting antidote for opioid overdose

PICK UP QUICK TIPS ON... co-prescribing naloxone to save a life

Identify patients at higher risk for opioid-related overdose and prescribe naloxone to reduce the risk of overdose death.

QUICK tipSC

Most insurances now cover naloxone nasal spray

QUICK FACTS TO CONSIDER

- Data suggests **providing naloxone and overdose education** to patients, family, and friends **encourages safer opioid use** and reduces the overdose rate.
- **Patient tolerance** (including respiratory depression) **to previous opioid dose is lost after 1 – 2 weeks** on a reduced dose or abstinence.

CANDIDATES FOR NALOXONE

Although guidelines/guidances offer varying suggestions, multiple ones agree on co-prescribing naloxone to patients **currently on chronic opioids in ANY ONE of the following groups:**

- Opioid dose ≥ 50 MME/day
- Concomitant benzodiazepine and opioid use
- History of opioid overdose
- History of substance use disorder
- Respiratory conditions (e.g., COPD, sleep apnea)
- Mental health condition(s)
- Excessive alcohol use

Multiple guidelines/guidances also suggest prescribing naloxone to patients **previously on chronic opioids who have lost tolerance** to a previous dose **and are at risk of resuming that dose** using prescription or illicit drugs (e.g., opioid taper underway, recent release from prison or detoxification facility).

HOW SUPPLIED

Nasal spray, Intranasal kit, Auto-IM injector (Solution for IM injection is also available.)

NALTREXONE

Maintenance treatment for opioid use disorder

PICK UP QUICK TIPS ON...managing opioid use disorder (OUD) with naltrexone

Identify patients with OUD who may benefit from treatment with **naltrexone**, a non-opioid approved option.

QUICK tipSC

Naltrexone can also be used to treat alcohol use disorder (AUD)

QUICK FACTS TO CONSIDER

- Data supports that **methadone, buprenorphine, and naltrexone injection are each more effective** at reducing illicit opioid use **than no medication at all.**
- **You do not need a special waiver** from the DEA **to prescribe naltrexone** for OUD.

CANDIDATES FOR NALTREXONE

Anyone beginning naltrexone must be opioid free. While there is no clear evidence to predict which patients with OUD are the best fit for naltrexone, good candidates to consider include:

- Able to be opioid free for ≥ 7 days before therapy
- Highly motivated (e.g., want to live)
- Desire a non-opioid option for OUD treatment
- Short term opioid use (e.g., younger patients)
- Poor response to other OUD treatment options
- In a mandated monitoring program (e.g., pilots)
- Co-morbid OUD and AUD

Patients who are not candidates for naltrexone include patients who used opioids in the last 7 days, have liver failure, acute hepatitis, or are pregnant. **Patients without supervised administration are not good candidates for oral therapy.** Patients with low muscle mass are not good candidates for the injection.

HOW SUPPLIED

Oral tablet, IM injection

(Look inside for prescribing details)

KEY: COPD Chronic Obstructive Pulmonary Disease; **DEA** Drug Enforcement Agency; **IM** Intramuscular; **MME** Morphine Milligram Equivalents

NALOXONE Quick-acting antidote for opioid overdose

Naloxone is an opioid antagonist that **effectively reverses respiratory depression in opioid overdose (only reverses the effects of opioids).** Acute physical withdrawal is a possibility; there is minimal risk of harm to patients not on opioids. Naloxone displaces opioids from opioid receptors for only 30 – 90 minutes, which is shorter than the duration of many opioids; **remind patients and caregivers always to call 911 prior to administering naloxone.** Naloxone for rescue is dispensed as two individual doses as there is the chance of having to repeat the dose after two to three minutes if no response to the first dose or if respiratory symptoms return before emergency medical assistance arrives.

- **Offering a naloxone prescription and** overdose education to patients may lead to safer opioid use among patients at higher risk for an opioid-related overdose and **can increase trust and improve communication** between you and your patient.
- Consider **offering to all patients on chronic opioids** (regardless of risk factors) as a routine and automatic part of patient education on opioid side effects, just like discussing constipation management.

No home with opioids carries zero risk of overdose for the patient or others

A conversation with the patient is just as important as the prescription. Consider:

- Emphasizing that it is the opioid medication that carries the risk and not the patient that is risky
- Using words like "opioid safety" and "bad reaction" or "accidental overdose" rather than "overdose"
- Sharing that prescribing naloxone is like prescribing someone with a food allergy an Epi-pen®. *"It is there to keep you safe in case something accidentally happens."*
- Sharing that "*Naloxone is like a fire extinguisher. It is there to keep you and your family safe.*"

NALOXONE RESCUE IN SC (SC Overdose Prevention Act [S.C. Code Section 44-130])

The Act provides immunity from civil liability and criminal prosecution to prescribers, dispensers, and community distributors of naloxone.

- A physician, physician assistant, or nurse practitioner may prescribe naloxone to a person at risk for opioid-related overdose or a caregiver of person at risk.
- Pharmacists can dispense naloxone without a prescription or standing order to a patient or caregiver. Go to http://naloxonesavessc.org to see the list of SC pharmacies that participate in naloxone distribution.
- Community organizations can distribute naloxone with a standing order.

Prescribers (and pharmacists) must document in medical (or pharmacy) record that patient or caregiver was provided information on opioid overdose and prevention, naloxone dosage and administration, activation of emergency medical services (i.e., calling 911), and care for overdose victim after naloxone administration.

NALOXONE PRESCRIPTION EXAMPLES

Naloxone Nasal Spray[1]

Providers Care
2B Safer Way
Hometown, SC 10000

Name _____ Date _____

Address _____

Naloxone Nasal Spray 4mg/0.1mL
#1 (2 pack)
SIG: Call 911. Spray contents of 1 sprayer into 1 nostril. Repeat with second sprayer into other nostril after 2-3 minutes if no or little response.

Refills: 2

_____ DISPENSE AS WRITTEN

Dr Les Overdose SUBSTITUTION PERMITTED

Naloxone HCl 1 mg/mL Injection[2] for Intranasal Kit

Quantity: #2 x 2 mL prefilled Luer-Lock needleless syringes PLUS #2 mucosal atomizer devices (MAD-300)

SIG: Call 911. Spray 1 mL (half the syringe) into each nostril. Use with MAD. Repeat after 2-3 minutes if no or little response.

Refills: 2

Naloxone HCl Auto-IM Injector[3] 2 mg/0.4 mL

Quantity: #1 (two pack)

SIG: Call 911. Follow audio instructions from device. Press black side firmly on outer thigh. Repeat after 2-3 minutes if no or little response.

Refills: 2

1. Generic approved (Narcan®, brand example). **2.** Naloxone injection (for IM, IV, SC) is not FDA-approved for intranasal administration. **3.** Brand only (Evzio®).

NALTREXONE Maintenance treatment for opioid use disorder

Naltrexone is an opioid antagonist approved **for the management of OUD** and **can be an appealing choice for patients who prefer not to be treated with opioids**. Naltrexone is also used to treat AUD (↓ drinking, ↓ cravings, ↑ abstinence) and may be a consideration in patients with comorbid OUD and AUD. **Buprenorphine or methadone, both opioid agonists, may be better options in patients with chronic pain** and comorbid OUD, or in a patient with a lengthy history of opioid use and/or high levels of dependence.

Despite the advantage of naltrexone (e.g., no abuse potential, decreased likelihood of relapse, no physical dependence), the difficulty of treatment initiation and non-adherence can limit its use.

- **Patients must wait 7 – 10 days** after the last opioid dose before starting naltrexone or 7 – 14 days if transitioning from buprenorphine or methadone.
- **Long-acting naltrexone injection improves adherence** by circumventing some of the issues with non-supervised oral therapy (e.g., intentional or unintentional missed daily doses).

Counsel patients on the increased risk of death if they discontinue naltrexone and resume opioid dose using prescription or illicit drugs (decreased tolerance)

Non-opioid medications may lessen distressful withdrawal symptoms during opioid taper/detoxification and subsequent opioid-free period needed before the first naltrexone dose.

Naltrexone can precipitate severe opioid withdrawal. **Confirm sufficient abstinence prior to starting naltrexone therapy** with a careful substance use-focused history, physical examination, and urine drug screen or testing that can detect all opioids the patient may have used (e.g., extended opioid panel).

Patients need to tell ALL their healthcare **providers about naltrexone use, especially before medical procedures, and carry a medical alert card or tag** to aid in emergency situations that may require pain management.

Conversations about OUD treatment are similar to conversations about any substance use disorder, including AUD.
Suggestions to ease the difficulty of talking about OUD with your patient include:

- **Expressing safety concerns.** *"I am concerned about your health and safety..."*
- **Emphasizing that no one chooses to develop OUD**
- **Sharing that OUD is a manageable chronic disease**, just like diabetes or hypertension
- **Providing education and support.** *"I want you to know there are different meds to choose from along with counseling and support groups/programs..."*
- **Reassuring patients you will not abandon them.** *"I'll stick by you..."*

OPIOID USE DISORDER (OUD) MEDICATION TREATMENT OPTIONS

Medication selection is based on your patient (e.g., patient history, patient preference) and treatment availability. All OUD medication options are considered better than no medication treatment at all.

	Naltrexone[1]		Buprenorphine/Naloxone	Methadone
Action	Opioid Antagonist		Partial Opioid Agonist	Full Opioid Agonist
Route (Usual Dosing)	Oral [2] (50 mg tablet daily)	IM Injection [3] (380 mg monthly)	Oral transmucosal [4,5] (varies)	Oral [6] (varies)
Initiation	Must be opioid free for a minimum of 7 days		Must wait until opioid withdrawal symptoms appear	Immediate initiation to avoid withdrawal
In Office Use	Yes		Yes	No
Prescribing Restrictions	None *(IM injection requires special acquisition and administration procedures)*		DATA 2000 Waiver Required	Must obtain from opioid treatment program (OTP)

1. First line medications for AUD include: naltrexone (dosing the same for OUD and AUD); acamprosate; disulfiram; topiramate (non-FDA approved). **2.** Generic available. **3.** Brand only (Vivitrol®). **4.** Generic available (Suboxone®, brand example). **5.** Buprenorphine single ingredient OUD treatment formulations include: oral transmucosal (generic available); depot injection (brand only, Sublocade®); subdermal implant (brand only, Probuphine®). **6.** Generics available.

RESOURCES

SC Medication Assisted Treatment Practice Support:
http://www.scmataccess.com
Phone: 843.792.5380

Substance Abuse Treatment Services Locator:
https://www.findtreatment.samhsa.gov

SELECTED RESOURCES FOR NALTREXONE PRESCRIBING

Resource	Web Address
Short-Term Medications to Assist with Opioid Withdrawal Symptoms	https://msp.scdhhs.gov/tipsc/sites/default/files/vermont_academic_opioid_handout_05_final.pdf
Clinical Opioid Withdrawal Scale (COWS) (opioid withdrawal assessment)	https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf
Urine Drug Screening	http://mytopcare.org/prescribers/about-urine-drug-tests/
Vivitrol2gether℠ Program (IM injection acquisition)	https://www.vivitrol.com/opioid-dependence/support
IM Injection Administration Video	https://vimeo.com/101010120/940e72505d

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Call 843.792.3896 or email druginfo@musc.edu for free access to MUSC's Drug Information Center to answer provider-specific questions and requests from materials delivered.

The information contained in this summary is intended to assist primary care providers in the management of chronic non-cancer pain and/or substance use disorders in adults in the primary care setting. This information is advisory only and is not intended to replace sound clinical judgement, nor should it be regarded as a substitute for individualized diagnosis and treatment. Special considerations are needed when treating some populations with certain conditions (such as respiratory/sleep disorders; cardiac, liver and renal impairment; debility; addiction; and pregnancy/breast-feeding).