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.

JULY 2021

MEDICATIONS FOR OPIOID USE DISORDER (OUD) CAN CHANGE A LIFE

https://www.schealthviz.sc.edu/tipsc-1

PICK UP QUICK TIPS ON...Identifying and supporting your patients with OUD

Dispel myths about OUD and help patients engage in medication treatment and counseling to manage OUD.

QUICK tip SC

A naloxone prescription and opioid overdose education can reduce overdoses – plus, it's now required by SC law to offer for all higher risk circumstances.

QUICK FACTS TO CONSIDER

- Odds are high you have at least **one patient who is at risk for or has OUD** that could benefit from management/treatment.
- Qualified providers **can now prescribe buprenorphine to as many as 30 patients** without the X-Wavier training.
- **Only 1 in 5 individuals** with OUD **receives treatment.**
- **Patients report high satisfaction** rates and tend to stick with their OUD treatment plan **when they receive buprenorphine from their primary care provider.**

OUD SYMPTOMS AND BEHAVIORS[1]

A good clinical interview along with good eye contact may uncover symptoms/behaviors of OUD in your patient.

DECLINE IN FUNCTIONING

- Failure to fulfill major role obligations at work, school, or home
- Important social, occupational, or recreational activities are reduced or given up
- Tolerance (*e.g., needing to take more and more to achieve same effect*)*
- Withdrawal (*e.g., feeling sick if opioid is not taken on time*)*

*Not applicable if taking opioid under medical supervision

LOSS OF CONTROL

- Taking larger amounts or for a longer time-period than was intended (*e.g., repeated requests for early refills, multiple office contacts regarding opioids*)
- Persistent desire or unable to cut down or control use
- Trying to obtain/use/recover from opioids consumes a lot of time
- Craving or a strong desire or urge to use opioids

CONTINUED USE DESPITE NEGATIVE CONSEQUENCES

- Ongoing use despite persistent or recurrent social or interpersonal problems related to the effects of opioids (*e.g., spouse or family member worried or critical about use*)
- Continued use despite ongoing physical or psychological problems caused by opioids
- Recurrent use in situations in which it is physically hazardous (*e.g., driving under influence repeatedly*)

MYTHS AND FACTS ABOUT OUD

OUD (previously called opioid addiction) is a chronic, manageable medical condition often characterized by behaviors that may include loss of control over drug use, craving, compulsive use, and continued use despite harm to health or relationships. **Just like hypertension and diabetes, OUD can be managed with ongoing medication treatment and counseling,** and the most successful patients are likely to be engaged with strong support systems. Established myths about OUD lead to continued misconceptions about life-altering treatment options for patients.

MYTH: "Addiction is a moral failing"

Addiction is not a moral failing or a sign of weak willpower; it occurs because opioids can change your brain. **People with OUD don't choose addiction** just like someone doesn't choose hypertension or diabetes. Like most patients with chronic diseases, patients will have times of successes interspersed with exacerbations.

MYTH: "Taking buprenorphine or methadone for OUD is just trading one addiction for another"

There is good evidence that patients with OUD can be well-managed with medication assisted treatment (MAT)[2] that includes opioid agonist medications (e.g., buprenorphine/naloxone, methadone). Any OUD medication option, including long-acting naltrexone[3] (the non-opioid option), is considered better than no medication treatment at all. **OUD treatment improves social functioning, allows for lifestyle/behavior changes, increases patients' retention in treatment, and decreases rates of relapse and fatal overdoses.**

1. A patient manifesting at least 2 of the 11 DSM-V assessment criteria within a 12-month time period should be further evaluated and managed for OUD. Severity of OUD is determined by the number of symptoms present (i.e.; mild: 2 – 3 symptoms; moderate: 4 – 5 symptoms; severe: 6 or more symptoms). **2.** Gold standard includes medications and counseling. **3.** There is good evidence that naltrexone also reduces unhealthy opioid use once patients complete the opioid-free period.

MEDICATIONS FOR OPIOID USE DISORDER (MOUD)

	Brand/Generic Name Strengths	Dosage Form	Patient Considerations *(Formulation Considerations)*	FDA Dosing *(Guideline dosing)*	
				Induction	Maintenance
Partial Opioid Agonist	**BUPRENORPHINE/ NALOXONE IMMEDIATE RELEASE**				
	Buprenorphine HCl/ Naloxone HCl 2/0.5 mg, 8/2 mg	Sublingual tablet	**Before first dose recommend being in mild to moderate withdrawal (COWS ≥ 8 – 12 and at least 12 hours since last dose of short-acting opioid or at least 24 hours since last dose of long-acting opioid[2])[3,4]** Often selected as a first choice Consider for patients who: responded well to buprenorphine in the past; patients that prefer office-based treatment; are pregnant Buprenorphine should not be ruled out if patient reports prior use of non-prescribed buprenorphine Unsuccessful past treatment with buprenorphine does not necessarily indicate it will be ineffective again *(Abuse-deterrent formulation [includes naloxone to lower risk for intravenous abuse/ misuse])*	*(**Day 1:** 2 – 4 mg buprenorphine & repeat this dose every 2 to 4 hours until relieve withdrawal symptoms; max daily dose 8 mg)* *(**Day 2:** Give day 1 dose plus additional 2 – 4 mg buprenorphine; repeat 2 – 4 mg dose after 2 to 4 hours if withdrawal symptoms not relieved; max daily dose 16 mg)*	Adjust dose up or down in increments of 2 – 4 mg buprenorphine to maintain treatment and suppress withdrawal symptoms; recommended dose is 16 mg (usual range 4 – 24 mg) buprenorphine as a single daily dose; no clinical advantage shown with doses > 24 mg
	Suboxone® **Buprenorphine HCl/ Naloxone HCl** 2/0.5 mg, 4/1 mg, 8/2 mg, 12/3 mg	Sublingual film		**Day 1:** 2/0.5 mg to 4/1 mg; titrate upwards in increments of 2 – 4 mg buprenorphine every 2 hours to maintain treatment and suppress withdrawal symptoms; max daily dose 8/2 mg) **Day 2:** Single daily dose of up to 16/4 mg is recommended	**Target dose:** 16/4 mg once daily (usual range: 4/1 – 24/6 mg once daily); limited evidence supports daily doses > 24/6 mg
	Zubsolv® 0.7/0.18 mg, 1.4/0.36 mg, 2.9/0.71 mg, 5.7/1.4 mg, 8.6/2.1 mg, 11.4/2.9 mg (5.7 mg equivalent to 8 mg buprenorphine)	Sublingual tablet		**Day 1:** 1.4/0.36 mg; give additional doses in increments of 1 to 2 tablets of 1.4/0.36 mg every 1.5 to 2 hours based on control of acute withdrawal; max dose 5.7/1.4 mg **Day 2:** Max single daily dose up to 11.4/2.9 mg	**Target dose:** 11.4/2.9 mg once daily (usual range: 2.9/0.71 – 17.2/4.2 mg once daily); adjust dose up or down in dosage increments of 2.9/0.71 mg or lower to maintain treatment and suppress withdrawal symptoms; no clinical advantage shown with doses > 17.2/4.2 mg
	BUPRENORPHINE IMMEDIATE RELEASE				
	Buprenorphine HCl 2 mg, 8 mg	Sublingual tablet	**Before first dose recommend being in mild to moderate withdrawal (COWS ≥ 8 – 12 and at least 12 hours since last dose of short-acting opioid or at least 24 hours since last dose of long-acting opioid[2])[3,4]** Consider for pregnancy *(Some potential for abuse/misuse)*	Give 2 – 4 mg dosage increments; reach adequate treatment dose quickly as possible *(Reassess after 60 to 90 minutes; increase dose in 2 – 4 mg increments)*	**Target dose:** 16 mg once daily (usual range 4 – 24 mg); no clinical advantage shown with doses > 24 mg
	BUPRENORPHINE EXTENDED RELEASE[5]				
	Sublocade™ 100 mg, 300 mg	Subcutaneous prefilled syringe	For patients with moderate to severe OUD; patients must initiate treatment and/or be stable on a transmucosal buprenorphine-containing product delivering 8 – 24 mg daily for a minimum of 7 days *(Little to no potential for abuse/misuse)*	300 mg monthly for 2 months then 100 mg monthly; dose may be increased to 300 mg monthly	
Opioid Antagonist	**NALTREXONE EXTENDED RELEASE[5]**				
	Vivitrol® 380 mg/5 mL	Intramuscular injectable suspension	Must be opioid free at least 7 - 10 days[6] Potential patient candidates: highly motivated (e.g., want to live); desire a non-opioid option; short-term opioid misuse (e.g., younger patients); poor response to other OUD treatment options; in a mandated monitoring program (e.g., pilots); co-morbid OUD and alcohol use disorder	380 mg every 4 weeks alternating buttocks for each subsequent injection	
	NALTREXONE IMMEDIATE RELEASE				
	Naltrexone HCl 50 mg	Immediate-release tablet	Must be opioid free at least 7 - 10 days[6] Evidence does not support oral use unless administered under supervision in a highly motivated patient or legally mandated treatment	25 mg (one-half tablet) once daily for 1 to 3 days; increase to 50 mg if no withdrawal signs occur	50 mg once daily
Opioid Agonist	**METHADONE**				
	Methadose™ **Methadone HCl Oral Concentrate** and **Dispersible Tablets**		Consider for patients who: need structured care; responded well to methadone in the past; are pregnant	MUST be prescribed, dispensed, and administered at a federally certified opioid treatment program by location	

1. May differ based on plan coverage. **2.** ≥ 36 - 72 hours since last dose of methadone. **3.** Patients should feel very lousy (e.g., higher COWS, higher SOWS if home induction, longer time since micro-dose induction (off-label). **5.** Requires special acquisition and administration procedures. **6.** Must be opioid free 7 – 14 days if transitioning from buprenorphine or methadone. **7.** Prior auth

Administration Instructions	SC Medicaid Coverage[1]			BCBSSC Coverage[1]	
	Covered	Prior Auth	Restrictions	Covered	Prior Auth
Start with moist mouth; avoid acidic drinks and nicotine	✓	N	Prior authorization required for doses > 24 mg daily	✓	N
If more than 1 tablet or film is required, place all tablets or films in different places under tongue at the same time Hold under tongue several minutes until completely dissolves; do not eat or drink Do not chew or swallow tablet or film May split tablet or cut film if necessary	✓	N	Prior authorization required for doses > 24 mg daily	✓	N
	✗	–		✓	N
Start with moist mouth; avoid acidic drinks and nicotine If more than 1 tablet is required, place all tablets in different places under tongue at the same time Hold under tongue several minutes until completely dissolves; do not eat or drink Do not chew or swallow tablet May split tablet if necessary	✓	Y	Only covered for pregnant women (must transition to combination product post delivery) or documented naloxone allergy	✓	Y
May have a lump that will gradually get smaller at the injection site for a few weeks. Do not rub or massage it or allow waistbands or belts to rub it	✓	Y	No concomitant use of opioid medications; no use of supplemental buprenorphine; dosing consistent with FDA labeling; listed restrictions must be met and will only be authorized for 6 months at a time	✓	N
	✓	N	For use with step therapy parameters that require the use of oral naltrexone, methadone, or any formulations of buprenorphine or buprenorphine/naloxone therapy	✓	N
Administer under supervision to prevent intentional or unintentional missed daily doses	✗	–		✓	N
n (OTP), including take home doses available for patients after meeting non-monitored criteria set	✓	N[7]		✓	N

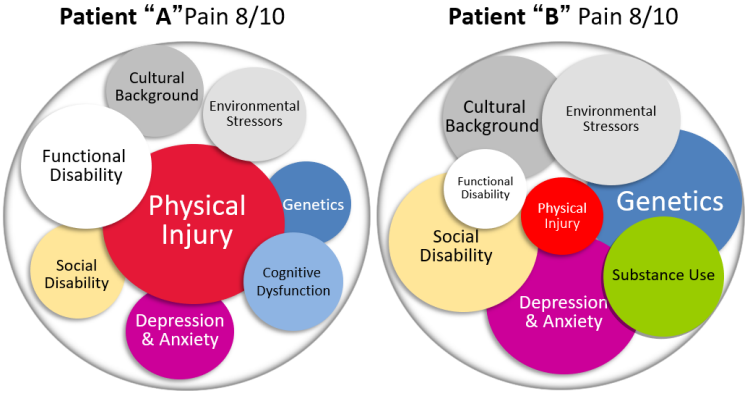
last opioid dose) to prevent precipitated withdrawal. **4.** For "traditional" inductions, not horization is not required for any OTP dispensed medication, including buprenorphine.

KEY: ✓ Covered; ✗ Not Covered; **Y** Yes; **N** No; – Not Applicable

ONGOING SUPPORTIVE CONVERSATIONS MAKE A DIFFERENCE

No two pain patients are alike. Distinguishing your pain patient on opioids without OUD from one with OUD is difficult enough. Talking to your patient about OUD and its treatment is another challenging and necessary step. Difficult conversations with patients are more meaningful and beneficial when tailored to the patient's unique situation. For example, a chronic pain patient with depression and OUD would benefit from a different interaction than someone with no obvious source of physical pain and who is otherwise healthy.

While no OUD discussion is one-size-fits-all, there are conversation nuggets to help depolarize any patient interaction.



Gatchel RJ. Am Psychol. 2004 Nov;59(8):795-805.
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Express Concern + Provide Feedback *"I am concerned about your health and safety."..."This is the 3rd time you have run out of pain medications early."..."You have been to the Emergency Department 6 times in the past 3 months."..."I am concerned that you are showing several signs of addiction."*

Validate Pain + Set Boundary *"I believe you are suffering/in pain. I can prescribe non-opioid pain medications."..."I cannot safely prescribe you opioids at this time." ..."There are treatments and medications other than opioids that can help you."*

Provide Education + Support *"I want you to know that there is excellent medication for opioid addiction that can help with pain and prevent withdrawal."..."We can try this OR I can refer you to someone that you can work with to get you feeling better."*

COUNTER STIGMA

Instead of:	→	Think and Say:
Overdose	→	Bad reaction, accidental overdose
Addict, user, junkie	→	Person with opioid use disorder
Abuse	→	Misuse, unhealthy use
Former addict, clean	→	Person in recovery/long-term recovery
Clean drug screen	→	Negative drug screen
Dirty drug screen	→	Testing positive for...

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Product labeling references available upon request

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Acknowledgements: The MUSC College of Pharmacy houses SCORxE as a research and service center advancing the strategic initiative Building Healthy Communities. The MUSC Drug Information Center provided assistance with background research.