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.

November 2023

MEDICATION MANAGEMENT OF ALCOHOL USE DISORDER (AUD) IN PRIMARY CARE

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

PICK UP QUICK TIPS ON...Screening all patients for alcohol use and helping patients reduce risky alcohol consumption

Offer evidence-informed pharmacotherapy to patients with AUD based on patient goals and characteristics.

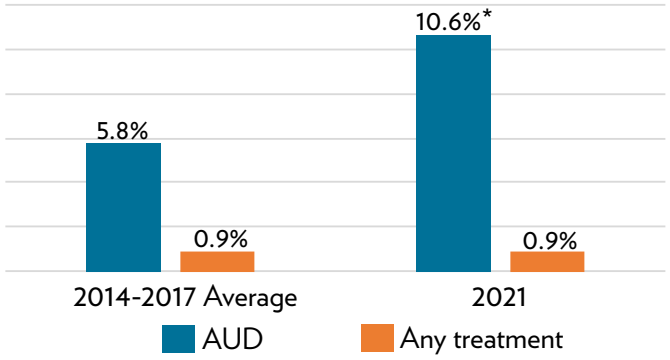
QUICK tip SC

Patients with AUD need your long-term support. Talk to them about managing AUD just like you talk about other chronic conditions (e.g., hypertension, diabetes, opioid use disorder).

QUICK FACTS TO CONSIDER

- **Alcohol screening plus brief alcohol counseling** reduces drinking in patients who do not meet diagnostic AUD criteria.
- A patient with AUD is **more likely to schedule a visit for a medical problem** caused by alcohol use than to discuss concerns about drinking too much.
- More recent data shows that **most patients** who agree to treatment for AUD **have reduced drinking** and not abstinence **as their goal.** Both goal choices improve drinking-related outcomes.
- **Abstinence** likely produces more physical and mental health benefits than reduced drinking; initial reduced drinking may lead to abstinence.
- **Alcohol consumption** (frequency and intensity) and **alcohol-related deaths** increased during the COVID-19 pandemic; the relative increase in the death rate involving alcohol (25.9%) outpaced that from all causes (16.6%) in 2020.

NATIONAL PREVALENCE OF AUD AND AUD TREATMENT



*Less than 2% of **patients with AUD** received FDA-approved medications for the treatment of AUD.

https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health

PRIMARY CARE – THE OPPORTUNITY TO ID, TREAT, MONITOR, & PREVENT

Screen for alcohol use at least annually and when prescribing medication that interacts with alcohol. Systematic screening of all patients takes away the impression of moral judgement, opens the door to **motivate at-risk patients to drink less,** and is a first step to **engage patients with AUD in treatment** tailored to their goals, including reduced drinking (abstinence does not resonate with all patients). Behavioral therapy, support groups, and medications are all part of AUD care.

BRIEF SCREENING TOOLS VALIDATED FOR USE IN PRIMARY CARE TO DETECT UNHEALTHY DRINKING

Tool	Description	Positive Score
Single-Item Alcohol Screening Questionnaire (SASQ)	One question: How many times in the past year have you had 5 (male)/ 4 (female) or more drinks in a day?	> 0
Alcohol Use Disorders Identification Test-Consumption (AUDIT-C)	First three questions of the 10-item AUDIT (Score range 0 – 12)	Men: ≥ 4 Women: ≥ 3

POSITIVE SCORE OR CONTRAINDICATION TO DRINKING?

- **Conduct brief intervention[1]**
- **Score 7 – 12?... Assess for AUD and negotiate goals and treatment[2]**

Improve AUDIT-C sensitivity for women by using "4 or more drinks" in question 3 about binge drinking

Conduct brief intervention for positive score

1. VA/DoD requires brief intervention for score ≥ 5 in men and women **2.** Kaiser WA score is ≥ 7 to assess for AUD; VA/DOD suggests to assess if ≥ 8.

KEY: Kaiser WA Kaiser Foundation Health Plan of Washington; **VA/DoD** Department of Veterans Affairs and Department of Defense

FOLLOW-UP ON POSITIVE AUD SCREENS – EDUCATE AND MOTIVATE

Consider using the Drinking Alcohol handout to help facilitate discussions with your patients

Primary care has the unique opportunity to **help motivate patients who drink more than medically safe** (yet do not meet criteria for AUD) reduce their alcohol consumption and minimize risks of alcohol-related adverse effects and AUD. If your evaluation identifies someone who is not drinking or at low risk, you can opt to reinforce their healthy choices.

Nonjudgmental conversation nuggets help **engage patients** you evaluate and identify **with AUD** (encompasses abuse and dependence) in open and honest discussion about problematic drinking patterns as well as treatment options and benefits. The Alcohol Symptom Checklist (see section below) can help with an AUD diagnosis and further promote discussions about AUD-related care.

RAISE THE SUBJECT

- *"I talk to all my patients about alcohol."*
- *"I would like to take a minute to talk about the alcohol screening question(s) you answered today."*

PROVIDE FEEDBACK

- *"Your score was positive for risky drinking." (give score if used AUDIT-C)*
- *"Drinking at this level may be contributing to the health problem you came in to see me about today."*
- *"It is my responsibility to tell you that drinking at this level can be harmful to your health."*
- *"I care about your health and safety – drinking at this level can cause health problems."*

ASK, ADVISE, AND ASSIST

- *"How do you feel about your drinking at the moment?"*
- *"Have you ever been worried about your drinking? In what way?"*
- *"So many people are grateful to be free of "needing" a drink."*
- *"When you are ready, I am here to help. There are medications, behavioral therapy, and support groups that can help reduce how much and how often you drink or help you quit."*

ASSESSMENT AND DIAGNOSIS OF AUD

The **Alcohol Symptom Checklist aligns with DSM-5 criteria** to help identify patients with AUD and assess severity of their problematic pattern of alcohol use based on symptom count over the past year (mild [2-3], moderate [3-5], and severe [6 or more]). It may be more important to **distinguish between at-risk drinking and AUD** than to distinguish alcohol abuse (mild AUD) from dependence (moderate to severe AUD) when determining an individualized treatment plan.

In the past 12 months...

1. Did you find that drinking the same amount of alcohol has less effect than it used to or did you have to drink more alcohol to get intoxicated?
2. When you cut down or stop drinking did you get sweaty or nervous, or have an upset stomach or shaky hands? Did you drink alcohol or take other substances to avoid these symptoms?
3. When you drank, did you drink more or for longer than you planned to?
4. Have you wanted to or tried to cut back or stop drinking alcohol, but been unable to do so?
5. Did you spend a lot of time obtaining alcohol, drinking alcohol, or recovering from drinking?
6. Have you continued to drink even though you knew or suspected it creates or worsens mental or physical problems?
7. Has drinking interfered with your responsibilities at work, school, or home?
8. Have you been intoxicated more than once in situations where it was dangerous, such as driving a car or operating machinery?
9. Did you drink alcohol even though you knew or suspected it causes problems with your family or other people?
10. Did you experience strong desires or craving to drink alcohol?
11. Did you spend less time working, enjoying hobbies, or being with others because of your drinking?

OFFER PHARMACOTHERAPY TO PATIENTS WITH AUD

Co-create with your patient a personalized treatment plan specific to their needs and goals of treatment based on your detailed assessment. **Individualize evidence-informed medication selection** based on the patient's goals for drinking, patient preference, co-morbidities, and medication profiles (see *Medications for AUD* table). Evidence for medication treatment in mild AUD is limited; most research has involved patients with moderate to severe AUD and some type of psychosocial support.

- Educate patients on **psychosocial treatment** options and **community resources** to support medication treatment.
- **Offer medications** to patients who meet the criteria for AUD and have no contraindications, **even if they decline psychosocial treatment.**

Refer when appropriate (e.g., pregnancy or considering pregnancy, more intensive treatment needed, patient preference). Find a treatment center at: https://findtreatment.gov/locator

ONGOING MEDICATION MONITORING BEGINS WITH A BASELINE ASSESSMENT

Use a standardized tool at baseline and ongoing to measure progress (e.g., AUDIT-C to assess consumption goals)

Baseline Assessment

Select laboratory tests and screens can help establish overall health status, identify alcohol-related issues, and influence medication selections, including:

- Hepatic and renal testing
- Complete blood count
- Testing for vitamin deficiencies (e.g., B12, thiamine)
- Depression screening (e.g., PHQ-9)*
- Tobacco and other substances
- Pregnancy test

Highest risk of relapse is within the first 90 days

Ongoing Monitoring and Assessment

Follow-up with patients at 1 month (consider phone check-in at 1 week), then periodically. Reassess at 3 - 6 months and adjust treatment plan as needed. Evaluation markers may include:

- Adherence and side effects
- Progress toward alcohol consumption goals
- Other indicators of progress, including:
  - Involvement in support groups or programs
  - Stabilization of medical problems (e.g., improved liver function, controlled blood glucose, lower blood pressure)
  - Reduced anxiety
  - Improved sleep
  - Improved relationships
  - Improved performance at home, school, and work
- Medication-specific labs (e.g., naltrexone: liver function tests)
- Depression and suicide risk*

**AUD increases the risk of suicide; item 9 in the PHQ-9 (Patient Health Questionnaire 9-item depression scale) screens for suicidal ideation.*

DOSING REGIMENS VARY

Some patients benefit from medication prescribed routinely over an extended or indefinite time; others may only want to take medication when faced with difficult or stressful events.

Is there evidence for targeted (PRN or as needed) dosing in patients with a goal of reduced heavy drinking?

The most evidence for this targeted dosing strategy is with oral naltrexone. Patients take 50 mg of oral naltrexone 1 - 2 hours before drinking is anticipated or during any stressful times or any risky drinking situation (e.g., wedding reception).

PRN naltrexone dosing controls drinking by blocking the reinforcing effects of alcohol and reducing the desire to continue drinking on drinking days or when cravings arise. The ideal candidate is someone interested in drinking less. It should not be used in patients desiring abstinence.

PRN dosing is not discussed in the American Psychiatric Association guidelines and is an off-label use of naltrexone.

Adapted with permission from the Vermont Academic Detailing Program. Prevention and Management of Alcohol Use Disorder. January 2023. (personal communication, November 13, 2023).

MEDICATIONS FOR ALCOHOL USE DISORDER (AUD)[1]

South Carolina Medicaid and Blue Cross Blue Shield of South Carolina **PAYERS COVER** all medications and dosage forms listed in this table.

Guidelines and guidances suggest **CONTINUING MEDICATION** at least 6 months to a year. Patients may need medication for an even longer duration.

Carefully consider risk-benefit of **NALTREXONE** in patients with alcohol-related **LIVER DYSFUNCTION** (LFTs ≥ 3-5 times ULN). Reduced drinking due to naltrexone may result in overall LFT reduction.

Refer to package inserts for **MORE DETAIL** on drug interactions, adverse effects, and medication monitoring: https://dailymed.nlm.nih.gov/dailymed/.

	Medication (Brand Example) Strength(s) Dosage Form(s)	FDA Approved	Typical AUD Dosing (Daily Dose Range)	Titration to Daily Dose Required (Suggested Titration)	Abstinence Prior to Initiation	AUD BENEFIT				CO-OCCURING CONDITIONS TO CONSIDER							Comments and Other Concerns
						Increased Abstinence	Reduced Number of Drinking Days	Reduced Heavy Drinking	Reduced Cravings	Hepatic Dysfunction	Hepatic Failure	Renal Dysfunction	Renal Failure	Older Adult (≥ 65)	Low Body Weight (< 60 kg)	On Opioids	
FIRST LINE	Naltrexone 50 mg Tablet	Y	50 mg PO once daily (12.5 - 100 mg)[2]	N	Not required[3]	Y	Y	**Y**	**Y**	⚠	✗[4]	✓	⚠[5]	✓	✓	✗[6,7]	**May prefer if goal is to reduce heavy drinking and cravings;** Consider if co-occurring AUD and OUD; Minimal side effects — nausea most common, typically subsides if abstinent (take with food to decrease GI effects); Consider IM injection if adherence is a concern; IM injection requires special acquisition, storage, and administration procedures
	Naltrexone ER (Vivitrol®) 380 mg Injection	Y	380 mg IM injection monthly or every 4 weeks	N	Not required[8]	Y	Y	**Y**	**Y**	⚠	✗[4]	✓	⚠[5]	✓	⚠[9]		
	Acamprosate (Campral®)[10] 333 mg Delayed-Release Tablet	Y	666 mg PO three times daily	N	Preferred[11]	**Y**	Y	N	Y	✓	✓	⚠ Reduce dose[12]	✗	✓	⚠[13]	✓	**May prefer if goal is abstinence;** Three times daily dosing and large tablet size may reduce adherence (cannot crush, split or chew tablet); Minimal side effects — diarrhea most common, often dose-related and transient
SECOND LINE	Disulfiram (Antabuse®)[10] 250, 500 mg Tablet	Y	250 mg PO once daily (125 - 500 mg)	N	Required (suggested time range 24 - 48 hours)	Y	For patients committed and motivated towards abstinence			⚠⚠	✗	⚠	⚠	⚠	✓	✓	Supervised dosing improves efficacy; Educate patient on disulfiram-alcohol reaction (can occur up to 14 days after the last dose);[14] Contraindicated in severe myocardial disease, coronary occlusion, and psychoses; Side effects (drowsiness most common) may limit use
	Topiramate IR (Topamax®) Tablet, Sprinkle Capsule, Oral Solution	N	200 - 300 mg PO per day in two divided doses (25 - 300 mg)[15]	Y (25 - 50 mg once weekly)[16]	Not needed	Y	Y	Y	Y	⚠	⚠	⚠ Reduce dose[17]	⚠ Reduce dose[17]	⚠	⚠	⚠	Side effects may limit use, most are dose-dependent, and may dissipate over time; Cognitive dysfunction, paresthesias, weight loss, and anorexia among most common; May decrease contraceptive effectiveness; Among first-line considerations for AUD and co-occurring PTSD in VA Guidelines
	Gabapentin IR (Neurontin®) Tablet, Capsule, Oral Solution	N	600 mg PO three times daily (300 - 1800 mg)	Y (300 mg every 1 - 2 days)[18]	Not needed	Y	Y	Y	Y	✓[19]	✓[19]	⚠ Reduce dose[20]	⚠ Reduce dose[20]	⚠	✓	⚠⚠	Caution for potential misuse; Dizziness, drowsiness, ataxia, peripheral edema among most common side effects

1. Other pharmacotherapy options with limited/inconsistent evidence: baclofen, ondansetron, prazosin, and varenicline. **2.** Outside FDA labeled dosing. **3.** Reports of improved results if abstinent ≥ 4 days. **4.** Do not use in acute hepatitis; FDA labeling states to discontinue if acute hepatitis symptoms arise. **5.** FDA labeling states to use caution as primary metabolite is excreted in urine. **6.** Must be off all opioids 7-10 days prior; 14 days if previously on buprenorphine or methadone. **7.** A naltrexone card or tag aids in situations that require emergency pain management. **8.** FDA labeling states patients should be abstinent prior to initiation. **9.** Use 1.5 inch needle for very lean patients; consider alternate treatment for obese patients. **10.** Available as generic only. **11.** May improve results if abstinent (abstinent time range of 3-7 days reported). **12.** FDA labeling states if CrCl 30 - 50 ml/min reduce dose to 333 mg TID. **13.** Consider dose reduction to 666 mg BID. **14.** Caution patients on hidden alcohol products (e.g., red wine vinegar, alcohol-containing medications). **15.** Do not stop abruptly. **16.** Initiate with 25 mg once daily for first week. **17.** FDA labeling states if CrCl < 70 ml/min to reduce dose to 50% and titrate more slowly. **18.** Initiate at 300 mg, typically adminstered as a single bedtime dose. **19.** Expert opinion to reduce dose. **20.** FDA labeling states to reduce dose for CrCl < 60 ml/min (refer to FDA labeling for dosing details).

KEY: ✓ Reported as safe to use or no evidence of risk reported; ⚠ Use with caution; ⚠⚠ Use with extreme caution; ✗ Do not use

BID Twice daily; **CrCl** Creatinine clearance; **FDA** Food and Drug Administration; **GI** Gastrointestinal; **IM** Intramuscular; **IR** Immediate release; **LFT** Liver function tests; **OUD** Opioid Use Disorder; **PO** By mouth; **PTSD** Post-traumatic Stress Disorder; **VA** United States Department of Veterans Affairs; **TID** Three times daily; **ULN** Upper limit of normal

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The information contained in this summary is intended to assist healthcare professionals in the management of alcohol use disorder (AUD) in non-pregnant 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 based on a patient's clinical presentation, including medical conditions and medications.