PCSS Medications for Opioid Use Disorders

Providers Clinical Support System

Online Case-Based Learning Collaborative Series on Treating Opioid Use Disorder

Methadone in the Era of Fentanyl

June 26, 2024

FACULTY & DISCLOSURES

Name	Role	Financial Relationship Disclosures
Katy Basques, APRN	Moderator & Faculty	No relevant financial relationships to disclose
Dr. Robert Sherrick, MD	Faculty	No relevant financial relationships to disclose

The content of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.

AGENDA

Activity	Length
Orientation and Introductions	5 Minutes
Didactic Presentation	40 Minutes
Didactic Presentation: Facilitated Discussion	15 Minutes
Faculty Real-World Case Scenario & Discussion	15 Minutes
Learner Case Discussion and Q&A	10 Minutes
Closing Announcements	5 Minutes

HOUSEKEEPING

- This event is brought to you by the Providers Clinical Support System – Medications for Opioid Use Disorders (PCSS-MOUD). Content and discussions during this event are prohibited from promoting or selling products or services that serve professional or financial interests of any kind.

- The overarching goal of PCSS-MOUD is to increase healthcare professionals' knowledge, skills, and confidence in providing evidence-based practices in the prevention, treatment, recovery, and harm reduction of OUD.

PARTICIPATION GROUND RULES

1. Please participate!
2. Everyone's experiences differ: Assume the best intentions.
3. Monitor your participation: Everyone is accountable.
4. If someone says something that is not your understanding of the evidence, ask questions and do so respectfully..

PARTICIPANT INTRODUCTIONS

Please introduce yourself in the Zoom chat:

1. **Name**
2. **Professional Role**
3. **Work Setting/ Organization**
4. **Location**

Methadone in the Era of Fentanyl

Dr. Robert Sherrick, MD

EDUCATIONAL OBJECTIVES

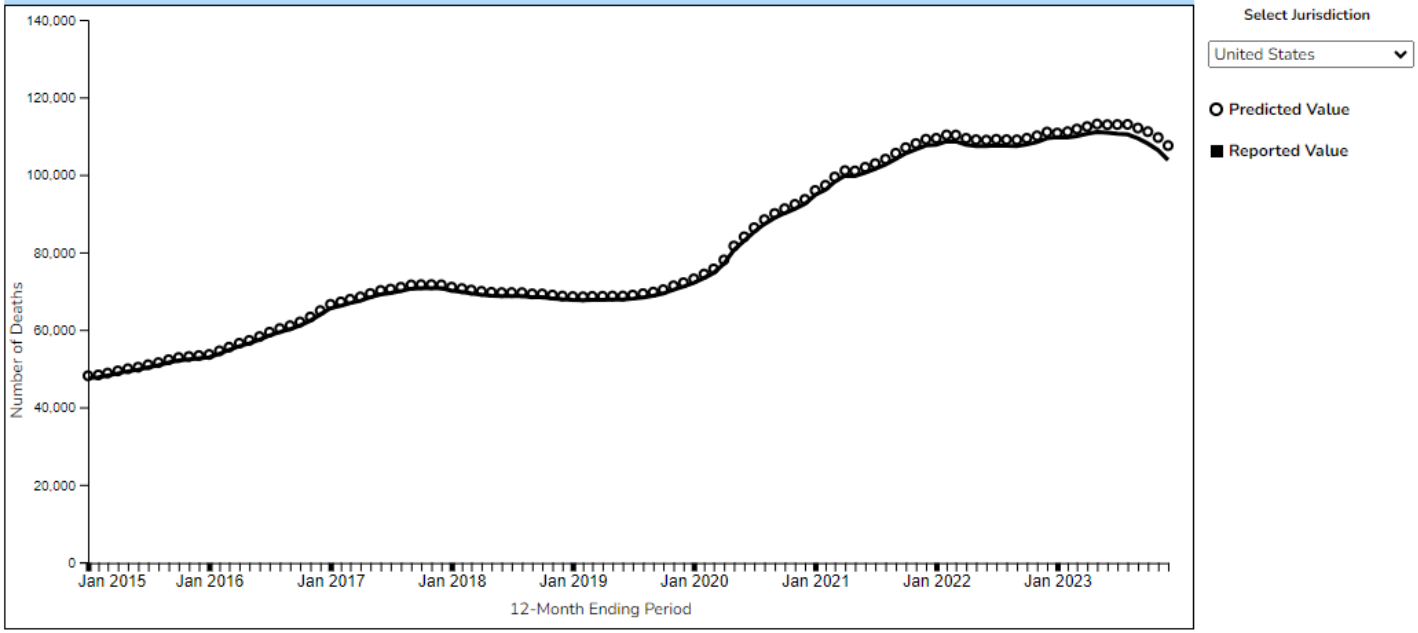
- At the conclusion of this activity participants should be able to:
  - Understand how the advent of fentanyl as the most commonly used illicit opioid has changed the treatment of Opioid Use Disorder with methadone.
  - Be able to balance the concerns over patient safety versus the importance of getting to a therapeutic dose as rapidly as possible.

US DRUG OVERDOSE RATES

12 Month-ending Provisional Number and Percent Change of Drug Overdose Deaths

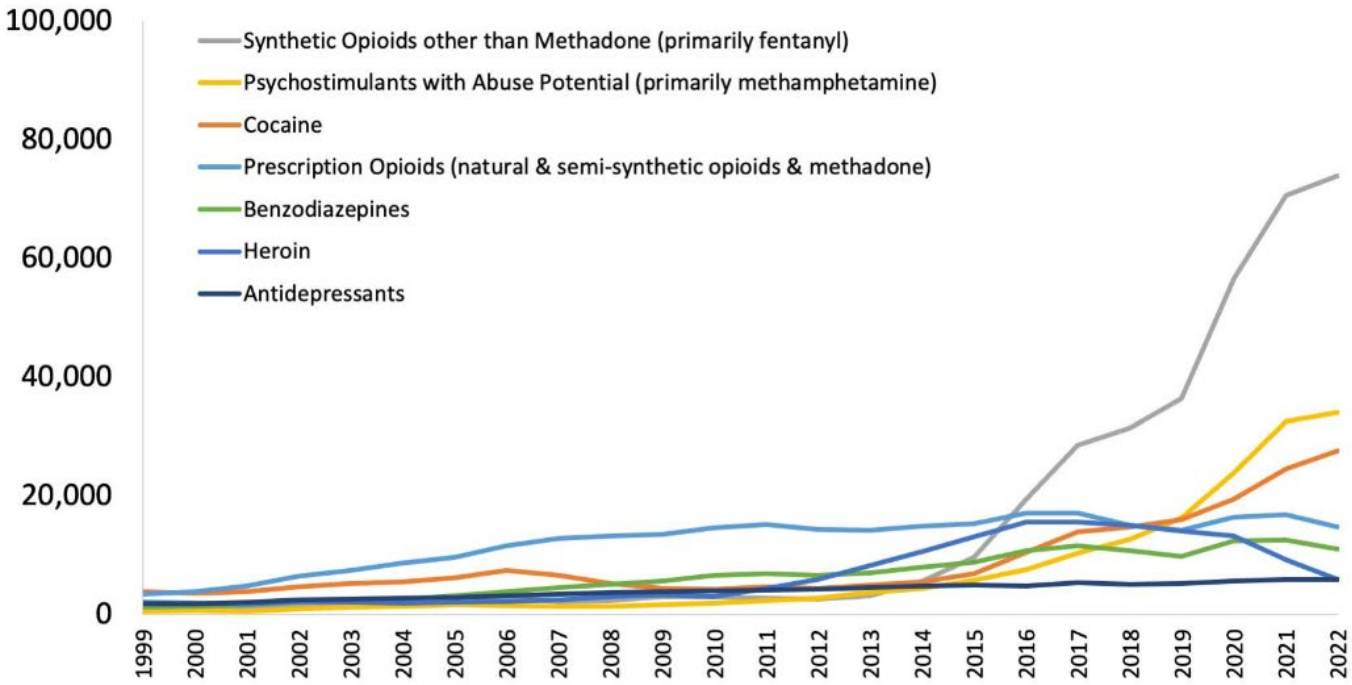
Based on data available for analysis on: May 5, 2024

Figure 1a. 12 Month-ending Provisional Counts of Drug Overdose Deaths: United States



Source: CDC National Center for Health Statistics - https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm accessed 6/4/24

FENTANYL OVERDOSE RATES



*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the International Classification of Diseases, 10th Revision. Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2022 on CDC WONDER Online Database, released 4/2024.

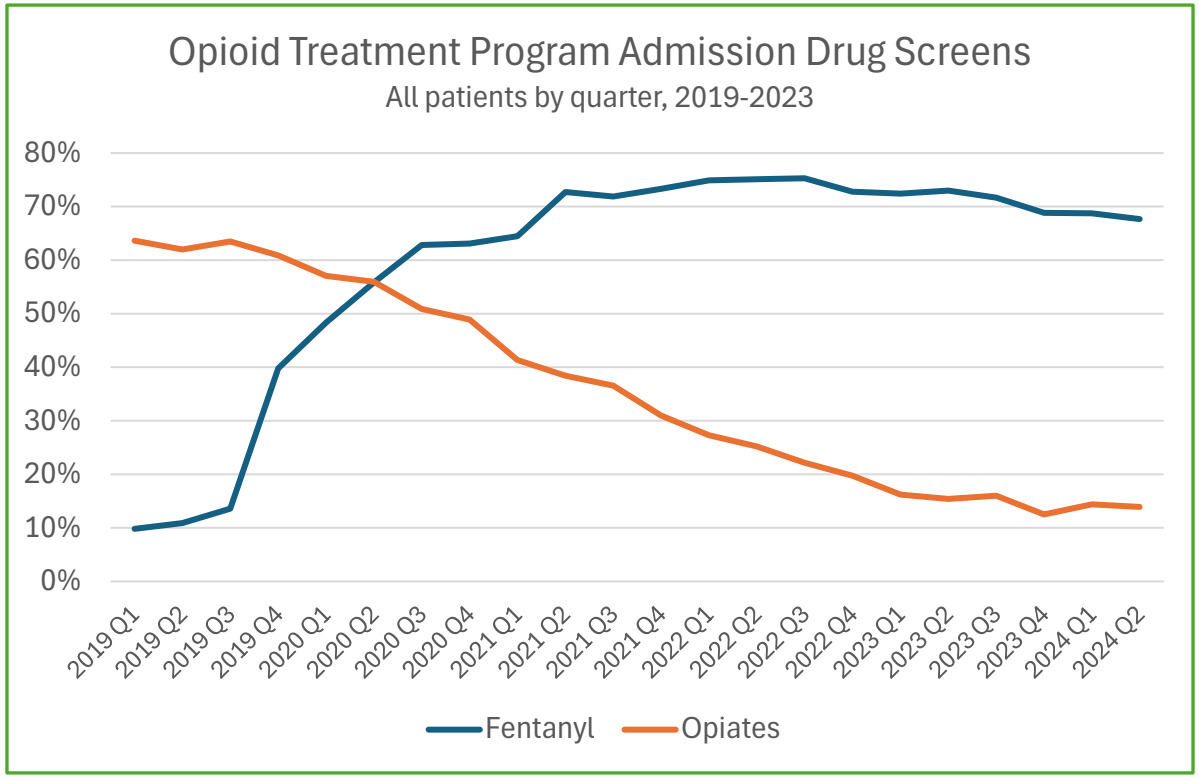
FENTANYL POTENCY

https://www.inmaricopa.com/opioid-epidemic-part-2/ accessed 6/4/24

THE “BLUES” – FAKE OXYCODONE

https://www.dea.gov/onepill/images

ADMISSION FENTANYL AND OPIATE DRUG SCREEN RESULTS



Based on unpublished data from 67 OTPs and 57,136 admission/readmissions – Community Medical Services Data Warehouse

FENTANYL CHARACTERISTICS

- 50-100x more potent than morphine
- Easier to manufacture, smuggle, and distribute – cheap and available
- Rapid initial phase redistribution half-life – 6-20 minutes – lipophilic
- Mostly metabolized by CYP3A4 to norfentanyl (inactive)
- Terminal half-life 7 hours (variable, 5-12 hours)
- Transdermal half-life 12-24 hours
- Adipose accumulation with slow release

Ramos-Matos CF, Bistas KG, Lopez-Ojeda W. Fentanyl. [Updated 2023 May 29]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK459275/

FENTANYL AND METHADONE - IMPORTANT CONSIDERATIONS

- Higher tolerance due to fentanyl potency
- Variable potency – increases risk for overdose
  - DEA has seized pills with over 500 MME; 42% of tested pills had over 200 MME.
  - LD50 for opioid-naïve adult is approximately 250 MME.
- Issues with contamination – xylazine, medetomidine
- Difficulty with buprenorphine induction due to precipitated withdrawal
- Less than full agonism may limit buprenorphine effectiveness
- Providing a “blocking dose” for drug euphoria may be more difficult

https://www.dea.gov/resources/facts-about-fentanyl

Juntao Li, Fu Zhang, Yan Gu, Yi Ye, Linfeng Li, Min Liu, Xufu Yi, Libing Yun, Forensic aspects about fatal morphine intoxication of an unusual body packer: Case report and literature review, Forensic Science International: Reports, Volume 3, 2021, 100207,

METHADONE, BUPRENORPHINE, AND FENTANYL

"We have an opportunity to change people's lives, and if we don't get methadone right, we're screwed. I mean, buprenorphine isn't going to do it. The fentanyl is too strong, and people that have been using drugs for long periods of time must have methadone. That's what I hear from other people, what I know from myself. So, buprenorphine being pushed is great. I'm glad it's available. But we've got to have methadone."

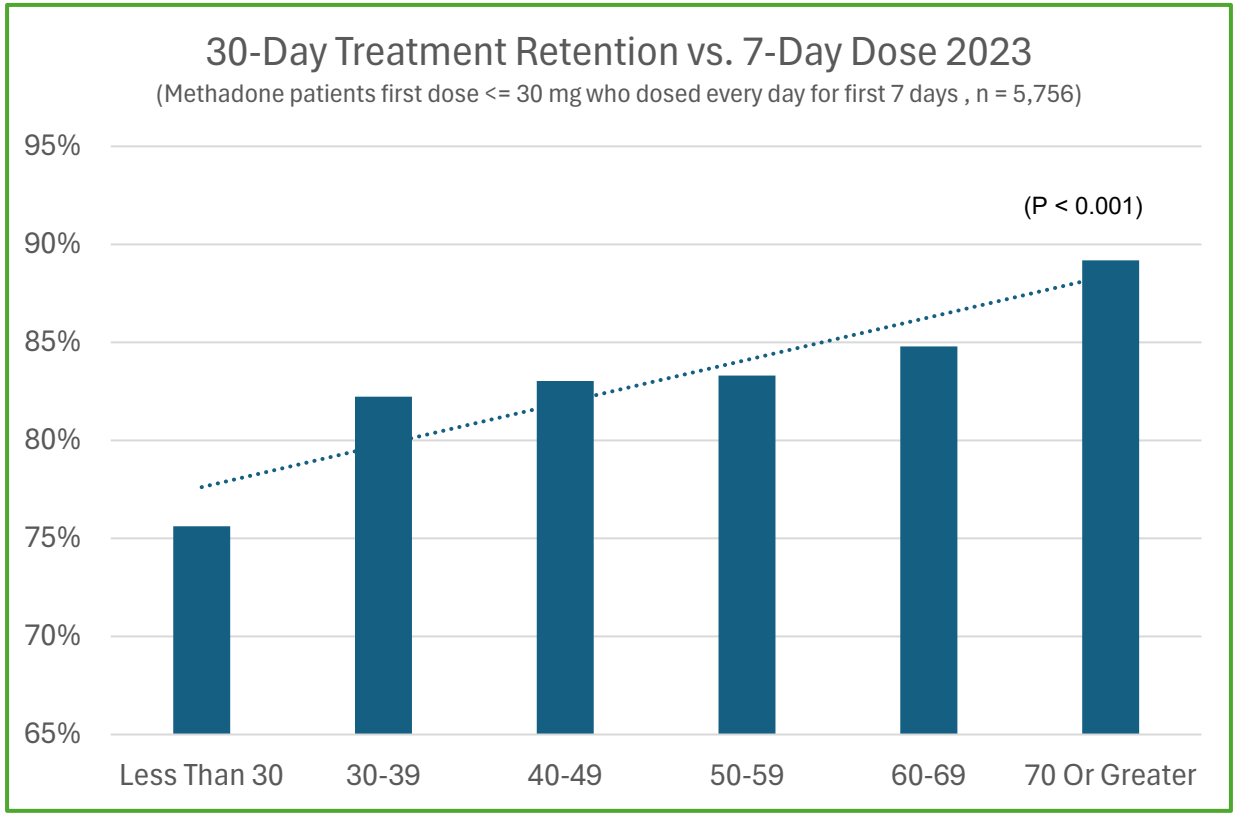
Louise Vincent, Executive Director, National Survivor's Union, January 2022

METHADONE AND OVERDOSE RISK

- Mortality decreases while on MOUD – 50% or more.
- However, higher mortality seen early in treatment with methadone (but not buprenorphine).
- It has been assumed that slower methadone inductions would decrease this risk.
- However, this has never been proven.
- It is also possible that slower dose titration leads to continuing use of street drugs to address ongoing withdrawal symptoms.
- Slower dose titration is associated with lower treatment retention.

Santo T, Clark B, Hickman M, et al. Association of Opioid Agonist Treatment With All-Cause Mortality and Specific Causes of Death Among People With Opioid Dependence: A Systematic Review and Meta-analysis. *JAMA Psychiatry.* 2021;78(9):979–993.
Srivastava A, Kahan M. Methadone induction doses: are our current practices safe? J Addict Dis. 2006;25(3):5-13.
Caplehorn JR, Drummer OH. Mortality associated with New South Wales methadone programs in 1994: lives lost and saved. Med J Aust. 1999 Feb 1;170(3):104-9.
Bao YP, Liu ZM, Epstein DH, Du C, Shi J, Lu L. A meta-analysis of retention in methadone maintenance by dose and dosing strategy. Am J Drug Alcohol Abuse. 2009;35(1):28-33. doi: 10.1080/00952990802342899. PMID: 19152203; PMCID: PMC3689307..

7-DAY DOSE AND TREATMENT DISCONTINUATION



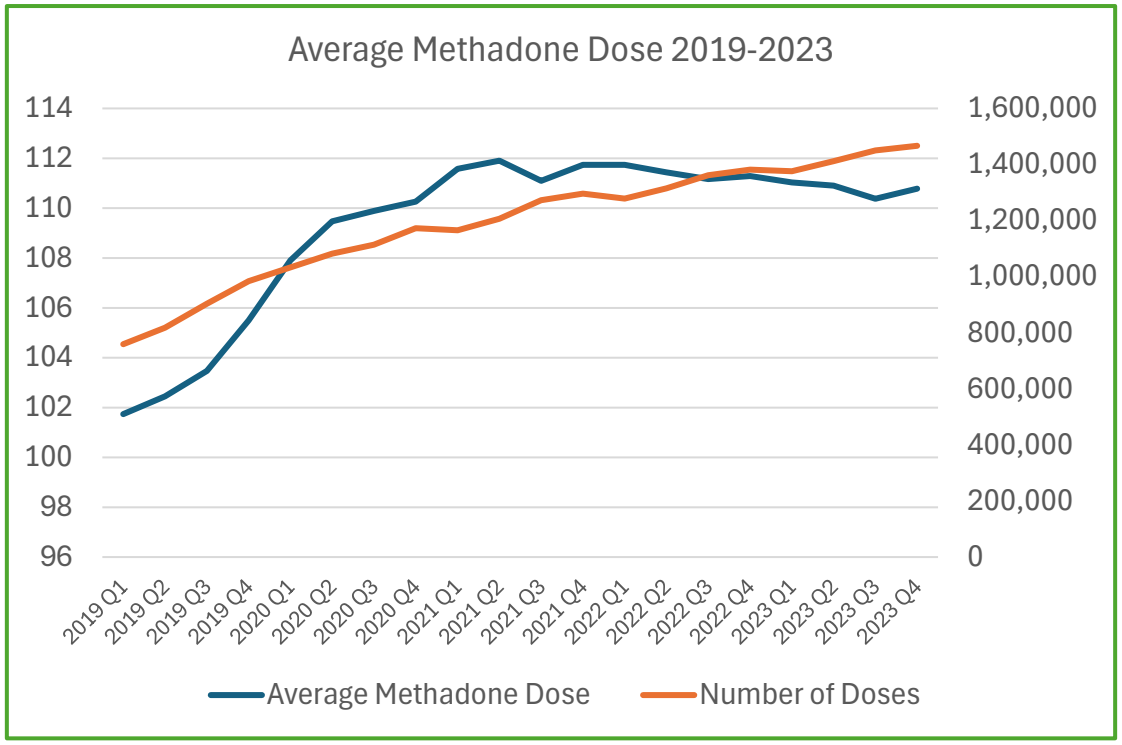
Based on unpublished data – Community Medical Services Data Warehouse

METHADONE INDUCTIONS – EXPERT GUIDANCE

- TIP 63: 30 mg followed by 5-10 mg increase no sooner than 3-4 days
- SAMHSA expert panel: 30 mg followed by 5 mg increase every 5 days.
- Canadian expert panel - start at 30mg methadone, increase of 10-15mg every 3-5 days.
- This creates a limit on the maximum dose at 7 days of 40-50 mg.
- This dose is not enough for most patients using fentanyl.

Treatment Improvement Protocol Tip 63: Medications for Opioid Use Disorder. SAMHSA. updated 2021.
Baxter et al. Safe methadone induction and stabilization: report of an expert panel. J Addict Med. 2013.
Bromley, L., Kahan, M., Regenstreif, L., Srivastava, A., Wyman, J., & Dabam, F. (2021). Methadone treatment for people who use fentanyl: Recommendations (p. 30). META:PHI. https://www.metaphi.ca/wp- content/uploads/Guide_MethadoneForFentanyl.pdf.

AVERAGE METHADONE DOSE 2019-2023



Based on unpublished data – Community Medical Services Data Warehouse

METHADONE DOSE TITRATION END POINTS

- Getting to the correct dose:
  - Withdrawal symptoms suppressed over 24 hours.
  - No sedation or impairment.
  - Improvement in function and SDOH.
  - Improvement in illicit drug use.

METHADONE DOSE TITRATION END POINTS

- "When provided at the appropriate dose to a person stabilized on methadone or buprenorphine, these medications have no adverse effects on intelligence, mental capability, physical functioning, or employability. Research studies demonstrate that MAT patients are comparable to non-patients in reaction time and their ability to learn, focus, and make complex judgments. MAT patients do well in a wide array of work settings, including professional positions, service occupations, and skilled, technical, and support jobs. MAT patients are lawyers, engineers, secretaries, truck and taxi drivers, teachers, computer programmers, and others."

SAMHSA, Know Your Rights, downloaded from: https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/Know-Your-Rights-Brochure.pdf,

BALANCING RISKS – OVERDOSE VS. TREATMENT RETENTION

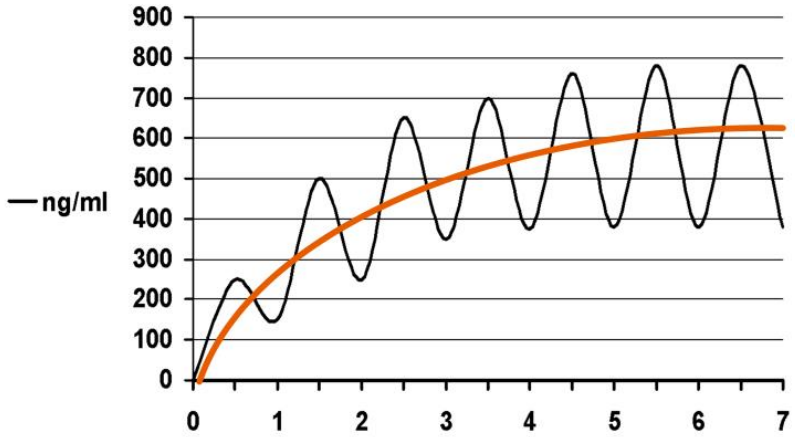
- Methadone works for SUD involving fentanyl.
- Slower inductions related to lower retention rates.
- Are faster inductions related to early overdoses?
- Concern over malpractice risk if methadone increased too rapidly.
- How to mitigate overdose risk in early treatment with methadone:
  - Safe use – naloxone, never use alone, sterile supplies
  - Warning about risk of accumulation, excess sedation

Stone AC, Carroll JJ, Rich JD, Green TC. One year of methadone maintenance treatment in a fentanyl endemic area: Safety, repeated exposure, retention, and remission. J Subst Abuse Treat. 2020 Aug;115:108031
Treatment Improvement Protocol Tip 63: Medications for Opioid Use Disorder. SAMHSA. updated 2021.
Baxter et al. Safe methadone induction and stabilization: report of an expert panel. J Addict Med. 2013.

METHADONE ACCUMULATION

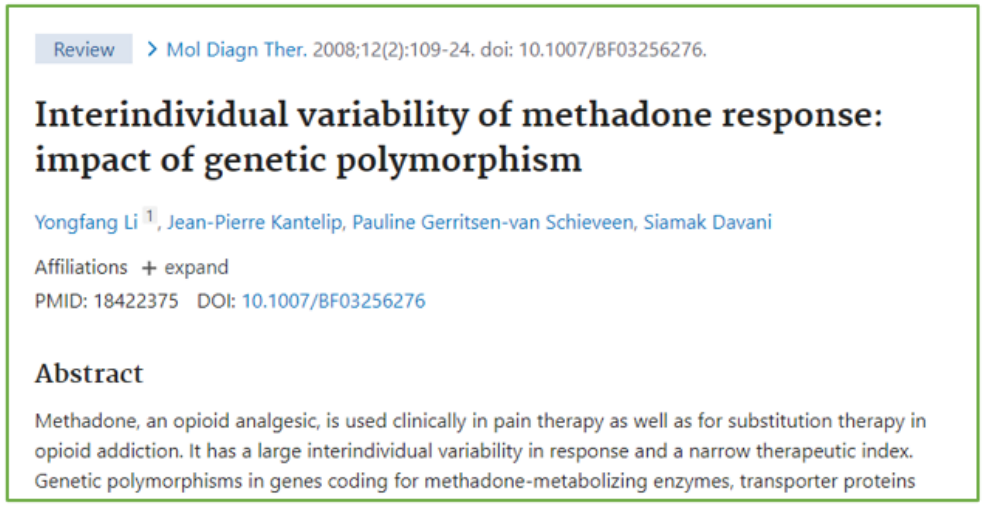
STEADY-STATE SIMULATION – MAINTENANCE PHARMACOTHERAPY

ATTAINED AFTER 4-5 HALF-TIMES - 1 "DOSE" Q HALF-LIFE



Source: Goodman and Gilman

METHADONE ACCUMULATION



Review > Mol Diagn Ther. 2008;12(2):109-24. doi: 10.1007/BF03256276.

Interindividual variability of methadone response: impact of genetic polymorphism

Yongfang Li [1], Jean-Pierre Kantelip, Pauline Gerritsen-van Schieveen, Siamak Davani

Affiliations + expand

PMID: 18422375 DOI: 10.1007/BF03256276

Abstract

Methadone, an opioid analgesic, is used clinically in pain therapy as well as for substitution therapy in opioid addiction. It has a large interindividual variability in response and a narrow therapeutic index. Genetic polymorphisms in genes coding for methadone-metabolizing enzymes, transporter proteins

" . . . in order to obtain methadone plasma concentrations of 250 ng/mL, doses of racemic methadone as low as 55 mg/day or as high as 921 mg/day can be required . . . "

FINAL RULE CHANGES AND METHADONE INDUCTION

- SAMHSA 42 CFR Part 8 revision took effect April 2, 2024.
- Allows for initial dose of 50 mg (increased from 30 mg).
  - (When allowed by state regulations)
- No restrictions on subsequent doses.
- No restrictions on split dosing.

- What is the best way to balance risk vs. benefit?

42 CFR part 8 - https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-8

WHO IS A CANDIDATE FOR FASTER METHADONE INDUCTION?

- Candidates for higher dose induction might be patients who:
  - Use larger amounts – higher tolerance.
  - Have a history of tolerating higher methadone doses.
  - Have adequate social support.
  - Have no significant medical comorbidity (COPD, CHF, elderly, etc.).
  - Are not using other substances that could increase overdose risk (including prescriptions) – benzodiazepines, alcohol, etc.

SHARED DECISION-MAKING MODEL

- Patients should be part of the treatment team.
- Involving patients in their care improves outcomes.
- Patients should be fully informed about the risks and benefits of slower vs. faster methadone titration
- Patients need to know that they will still have withdrawal symptoms for a while until their dose is stabilized but that the goal is for them to not have any withdrawals.
- Part of the treatment plan involves interventions to minimize overdose risk
  - Naloxone, involvement of family/friends, frequent nursing assessments, informed patients.
- The best way to minimize your risk of a lawsuit is to fully inform the patient of all treatment options, help the patient make informed consent decisions, and fully document your actions and clinical reasoning.

Montori VM, Ruissen MM, Hargraves IG, Brito JP, Kunneman M. Shared decision-making as a method of care. BMJ Evid Based Med. 2023 Aug;28(4):213-217. doi: 10.1136/bmjebm-2022-112068. Epub 2022 Dec 2. PMID: 36460328; PMCID: PMC10423463.

EXAMPLES OF FASTER METHADONE INDUCTIONS

- Racha, *et al* – inpatient case review - 30, 40, 50, 60 mg.
  - 25 cases, no adverse events
- Klaire, *et al* – inpatient average dose 65 mg at 7 days.
  - 168 episodes, average 1st day dose 41 mg
  - No adverse outcomes, 2 events of sedation not requiring intervention

Klaire S, Fairbairn N, Ryan A, Nolan S, McLean M, Bach P. Safety and Efficacy of Rapid Methadone Titration for Opioid Use Disorder in an Inpatient Setting: A Retrospective Cohort Study. J Addict Med. 2023 Aug 7.
Racha S, Patel SM, Bou Harfouch LT, Berger O, Buresh ME. Safety of rapid inpatient methadone initiation protocol: A retrospective cohort study. J Subst Use Addict Treat. 2023 May;148:209004. doi: 10.1016/j.josat.2023.209004. Epub 2023 Mar 15. PMID: 36931605.

EXAMPLES OF FASTER METHADONE INDUCTIONS

- Canadian inpatient induction review of 12 pregnant women, all using fentanyl.
- Rapid induction with average 7-day dose of 65 mg.
- Median discharge dose 85 mg, median inpatient stay 12 days.
- Half also received slow-release oral morphine.

Rodger L, Nader M, Turner S, Lurie E. Initiation and rapid titration of methadone and slow-release oral morphine (SROM) in an acute care, inpatient setting: a case series. Eur J Med Res. 2023 Dec 8;28(1):573. doi: 10.1186/s40001-023-01538-0. PMID: 38066517; PMCID: PMC10704823.

EXAMPLES OF FASTER METHADONE INDUCTIONS

- Inpatient rapid induction - max allowed doses 60, 70, 80, 100 mg.
- Actual doses averaged 53, 69, 75, 80, 87, 92, 97 mg over first week.
- Strict inclusion and exclusion criteria.
- No adverse events or holding of doses.

Liu, Patricia MD; Chan, Brian MD; Sokolski, Eleasa MD; Patten, Alisa MA; Englander, Honora MD. Piloting a Hospital-Based Rapid Methadone Initiation Protocol for Fentanyl. Journal of Addiction Medicine ():10.1097/ADM.0000000000001324, June 4, 2024. | DOI: 10.1097/ADM.0000000000001324

EXAMPLE OF OTP DOSING GUIDELINES

- Rapid induction prior to Final Rule:
  - First day maximum 30 mg (plus 10 after 2 hours)
  - Maximum increase 10 mg per day
  - Maximum dose at day 7 - 70 mg
- Rapid induction after Final Rule:
  - First day maximum 50 mg
  - Maximum increase 10 mg per day
  - Maximum dose at day 7 - 80 mg
- All dose increases require nursing assessment prior to implementation.
- All patients must follow up at 7 days for medical reassessment.

POSSIBLE AREAS FOR FURTHER RESEARCH

- More data on early mortality and dosing for methadone.
- Rapid symptom-triggered inpatient inductions:
  - Reassess patient after 3-4 hours and administer additional doses until patient is no longer in withdrawal.
  - Consider severe OUD to be a medical emergency requiring inpatient treatment.
- Using early laboratory testing
  - Methadone and EDDP levels assessed on day 2 or 3.
  - Continuous methadone level monitors (similar to monitoring glucose).
  - Using the MMR (methadone to metabolite ratio) to estimate half-life.
  - Genetic screening for slow/fast metabolism variants.

Saxon AJ. Potential for Precision Medicine in Methadone Treatment of Opioid Use Disorder. J Addict Med. 2020 Sep/Oct;14(5):362-363. doi: 10.1097/ADM.0000000000000619. PMID: 32058338; PMCID: PMC7423601.

CME POST-TEST QUESTION #1

Which is true concerning methadone versus buprenorphine?

A. Buprenorphine is associated with better treatment retention than methadone.
B. Buprenorphine is less likely to cause an overdose than methadone.
C. Buprenorphine is associated with a larger decrease in overdose risk than methadone.
D. Extended-release naltrexone is a better initial option because it is not an opioid agonist.

Rationale: Correct answer B - Metanalyses have shown methadone to have equal or better retention and overdose risk decrease than buprenorphine. ER-naltrexone does not decrease overdose risk.

Reference: British Columbia Centre on Substance Use, BC Ministry of Health, and BC Ministry of Mental Health and Addictions. A Guideline for the Clinical Management of Opioid Use Disorder. Published November 2023. Available at: https://www.bccsu.ca/opioid-use-disorder/

CME POST-TEST QUESTION #2

According to the most recent update of the federal regulations for Opioid Treatment Programs released by SAMHSA, what is the maximum recommended dose of methadone allowed on day 1.

A. 30 mg
B. 40 mg
C. 50 mg
D. 60 mg

Rationale: Correct answer C - The new Final Rule increases the initial allowed dose from 30 mg to 50 mg. Additional doses can be given if the medical provider "finds sufficient medical rationale . . and documents in the patient's record that a higher dose was clinically indicated."

Reference: 42 CFR part 8 - https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-8

CME POST-TEST QUESTION #3

Which of the following are potential problems when using buprenorphine to treat patients who are using fentanyl

A. Patients using fentanyl may have a higher opioid tolerance.

B. Buprenorphine may precipitate withdrawal upon initiation in fentanyl users.

C. Patients' prior experience with buprenorphine may make them unwilling to try it again.

D. All of the above are potential problems when using buprenorphine to treat patients who are using fentanyl.

Rationale: Correct answer D - Due to persistence of fentanyl release from adipose tissue, precipitated withdrawal may provide a challenge to the initiation of buprenorphine. The higher opioid tolerance and partial agonism of buprenorphine may lead to it not being as effective for patients using high doses of fentanyl.

Reference: Silverstein SM, Daniulaityte R, Martins SS, Miller SC, Carlson RG. "Everything is not right anymore": Buprenorphine experiences in an era of illicit fentanyl. Int J Drug Policy. 2019 Dec;74:76-83. doi: 10.1016/j.drugpo.2019.09.003. Epub 2019 Sep 25. PMID: 31563098; PMCID: PMC6914257.

CME POST-TEST QUESTION #4

Data suggest that during early methadone induction, overdose risk increases. Which is true concerning this risk increase?

A. Using a slower dose titration decreases this risk.
B. Using a slower dose titration increases this risk.
C. The risk increase is about the same no matter what dose regimen is used.
D. There are currently not adequate data to answer this question.

Rationale: Correct answer D - There are currently no data to inform whether a slower methadone dose titration increases or decreases the overdose risk in early treatment.

References: Santo T, Clark B, Hickman M, et al. Association of Opioid Agonist Treatment With All-Cause Mortality and Specific Causes of Death Among People With Opioid Dependence: A Systematic Review and Meta-analysis. JAMA Psychiatry. 2021;78(9):979–993.

Srivastava A, Kahan M. Methadone induction doses: are our current practices safe? J Addict Dis. 2006;25(3):5-13.

Caplehorn JR, Drummer OH. Mortality associated with New South Wales methadone programs in 1994: lives lost and saved. Med J Aust. 1999 Feb 1;170(3):104-9.

CME POST-TEST QUESTION #5

Which characteristics would suggest a patient may be appropriate for a higher-dose methadone induction?

A. Longer use of larger amounts of fentanyl
B. Intravenous vs. intranasal use
C. Prior experience with methadone treatment
D. Adequate social support
E. All of the above would suggest a patient may be appropriate for a higher-dose methadone induction

Rationale: Correct answer E - Those who may have lower opioid tolerance, medical co-morbidities, or poor social support may be considered for lower dose methadone inductions.

Reference: Taylor JL, Laks J, Christine PJ, Kehoe J, Evans J, Kim TW, Farrell NM, White CS, Weinstein ZM, Walley AY. Bridge clinic implementation of "72-hour rule" methadone for opioid withdrawal management: Impact on opioid treatment program linkage and retention in care. Drug Alcohol Depend. 2022 Jul 1;236:109497. doi: 10.1016/j.drugalcdep.2022.109497. Epub 2022 May 14. PMID: 35607834.

CME POST-TEST QUESTION #6

Which of the following are true concerning fentanyl?

A. It is 50-100x more potent than morphine.
B. It has a rapid initial phase redistribution half-life – 6-20 minutes.
C. It is mostly metabolized by CYP3A4 to norfentanyl.
D. There is significant adipose accumulation with slow release.
E. All of the above are true concerning fentanyl.

Rationale: Correct answer E - All of the above characterize fentanyl.

Reference: Ramos-Matos CF, Bistas KG, Lopez-Ojeda W. Fentanyl. [Updated 2023 May 29]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK459275/

CASE PRESENTATION

- CJ is a 33-year-old female who presents asking for help with her opioid use. She has been using fentanyl 30-40 “blues” per day. She started with oxycodone after surgery 10 years ago, then switched to heroin, then to fentanyl. She has overdosed and required naloxone 5 times and been to the ER 3 times. She was told in the ER at her last visit that she needed to stop using fentanyl or she could die, but did not receive naloxone, buprenorphine, or a referral to medication treatment in the ER. The only other substance she uses is methamphetamine, which she mixes with fentanyl.
- She has used intravenously in the past, but in the last 3 months has switched to smoking only, hoping that would decrease her overdose risk.
- She is living in a car with her boyfriend. They are both unemployed. She has one son aged 3 who is living with her parents.

  - How much is she using daily in morphine milligram equivalents (MMEs)?

  - Did the ER meet the standard of care?

Larochelle MR, Bernson D, Land T, Stopka TJ, Wang N, Xuan Z, Bagley SM, Liebschutz JM, Walley AY. Medication for Opioid Use Disorder After Nonfatal Opioid Overdose and Association With Mortality: A Cohort Study. Ann Intern Med. 2018 Aug 7;169(3):137-145. doi: 10.7326/M17-3107. Epub 2018 Jun 19. PMID: 29913516; PMCID: PMC6387681..

CASE PRESENTATION

- She has tried buprenorphine several times. She was successful on it for 6 months a few years ago but was discharged for continued use of methamphetamine.
- She has tried buprenorphine several times since then. She has had significant problems with precipitated withdrawals, although one time she was able to get onto buprenorphine with success. However, even at 24 mg per day, she did not feel well and had significant cravings, and returned to using fentanyl. The last time she tried buprenorphine was “horrible” and she is unwilling to try it again.
  - Why did she not respond to buprenorphine?
  - Her earlier experience emphasizes the importance of low-threshold treatment.

CASE PRESENTATION

- She is started on methadone, coming in for dosing 6 days a week. Her initial dose is 30 mg. After 3 days her dose is increased to 40 mg and at 1 week is to 50 mg. She misses several doses during the week.
- When she returns, she says that the methadone “doesn’t really help much” and although she has decreased her fentanyl use a little, she is still at around 20 or more “blues” per day.
  - Why didn’t her dose of methadone work for her?
  - Did the requirement to come in for daily dosing help her or was it a barrier to treatment?

CASE PRESENTATION

- She struggles with frequent missed doses, but eventually her dose is increased to 120 mg. She reports that when she takes the methadone, it does not make her drowsy or sedated, but she is having trouble getting in for dosing due to transportation issues.
- She continues to use fentanyl – only 1-3 “blues” when she gets a dose of methadone and 10 or more if she misses dosing.
  - Why is she still using fentanyl?
  - Does this represent a treatment failure or a treatment success?
  - What can be done to improve her treatment outcomes?

CASE PRESENTATION

- After 6 months of treatment, she reports she stopped using fentanyl, with her last use 3 weeks ago, although she still uses “a little” methamphetamine every day. Her UDS from yesterday is still positive for fentanyl and amphetamines.
  - Is she lying about stopping fentanyl use? Why is her urine test from yesterday positive?
  - How much of a problem is her methamphetamine use?

CASE PRESENTATION

- She has been in treatment now for 9 months. She reports she now has full time work as a stylist and her own apartment. She has a new relationship with a person who does not use drugs or alcohol.
- She has stopped using fentanyl, but still uses methamphetamine on occasion.
- Her urine drug screen tests are negative for fentanyl and positive for amphetamines.

  - How should her methamphetamine use be addressed?

  - Should she be allowed to have more take-home doses?

END OF CASE

FACULTY REAL-WORLD CASE SCENARIO & DISCUSSION

Katy Basques

LEARNER CASE DISCUSSION AND QUESTIONS

Katy Basques & Dr. Robert Sherrick

PCSS-MOUD MENTORING PROGRAM

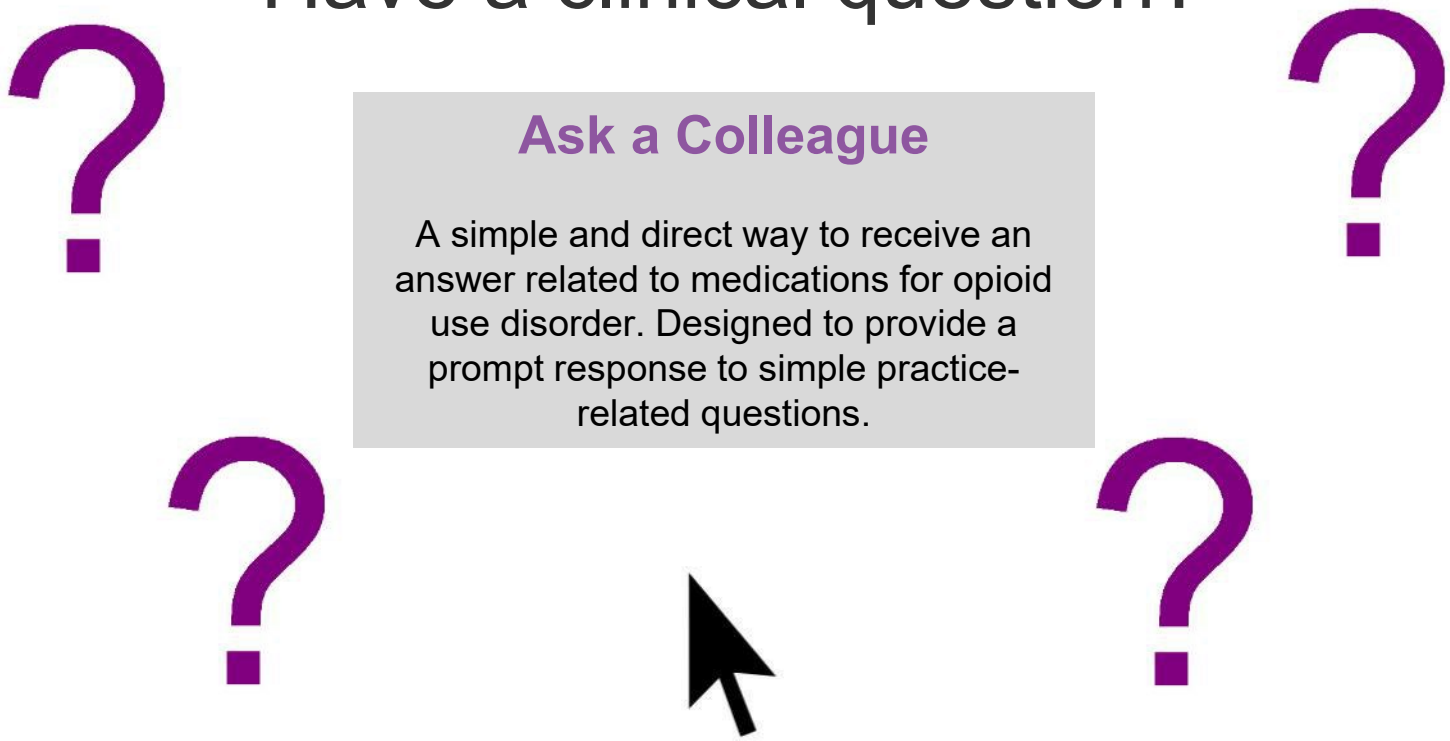
- PCSS-MOUD Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid use disorder.
- PCSS-MOUD Mentors are a national network of providers with expertise in **addictions, pain, and evidence-based treatment including medications for opioid use disorder (MOUD)**.
- 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.
- No cost.

For more information visit:

https://pcssNOW.org/mentoring/

PCSS-MOUD DISCUSSION FORUM

Have a clinical question?



Ask a Colleague

A simple and direct way to receive an answer related to medications for opioid use disorder. Designed to provide a prompt response to simple practice-related questions.

http://pcss.invisionzone.com/register

PCSS Medications for Opioid Use Disorders

Providers Clinical Support System

PCSS-MOUD is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with:

Addiction Policy Forum	American College of Medical Toxicology
Addiction Technology Transfer Center*	American Dental Association
African American Behavioral Health Center of Excellence	American Medical Association*
American Academy of Addiction Psychiatry*	American Orthopedic Association
American Academy of Child and Adolescent Psychiatry	American Osteopathic Academy of Addiction Medicine*
American Academy of Family Physicians	American Pharmacists Association*
American Academy of Neurology	American Psychiatric Association*
American Academy of Pain Medicine	American Psychiatric Nurses Association*
American Academy of Pediatrics*	American Society for Pain Management Nursing
American Association for the Treatment of Opioid Dependence	American Society of Addiction Medicine*
American Association of Nurse Practitioners	Association for Multidisciplinary Education and Research in Substance Use and Addiction*
American Chronic Pain Association	Coalition of Physician Education
American College of Emergency Physicians*	College of Psychiatric and Neurologic Pharmacists
	Black Faces Black Voices

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Columbia University, Department of Psychiatry*	Partnership for Drug-Free Kids
Council on Social Work Education*	Physician Assistant Education Association
Faces and Voices of Recovery	Project Lazarus
Medscape	Public Health Foundation (TRAIN Learning Network)
NAADAC Association for Addiction Professionals*	Sickle Cell Adult Provider Network
National Alliance for HIV Education and Workforce Development	Society for Academic Emergency Medicine*
National Association of Community Health Centers	Society of General Internal Medicine
National Association of Drug Court Professionals	Society of Teachers of Family Medicine
National Association of Social Workers*	The National Judicial College
National Council for Mental Wellbeing*	Veterans Health Administration
National Council of State Boards of Nursing	Voices Project
National Institute of Drug Abuse Clinical Trials Network	World Psychiatric Association
Northwest Portland Area Indian Health Board	Young People In Recovery

PCSS
Medications for Opioid Use Disorders

Providers Clinical Support System

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Thank you for Attending!

Sign up for a future session and complete the session evaluation here:

https://elearning.asam.org/oud-learning-collaboratives