ASAM American Society *of* Addiction Medicine

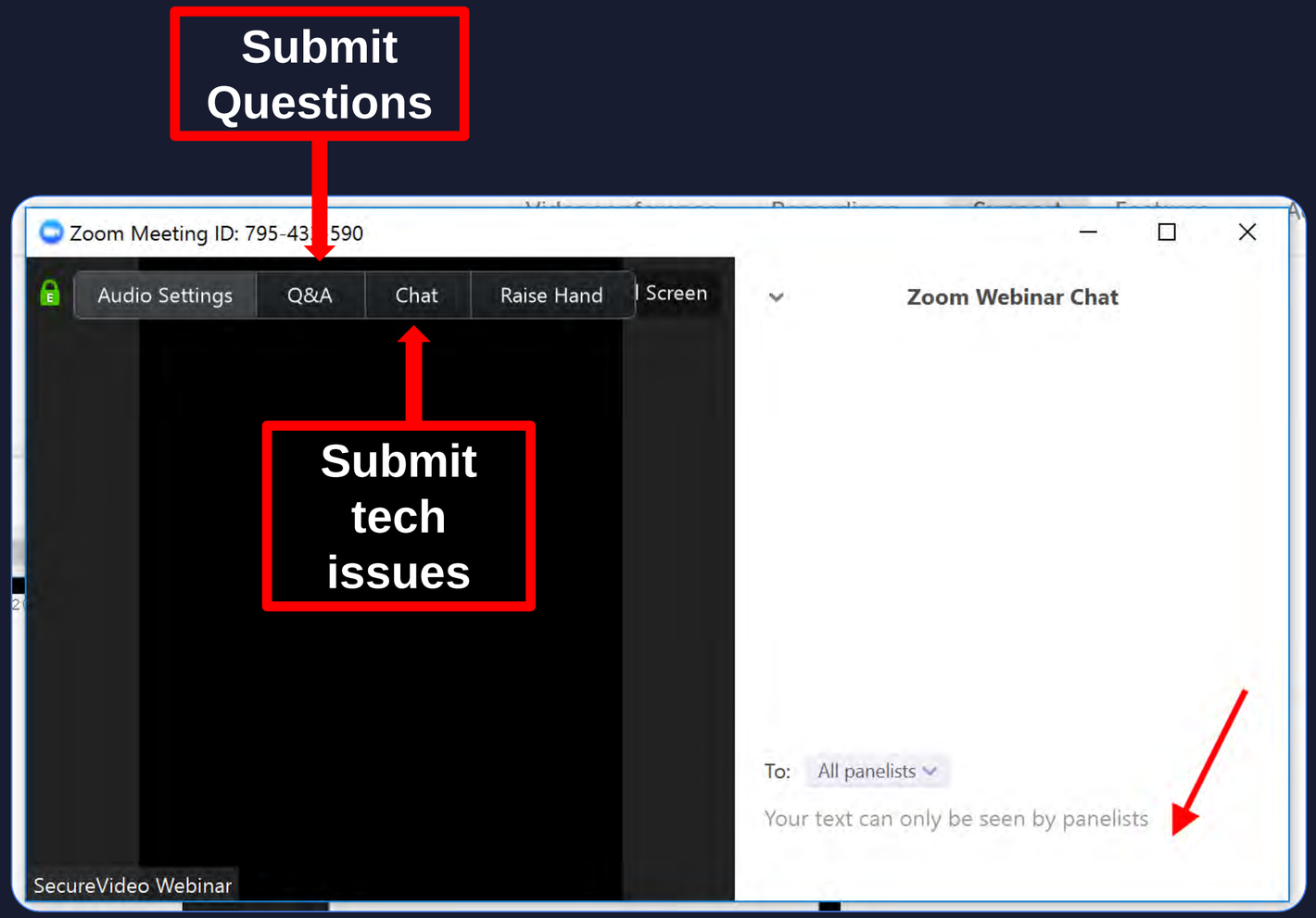
THE ASAM NATIONAL PRACTICE GUIDELINE FOR THE TREATMENT OF OPIOID USE DISORDER: 2020 FOCUSED UPDATE WEBINAR

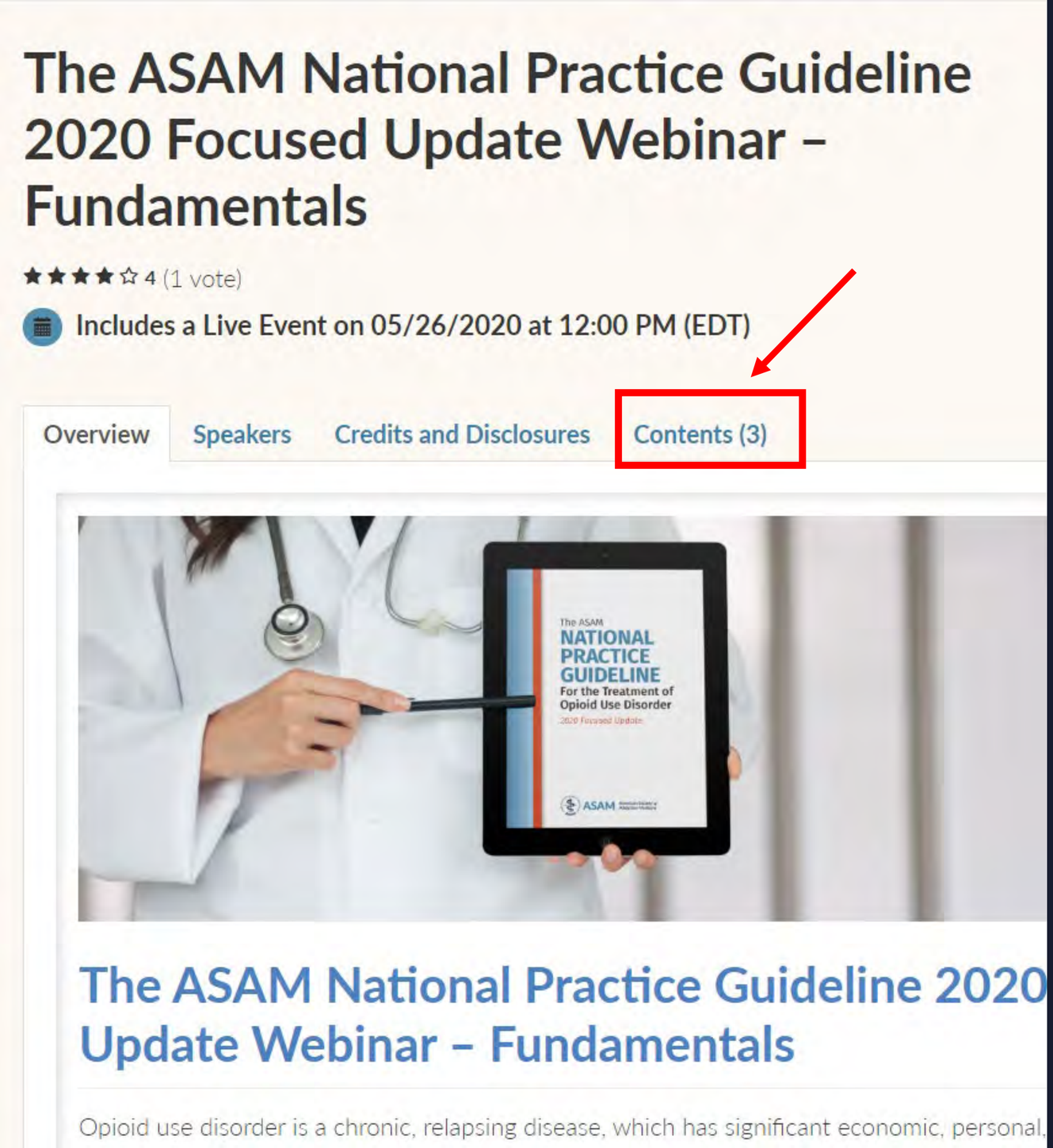
SCHEDULE

12:00 – 12:05 pm	Announcements ASAM STAFF
12:05 – 12:40 pm	Presentation DR. KYLE KAMPMAN
12:45 – 1:00 pm	Questions & Answers DR. KYLE KAMPMAN
1:00 pm	Concluding Remarks ASAM STAFF

ANNOUNCEMENTS

1. Information on obtaining your CME: Provided at the end of the webinar.
2. Attendee Audio: Your mics are automatically set to mute.
3. Questions? Type questions into the Q&A box.
4. Technical Issues? Use the chat box feature to submit questions to your hosts.





HOW TO OBTAIN CME

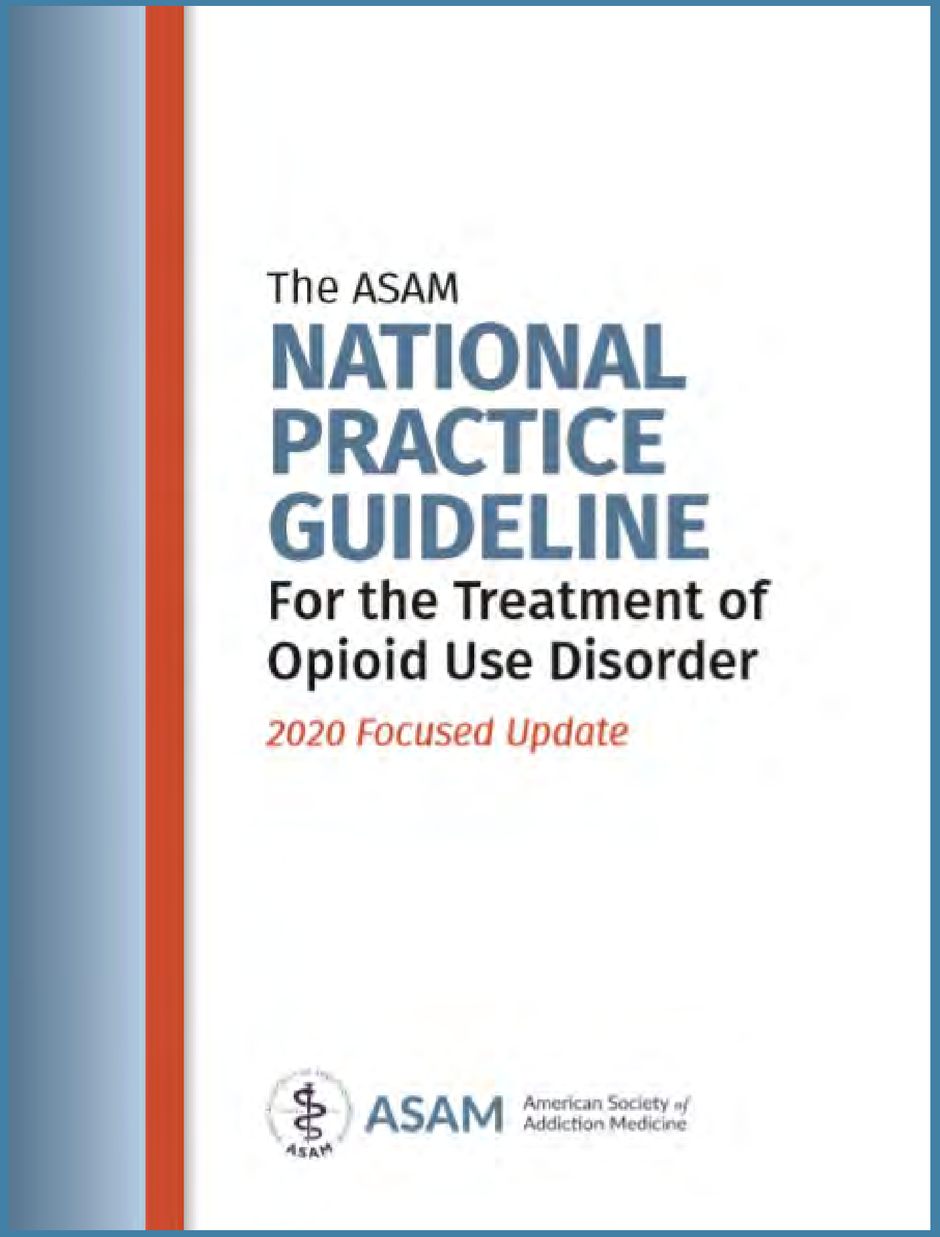
1. Go to:

   https://elearning.asam.org/p/NPG2020

2. Go to *Contents* tab

3. Complete:

   - ❑ CME Quiz
   - ❑ Evaluation
   - ❑ Credit and Certificate



THE ASAM NATIONAL PRACTICE GUIDELINE FOR THE TREATMENT OF OPIOID USE DISORDER: FUNDAMENTALS

PRESENTER

Kyle Kampman, MD

- Dr. Kyle Kampman is a professor in the Department of Psychiatry at the University of Pennsylvania with extensive experience in the treatment of alcohol cocaine and opiate dependence.
- He chaired the committee that wrote the ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use and is a recognized authority on the cocaine withdrawal syndrome.
- Dr. Kampman also works at the Addiction Recovery Unit of the Philadelphia VA Medical Center where he continues to treat cocaine, alcohol, and opiate dependent patients with both medications and psychotherapy.

FINANCIAL DISCLOSURES

World Meds (Clinical Condition: Opioid Use Disorder): Consultant/Advisory Board

LEARNING OBJECTIVES

At the end of the webinar, you will be able to:

- Summarize the guideline's **new and updated treatment recommendations** and discuss how they should be used in practice
- Address the changing epidemiology of opioid use disorder and the remaining gaps in the treatments of OUD
- Describe the **new buprenorphine formulations** including generic and brand names, route of administration, dosing, and clinical considerations

AGENDA

01 – Rationale for the focused update

02 – Background on opioid use disorder and treatment

03 – Guideline development and focused update

04 – How to use this document

05 – New FDA-approved buprenorphine formulations

06 – Key changes

07 – New and major revisions

08 – Common clinical questions

RATIONALE FOR THE FOCUSED UPDATE

The purpose of the focused update was to **develop new and revised recommendations**

Why: Since publication of the last guideline in 2015, important new developments (in the form of newly available formulations and medications), published evidence, and clinical guidance related to the treatment of addiction involving opioid use have emerged.

BACKGROUND ON OPIOID USE DISORDER AND TREATMENT

- Opioid use disorder is a serious biopsychosocial illness that, like all addictions, involves brain reward, motivation, memory, and related circuitry
- In 2018, an estimated 10.3 million people in the United States misused opioids
- Pharmacological treatments for addiction work on specific receptors and neurotransmitter systems in the nervous system

ASAM defines addiction as

“a **treatable**, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual’s life experiences. People with addiction use substances or engage in behaviors that **become compulsive** and often continue despite harmful consequences.”

GUIDELINE DEVELOPMENT AND FOCUSED UPDATE

- ASAM Quality Improvement Council (QIC) was the oversight committee for the development of the guidelines and focused update.
- Other participants included:

2015 Guidelines

Guideline Committee
Rated appropriateness of clinical practices

Treatment Research Institute
Provided research and technical assistance

2020 Focused Update

Guideline Committee
Rated appropriateness of clinical practices

RTI International
Provided research and technical assistance

GUIDELINE DEVELOPMENT AND FOCUSED UPDATE

The guideline was developed using the **RAND/UCLA Appropriateness Method**

Hypothetical clinical statements generated from literature review

Expert panelists individual rate statements' appropriateness

Expert panelists meet to discuss disagreements

Expert panelists re-rate statements

Expert panelists considered **both empirical evidence and clinical experience** when rating appropriateness statements.

Focused Update Guideline Committee/Expert Panel

Daniel Langleben, MD

Marjorie Meyer, MD

Sandra Springer, MD, FASAM

George Woody, MD

Tricia E. Wright, MD, MS, FACOG, DFASAM

Stephen Wyatt, DO, FAOAAM, FASAM, *Co-Chair*

Chinazo Cunningham, MD, MS, FASAM

Mark J. Edlund, MD, PhD

Marc Fishman, MD, DFASAM

Adam J. Gordon, MD, MPH, FACP, DFASAM

Hendrée E. Jones, PhD

Kyle M. Kampman, MD, FASAM, *Chair*

This was a **multidisciplinary panel** as recommended by the RAND/UCLA Appropriateness Method.

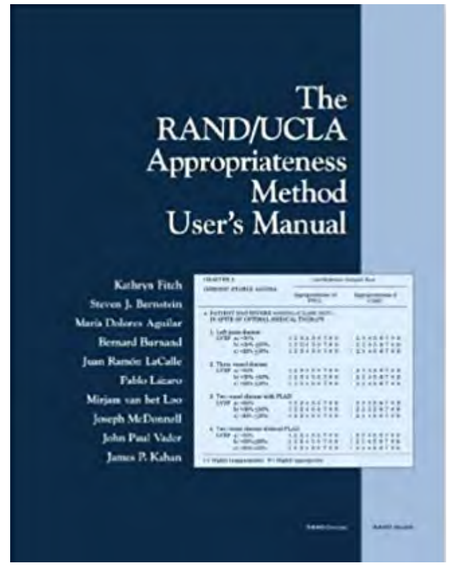
Expert Panel included Members from:

- **Variety of Specialties**
  - Addiction medicine
  - Obstetrics and Gynecology
  - Psychiatry
  - Internal medicine
- **Range of practice settings**
  - Addiction clinics
  - Primary care
  - Department of Veterans Affairs
  - Criminal justice
  - Community centers
  - Emergency room
  - Academic medical centers

METHODOLOGY FOR THE FOCUSED UPDATE

Conducted a targeted search of the peer-reviewed literature to identify new practice guidelines and relevant systematic reviews that are:

- **Clinically meaningful and applicable** to a broad range of clinicians treating addiction involving opioid use
- **Urgently needed** to ensure the existing guideline reflects the current state of the science, aligns with other relevant practice guidelines, and reflects newly approved drugs and formulations



Employed the RAND/UCLA Appropriateness Method to facilitate the development of new and revised recommendation statements.

HOW TO USE THE DOCUMENT

Clinicians, at any level, involved in evaluating patients and providing authorization for treatments for opioid use disorder are encouraged to use this guideline to improve the quality of their care.

In circumstances in which the Guideline is being used as the basis for regulatory or payer decisions, improvement in quality of care should be the goal.

Recommendations in this Guideline do not supersede any Federal or state regulation.

NEWLY APPROVED BUPRENORPHINE FORMULATIONS

Data regarding the effectiveness of these products are currently limited, clinicians should use as indicated and be mindful of emerging evidence as it becomes available.

BUPRENORPHINE FORMULATIONS

Generic Name	Route of Administration (Dosing)	Brand Names	For the Treatment of	Formulation Considerations
Buprenorphine (monoproduct)	Sublingual Tablets (Daily)	Generic versions available similar to Subutex*	Opioid withdrawal and opioid use disorder	Some risk for diversion or misuse; Requires daily Compliance
Buprenorphine and naloxone	Sublingual tablets and film (Daily)	Generic versions available in addition to Suboxone, Cassipa^, Zubsolv, Bunavail	Opioid withdrawal and opioid use disorder	Lower potential for misuse and diversion (compared to monoproduct); Requires daily compliance
Buprenorphine extended-release	Extended-release Injection (Monthly)	Sublocade^	Moderate to severe opioid use disorder in patients who have initiated treatment with transmucosal buprenorphine followed by dose adjustment for a minimum of 7 days	No risk for patient diversion or misuse; Requires patients to be on a stable dose of transmucosal buprenorphine for at least 7 days; Monthly instead of daily medication compliance; Less fluctuation in buprenorphine levels (compared to daily doses)

**Subutex was discontinued. ^ New/tentative FDA approval (since 2015 Guideline release)*
Some patients may experience withdrawal/cravings when switched to a different formulation.
Table content was derived from FDA labels. Labels and label updates can be accessed at https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm.

BUPRENORPHINE FORMULATIONS CONT'D

Generic Name	Route of Administration (Dosing)	Brand Names	For the Treatment of	Formulation Considerations
Buprenorphine extended-release	Extended-release Injection (Weekly or Monthly)	Brixadi^	Moderate to severe opioid use disorder in patients who have initiated treatment with a single dose of transmucosal buprenorphine or who are already being treated with buprenorphine	Tentative approval from FDA (not eligible for marketing in the U.S. until November 30, 2020). No risk for patient diversion or misuse; only a single prior dose of transmucosal buprenorphine required prior to initiation; Weekly or Monthly instead of daily medication compliance; Less fluctuation in buprenorphine levels (compared to daily doses)
Buprenorphine hydrochloride	Subcutaneous Implant (Every 6 months)	Probuphine Implant^	Treatment of opioid use disorder in patients who have achieved and sustained prolonged clinical stability on low-to-moderate doses of a transmucosal buprenorphine (i.e., no more than 8 mg per day)	Requires prolonged stability on 8 mg per day or less transmucosal buprenorphine; No risk for patient diversion or misuse; Healthcare provider training required for implant insertion and removal; Insertion site should be examined one week after insertion; Implant must be removed after 6 months; Risks associated with improper insertion and removal; Currently only FDA approved for a total treatment duration of one year (one insertion per arm); Less fluctuation in buprenorphine levels (compared to daily doses)

**Subutex was discontinued. ^ New/tentative FDA approval (since 2015 Guideline release)*
Some patients may experience withdrawal/cravings when switched to a different formulation.
Table content was derived from FDA labels. Labels and label updates can be accessed at https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm.

NEW AND MAJOR REVISIONS

PART 1:
ASSESSMENT AND DIAGNOSIS OF OPIOID USE DISORDER

NEW AND MAJOR REVISIONS

NEW RECOMMENDATION

Comprehensive assessment of the patient is critical for treatment planning. However, completion of all assessments **should not delay or preclude** initiating pharmacotherapy for opioid use disorder. If not completed before initiating treatment, assessments should be completed soon thereafter.

Rationale:

- Since patients with opioid use disorder are at risk for significant harm – including overdose and overdose death – a delay in completion of each assessment should not delay treatment.
- This is important for enabling low-threshold treatment initiation in acute care settings.

PART 2:
TREATMENT OPTIONS

NEW AND MAJOR REVISIONS

NEW RECOMMENDATION

There is **no recommended time limit** for pharmacological treatment.

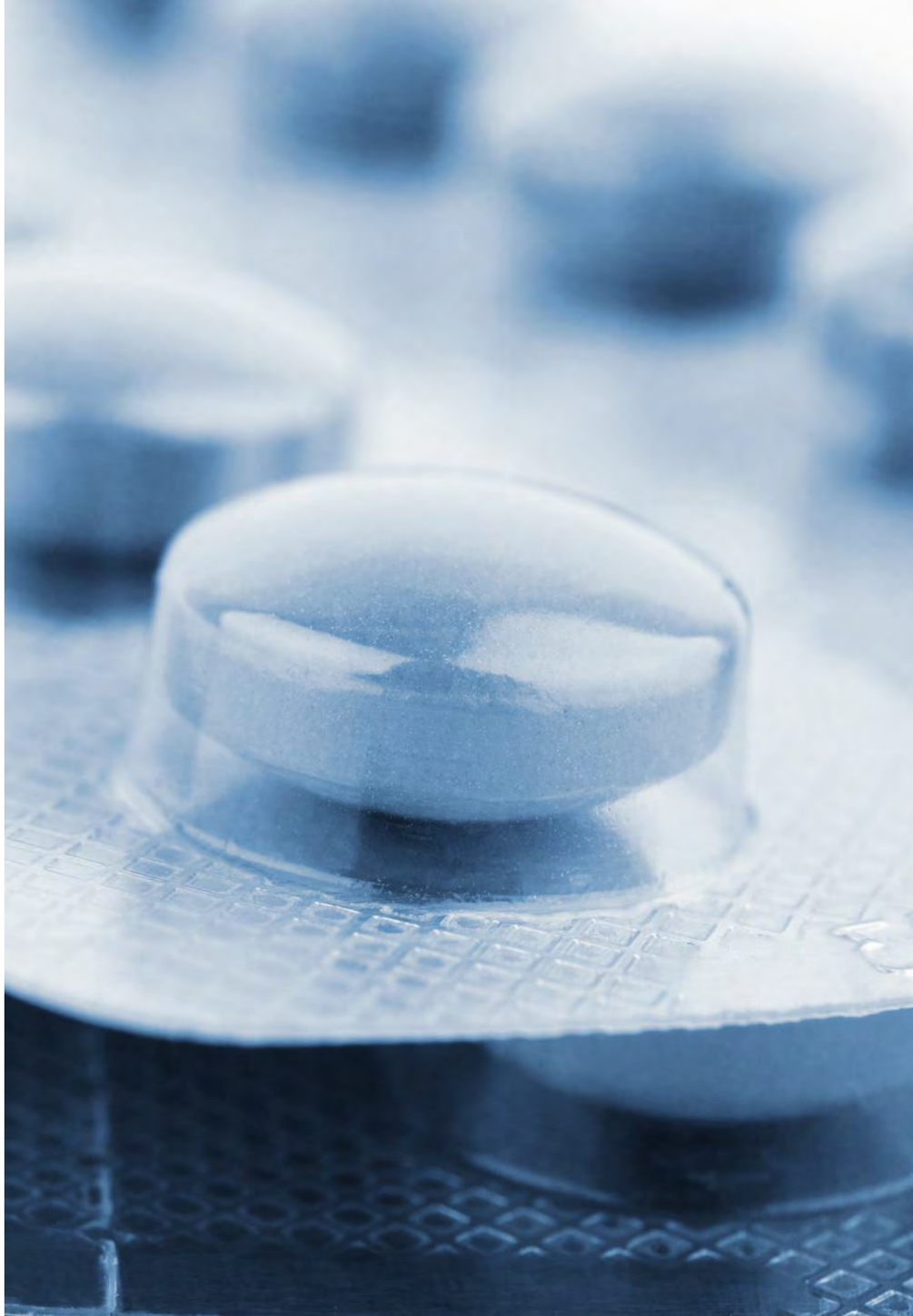
- Individuals progress through addiction treatment at various rates
- Positive outcomes depend on adequate treatment duration
- Treatment participation for less than 90 days is of limited effectiveness

NEW AND MAJOR REVISIONS

NEW RECOMMENDATION

Opioid dosing guidelines developed for chronic pain, expressed in morphine milligram equivalents (MME), **are not applicable** to medications for the treatment of opioid use disorders.

Rationale:
Higher MME dosage of medications used in the treatment of opioid use disorder are necessary and clinically indicated for effective treatment.



NEW AND MAJOR REVISIONS

MAJOR REVISION

- **All FDA approved medications** for the treatment of opioid use disorder **should be available to all patients**.
- Clinicians should consider the patient's:
  - preferences
  - past treatment history
  - current state of illness
  - treatment setting when deciding between the use of methadone, buprenorphine, and naltrexone.

Rationale:

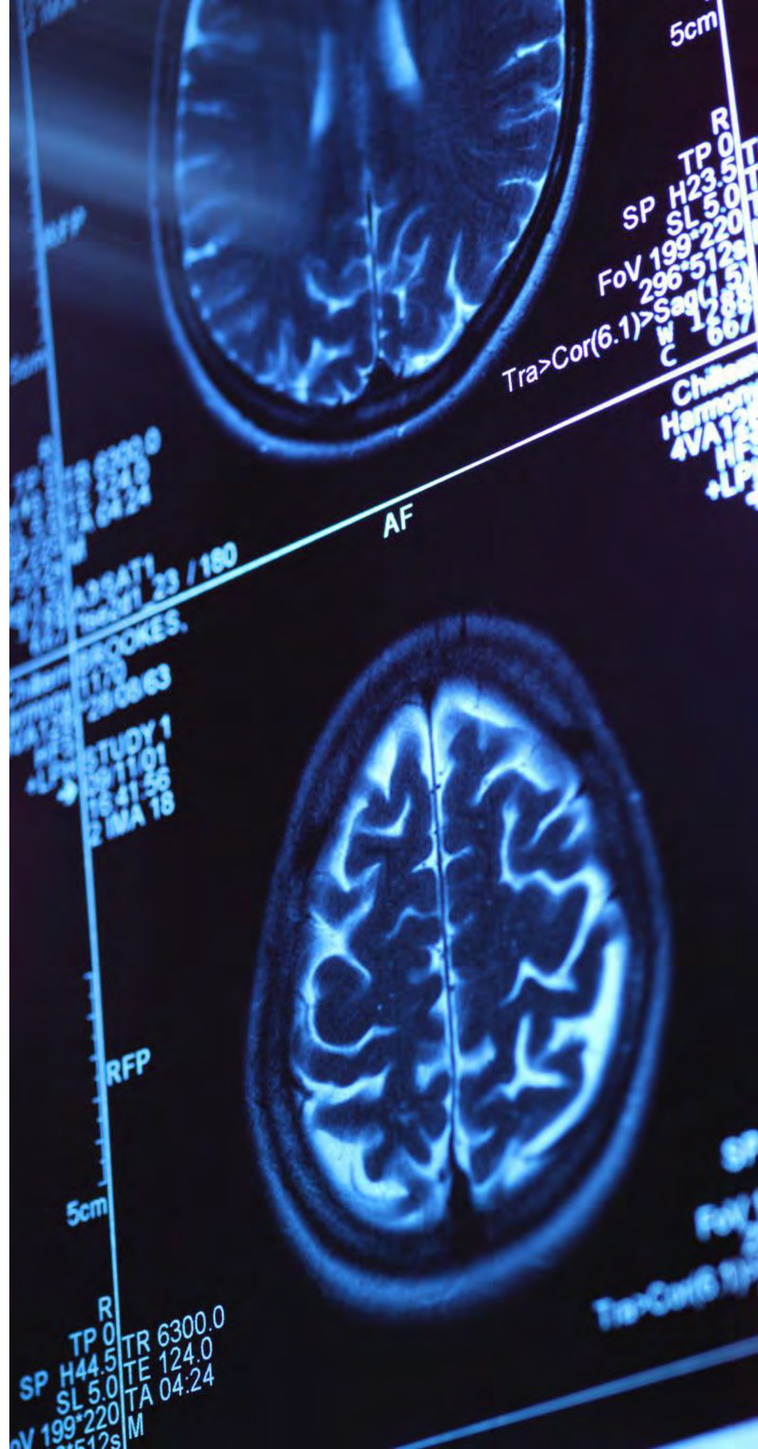
- Several factors should be considered in deciding what treatment(s) to choose for a given patient.
- The choice among all FDA approved treatment options should be a shared decision between the clinician and the patient.

NEW AND MAJOR REVISIONS

MAJOR REVISION

For patients on methadone or buprenorphine a risk-benefit analysis should be conducted when deciding whether to co-prescribe **benzodiazepines or other sedative-hypnotics**.

Rationale:
While the combined use of these medications increases the risk of serious side effects, the harm caused by untreated opioid use disorder can outweigh these risks.



PART 3:
TREATING OPIOID WITHDRAWAL

NEW AND MAJOR REVISIONS

MAJOR REVISION

Opioid withdrawal management with buprenorphine **should not be initiated until there are objective signs of opioid withdrawal**.

Rationale:
To avoid precipitated withdrawal.

Once signs of withdrawal have been objectively confirmed, a dose of buprenorphine sufficient to suppress withdrawal symptoms is given (an initial dose of 2–4mg titrated up as needed to suppress withdrawal symptoms).

NEW AND MAJOR REVISIONS

MAJOR REVISION

Alpha-2 adrenergic agonists (e.g., FDA-approved lofexidine and off-label clonidine) are safe and effective for management of opioid withdrawal,

⬇

However, methadone and buprenorphine are more effective in reducing the symptoms of opioid withdrawal, in retaining patients in withdrawal management, and in supporting the completion of withdrawal management.

PART 4:
METHADONE

NEW AND MAJOR REVISIONS

MAJOR REVISION

The recommended initial dose of methadone ranges from 10 to 30 mg, with reassessment as clinically indicated (typically in 2 to 4 hours). **Use a lower-than-usual initial dose (2.5 to 10 mg) in individuals with no or low opioid tolerance.**

Rationale:
Initial dosing of methadone depends on the level of physical dependence.

NEW AND MAJOR REVISIONS

MAJOR REVISION

Following initial withdrawal stabilization, **the usual daily dose of methadone ranges from 60 to 120 mg**. Typically, methadone can be increased by **no more than 10 mg approximately every 5 days** based on the patient's symptoms of opioid withdrawal or sedation.

Some patients may respond to lower doses and some may need higher doses.

Methadone titration should be individualized based on careful assessment of the patient's response.

Long half-life of methadone contributes to overdose risk of titrated too rapidly. Revision provides more flexibility on rate of titration within appropriate range.

PART 5:
BUPRENORPHINE

NEW AND MAJOR REVISIONS

NEW RECOMMENDATION

The updated guideline adds a new statement making it explicit that **Buprenorphine is a recommended treatment** for patients with opioid use disorder, who:

- can give informed consent and
- have no specific contraindication for this treatment.

NEW AND MAJOR REVISIONS

NEW RECOMMENDATION

- The **FDA recently approved several new buprenorphine formulations** for treatment of opioid use disorder.
- As data regarding the effectiveness of these products are currently limited, clinicians should use these products as indicated and be **mindful of emerging evidence** as it becomes available.

NEW AND MAJOR REVISIONS

MAJOR REVISION

- Once **objective signs of withdrawal are observed**, initiation of buprenorphine should start with a dose of 2 to 4 mg.
- Dosages may be increased in increments of 2 to 8 mg.

Rationale:
To avoid precipitated withdrawal, objective signs of withdrawal are important

NEW AND MAJOR REVISIONS

MAJOR REVISION

- Both office-based and **home-based initiation of buprenorphine** are **considered safe and effective** when starting buprenorphine treatment.

- Consider the patient's past experience with buprenorphine and assessment of their ability to manage initiation at home.

Rationale:
Home-based buprenorphine initiation has become increasingly common in recent years and is considered. safe and effective under appropriate circumstances

NEW AND MAJOR REVISIONS

MAJOR REVISION

- Following initiation, buprenorphine dose should be titrated to alleviate symptoms. **Evidence suggests that 16mg per day or more may be more effective than lower doses**.

- There is limited evidence regarding the relative efficacy of doses higher than 24mg per day, and the use of higher doses may increase the risk of diversion.

PART 6:
NALTREXONE

NEW AND MAJOR REVISIONS

MAJOR REVISION

Extended-release injectable naltrexone is a recommended treatment for preventing relapse to opioid use disorder in patients who are:

- no longer physically dependent on opioids
- able to give informed consent,
- and have no contraindications for this treatment.

Rationale:

- XTR-Naltrexone has been shown to prevent relapse to opioid use disorder.
- While not eliminating, extended-release naltrexone reduces the poor adherence observed with the oral formulation

NEW AND MAJOR REVISIONS

MAJOR REVISION

Extended-release injectable naltrexone should generally be administered every 4 weeks by deep IM injection in the gluteal muscle at the set dosage of 380 mg per injection.

Some patients, including those who metabolize naltrexone more rapidly, may benefit from dosing as frequently as every 3 weeks.

NEW AND MAJOR REVISIONS

MAJOR REVISION

Oral naltrexone is **not recommended** except under limited circumstances.

Rationale:
Oral naltrexone often lacks effectiveness due to poor medication adherence and should be reserved for patients who can comply with special techniques to enhance adherence.

PART 7:
PSYCHOSOCIAL TREATMENT IN CONJUNCTION WITH MEDICATIONS FOR THE TREATMENT OF OPIOID USE DISORDER

NEW AND MAJOR REVISIONS

MAJOR REVISION

A patient’s decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay pharmacological treatment of opioid use disorder, with appropriate medication management.

Motivational interviewing or enhancement can be used to encourage patients to engage in psychosocial treatment.

Patients should be offered or referred to psychosocial treatment, based on their individual needs.

Rationale:

- Requirements for psychosocial treatment can present barriers to access to treatment for some patients
- Research has shown that methadone and buprenorphine treatment reduce mortality even without psychosocial treatment.

PART 8:
SPECIAL POPULATIONS: PREGNANT WOMEN

KEY RECOMMENDATION CHANGES

The **combination buprenorphine/naloxone** product is frequently used in pregnancy and **is considered safe and effective**. Naloxone is minimally absorbed when these medications are taken as prescribed.

Rationale:
While the evidence on the safety and efficacy of naloxone in pregnant women remains limited, the combination buprenorphine/naloxone product is frequently used and the consensus of the guideline committee is that the combination product is safe and effective for this population.

NEW AND MAJOR REVISIONS

MAJOR REVISION

- If a woman becomes pregnant while she is receiving **naltrexone**, it may be appropriate to **discontinue the medication** if the patient and clinician agree that the risk of relapse is low.
- A decision to remain on naltrexone during pregnancy should be carefully considered by the patient and her clinician and should include a discussion on the **insufficiency of research on risks (if any) of continued use of naltrexone**.
- If the patient chooses to discontinue treatment with naltrexone and is at risk for relapse, treatment with methadone or buprenorphine should be considered.

PART 9:
SPECIAL POPULATIONS: INDIVIDUALS WITH PAIN

NEW AND MAJOR REVISIONS

NEW RECOMMENDATION

Naltrexone's blockade of the mu opioid receptor can often be **overcome when necessary with high potency full agonist opioids**. In these instances, patients should be **closely monitored** in an emergency department or hospital setting.

Rationale:

- Higher doses of opioids needed to override the opioid receptor blockade.
- This should be done in an inpatient setting with monitoring of vitals

NEW AND MAJOR REVISIONS

MAJOR REVISION

For patients taking **methadone or buprenorphine** for the treatment of opioid use disorder, temporarily increasing the dose or dosing frequency (i.e., **split dosing** to maximize the analgesic properties of these medications) may be effective for managing pain.

Rationale:
The withdrawal and craving suppressing properties of methadone typically last for 24–36 hours while its analgesic effects typically last for 6–8 hours.

NEW AND MAJOR REVISIONS

NEW RECOMMENDATION

Patients receiving buprenorphine for opioid use disorder who have **moderate to severe acute pain refractory to other treatments** and require additional opioid-based analgesia may benefit from the **addition of as-needed doses of buprenorphine**.

NEW AND MAJOR REVISIONS

MAJOR REVISION

For patients taking **methadone** for the treatment of opioid use disorder who have acute pain refractory to other treatments and require additional opioid-based analgesia, **adding a short acting full agonist opioid to their regular dose of methadone can be considered** to manage moderate to severe acute pain.

NEW AND MAJOR REVISIONS

MAJOR REVISION

- **When a full opioid agonist is needed for pain management, discontinuation of buprenorphine is not required.**
- The addition of a **short-acting full agonist opioid** to the patient's regular dose of buprenorphine **can be effective for the management of severe acute pain in supervised settings**, such as during hospitalization.
- It is not known whether this adjunct treatment can be safely prescribed in ambulatory care settings.

Rationale:
An increased risk of relapse and overdose are the main concerns when prescribing a full opioid receptor agonist for acute pain care in individuals with opioid use disorder.

NEW AND MAJOR REVISIONS

MAJOR REVISION

Discontinuation of methadone or buprenorphine before surgery is not required. Higher-potency intravenous full agonists opioids can be used perioperatively for analgesia.

Rationale:

- Research has demonstrated that the addition of full-opioid agonists can be effective for the treatment of pain in these patients.
- Pain treatment should be coordinated with the opioid use disorder treating clinician to help optimize pain care and reduce the potential for relapse.

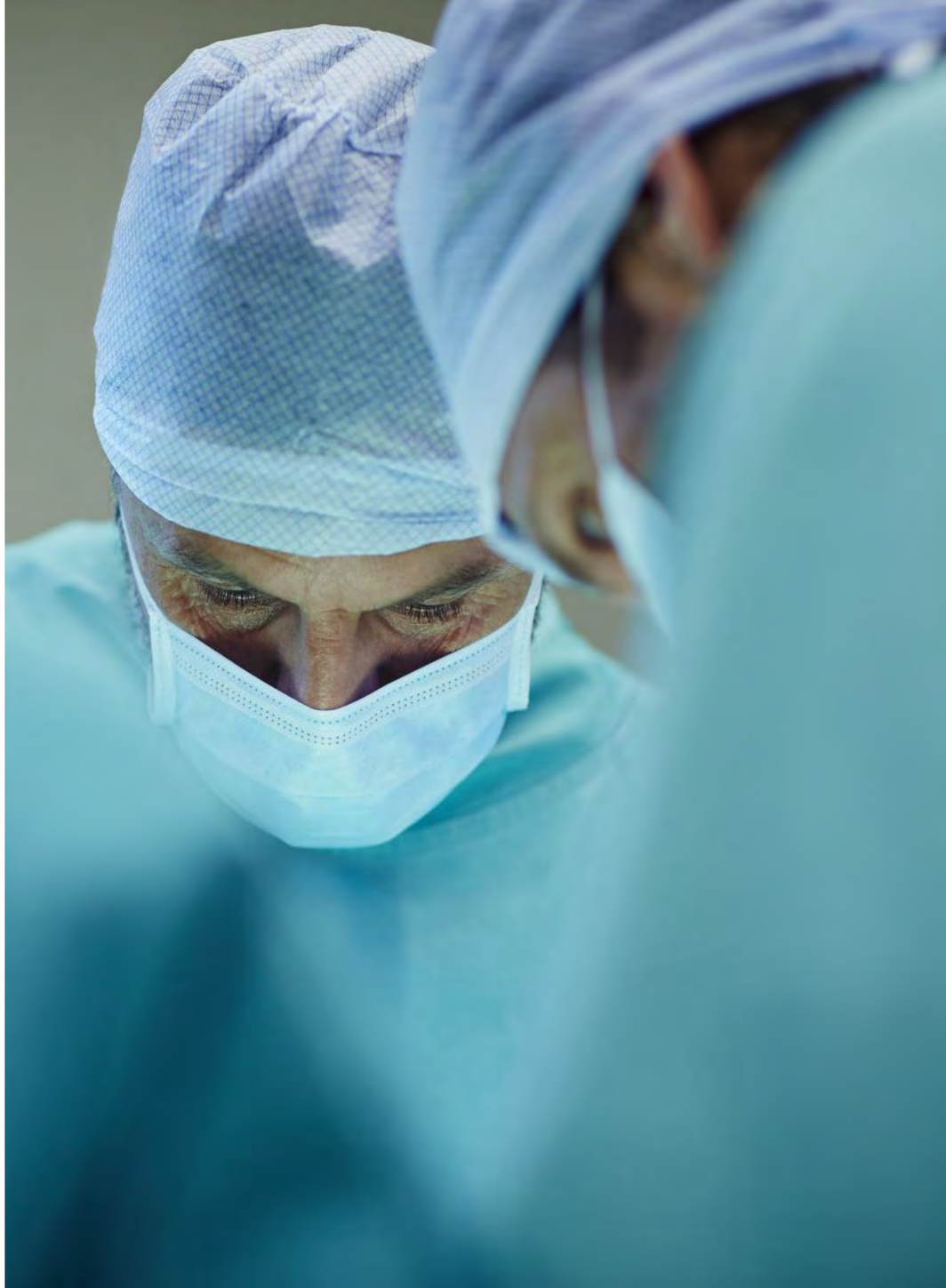
NEW AND MAJOR REVISIONS

MAJOR REVISION

If it is decided that buprenorphine or methadone should be discontinued before a planned surgery, this may occur **the day before or the day of surgery**.

Methadone or buprenorphine can be **resumed postoperatively**. In general, pre-surgery daily doses of these medications can be resumed if they were withheld for less than 2 to 3 days.

Rationale:
The longer the duration of discontinuation of OUD medication the greater the changes for treatment disengagement and relapse



PART 12:
SPECIAL POPULATIONS: INDIVIDUALS IN THE CRIMINAL JUSTICE SYSTEM

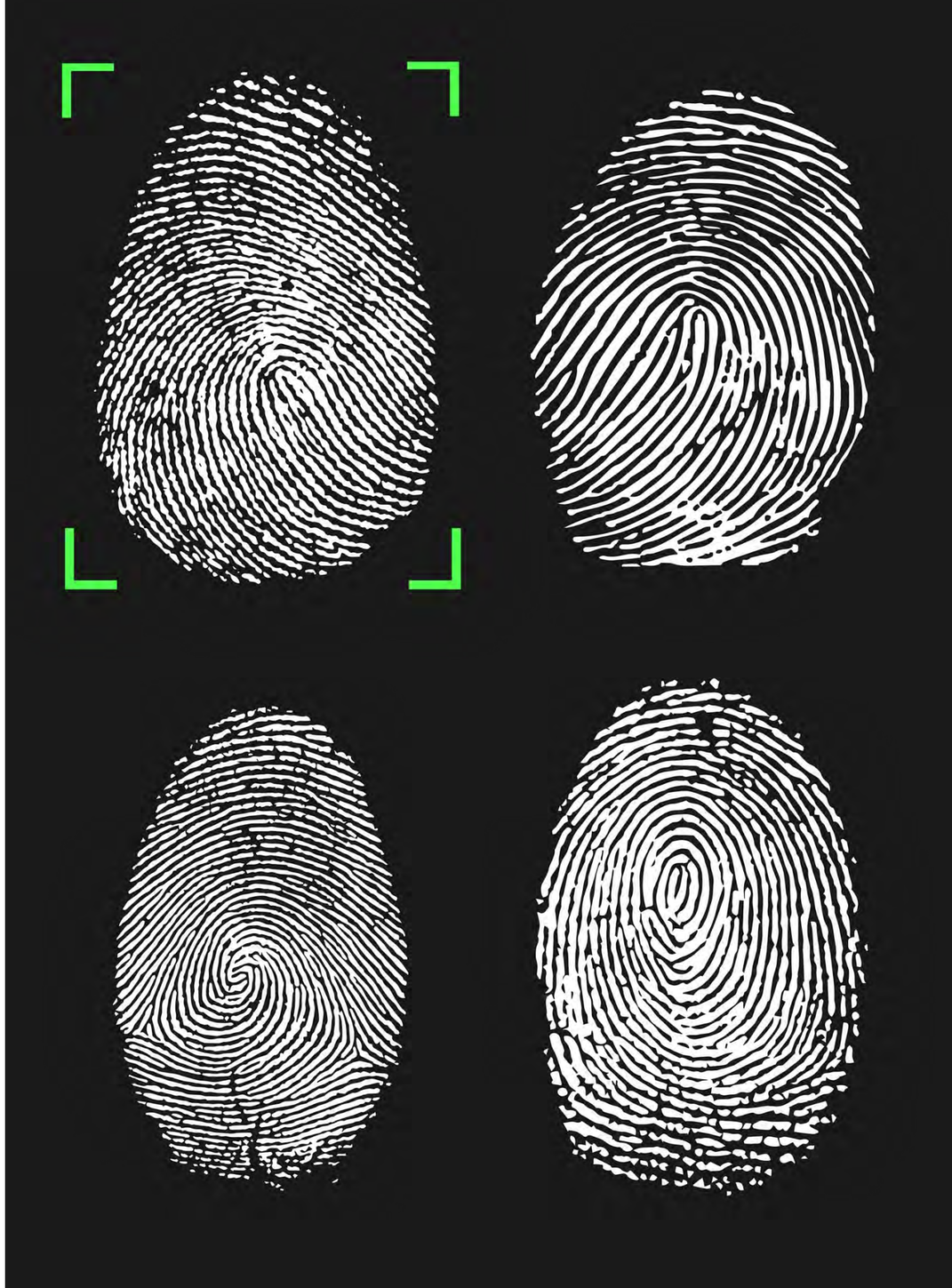
NEW AND MAJOR REVISIONS

NEW RECOMMENDATION

All FDA approved medications for the treatment of opioid use disorder **should be available to individuals receiving healthcare within the criminal justice system**.
The treatment plan, including choice of medication, should be based on the patient's individual clinical needs.

Rationale:

- Federal law requires that incarcerated individuals be treated for health problems since they have no other way to access medical care.
- Addiction treatment has historically been excluded from the range of services provided in U.S. correctional facilities.
- Use of OUD medications in criminal justice settings reduces mortality.



NEW AND MAJOR REVISIONS

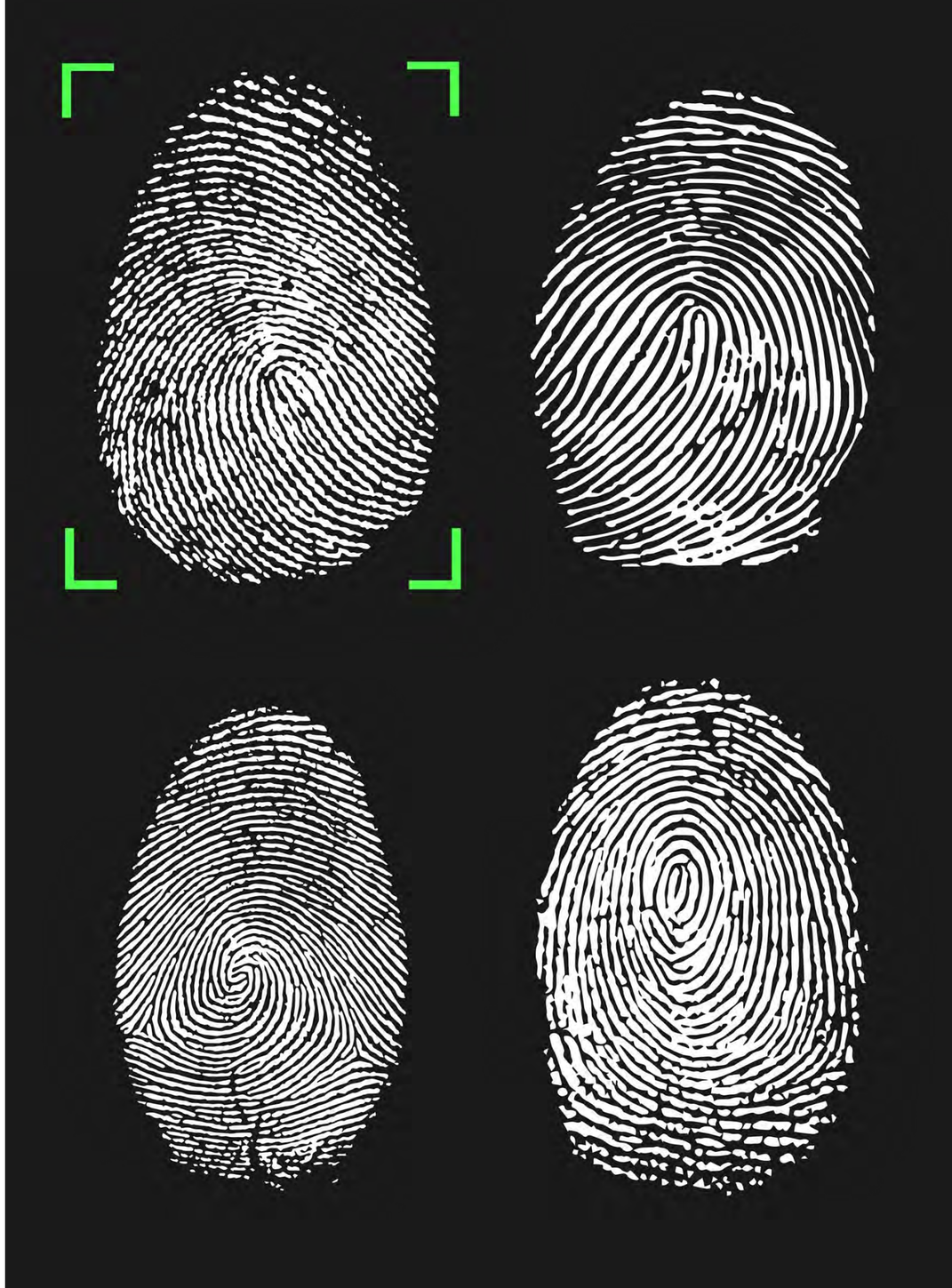
NEW RECOMMENDATION

Individuals entering the criminal justice system should **not be subject to forced opioid withdrawal**.

- Patients being treated for opioid use disorder at the time of entrance into the criminal justice system should continue their treatment.
- Patients with opioid use disorder who are not in treatment should be assessed and offered individualized pharmacotherapy and psychosocial treatment as appropriate.

Rationale:

- Forced withdrawal from OUD medications can make patients less likely to engage in treatment after re-entry.
- The standard of care within criminal justice settings should not be different from the standard of care in the community.

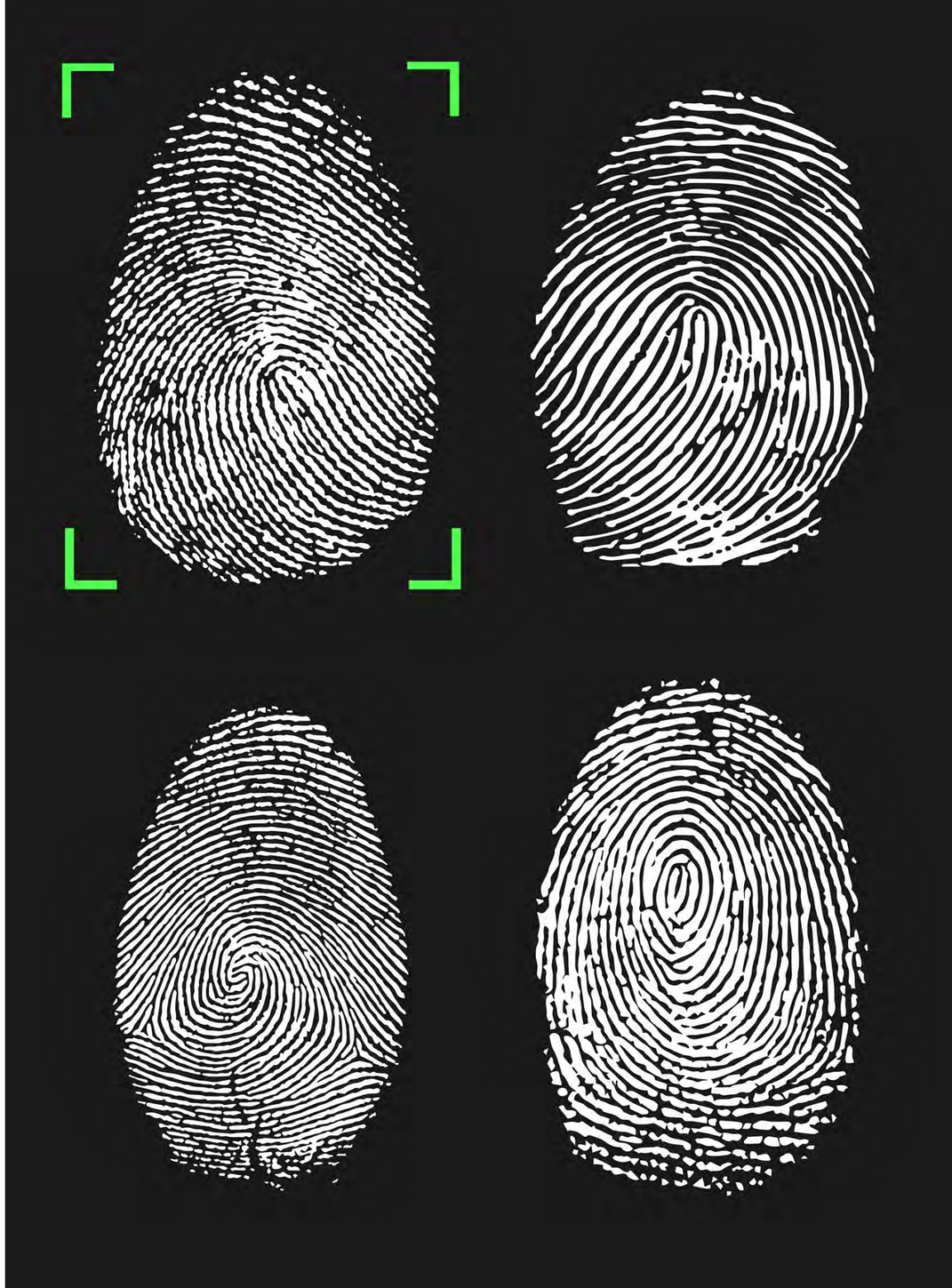


NEW AND MAJOR REVISIONS

NEW RECOMMENDATION

- If an Opioid Treatment Program is not accessible, providers may need to **transition individuals from methadone to buprenorphine**.
- Effectively transitioning from methadone to buprenorphine can be challenging but can be achieved safely if managed by a provider experienced in the procedure.

Rationale:
In the absence of an OTP, incarcerated individuals should be treated for opioid use disorder since they have no other way to access medical care.



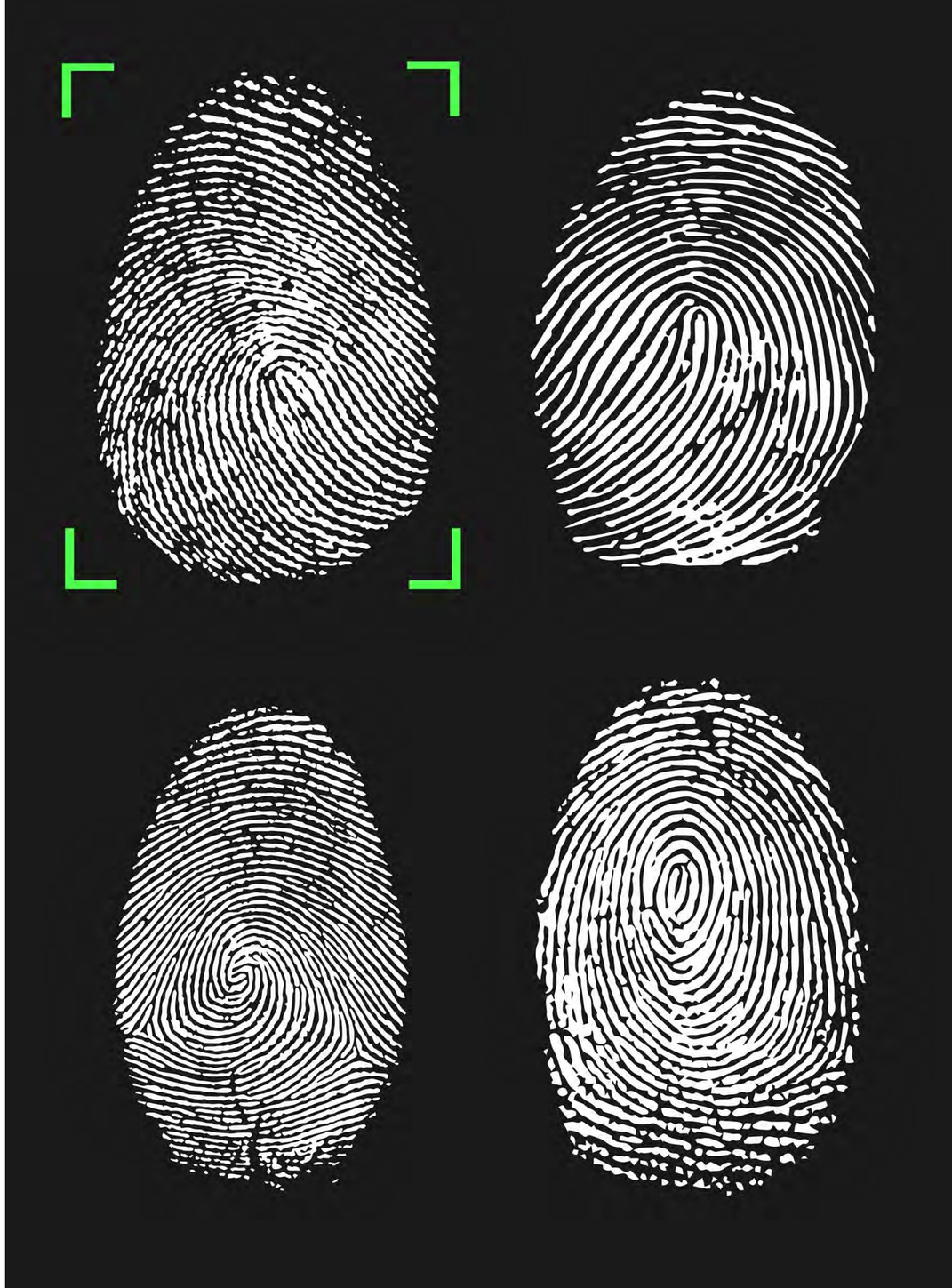
NEW AND MAJOR REVISIONS

NEW RECOMMENDATION

Naloxone kits should be available within correctional facilities. Individuals with opioid use disorder should receive a naloxone kit prior to release, and individuals and families should be educated in how to administer naloxone.

Rationale:

- Individuals reentering the community are at high risk of overdose and overdose death.
- New formulations (including a naloxone nasal spray approved in 2015) have made the use of naloxone for the treatment of opioid overdose accessible to potential bystanders.



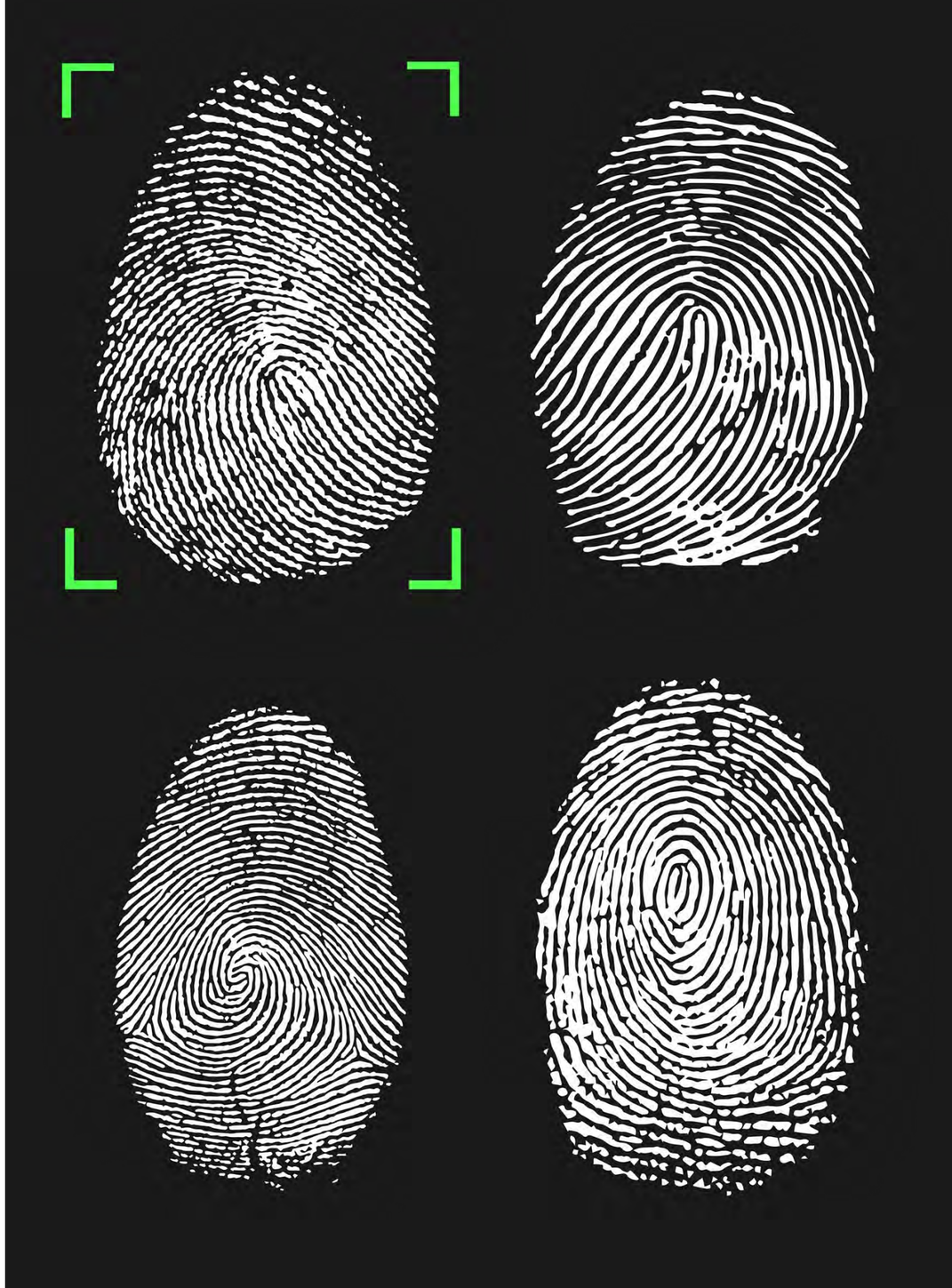
NEW AND MAJOR REVISIONS

MAJOR REVISION

- **Initiation or maintenance of pharmacotherapy for the treatment of opioid use disorder is recommended for individuals within the criminal justice system** (including both jails and prisons).
- Criminal justice staff should coordinate care and access to pharmacotherapy to avoid interruption in treatment.
- Patients should not be forced to transition from agonist (methadone or buprenorphine) to antagonist (naltrexone) treatment.

Rationale:

- The standard of care within criminal justice settings should not be different from the standard of care in the community.
- Recent research has clearly demonstrated that initiating pharmacotherapy in jails and prisons dramatically reduces mortality.



NEW AND MAJOR REVISIONS

MAJOR REVISION

- Patients being treated for opioid use disorder while in prison or jail should **be stabilized on pharmacotherapy** (methadone, buprenorphine or naltrexone) **and continue in treatment after their release**.
- Patient care on reentry to the community should be **individualized and coordinated** with treatment providers in the community.

Rationale:

- The standard of care within criminal justice settings should not be different from the standard of care in the community.
- Recent research has clearly demonstrated that initiating pharmacotherapy in jails and prisons dramatically reduces mortality.

PART 13:
NALOXONE FOR THE TREATMENT OF OPIOID OVERDOSE

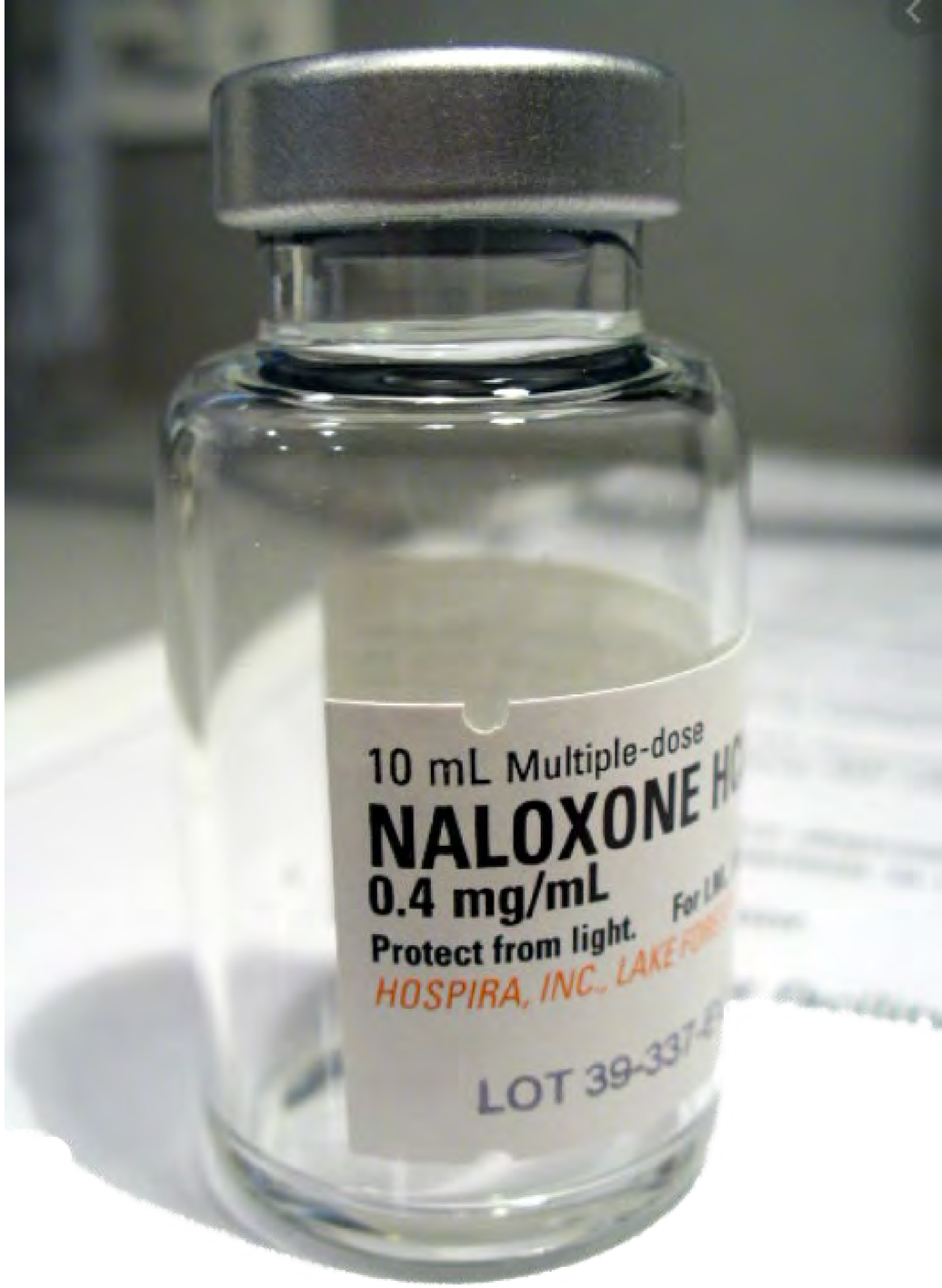
NEW AND MAJOR REVISIONS

MAJOR REVISION

Naloxone should be administered in the event of a **suspected opioid overdose**.

Rationale:

- Revised to clarify that if opioid overdose is suspected naloxone should be given



9 COMMON CLINICAL QUESTIONS

COMMON CLINICAL QUESTION #1

Can I start buprenorphine treatment before a comprehensive evaluation is completed?

ANSWER

- Completion of a comprehensive assessment should not delay or preclude initiating pharmacotherapy.
- The evidence demonstrating the ability of buprenorphine to reduce rates of opioid overdose deaths is compelling and it is important to start medications as soon as possible.
- Buprenorphine can be started in settings such as emergency rooms and the comprehensive assessment completed as soon as possible after medications are initiated.

COMMON CLINICAL QUESTION #2

Should I make participating in psychosocial treatment a requirement for receiving medications for the treatment of opioid use disorder?

ANSWER

- Patients' psychosocial needs should be assessed, and patients should be offered or referred to psychosocial treatment based on their individual needs. However…
- A patient's decision to decline psychosocial treatment or the absence of available psychosocial treatment should not preclude or delay pharmacological treatment of opioid use disorder, with appropriate medication management.
- Motivational interviewing can be used to encourage patients to engage in psychosocial treatment services appropriate for addressing their individual needs."

COMMON CLINICAL QUESTION #3

What dose of buprenorphine should I use?

ANSWER

- Following initiation the dose of buprenorphine should be titrated to alleviate symptoms including withdrawal symptoms, opioid craving and opioid use.
- Evidence suggests 16 mg per day or more may be more effective than lower doses.
- There is less consistent evidence regarding maximum dosing. There is some evidence regarding the relative efficacy of doses higher than 24 mg per day, but the use of higher doses may increase the risk of diversion.

COMMON CLINICAL QUESTION #4

What type of patient should be offered extended release injectable naltrexone?

ANSWER

- Extended release injectable naltrexone is recommended for preventing relapse to opioid use in opioid use disorder patients who are no longer physically dependent on opioids, able to give informed consent and who have no contraindications for this treatment

- Contraindications include: hypersensitivity reactions to naltrexone, or for injectable previous hypersensitivity reactions to polylactide-co-glycolide, carboxymethylcellulose, or any other constituent of the diluent, active hepatitis (hepatitis or if LFTs are > 3x normal), patients currently physically dependent on opioids, including partial agonists, patients receiving opioid analgesics, and patients in acute opioid withdrawal.

COMMON CLINICAL QUESTION #5

Is oral naltrexone recommended for the treatment of opioid use disorder?

ANSWER

▷ The use of oral naltrexone is recommended for the treatment of opioid use disorder only under very limited circumstances.

Examples of limited circumstances under which treatment with oral naltrexone might be considered include:

- For highly compliant and motivated patients such as healthcare professionals or other individuals with high levels of monitoring and negative consequences for nonadherence, who may not be permitted to have opioid agonist treatment.
- Patients who wish to take an opioid receptor antagonist but are unable to take extended-release naltrexone.
- Patients leaving controlled environments (eg, prisons, hospitals, inpatient addiction rehabilitation) who may benefit from medication to prevent return to illicit drug use but cannot or will not take extended-release naltrexone and do not wish to be treated with (or do not have access to) opioid agonists.

COMMON CLINICAL QUESTION #6

How long should patients be on medications for opioid use disorder?

ANSWER

We don't know. Months to years is much better than days to week but no specific time has been identified.

COMMON CLINICAL QUESTION #7

Do these medications cure opioid use disorder?

ANSWER

No, they reduce the potential of harm from untreated OUDs, but do not cure them in the sense that antibiotics cure infections.

COMMON CLINICAL QUESTION #8

Does long-term use of buprenorphine, methadone or naltrexone cause serious harmful physical or mental effects?

ANSWER

Long-term use is not known to cause serious harmful effects.

COMMON CLINICAL QUESTION #9

In view of what is known about untreated opioid use disorder, what can be said about the risk/benefit ratio of medication-assisted treatment?

ANSWER

The risk/benefit ratio of medication-assisted treatment is favorable.

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AUDIENCE Q & A

UPCOMING EVENTS

THE ASAM NATIONAL PRACTICE GUIDELINE SERIES

❑ **The ASAM National Practice Guideline 2020 Focused Update Webinar: Pregnant Women**	**Tricia Wright,** MD, MS, FACOG, DFASAM	**Tuesday, June 30 @ 2:00 p.m. EST**
❑ **The ASAM National Practice Guideline 2020 Focused Update Webinar: OUD and Pain**	**Timothy Wiegand,** MD, FACMT	**Tuesday, July 21 @ 1:00pm EST**
❑ **The ASAM National Practice Guideline 2020 Focused Update Webinar: Individuals in the Criminal Justice System**	**Sandra Springer,** MD, FASAM	**Thursday, Sept. 3 @ 12:00 p.m. EST**
❑ **The ASAM National Practice Guideline 2020 Focused Update Webinar: Adolescents and Young Adults**	**Marc Fishman,** MD, DFASAM	**Tuesday, Sept. 24 @ 1:00 p.n. EST**

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THANK YOU.