Abuse Prevention
vs
Abuse Potential:
Opioid Abuse Prevention Medications

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Disclosure Statement

I have no personal or financial conflicts of interest relating to this presentation

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Objectives

- **Predict potential for abuse of medications prescribed to treat and prevent illicit drug use.**
- **Assess patients for potential abuse of medications being prescribed to them due to substance abuse.**
- **Educate patients on proper use of alternative dosage methods for substance abuse medications.**

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Abbreviations

- **ICU: Intensive Care Unit**
- **IM: intramuscular**
- **IV: Intravenous**
- **PDMP: Prescription Drug Monitoring Program (previously PMP)**

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Treatments

- Always remember: no cure available
- Symptom management
- Teaching coping skills -> replace a relapse
  - Coping skills are their illicits
  - Replace the illicits with actual coping skills
- Too large a topic for 1 discussion

https://www.drugabuse.gov/drug-topics/opioids/opioid-overdose-crisis

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Treatment

- Always attempt to have patients enter treatment
- Previous attempts may not have been for the right reason
  - Prevent going to jail
  - Family, friends requesting
  - Forced to go
  - Prevent loss of children, etc

https://blog.mass.gov/blog/health/kick-the-addiction-alcohol-drug-abuse-prevention-treatment/

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Treatments

- Tests for illicit substances may not catch all of them
- Always test for what is being prescribed
  - Requires patient trust
  - Educate patients: for their benefit and remission
- Nothing works for everyone
- 'Newest' therapies sometimes fail

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Treatment Questions

- What have you tried in past
- What did not work at all
- What worked, but you relapsed:
  - Did you have uncontrolled pain
  - Do you have coping skills for situations
  - Difficulty obtaining buprenorphine?
  - Difficulty obtaining methadone?

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Methadone

- Treatment action for addiction: 24 hours 
- Treatment action for pain 6 to 8 hours 

- Once daily, every 24 hours, methadone dosing:
  - Prevents withdrawal symptoms
  - Obtained at methadone clinic

- Every 6 to 8 hour methadone dosing:
  - Prevents withdrawal symptoms
  - Needs to be 'to go' med from methadone clinic or prescription

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Methadone

- Start with lowest dose potentially needed
- Decrease dose when possible, but not to point of cravings
- Ensure safety with methadone clinic
  - Dealers often provide free illicits near
  - Public perception may be a problem

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Methadone

- Patients can get high from methadone
- Avoid prescribing meds that interact
  - Paroxetine increases methadone levels fluoxetine does not
  - Cimetidine increases methadone levels, etc
- Has 'street value'
- Patients should always be tested before dosing methadone

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Buprenorphine, Buprenorphine-Naloxone (Suboxone)

- **Action for addiction lasts 24 hrs** 
- **Action for pain lasts 6 to 8 hours** 
  - **Split daily dose**
  - **Example: Buprenorphine-naloxone 8 mg-2 mg daily: 2 mg-0.5 mg every 6 hours**
- **Easier for many patients to take, instead of going to daily methadone clinic**

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Buprenorphine

- **Plain buprenorphine may be injected**
- **Rarely needed as sole agent**
- **Ensure valid reason for plain buprenorphine**
- **May be more difficult to find at pharmacies**
- **Higher 'street value' than buprenorphine-naloxone**

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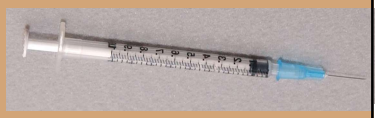
Buprenorphine – Naloxone (Suboxone)



- **Naloxone only has effect if injected**
- **Still may be injected to get high**
- **Patients request higher and higher sublingual doses, to get high OR**
- **Patients request higher and higher doses to stop cravings**

https://www.dea.gov/galleries/drug-images/drug-paraphernalia

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Buprenorphine – Naloxone (Suboxone)

- **Ability to provide induction kit, pending patient ability to go to Addiction clinic?**
- **See last slides for example**
- **Does not have to be Pharmacist educating patient**
- **Has 'street value'**

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Pain

Methadone, buprenorphine, buprenorphine-naloxone:

- **Pain and addiction treatment**
- **Patients may be resistant**
  - **Fear relapsing, fear less addiction action**
  - **May not believe pain effect better**

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Pain

- **Methadone:**
  - **Full agonist- synthetic opiate blocks effects other opiates**
  - **Legal restrictions do not apply when used for pain only**
- **Buprenorphine, Buprenorphine-Naloxone (Suboxone)**
  - **Partial agonist- functions on same brain receptors as morphine**
  - **Weak opiate effect**

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Nasal naloxone

- **Free kits available to patients?**
- **Do friends and family know how to use**
  - **If patient allows their education**
  - **Family members are not the patient (privacy issue)**
- **Importance of carrying on their person**
- **Importance of putting overdose patient on side**
- **Importance of calling 911**

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False Rumors

- Naloxone, in buprenorphine/naloxone (Suboxone) causes withdrawal
- Buprenorphine-naloxone tablets work better than films, films work better than tablets; patient preference due to poor taste
- Pain medications cannot be administered to patients on buprenorphine-naloxone
- Patients cannot get high from buprenorphine-naloxone

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Naltrexone: opioids and alcohol

- Patients require prescription for use
- Should still be tested for substances of abuse
- Patients must be 'clean' for 7 to 10 days prior to initiation
- Unlikely to be able to abuse this medication
- Dosed daily or as monthly intramuscular injection
  - Homeless patients may benefit more from monthly injections
  - Patients with poor daily medication compliance may benefit more from monthly injections

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Naltrexone: opioids and alcohol

- Used for opioid abuse, to block effect
  - Potentially prevent the 'high' from opioids
  - Potentially decrease cravings for opioids
- Used for alcohol abuse, to block effect
  - Potentially prevent intoxication
  - Potentially prevent 'high' from alcohol
  - Potentially decrease cravings for alcohol

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Phenobarbital

- Severe alcohol withdrawal, refractory to benzodiazepines
- Choose patients carefully
- Never patients who may elope or leave against medical advice
- Initial data flawed

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Phenobarbital

- Primarily used intramuscular
- No benzodiazepines once start phenobarbital pathway
- IV dosing for very severe patients, if going to an ICU
- No IM dosing with IV dosing
- Single IV dose equivalent to 3 IM doses

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Topiramate

- Some data for remission from both cocaine and alcohol abuse
- Easy for patient to obtain
- Consider drug tests to ensure compliance
- Has a ‘street value’

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Topiramate

- Data supports use to decrease cravings
- Unfortunately, data shows may increase effects of methamphetamine, cocaine
- Some data recommends concurrent therapy, if used
  - Increase likelihood of remission
  - Decreases cravings, does not eliminate them

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Oxcarbazepine

- **Adjunct therapy for alcohol withdrawal**
  - **Not recommended as monotherapy**
  - **Currently unknown if subset population may tolerate as monotherapy**
- **Less data for treatment than other medications**

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Oxcarbazepine

- **Abuse potential has not been studied**
- **Some studies state no abuse potential**
  - **Theoretical that no abuse potential exists**
  - **Risky for your patient's potential remission, to assume no abuse potential**
- **Less data for treatment than other medications**

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Education

- Action of medications, how long effect lasts
- Determine effect
  - Injected multiple times per day, may require splitting of daily dose to assist with remission
  - Just medications won't work
  - Underlying cause for injecting, beyond the feeling

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Questions?

Thank you for having me speak!

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Policy:	ED Buprenorphine/naloxone Home Induction Protocol
Applies to:	
Effective Date:	
Reviewed by:	
Approved by:	
Last Revision:	

Standards/Definitions:
The following protocol has been developed to provide guidance initiating treatment with buprenorphine/naloxone (Suboxone) for Emergency Department (ED) patients with opioid use disorder. The management of opioid use disorder is based on individual assessment and may vary based on specific clinical presentations. The procedure applies to patients equal to or greater than 18 years old and have an opioid use disorder based on meeting at least three of the following criteria:

Using larger amounts or over longer period than intended.	Craving.
Persistent desire or unsuccessful efforts to cut down/control use.	Tolerance.
Great deal of time spent obtaining, using, recovering from use.	Withdrawal.
Recurrent use resulting in a failure to fulfill major role obligations.	Recurrent use in situations in which it is physically hazardous.
Continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by substance.	Continued use despite knowledge of having a persistent or recurrent physical or psychological problem caused or exacerbated by use.
Important activities given up because of use.	

Note: The provision of buprenorphine/naloxone from the ED for at home induction is intended to be a onetime event to transition the patient to outpatient treatment.

Detailed Procedure:

Providers MUST:
- Possess a DEA waiver to treat opioid addiction prior to prescribing buprenorphine/naloxone for home induction
- Run Prescription Monitoring Program (PDMP) to check for prescriptions not reported

Patients should NOT:
- Have acute/chronic pain requiring opioid management
- Need of higher levels of care due to advanced psychiatric illness or poly-substance use prior to induction
- Be on methadone maintenance

Assessment:
- Medical exam
- Offer substance use disorder evaluation
- Pregnancy test on females of child-bearing age, unless not clinically indicated

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- For patients that are pregnant recommend contacting OB. Subutex preferred and ED opioid withdrawal protocol can be used for guidance
- Consider laboratory tests: toxicology screening, complete blood count, comprehensive metabolic panel, hepatic function
- Use caution when combined with other central nervous system depressants, especially benzodiazepines as severe respiratory depression can occur
- Patient education should be conducted, ensuring patient makes an informed decision to take buprenorphine products. Provider will document that this discussion took place
-
- **Medication orders:**
- ED Provider will order buprenorphine/naloxone (Suboxone) SL film 8mg-2mg outpatient kit using the template with the custom frequency to block the admin from the MAR
- Buprenorphine/naloxone kit containing four films will be provided onsite rather than as a prescription
- Pharmacist to provide take home doses to patient and education about at home induction:
- Day 1:
  - After experiencing withdrawal signs and symptoms patient to take ½ of film (4mg/1mg)
  - Followed by ½ of film every 6 hours as needed for withdrawal symptoms
  - Do not exceed 16mg in first 24 hours
- Day 2:
  - Dosage that was required on day 1 to prevent withdrawal symptoms would be dose for second day
-
- **Discharge:**
- Referral to *** Addiction Clinic the next day
- ***Educate patient as to the need to follow up at outpatient clinic for continued treatment with buprenorphine/naloxone as additional doses will not be provided at the Emergency Department***
- Instruction information for home induction (see attached)
- Ensure all patients are given intranasal naloxone kit to take home

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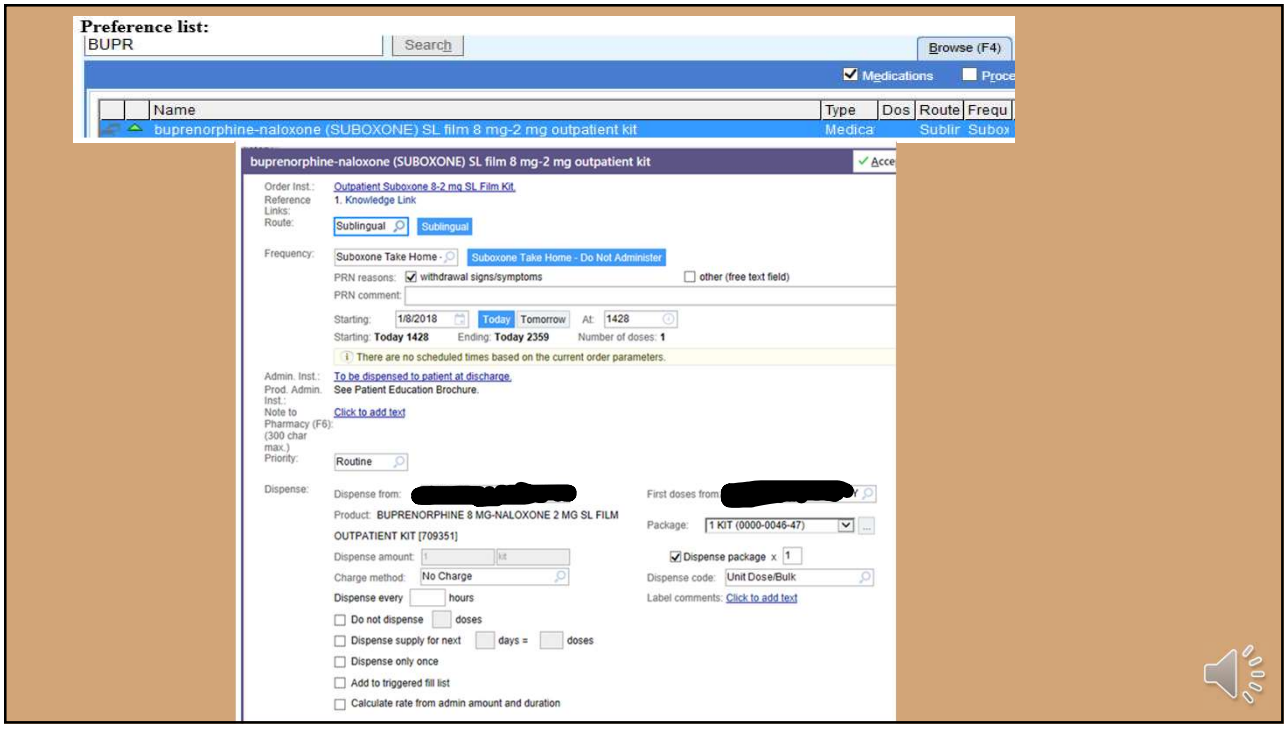
Preference list:
BUPR
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Medications
Name
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buprenorphine-naloxone (SUBOXONE) SL film 8 mg-2 mg outpatient kit
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Outpatient Suboxone 8-2 mg SL Film Kit.
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Frequency:
Suboxone Take Home -
Suboxone Take Home - Do Not Administer
PRN reasons:
withdrawal signs/symptoms
other (free text field)
PRN comment:
Starting:
1/8/2018
Today
Tomorrow
At:
1428
Starting: Today 1428
Ending: Today 2359
Number of doses: 1
There are no scheduled times based on the current order parameters.
Admin. Inst.:
To be dispensed to patient at discharge.
Prod. Admin. Inst.:
See Patient Education Brochure.
Note to Pharmacy (F6): (300 char max.)
Click to add text
Priority:
Routine
Dispense:
Dispense from:
First doses from
Product: BUPRENORPHINE 8 MG-NALOXONE 2 MG SL FILM OUTPATIENT KIT [709351]
Package:
1 KIT (0000-0046-47)
Dispense amount:
Dispense package x
Charge method:
No Charge
Dispense code:
Unit Dose/Bulk
Dispense every
hours
Label comments:
Click to add text
Do not dispense
doses
Dispense supply for next
days =
doses
Dispense only once
Add to triggered fill list
Calculate rate from admin amount and duration

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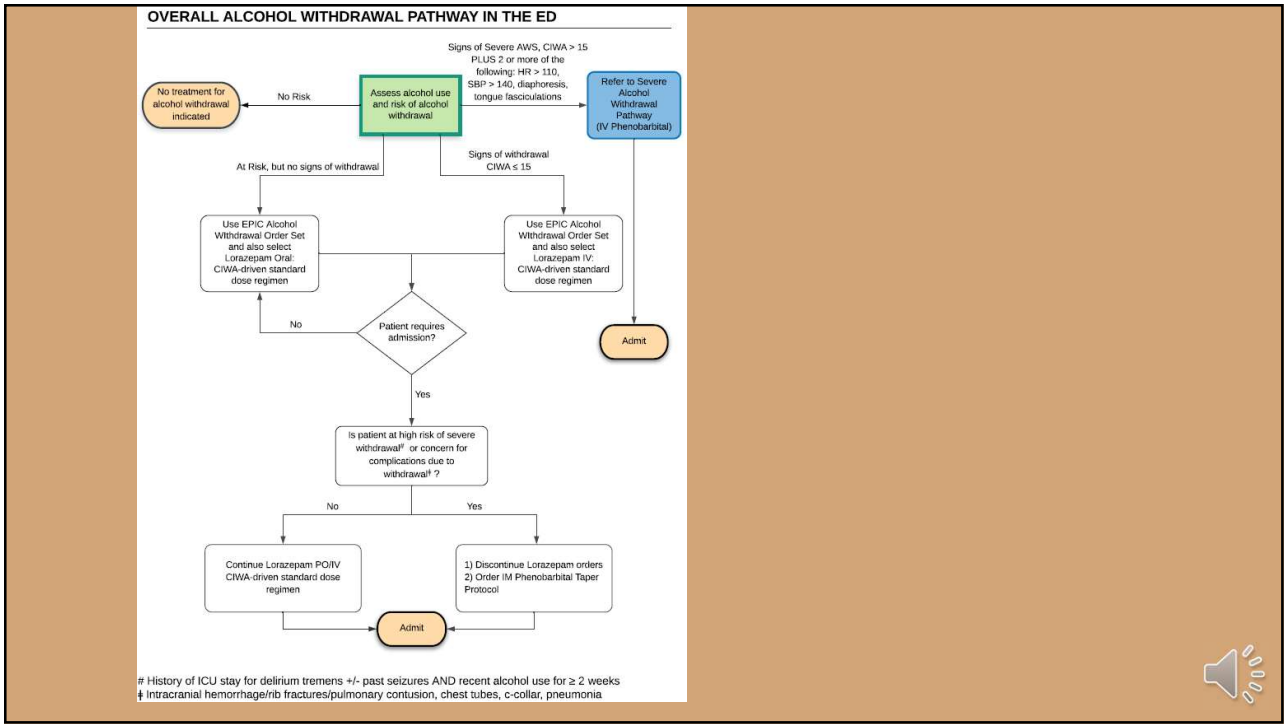
OVERALL ALCOHOL WITHDRAWAL PATHWAY IN THE ED
Signs of Severe AWS, CIWA > 15 PLUS 2 or more of the following: HR > 110, SBP > 140, diaphoresis, tongue fasciculations
No treatment for alcohol withdrawal indicated
No Risk
Assess alcohol use and risk of alcohol withdrawal
Refer to Severe Alcohol Withdrawal Pathway (IV Phenobarbital)
At Risk, but no signs of withdrawal
Signs of withdrawal CIWA ≤ 15
Use EPIC Alcohol Withdrawal Order Set and also select Lorazepam Oral: CIWA-driven standard dose regimen
Use EPIC Alcohol Withdrawal Order Set and also select Lorazepam IV: CIWA-driven standard dose regimen
No
Patient requires admission?
Admit
Yes
Is patient at high risk of severe withdrawal# or concern for complications due to withdrawal‡ ?
No
Yes
Continue Lorazepam PO/IV CIWA-driven standard dose regimen
1) Discontinue Lorazepam orders 2) Order IM Phenobarbital Taper Protocol
Admit
History of ICU stay for delirium tremens +/- past seizures AND recent alcohol use for ≥ 2 weeks
ǂ intracranial hemorrhage/rib fractures/pulmonary contusion, chest tubes, c-collar, pneumonia

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