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ARCA Medication Guidelines and Guidelines in the Age of COVID-19 (Version 6)

The COVID-19 has pushed us to innovate to continue serving our established patient and reach new patients in need of treatment for substance use disorders and co-occurring mental illness. We have had to creatively use telehealth and methods of virtual care in ways unimagined prior to the pandemic. Our staff have creatively developed new processes for connecting with patients, documenting encounters, and promoting patient and community safety.

We are continuing these guidelines to standardize the medication portion of treatment. The primary audiences for these guidelines are ARCA providers and staff. However, our partnering agencies can benefit from understanding our standard ways of practice for several reasons, including patient educations, development of treatment plans, coordination of services, and interagency communications. Also, partnering agencies can work with our providers to adapt aspects of each guideline—such as follow-ups, prescription fills and refills, and referrals—based on the capacity of the agency and the safety and well-being of the agency and its community.

These guidelines are just that—guidelines, not inflexible mandates on practice. We have created them by using the expertise of ARCA, national guidelines published by SAMSHA, the CDC, and ASAM, and other professional and scientific organizations. Providers may deviate from these guidelines when their clinical judgment dictates a change. In these encounters, we ask our providers to document their clinical decision-making so that patients, staff, and partnering agencies understand the process and the treatment goal.

In this version, we have added some options for methamphetamine treatment. While none of the medications are yet FDA-approved, we are living in an epidemic, so we have to consider all tools in the toolbelt. We will continue our ongoing conversations about benefit vs. risk and optimizing safety while minimizing injury and death due to substances.

Other updates include guidelines for tobacco use disorder, benzodiazepine-sparing alcohol detoxification, and adjusted guidelines for limited contact and virtual encounters during COVID-19. Buprenorphine home induction instructions and the ARCA-Patient Medication Agreement have been updated. The appendices include ARCA Medication Guidelines and Guidelines, Supplemental COVID -19 Edition (3/31/2020) as well as general medication guidance, with benefit outweighing risk, only to be used during period of limited patient contact or virtual-only visits due to COVID-19 pandemic.

This is a growing and changing document—much like the field of Addiction Medicine. We will continue to build guidelines as more resources, studies, and best practices become available.

Thank you for taking time to read and implement these guidelines.

Thank you,

Fred Rottnek, MD, MAHCM

Medical Director, ARCA

Controlled Substances and ARCA Prescribing Patterns (Special Communication, 12/2018)

As we continue to build our practice to respond to community need—both locally and by telehealth—we are constantly taking the pulse of partnering agencies regarding the effectiveness of our collaborations and the well-being of our communities.

One trend we are noting is not new, but it is increasing in effect. That trend is the availability of controlled substances in our communities. Regarding our prescribing, we always have to balance minimizing patient barriers to care with maximizing patient and community safety—particularly with controlled substances. Our partnering agencies have been very clear in this regard. They do not want to be perceived—rightly or wrongly—as contributing to their local overdose epidemic by providing patients, particularly those early in recovery, with 30-day supplies of controlled and/or abuseable medications. Many of our partnering agencies are being pressured by local law enforcement agencies to reduce the controlled medication burden in their communities—and we need to do our best to honor these requests. We need to have the communities perceive us as part of the solution, not part of the problem.

In this spirit, we ask all prescribing providers to

1. Adhere to the recommended filling guidelines for buprenorphine—refer to our ARCA Medication Guidelines
2. Apply these guidelines to other controlled substances, including benzodiazepines and amphetamines, as well as other potentially abuseable substances, such as gabapentin
3. Review our ARCA medication guidelines and use non-controlled/non-abuseable substances whenever possible as first line therapies.
4. Comfort meds should be limited to stabilization. They have fill limits on the guidelines. While these doses can be adjusted, and length of fill varied, they should have clear end dates.
5. Work with ARCA nursing staff to initiate 1-2 week fills of all controlled substances—again particularly during the first few months of treatment. We all recognize this is a challenging time in a patient's sobriety, and we want to minimize adverse outcomes due to supply of potentially lethal supplies of medication. ARCA nursing staff work closely with our partnering agency staff—they can provide key informative on patient progress and can recommend fill patterns.
6. 30-day supplies of controlled substances should not be considered until—at the very earliest—the 3rd month of successful treatment adherence. Again, smaller fills/partial fills can be done multiple ways—and refill authorization does not usually require a prescribing visit. Work with your nurses, your case managers, and your peep support specialist for fill recommendations.

Overdose Education and Naloxone Distribution

Randall Williams, MD, Director of Missouri's Department of Health and Senior Services wrote a standing order on August 28, 2018, that allows anyone to purchase/obtain with coverage naloxone at a Missouri pharmacy without a prescription if they align with one of the following categories:
Persons who voluntarily request naloxone and are at risk of experiencing an opiate-related overdose, including but not limited to:

- Current illicit or non-medical opioid users or persons with a history of such use
- Persons with a history of opioid intoxication or overdose and/or recipients of emergency medical care for acute opioid poisoning
- Persons with a high dose opioid prescription (>50 morphine mg equivalents per day)
- Persons with an opioid prescription and known or suspected concurrent alcohol use
- Persons from opioid detoxification and mandatory abstinence programs
- Persons entering methadone maintenance treatment programs (for addiction or pain)
- Persons with opioid prescription and smoking/COPD or other respiratory illness or obstruction
- Persons with an opioid prescription who also suffer from renal dysfunction, hepatic disease, cardiac disease, HIV/AIDS
- Persons who may have difficulty accessing emergency medical services
- Persons enrolled in prescription lock-in programs

- Persons who voluntarily request naloxone and are the family member or friend of a person at risk of experiencing an opiate-related overdose
- Persons who voluntarily request naloxone and are in the position to assist a person at risk of experiencing an opiate-related overdose
- For the original document, visit https://health.mo.gov/data/opioids/pdf/naloxone-standing-order.pdf

Coverage for nasal Narcan

- Missouri Medicaid covers nasal Narcan.
- Patients on other insurance should check with their insurance carriers for coverage. (If these clients are unable to afford Narcan, check with ARCA leadership for area resources for free Narcan).
- Please note: there is no reason for anyone in Missouri for whom Narcan is indicated not to have Narcan. It is just a matter for us to find the correct resource.

For all clients seen at ARCA who align with the above categories:

1. Prescribing providers prescribe one nasal Narcan (2-unit dose-pack) with two refills at the initial office visit. (See medication templates below).
2. All ARCA staff check with clients at each office visit if they need a refill or to check the expiration date of their current naloxone supply.
3. Any ARCA staff member may call in a nasal Narcan prescription for any registered client—this standing order can be called in under any prescribing provider's name or under the Medical Director's name.

4. Per Dr. Williams' standing order, all clients who are prescribed Narcan must receive literacy-level appropriate education about its use. We recommend, when possible, that the client brings in someone they live with (or use with) for this education.
5. Use Naloxone Patient information (Narcan nasal spray)

Comfort Medications (Customize to substance(s) being addressed)

Encourage hydration prior to and curing the withdrawal process. Encourage a minimum of eight 8-oz glasses of water per day. Encourage sips, not gulping. Encourage use of ice chips and freezer pops.

Encourage the patient to use comfort medications. However, also ask the patient if the patient has detoxed before if they found the comfort medications useful. If they did not, and they do not want them. Do not prescribe them.

Medications

1. Trazodone 100mg - Take one tablet daily 30 mins before bedtime as needed for sleep. Allow 7-8hours of sleep #10 (no routine refill)
2. Compazine 10mg- Take one tablet three times daily as needed for Nausea #30 (no routine refill)
3. Clonidine 0.1mg- Take one tablet every 12 hours daily as needed for anxiety, agitation, rapid heart rate, headache #20 Hold for BP less than 100/60 (no routine refill)
4. Baclofen 10 mg orally three times daily as needed for cramping (#30) (no routine refill) or Flexeril 10mg- Take one tablet every 8 hours as needed for muscle cramping #30 (no routine refill)

Alcohol Detoxification Guideline

1. Conduct and document PAWSS—see appendix. A score ≥ 4 suggests that a patient is at risk for a more complicated withdrawal process. Patients with a score ≥ 4 should be encouraged to detox in a hospital or higher acuity setting. However, not all patients are able and/or willing to do so. Document this conversation.
2. Medications
    a. Naltrexone 50mg - Take 1/2 tablet the first day and then one tablet by mouth daily AFTER eating #30
    b. Librium/ Chlordiazepoxide 25mg, DO NOT drive on this medication. DO NOT drink on this medication:
        i. Take 1 capsule every 6hrs for the first 2 days
        ii. Take 1 capsule every 8 hours for the next 2 days
        iii. Take 1 capsule every 12 hours for the next 2 days
        iv. Take 1 capsule every 24 Hours for the final 2 days (no routine refill)
    c. Folic Acid (Vitamin B9) - 1mg Take 1 tablet daily for 14 days (no routine refill)
    d. Thiamine (vitamin B1) - 100mg - Take 1 tablet daily for 14 days (no routine refill)
    e. Seizure prophylaxis: Choose one if client has had history of complicated alcohol withdrawal
        i. Tegretol/carbamazepine 200 orally two times daily for 7 days
        ii. Gabapentin 300 orally three times daily for 7 days

Patient instructions:

1. Have someone at home with you during, at least, the first 3 days of this process. Have them assist you in taking medications on schedule.
2. Do not to take more than the prescribe medication unless authorized. If you have any questions or concerns, contact ARCA Medical Staff.
3. Do not drive or operate potentially dangerous equipment while taking Librium.

Labs and Other monitoring:

1. Initial labs
    a. CMP, CBC
    b. Qualitative HCG (if female and at each visit if on medications);
    c. UDS (and at each visit)
2. Follow up labs:
    a. Routine labs and frequency if labs are within normal limits
        i. CMP, CBC, qualitative HCG, UDS every three months if client is on naltrexone, for year 1
        ii. CMP, CBC, qualitative HCG, UDS every six months if client is on naltrexone, for year 2 and following
    b. Routine labs and frequency if labs are not within normal limits.
        i. CMP and CBC every month if client is asymptomatic and until each panel is within normal limits, or
        ii. Check with provider for frequency of labs

Alcohol Detoxification Guideline—benzodiazepine-sparing

Some of our patients at ARCA do not wish to use benzodiazepines for alcohol detox and stabilization. For these patients, consider using a benzo-sparing protocol.

See Maldonado JR. Novel Algorithms for the Prophylaxis and Management of Alcohol Withdrawal Syndromes-Beyond Benzodiazepines. Crit Care Clin. 2017 Jul;33(3):559-599. doi: 10.1016/j.ccc.2017.03.012. PMID: 28601135.

1. Conduct and document PAWSS—see appendix. A score $\geq$ 4 suggests that a patient is at risk for a more complicated withdrawal process. Patients with a score $\geq$ 4 should be encouraged to detox in a hospital or higher acuity setting. However, not all patients are able and/or willing to do so. Document this conversation.
2. Medications
    a. Naltrexone 50mg - Take 1/2 tablet the first day and then one tablet by mouth daily AFTER eating #30
    b. Detox and stabilization medication options include valproic acid, gabapentin, and clonidine—see Maldonado's paper above for his algorithm and addition comfort medications.
    c. Folic Acid (Vitamin B9) - 1mg Take 1 tablet daily for 14 days (no routine refill)
    d. Thiamine (vitamin B1) - 100mg - Take 1 tablet daily for 14 days (no routine refill)

Do not take more than the prescribe medication unless authorized. If you have any questions or concerns, contact ARCA Medical Staff.

Patient instructions:

1. Have someone at home with you during, at least, the first 3 days of this process. Have them assist you in taking medications on schedule.
2. Do not to take more than the prescribe medication unless authorized. If you have any questions or concerns, contact ARCA Medical Staff.
3. Do not drive or operate potentially dangerous equipment while taking Librium.

Labs and Other monitoring;

1. Initial labs
    a. CMP, CBC
    b. Qualitative HCG (if female and at each visit if on medications);
    c. UDS (and at each visit)
2. Follow up labs:
    a. Routine labs and frequency if labs are within normal limits
        i. CMP, CBC, qualitative HCG, UDS every three months if client is on naltrexone, for year 1
        ii. CMP, CBC, qualitative HCG, UDS every six months if client is on naltrexone, for year 2 and following
    b. Routine labs and frequency if labs are not within normal limits.
        i. CMP and CBC every month if client is asymptomatic and until each panel is within normal limits, or
        ii. Check with provider for frequency of labs

Opioid Detox Guideline (and Home BUP/Ntx Induction)

BUP/Ntx: 8mg/2mg films (Preferred form of medication)

1. Routine Dose
    a. Take the prescribed tablet under the tongue daily x 8 days
    b. When starting medication, you must wait until you are in active withdrawal. On a scale of 1-10, you want your withdrawal symptoms to be at a 7-8. If you are using the COWS or SOWS scale, you should be in moderate withdrawal. Start by taking one tablet of your prescribed dose. IF you take the first tablet and are feeling worse, DO NOT take any more, and contact the ARCA staff. DO NOT take more than the prescribed medication unless authorized.
2. Custom Dose
    a. Check with provider for schedule, rationale, and documentation needs

BUP/Ntx: 8mg/2mg films

3. Routine Dose
    a. Take 1, 1.5, or 2 films under the tongue daily x 8 days
    b. When starting medication, you must wait until you are in active withdrawal. On a scale of 1-10, you want your withdrawal symptoms to be at a 7-8. Start by taking 1/4 of a film under your tongue. Wait 15mins, and then take another 1/4 of a film. Continue this until you have taken a full film. IF you take the first 1/4 of a film and are feeling worse, DO NOT take any more, and contact the ARCA staff. DO NOT take more than the prescribed medication unless authorized.
4. Custom Dose
    a. Check with provider for schedule, rationale, and documentation needs

Zubsolv Dosing

1. 1.4 mg buprenorphine with 0.36 mg naloxone is equivalent to 2mg BUP/Ntx (1/4 strip)
2. 5.7 mg buprenorphine with 1.4 mg naloxone is equivalent to 8mg/2mg BUP/Ntx (1 strip)

Labs and Other monitoring;

1. Initial labs;
    a. CMP, CBC
    b. qualitative HCG (if female and at each visit);
    c. UDS (and at each visit)
    d. Strongly encourage your patient to get an HIV test and a PPD test at their local health center or community screening.
2. Follow up labs:
    a. Routine labs and frequency if labs are within normal limits
        i. CMP, qualitative HCG, UDS every three months if client is on BUP/Ntx for year 1

   ii. CMP, qualitative HCG, UDS every three months if client is on BUP/Ntx for year 2 and following

b. Routine labs and frequency if labs are not within normal limits.
   i. CMP and CBC every month if client is asymptomatic and until each panel is within normal limits, or
   ii. Check with provider for frequency of labs

Dosing Schedule (ARCA Routine BUP/Ntx Dosing Schedule)[1]
(Assuming client is doing well, has no new complaints, does not need to see the provider, is taking BUP/Ntx, and has negative UDS). Based on positive drug screens for controlled substances, the client may be taken back to any previous month in the guideline, or the client may be restarted at Week #1

Month	Week	Visit	Prescription	Refill?
1	1	Prescribing Provider	8 days	Three refills available, but must be authorized by RN or trained staff [2]
	2	RN or trained staff	RN or trained staff authorizes refill[3]	
	3	RN or trained staff	RN or trained staff authorizes refill	
	4	RN or trained staff	RN or trained staff authorizes refill	
2	1	Prescribing Provider	15 days[4]	One refill available, but must be authorized by RN or trained staff
	3	RN or trained staff	RN or trained staff authorizes refill	No
3	1	Prescribing Provider	30 days (if 16 mg or less)[5]	No

*Defined here as a 4-week block

Notes:

1. If a prescribing provider deviates from this process, he/she must document medical decision-making in the encounter.
2. The prescribing provider indicates if follow-up checks and prescription authorization visits are in-person or via telephone.
3. RN or trained staff completes *Staff Check-in Sheet for Patients on BUP/Ntx form (TBD)*
4. If a client is on more than 16 mg of BUP/Ntx, refills can only be called in for 2 weeks supply. Scripts may be written for a 2-week supply with one refill, but the nurse must call the pharmacy to authorize the refill.
5. Provider decides with RN or trained staff at agency site if the client has demonstrated behaviors and treatment adherence that allow a complete 30-day prescription fill.

Additional Dosing Instructions

1. Initial BUP/Ntx dose on induction
    a. Many of our client do well starting on 4-8 mg, most do well at 8mg
    b. However, many of our clients need higher doses for induction—sometimes up 16 mg, rarely up to 24 mgs.
    c. Initial and maintenance dosing depend on several client use factors. **Avoid under-dosing on both induction and maintenance dose.** Under-dosed clients are at increased risk of overdose. (Severity of factors below suggest higher induction dose and maintenance dose)
        i. Types of opioids
        ii. Quantity of opioids
        iii. Other addictive substances used routinely or episodically
        iv. Age of onset of use of addictive substances
2. Maintenance dose
    a. While it is best to maintain a client on the lowest effective dose of any therapeutic agent, be mindful, particularly in the first year of maintenance, that clients will have good days and bad days, higher craving days, and changes in their lives. This is a normal part of the recovery process
        i. **Avoid under-dosing maintenance dose.**
        ii. Consider some creative dosing in prescriptions, for example
            1. Write prescriptions and instruct clients to allow for an extra 5-10 days of 4 mg BUP/Ntx
            2. Discuss other medications and/or non-medication tools to help on higher craving days
3. Accountability structures
    a. Explain initially, and frequently, that accountability structures are ways to promote client safety—they are not punishments
    b. UDS's and PDMP alerts are conversation starters, not sledgehammers.
        i. Positive UDS's and PDMP alerts should be followed by a question—*What's going on?*
        ii. Polysubstance use and relapse are parts of the recovery process—expect bumps along the way and work with your client to develop new/more effective coping skills
    c. Explore options with each community partner to promote accountability-oriented communications. These include
        i. Staff can count BUP/Ntx wrappers since last visit
        ii. Staff can develop guidelines for phone calls, texting, and communications with clients to promote trust and relationship building. For example,
            1. Routine calls: "How are you doing" calls
            2. Calls for appointment reminders
4. BUP/Ntx tapering
    a. Tapering and discontinuing BUP/Ntx for a client who wants BUP/Ntx maintenance and is responding well to BUP/Ntx therapy is not a recommended treatment priority.
    b. When a client responds well to a therapeutic dose of BUP/Ntx, the therapeutic goal is

i. Patient's ongoing engagement in treatment
ii. Patient utilization of resources to stabilize his/her life—including appropriate therapy, utilizing of agency and partner resources
iii. Time on BUP/Ntx therapy to allow the client's neurological system to heal/repair

c. If anyone on the treatment team becomes aware that a client wants to discontinue BUP/Ntx, inform the prescribing provider and the RN or staff member coordinating the client's care.
    i. Explicitly share risks associated with BUP/Ntx discontinuation, including 50-90% relapse, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4382404/
    ii. Ask the client for reasons why the client wants to discontinue treatment
        1. Is it the client's choice, or is the client receiving pressure from an external source, e.g., family member, loved one, criminal justice system?
        2. What isn't working with the current treatment plan?
        3. Assess for under-dosing

d. If the client still wants to discontinue BUP/Ntx,
    i. Encourage a slow taper and use of Vivitrol or another agent
    ii. Encourage continued participation in other elements of the treatment plan and other agency programs

Sublocade (buprenorphine extended release) https://www.sublocade.com/

1. Indications and patient selection
    a. SUBLOCADE is indicated for the treatment of moderate to severe OUD in patients who have initiated treatment with a transmucosal buprenorphine-containing product, followed by dose adjustment for a minimum of 7 days
    b. Patients appropriate for SUBLOCADE are adults who have initiated treatment on a tr ansmucosal buprenorphine containing product delivering the equivalent of 8 to 24 mg of BUP daily
2. Recommended dosing
    a. The recommended dose of SUBLOCADE following induction and dose adjustment with transmucosal buprenorphine is 300 mg monthly for the first two mon ths followed by a maintenance dose of 100 mg monthly. A follow-up dose of 300 mg/month is also acceptable, particularly for patients on very high opioid doses prior to BUP and Sublocade induction.
    b. A patient who misses a dose should receive the next dose as soon as possible, with th e following dose given no less than 26 days later. Occasional delays in dosing up to 2 weeks are not expected to have a clinically significant impact on treatment effect.
3. Clinically significant drug interactions
    a. Benzodiazepines and other CNS depressants
    b. Serotonergic drugs
    c. Inhibitors of CYP3A4, e.g., macrolide antibiotics, azole-antifungals, and protease inhibitors
    d. CYP3A4 inducers, e.g., rifampin, carbamazepine, phenytoin, phenobarbital
    e. Antiretrovirals
        i. NNRTI's
        ii. Protease inhibitors
        iii. NRTI's
        iv. MAOI's
    f. Muscle relaxants
    g. Diuretics
    h. Anticholinergics

Naltrexone Extended Release (Vivitrol) Induction Guideline

1. On the initial visit, client is started on oral naltrexone 50mg #30
    a. 1/2tab with food if UDS negative for opiates, BUP/Ntx, and methadone, and the urine qualitative HCG is negative.
    b. If tolerated take other 1/2 tab in 30 mins, then take 1 tab daily with food.
    c. CBC, CMP and qualitative HCG (if female) is drawn
    d. Patient is scheduled to come back to the office in 2-3 days.
2. If client's labs are WNL and qualitative HCG is negative, client may receive a Vivitrol injection. (If client's labs are not WNL/negative, check with the medical provider or medical director for additional orders).
3. Initial Vivitrol injection
    a. All clients receiving Vivitrol must sign a consent with two contacts. The first could be a family member and the second an emergency contact.
    b. Once this is completed, the client may receive an injection.
        i. Vivitrol 380mg #1 Administer deep IM every 4 Weeks. Start if Labs are within normal limits.
        ii. Once Vivitrol is started, client may take Naltrexone 50mg daily as needed for cravings.
    c. Schedule a return visit for 24-28 days. Schedule this as a provider visit or nurse visit, based on the provider's orders.
4. Delayed or missed visits
    a. If the client does not show up the scheduled day, call the client and remind him/her of the appointment. If you cannot contact the client, and the client has not shown up within a 32-day window, call the family member and if no response within 24 hours, call the emergency contact.
    b. Window for Vivitrol injections: Vivitrol can be safely administered up to 33 days past the last shot.
    c. Although the product information states the therapeutic effects last 28 days, the medication lasts longer, especially after the second injection. If there is any concern on the part of the client or clinical staff, a naltrexone tablet can be administered. Give half tablet (25 mg), wait 15 minutes and if the client shows no signs of withdrawal, administer the injection. This procedure can often be utilized up to 35 days even in cases of the client testing positive for opioids.
    d. If the client comes to the clinics after 35 days or longer, assume the client has relapsed and needs detox. Contact the client's provider or the medical director for orders. The best approach is a short detox using buprenorphine. If the client does not want buprenorphine, other detox guidelines can be utilized.
    e. Under no circumstances should a client on Vivitrol be sent away without the Vivitrol, direct observed ingestion of oral naltrexone, or opioid detox meds--with or without buprenorphine. Contact the client's provider or medical director for orders.

Labs and Other monitoring;

1. Initial labs;
    a. CMP, CBC
    b. Qualitative HCG (if female and at each visit);
    c. UDS (and at each visit)
2. Follow up labs:
    a. Routine labs and frequency if labs are within normal limits
        i. CMP, qualitative HCG, UDS every three months if client is on Vivitrol
    b. Routine labs and frequency if labs are not within normal limits.
        i. CMP and CBC every month if client is asymptomatic and until each panel is within normal limits, or
        ii. Check with provider for frequency of labs

Additional resources on Vivitrol can be found on Alkermes' website, https://www.vivitrolhcp.com/

- **Risk Evaluation and Mitigation Strategy (REMS) >**
- **Vivitrol2gether^{SM} Patient Support Services >**
- **Understanding the VIVITROL Prescription Process >**

Outpatient microdosing induction schedule for buprenorphine–naloxone, The Bernese Method

This method has been particularly useful with patient using synthetic opioids such as fentanyl.

Microdosing instructions:

1. Doses below use BUP/Ntx, **2 mg strips**
2. Utilize comfort medications as listed above

Doses using BUP/Ntx, 2 mg strips

Day 1: 0.5 mg once a day
Day 2: 0.5 mg twice a day
Day 3: 1 mg twice a day
Day 4: 2 mg twice a day
Day 5: 3 mg twice a day
Day 6: 4 mg twice a day
Day 7: 12 mg (stop other opioids)

References:

- Privia A. Randhawa BScH MPH, Rupinder Brar MD and Seonaid Nolan MD. Canadian Medical Association Journal, 2020-01-20, Volume 192, Issue 3, Pages E73-E73
- Hämmig R., Kemter A., Strasser J., et. al.: Use of microdoses for induction of buprenorphine treatment with overlapping full opioid agonist use: the Bernese method. Subst Abuse Rehabil 2016; 7: pp. 99-105.

Microdosing Instructions from the WISH Clinic at SSM Health St. Mary's Hospital

1035 Bellevue Ave, Suite 205
St. Louis, MO 63117
314-768-8230 or 314-768-8339 (Clinical Pharmacist)

The WISH (Women and Infant Substance Help) Center provides comprehensive, high-risk maternity care for women who are dependent on opioids and other drugs. It is the only facility of its kind in the St. Louis region. Located on the campus of SSM Health St. Mary's Hospital in St. Louis, the WISH Center's multidisciplinary team includes maternal fetal medicine specialists, specially trained nurse practitioners, nurses, social workers, nurse coordinators and a dedicated OB pharmacist. The team coordinates with behavioral medicine therapists.

Women in this program are prescribed buprenorphine or methadone to alleviate withdrawal from opioids. The team is developing a full two-year program that extends care for new moms after the baby is born when the risk of relapse is the greatest. The plans include a partnership with outside organizations to help with job skills, housing, life skills and parenting to help moms maintain sobriety. https://www.ssmhealth.com/locations/location-details/wish-center

Microdosing Instructions

Take Suboxone® according to the table. The first strip will be cut into 2 pieces, half of it is then cut into 4 pieces (1/8 of a strip). The other half can be cut in two on day 3 (1/4 of a whole strip).

*You are using 2 mg Suboxone® strips.

Day	Date	Day	Am	pm	Other instructions	Taken?
1			1/8 strip		Begin to cut down your opioid use	
2			1/8 strip	1/8 strip	Continue to cut down on your opioid use	
3			¼ strip	¼ strip	Continue to cut down on your opioid use	
4			½ strip	½ strip	Continue to cut down on your opioid use	
5			1 strip	1 strip	Continue to cut down on your opioid use	
6			2 strips	2 strips	Continue to cut down on your opioid use, stop by that night	
7			4 strips	2 strips	Stop opioid use	
8			4 strips		Come in to office	

Guideline for Tapering BUP

BUP tapering and discontinuation is only done at the client's request. No staff member or contracted provider should coerce or otherwise force a client to taper off BUP for any reason. If a prescribing provider thinks it may be in the client's interest to discontinue BUP, he or she should contact the ARCA Medical Director prior to any change in treatment plan so that options can be reviewed and discussed.

Tapering

If, after weighing the risks of relapse a client chooses to discontinue buprenorphine, the client should do so through a safe, structured guideline. The client should consult with the treatment team to agree upon a longer or a shorter taper based on the client's history and resources. Special planning must be focused on the 5-7 day "BUP/Ntx wash-out period" between the last BUP/Ntx dose and the first Vivitrol injection. The client and the treatment must successfully develop a support and resource plan to mitigate risk of relapse during this period.

Note that the rate of taper has more to do with percent decrease than absolute dose decrease. In other words, it is often easier for clients to go from 14 mg to 12 mg than 6 mg to 4 mg.*

*Doses described on this page were established with the original BUP/Ntx® sublingual tablets and should be adjusted for the formulation you are using.

Guidelines Recommend Longer Tapering

Guidelines on medication-assisted treatment produced by ASAM recommend that tapering and stopping buprenorphine should be achieved slowly, usually over several months, with close monitoring (ASAM, 2015). Furthermore, they recommend that clients remain in treatment for ongoing monitoring, even after buprenorphine is completely discontinued. A long-period may be more favorable for clients who would be less willing or able to seek outside support during treatment. Additionally, a lengthier process may help decrease the severity and occurrence of withdrawal symptoms as the client's dose is tapered. Slower tapers typically are conducted at the rate of 2mg decrease of BUP/Ntx every 7-10 days.

Shorter Tapering

However, some research found no benefit for a 28-day taper in comparison to a 7-day taper. Another multi-site study sponsored by NIDA's Clinical Trials Network found similar results (Ling et al., 2009). The following table highlights their 7-day tapering guideline.

Stabilization Dose	8 mg	16 mg	24 mg
Day 1	8	16	24
Day 2	6	12	20
Day 3	6	10	16
Day 4	4	8	12
Day 5	4	4	8
Day 6	2	2	4
Day 7	2	2	2

Transitioning from BUP/Ntx to Naltrexone Extended Release (Vivitrol) Guideline

1. At the initial visit, the provider will order lab tests (CMP, CBC with Diff, and qualitative HCG Qualitative, if applicable).
2. Follow the BUP/Ntx taper guideline above.
3. Comfort medications:
    a. Trazodone 100mg - Take one tablet daily 30 mins before bedtime AS NEEDED for sleep. Allow 7-8hours of sleep #14 (no routine refill)
    b. Compazine 10mg- Take one tablet three times daily AS NEEDED for Nausea #30 (no routine refill)
    c. Clonidine 0.1mg- Take one tablet EVERY 12 hours daily AS NEEDED for anxiety, agitation, rapid heart rate, headache #20 Hold for BP less than 100/60 (no routine refill)
    d. Baclofen 10 mg orally three times daily as needed for cramping (#30) (no routine refill) or Flexeril 10mg- Take one tablet every 8 hours daily as needed for muscle cramping #30 (no routine refill)
4. While on a slow BUP/Ntx taper, the client must see the provider every month.
5. If the client tests positive for opiates 2 consecutive times after the initial appointment with the provider, the client will be scheduled with the provider the following week. The provider will determine whether BUP/Ntx will be continued until seeing provider.
6. For the client to receive naltrexone, their system needs to be free of BUP/Ntx and opiates, preferably for 3-8 days.
    a. If client returns to start naltrexone/Vivitrol but is positive for BUP/Ntx, schedule an RN appointment for approximately 3 days later, and continue to do this until negative for BUP/Ntx (and opiates).
    b. If client returns to start naltrexone/Vivitrol, but is positive for opiates, reschedule with the provider for their next available appointment time.
7. When the client returns after their "BUP/Ntx wash-out period" for their transition to naltrexone/Vivitrol, and the client is negative from BUP/Ntx and opiates, RN will administer naltrexone 25 mg po with food. After receiving dose, client will be observed for 30 minutes. If no negative reaction is noted or reported, dose will be repeated, and client will be observed for an additional 30 minutes, unless otherwise indicated.
8. If there is no negative reaction, the client will receive either a 1-month prescription for naltrexone or the Vivitrol injection (per MDO).
9. Patient will return approximately every 28 days for an additional prescription or injection.
10. During this time the client will be seen by the provider every 3 months, unless otherwise indicated.
11. Follow up labs:
    a. Routine labs and frequency if labs are within normal limits
        i. CMP, qualitative HCG, UDS every three months if client is on Vivitrol
    b. Routine labs and frequency if labs are not within normal limits.
        i. CMP and CBC every month if client is asymptomatic and until each panel is within normal limits, or
        ii. Check with provider for frequency of labs

The Shane Parish/Salvation Army BUP/Ntx taper towards Naltrexone Extended Release (Vivitrol) Induction

Day	Tablet dose	# of tablets	# tablets to dispense
1 & 2	2 mg/ 0.5 mg	4	8
3 & 4	2 mg/ 0.5 mg	3	6
5 & 6	2 mg/ 0.5 mg	2	4
7 & 8	2 mg/ 0.5 mg	1	2
Total			20

1. Encourage regular hydration throughout process.
2. Provide comfort medications, see above, throughout process
3. Then, after 8 days administer Vivitrol.

Methadone to BUP/Ntx Guideline

Methadone tapering and discontinuation and initiation onto BUP is only done at the client's request. No staff member or contracted provider should coerce or otherwise force a client to taper off methadone for any reason.

Methadone has a long track record as an effective medication for OUD; however, the barriers for treatment access and maintenance are significant and methadone has a high overdose potential—particularly when someone uses it in combination with other substances. The increased utilization of BUP and the greater acceptance of client services for OUD (other than OTP's) has resulted in increased number of clients choosing to transfer from methadone to BUP treatment for their OUD.

ARCA has a successful track record in providing these services. However, this transfer of services can be challenging and requires

1. Clear and encouraging client education about the process. Including the acknowledgement that the client will likely be uncomfortable for a few hours during the transfer—despite our best efforts at providing comfort medications.
2. Clear communication among ARCA team member for a clear treatment plan and shared language around process and expectation
3. Customization of the process for each client, including
    a. Office detox/transfer vs. home detox/transfer
    b. Frequency of initial visits with providers and/or staff during the medication transfer
    c. Frequency of phone checks with the client during the transfer process

Methadone-BUP Process

1. In the initial assessment, include the following information:
    a. How much methadone is the client usually taking daily?
    b. How long has the client used methadone?
    c. How consistently has the client use methadone? Has the client missed doses sporadically? Routinely?
2. Amount of daily dose of methadone at time of transfer to BUP
    a. Most resources recommend that a client should be on 30 mg or less at time of transfer; however, there is not much research to support this number. Ideally, we would like a client to be at 30 mg or less for transfer to BUP. If a potential client goes to an OTP for services and want to transfer to BUP under our care, recommend that they taper down to 30 mg.
    b. Many people, however, cannot taper down to 30 mg prior to transfer to BUP. The following guideline has been developed for people on a daily dose of methadone at 50 mg or less. **Providers should contact ARCA leadership if clients have a higher daily dose than 50 mg—with the client's full assessment--so that treatment plans can be previewed for best client outcomes.**

3. Educate the client on the treatment plan
    a. The transfer works best when the client blood level of methadone is in the 30-50 mg dose. The half-life of methadone is 55 hours. For example
        i. If someone takes 60 mg and she stops methadone on Day 1, she will typically have a blood level around 30 mg on Day 3, and around 15 mg on Day 4
        ii. If some takes 100 mg daily and he stops methadone on Day 1, he will typically have a blood level around 50 mg on Day 3, 25 mg on Day 4, and 13 mg on Day 5.
        iii. Ideally, we would like a client to be at as low a dose of methadone as possible prior to transfer. This is because BUP has a ceiling opioid effect, and methadone does not. Since a patient is usually very uncomfortable coming off the methadone, we can initiate the BUP on the day that corresponds to the 30-50mg level.
    b. Prescribe the following medications for transfer to BUP
        i. Standard ARCA opioid comfort meds. The client should start these on the first day methadone is discontinued
    c. On the day Subutex is initiated
        i. Office inductions should be encouraged for all patients, but it should be strongly encouraged for all patient who were on 30 mg of methadone or more per day.
        ii. When starting medication, the client must be in active withdrawal. On a scale of 1-10 (10 most severe), the client's withdrawal symptoms should be at a 7-8. The patient should be on scheduled doses of comfort medications.
        iii. The patient starts by taking 1/4 of a film under the tongue. The client waits 15mins, and then takes another 1/4 of a film. The patient should add 2 mg of Subutex every 15 minutes until cravings are controlled and withdrawal symptoms subside.
        iv. Maximum dose of Subutex at Day #1: 16 mg
    d. For the next two days
        i. Provider or delegate should assess client for adequacy of dosing using a SOWS assessment.
        ii. Continue or increase this cumulative dose, up to 24 mg, once daily
        iii. Continue comfort meds as prescribed
        iv. Have patient follow up with ARCA prescribing provider and/or staff as indicated. Intensify monitoring for patients who had higher methadone doses, co-occurring disorders, fewer personal and social resources, and previous unsuccessful transfers.
    e. On Day #4, the client switches over to BUP/Ntx after an assessment.
        i. Discuss with the patient the level of BUP dosing—is it controlling cravings? Is it causing side effects, and requiring a reduction in dose?
    f. Day #5 and beyond, the client's care follows the ARCA BUP/Ntx guideline.

Responsible Benzodiazepine Prescribing

Adapted from SAMHSA-HRSA Center for Integrated Health Solutions, Safe & Effective Use of Benzodiazepines in Clinical Practice, May 31, 2017
https://www.integration.samhsa.gov/

1. Generally agreed upon indications in psychiatry
    a. Anxiety: acute and chronic (especially PD, GAD, SAD)
    b. Acute insomnia
    c. Acute agitation particularly in mania and psychosis
    d. Alcohol withdrawal
    e. Akathisia
    f. Catatonia
    g. Co-prescription during initiation phase of antidepressant in PD and GAD
    h. Tremor
2. Disputed indications in psychiatry
    a. Acute stress disorder
    b. Posttraumatic stress disorder
    c. Chronic insomnia
3. Relative Contraindications
    a. Patients 65 years and older
    b. Current substance use disorder
    c. History of substance use disorder
    d. Borderline Personality Disorder
    e. Co-prescription of opiate pain medications (especially methadone and BUP/Ntx)
    f. Clients with recent suicidal ideation and/or poor impulse control
4. Absolute Contraindications
    a. Active use of alcohol with unreliable reports about use and increasing requests for meds, unless benzodiazepines is a component of a prescribes alcohol withdrawal guideline
5. Documentation standards when prescribing benzodiazepines
    a. Documentation of a clear rational for indications, balance of indications and contraindications
    b. Indications for *short term use* of benzodiazepines should be documented, including a timeframe for review. Follow up is necessary and includes any indications of dependence or need for a discontinuation taper.
    c. Indications for *long term use* of benzodiazepines should be documented, including use of (or consideration of) alternative interventions. Stability of dosing should be noted along with any indications of dependence or need for a discontinuation taper.
    d. As needed/PRN dosing should be used judiciously.
    e. Recommendations for combined psychopharmacology treatment with psychosocial interventions to manage anxiety, distress tolerance, insomnia and drug seeking behavior. These include Motivational Interviewing, Cognitive Behavioral Strategies and Mindfulness techniques.
6. Prescribing guidelines
    a. For new patients reporting prior prescription treatment with benzodiazepines and requesting continuation

i. Obtain medical records from previous prescriber
ii. Check the PDMP's of the state in which the patient resides for flags or other concerns
iii. Inquire with pharmacy if they are flagged as inappropriately drug seeking
iv. Inquire with patient if they had been receiving benzodiazepines from more than one prescriber and/or telling him that more than one pharmacy in prior 12 months

b. For current patient requesting new start for benzodiazepines
   i. Inquire with patient if they had been receiving benzodiazepines from any other prescribers
   ii. Check the PDMP's of the state in which the patient resides for flags or other concerns
c. Safest and most effective utilization of benzodiazepines: Benzodiazepines are most effective and safe when used for limited time and or on an intermittent PRN basis. **When used as a standing daily dose indefinitely they will become ineffective for a substantial portion of patients.** Examples of clinically appropriate uses:
   i. Time-limited for acute situational anxiety such as death of a loved one. Instruct the patient only to use the benzodiazepine as an intermittent PRN basis and not as a standing daily dose. Instruct the patient that the medication will not be continued indefinitely and set a time in the future by which you expect the medication to be discontinued of no more than three months
   ii. Ongoing intermittent PRN usage. Intermittent PRN usage avoids development of tolerance and reinforces self-management of anxiety and worry. It is important to instruct patients that the medication is more effective if used intermittently and tends to become ineffective if taken as an ongoing daily dose. Example of this type of prescribing is clonazepam 0.5mg, #10/month
d. The following examples are first line treatments for anxiety. Joseph Parks, MD, who delivered the teleconference referenced here cautions, *I will not prescribe benzodiazepines for patients who have refused a trial of the usual recommended medications prior to taking benzodiazepines. I use the following medications prior to resorting to the benzodiazepines*
   i. High-dose SSRIs, e.g.,
      1. Prozac 40 to 60 mg
      2. Celexa 40 to 60 mg
   ii. Low dose propranolol (20-40mg twice daily) for blocking autonomic symptoms of anxiety such as sweating, palpitations, tremulous
   iii. Buspirone, with the target dose of 60 mg daily
   iv. Hydroxyzine, up to 100 mg three times daily
   v. Reduction/Elimination of caffeine
   vi. Increase of physical activity– "feeling anxious as a reminder that it's time to take a walk"

Resource: SAMHSA-HRSA Center for Integrated Health Solutions, https://www.integration.samhsa.gov/

Benzodiazepine Detoxification and Treatment

Resources from the Veterans Administration, Helping Patients Taper from Benzodiazepines
https://www.va.gov/painmanagement/docs/OSI_6_Toolkit_Taper_Benzodiazepines_Clinicians.pdf

Benzodiazepine Taper *Example*—moderate to high dose benzodiazepine

(emphasis of *slow* taper)

Week	Clonazepam Dose (in mg)	Clonazepam Frequency*	Clonidine (0.1 mg dose) *	Gabapentin (300 mg) * or Tegretol/carbamazepine (400 orally)
1	1	4x daily	1 2x daily	1 2x daily
2	1	4x daily	1 2x daily	1 2x daily
3	1	3x daily	1 2x daily	1 2x daily
4	1	3x daily	1 2x daily	1 2x daily
5	1	2x daily	1 2x daily	1 2x daily
6	1	2x daily	1 2x daily	1 2x daily
7	0.5	2x daily	1 2x daily	1 2x daily
8	0.5	2x daily	1 2x daily	1 2x daily
9	0.5	1 daily	1 2x daily	1 2x daily
10	0.5	1 daily as needed for anxiety	1 2x daily	1 2x daily
11	0	0	1 daily	1 daily
12	0	0	0	0

*Scheduled

Continue Baclofen or cyclobenzaprine as needed for muscular cramping for as long as needed

ARCA Clients Presenting with Reports of ADD/ADHD

A common presentation at ARCA is Adult ADD/ADHD. And this presentation often co-occurs with other behavior health issues and/or addictions. Many people with ADD/ADHD require medications for treatment. And, since many of the medications for ADD/ADHD are controlled and addictive, sustained use of these medications can be problematic for clients, families, and communities.

ARCA has a structured approach to diagnosing and treating ADD/ADHD

1. For an accurate diagnosis of ADD and ADHD in an adult, ARCA recommends the following:
    a. A history of the adult's behavior as a child
    b. An interview with the adult's life partner, parent, close friend, or other close associate
    c. A thorough physical exam that may include neurological testing
    d. Psychological testing
2. Other useful resources that the ARCA treatment team uses for confirming Adult ADHD include
    a. Medical records that report diagnosis and treatment
    b. Pharmacy records that indicate medication treatment
3. ARCA uses a validated screening test for ADD/ADHD, ARCA uses the ASRS. See Resource #1 below.
    a. At the initial visit
    b. To gauge treatment progress
    c. At least annually if treatment is chronic
4. Unless there are significant barriers due to patient finances, ARCA clients receive a trial with a non-stimulant/non-controlled medications. Examples include
    a. Atomoxetine (Strattera)
    b. Guanfacine (Intuniv)
    c. Clonidine (Kapvay)
    d. Wellbutrin (Buproprion)
5. If the patient's symptoms are not controlled, ARCA providers will consider prescribing stimulants—as monotherapy or combined with the medications above. Stimulants include
    a. Dexmethylphenidate (Focalin)
    b. Dextroamphetamine(Dexedrine)
    c. Amphetamine/Dextroamphetamine (Adderall, Adderall XR)
    d. Lisdexamfetamine (Vyvanse)
    e. Methylphenidate (Concerta, Daytrana, Metadate, Methylin, Ritalin, Quillivant XR)

Resources

1. Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist, https://add.org/wp-content/uploads/2015/03/adhd-questionnaire-ASRS111.pdf
2. SAMHSA ADD/ADHD, https://www.samhsa.gov/treatment/mental-disorders/adhd
3. ADHD Justice Support Center, http://adhdjustice.add.org/
4. ADHD in Adults, https://www.webmd. /add-adhd/guide/adhd-adults#3
5. Diagnosing ADHD in Adults, https://www. com webmd.com/add-adhd/guide/diagnosing-adhd#2-3

Medications to Consider for Methamphetamine Use Disorder

Since there are no FDA-approved medications for treatment of amphetamine use disorder, we have limited options for treatment. And much of the buzz on the street is simply that buzz and anecdotes.

Two therapies that show promise in short term are cognitive behavioral therapy (CBT) and contingency management (CM).
A link to a systematic review and meta-analysis of the topic:
https://www.ncbi.nlm.nih.gov/pubmed/31328345

No medications have had terrific results when prescribed off label.
But the most promising approach from the article above have included naltrexone, bupropion, topiramate, and stimulants.

- Anecdotal approaches usually emphasize dual therapy—usually oral naltrexone and bupropion, at typical doses
- Topiramate is not on the DMH formulary, but it is on other formularies.
- And, of course, prescribing stimulants to treat AMP use disorder is problematic.

So, what can you do as a provider?

1. Considering screening anyone with this history with the Adult ADHD screen. https://add.org/wp-content/uploads/2015/03/adhd-questionnaire-ASRS111.pdf Treat results as appropriate.
2. Check with the patient to see if he/she is interested in CBT. Direct admit SOR patients have access to ARCA therapists.
3. Consider treatment with non-FDA approved medications, after consideration of co-occurring conditions and drug-drug interactions—as usual. If you decide to prescribe, make sure the patient understands risks/benefits of taking a medication that is not approved by the FDA. Be sure to document this in the note. I'd recommend starting with a naltrexone and bupropion combination unless there are any contraindications.
4. Utilize peers for telephone follow-up and documentation of outcomes—in addition to typical follow-ups. We need to track what works for our patient population.

Guidelines for Treatment of Nicotine Use Disorder

Use the tools in the appendix to assess patient's readiness to change regarding alcohol use. These tools also include motivational language to help the patient move forward in behavioral change. They also include instructions to help patient prepare for quit date and engage in positive change.

Bupropion (Zyban®, Wellbutrin®)
Dose: 150 mg QD x 3 days, then BID for 2-3 months. Some patients may require longer maintenance therapy for up to 6 months. Quit date is set for within the first 1-2 weeks of therapy.
*Dose should not exceed 300 mg QD due to a dose-dependent increased risk of seizure
*Dosing frequency must be reduced in hepatic impairment and renal impairment. There are no exact recommendations for this dosing reduction; clinical judgment will be used. In severe hepatic cirrhosis, the dose should be 150 mg QOD.

Administration: Twice daily dosing should be taken 12 hours apart, but if insomnia occurs, the doses may be taken 8 hours apart. Dose may be decreased to 150 mg QD if side effects occur. If patient has made no progress after 7 weeks, may consider discontinuing therapy.

Contraindications: Bupropion will not be used in patients with seizure disorders, a history of or a current diagnosis of anorexia or bulimia, or with concomitant MAOIs.

Other concerns: If patient is currently pregnant, treatment will be discussed with the referring physician before beginning therapy. Check for drug interactions

Varenicline (Chantix)
Dose: 0.5mg PO once daily for three days, then 0.5mg PO BID for four days, then increase to 1mg PO BID

Administration: Take by mouth with water. Begin one week before quit date. Continue for 12 to 24 weeks.

Contraindications: None known

Other Concerns: Pregnancy Category C. Potential for serious neuropsychiatric symptoms, observe for changes in behavior and/or suicidal ideation.

Side effects: Nausea, sleep disturbance, constipation, vomiting.

Guidelines for Treatment of Nicotine Use Disorder (Continued)

Nicotine Patch

Doses:

NicoDerm CQ (24 hours) OTC 21 mg (4 wk), 14 mg (2 wk), 7 mg (2 wk)
Nicotrol (16 hr) OTC 15 mg (8 wk)
Habitrol (24 hr) Rx: 21 (4 wk), 14 mg (2 wk), 7 mg (2 wk)
ProStep (24 hr) OTC 22 mg (4 wk), 11 mg (4 wk)

**Different or longer regimens may be used, depending on patient specific issues and based on clinical judgment

**Patient's starting patch dose will be correlated as best as possible to their current cigarette intake; one cigarette = 1mg nicotine. The max dose of patches proven to be safe and effective is 44 mg.
If current smoking is <15 CPD, may consider starting with 14 mg patches
If current smoking is >30 CPD, may consider starting with a higher dose of nicotine patches.[2, 3]

Administration: Apply patch to hairless area between neck and waist, rotating sites. If vivid dreams occur with the 24-hour patch, this effect may be less with the 16 hour patch.

Contraindications: Smoking while on the patch; immediately post-MI (within 2 weeks), serious arrhythmias, or serious or worsening angina

Other concerns: If patient is currently pregnant or has severe vascular disease, treatment will be discussed with the referring physician before beginning therapy.

Side Effects: skin irritation, vivid dreams, insomnia, GI complaints[1]

Nicotine gum (Nicorette – OTC)

Dose: 30 2 mg pieces/day (max) or 20 4 mg pieces/day (max). Patients with high nicotine dependence (previous severe withdrawal symptoms, smoking >1 PPD, or smoking first cigarette within 30 minutes of waking) or those smoking >25 CPD should be advised to use 4 mg gum.

Administration: Chew until peppery taste or "tingling" is felt, then "park" the gum between gum and cheek until sensation is gone (usually 1-3 minutes). Rechew every few minutes and "park" again. Chew each piece for 30 minutes, with 1 piece every 1-2 hours. Do not eat or drink anything except water 15 minutes before or during chewing. Taper dose slowly. Not to be used for more than 6 months. Also may be useful for prn use only, especially in combination with other agents.

Contraindications: immediately post-MI (within 2 weeks), serious arrhythmias, or serious or worsening angina

Key Points of Patient Education for Buprenorphine

Before starting OUD treatment with buprenorphine, clients should:

• Tell providers the prescribed and over-the-counter medications they take, to allow drug interaction assessment.

• Understand the goal of the first week of treatment: To improve withdrawal symptoms without over-sedation.

• Tell providers if they feel sedated or euphoric within 1 to 4 hours after their dose.

• Be given the appropriate buprenorphine medication guide.

• Know possible side effects, including:

- Headache.
- Dizziness.
- Nausea.
- Vomiting.
- Sweating.
- Constipation.
- Sexual dysfunction.

• Agree to store medication securely and out of the reach of others.

• Alert providers if they discontinue medications, start new ones, or change their medication dose.

• Understand that discontinuing buprenorphine increases risk of overdose death upon return to illicit opioid use.

• Know that use of alcohol or benzodiazepines with buprenorphine increases the risk of overdose and death.

• Understand the importance of informing providers if they become pregnant.

• Tell providers if they are having a procedure that may require pain medication.

• Be aware of resources through which to obtain further education for:

- Themselves (https://store.samhsa.gov/product/SMA16-4993).

- Their families and friends (http://www.ct.gov/dmhas/lib/dmhas/publications/MAT-InfofamilyFriends.pdf).

Key Points of Patient Education for Naltrexone

• Do not use any opioids in the 7 to 10 days (for short acting) or 10 to 14 days (for long acting) before starting XR-NTX, to avoid potentially serious opioid withdrawal symptoms. Opioids include:

- Heroin, fentanyl, carfentanil
- Prescription opioid analgesics, such as oxycodone, oxycontin, hydrocodone (including tramadol)
- Cough, diarrhea, or other medications that contain codeine or other opioids
- Methadone
- Buprenorphine

• Seek immediate medical help if symptoms of allergic reaction or anaphylaxis occur, such as:

- Itching
- Swelling
- Hives
- Shortness of breath
- Throat tightness

• Do not try to override the opioid blockade with large amounts of opioids

• Understand the risk of overdose from using opioids near the time of the next injection, after missing a dose, or after stopping medications.

• Report rare injection site reactions including:

- Pain
- Skin hardening
- Lumps
- Blisters
- Blackening and/or bruising
- Scabs
- An open wound

Some of these reactions could require surgery to repair (rarely).

• Report signs and symptoms of hepatitis

• Report depression or suicidal thoughts. Seek immediate medical attention if these symptoms develop

• Seek medical help if symptoms of pneumonia appear (e.g., shortness of breath, fever).

• Tell providers of naltrexone treatment, as treatment differs for various types of pneumonia.

• Inform all healthcare professionals of XR-NTX treatment.

• Report pregnancy.

• Inform providers of any upcoming medical procedures that may require pain medication.

• Understand that taking naltrexone may result in difficulty achieving adequate pain control if acute medical illness or trauma causes severe acute pain.

• Wear medical alert jewelry and carry a medical alert card indicating you are taking XR-NTX. A client wallet card or medical alert bracelet can be ordered at 1-800-848-4876.

ARCA Patient-Practice Medication Agreement

I agree to accept the following treatment agreement for medications prescribed to me by an ARCA provider:

1. I understand that I will ask my healthcare provider or an ARCA nurse if I have medication questions or concerns.

2. I understand that I will ask my healthcare provider or an ARCA nurse if I have medication questions or concerned about the risks and benefits of other treatment for opioid use disorder (including methadone, naltrexone, and nonmedication treatments).

3. I will keep my medication in a safe, secure place away from children (for example, in a lockbox). My plan is to store it [describe where and how] _____.

4. I will take the medication exactly as my healthcare provider prescribes. If I want to change my medication dose, I will speak with my healthcare provider first. Taking more medication than my healthcare provider prescribes or taking it more than once daily as my healthcare provider prescribes is medication misuse and may result in supervised dosing at the clinic. Taking the medication by snorting or by injection is also medication misuse and may result in supervised dosing at the clinic, referral to a higher level of care, or change in medication based on my healthcare provider's evaluation.

5. I will be on time to my appointments and respectful to the office staff and other clients.

6. I will keep my healthcare provider informed of all my medications (including over-the-counter medications, herbs, and vitamins) and medical problems.

7. If I am taking buprenorphine, I agree not to obtain or take prescription opioid medications prescribed by any other healthcare provider without consulting my buprenorphine prescriber.

8. If I am going to have a medical procedure that will cause pain, I will let my healthcare provider know in advance so that my pain will be adequately treated.

9. If I miss an appointment or lose my medication, I understand that I may not get more medication until my next office visit. I may also have to start having supervised buprenorphine dosing.

10. If I come to the office intoxicated, I understand that my healthcare provider may not see me, and I may not receive more medication until the next office visit.

11. I understand that it's illegal to give away or sell my medication; this is diversion. If I do this, my treatment may require referral to a higher level of care, supervised dosing at the clinic, and/or a change in medication based on my healthcare provider's evaluation.

12. Violence, threatening language or behavior, or participation in any illegal activity at the office will result in treatment termination from the clinic.

13. I understand that random urine drug testing is a treatment requirement. If I do not provide a urine sample, it will count as a positive drug test.

14. I understand that I will be called at random times to bring my medication container into the office for a pill or film count. Missing medication doses could result in supervised dosing or referral to a higher level of care at this clinic and/or potentially at another treatment provider based on my individual needs.

15. If I am receiving **buprenorphine** as treatment,

a. I understand that I will ask my healthcare provider or an ARCA nurse if I have questions or concerned about buprenorphine and other medications.
b. I understand that initially I will have weekly office visits until I am stable. I will get a prescription for 7 days of medication at each visit.
c. I can be seen every 2 weeks in the office starting the second month of treatment if I have negative urine drug tests. I will then get a prescription for 14 days of medication at each visit.
d. I will go back to weekly visits if I have a positive drug test. I can go back to visits every 2 weeks when I have two negative drug tests in a row again.
e. I may be seen less than every 2 weeks based on goals made by my healthcare provider and me.
f. I understand that people have died by mixing buprenorphine with alcohol and other drugs like benzodiazepines (drugs like Valium, Klonopin, and Xanax).
g. I understand that treatment of opioid use disorder involves more than just taking medication. I agree to comply with my healthcare provider's recommendations for additional counseling and/or for help with other problems.
h. I understand that there is no fixed time for being on buprenorphine and that the goal of treatment is for me to stop using all illicit drugs and become successful in all aspects of my life.
i. I understand that I may experience opioid withdrawal symptoms when I stop taking buprenorphine.
j. I have been educated about the increased chance of pregnancy when stopping illicit opioid use and starting buprenorphine treatment and been informed about methods for preventing pregnancy.
k. I understand that my medication must be protected from theft or unauthorized use. I understand that BUP/Ntx must be stored safely, and securely where it cannot be taken accidentally by children, pets, or be stolen. If my medications are stolen, I will file a report with the police and bring a copy to my next visit. If another person ingests my BUP/Ntx, I will immediately call 911 or Poison Control at 1-800-222-1222. I agree to take full responsibility for the safekeeping of my buprenorphine. Lost or stolen buprenorphine will not be refilled before the date it was due to be renewed unless I can give the clinic a copy of the police report of the loss. I understand my provider reserves the right to refuse refills. I also understand that if more that if my medications are reported lost or stolen more than twice, I may be dismissed from the buprenorphine maintenance clinic and I may not be given any refills for my medication.

16. If I am receiving **Vivitrol** as treatment,
    a. I understand that I will ask my healthcare provider or an ARCA nurse if I have questions or concerned about buprenorphine and other medications.
    b. I understand that there is no fixed time for being on naltrexone and that the goal of treatment is for me to stop using all illicit drugs and become successful in all aspects of my life.
    c. I understand that my risk of overdose increases if I go back to using opioids after stopping naltrexone.
    d. I have been educated about the increased chance of pregnancy when stopping illicit opioid use and starting naltrexone treatment and have been informed about methods for preventing pregnancy.
    e. I have been informed that if I become pregnant during naltrexone treatment, I should inform my provider and discuss the risks and benefits of continuing to take naltrexone.
    f. I am aware of the following guideline if I am do not show up for a schedule appointment for a Vivitrol injection, ARCA staff will call me and remind me of the appointment. If I am cannot be contacted and I do not show up at ARCA within 32 days following my last injection, ARCA staff will my first contact (family member or friend). If I do not respond to ARCA with 24 hours of that call, ARCA will call my emergency contact.

17. I agree that a network of support is an important part of my recovery, and honest communication among people within the network is important for my treatment. I will provide authorization to allow telephone, email, or face-to-face contact, between the clinic staff and providers, therapists, peer specialists, probation or parole officers, the Department of Social Services, and parents to discuss my treatment and progress. I consent to allow the staff of the MAT clinic to provide others with information regarding my medication usage as needed for my treatment or as otherwise permitted or required by law.

18. If I miss an appointment or if I need to reschedule an appointment for a later date, I understand that my medications may not be refilled until the time of my next scheduled appointment with a buprenorphine provider. I understand that if I miss, or am late to, three appointments and did not call the clinic in advance, and provide at least 24hr notice, I may be dismissed from the buprenorphine maintenance clinic and I may not be given any refills for my medication. I may also be given a lower dose, enough to sustain and avoid withdrawal.

19. Other specific items unique to my treatment include:

Patient's Name (print) and cell #: _____

Patient's Signature: _____ Date: _____

My first contact (family member or friend) and cell #: _____

My second (emergency) contact (if on Vivitrol) and cell #: _____

Witness: _____

This form is adapted from the American Society of Addiction Medicine's *Sample Treatment Agreement*

Client-Provider Continuity at ARCA

Client continuity with a treatment team is a necessary component of safe, effective care. However, prescribing provider continuity is not always possible with ARCA providers due to

- ARCA's provision of same day/next day services to new clients
- ARCA's commitment to flexibility in provision of urgent telehealth services to partnering agencies

In order to promote continuity in client services, ARCA is developing policies and procedures for the following situations:

1. **Missed appointments:** If a patient misses an appointment and is at risk of running out of medications—but is otherwise stable, contact your ARCA RN so that the RN can request an adequate refill until the client can be scheduled with his/her continuity provider. If the provider is not readily available, the RN can contact the ARCA Medical Director. If the missed appointments become habitual, contact your ARCA supervisor for discussion.
2. **Managing client requests to change prescribing providers**: Occasionally a client may request to change prescribing providers. When a client makes this request,
    a. Inquire and document the reason in the medical record
    b. Inform the client that due to safety, efficacy, and continuity concerns, a client can change an ARCA continuity provider only after six months after initiation of treatment—unless the change is approved by ARCA's Medical Director.
    c. Share the request verbally with your ARCA RN, so that the RN can evaluate the request, and, if necessary, discuss with the ARCA Medical Director.

ARCA Clients Participating in Treatment Courts

Treatment courts (aka, Drug Courts and/or Mental Health Courts) have grown in popularity in recent decades and have generally shown positive results for client involved—see references below.

Treatment courts, however, have been somewhat uneven in their acceptance of medication use among their clients. Some still do not accept any medications, while other judges support use of all evidence-based treatments. While ARCA advocates for all evidence-based treatments, ARCA also realizes that our community partners must work with treatment courts in ways that are realistic and beneficial for all stakeholders. In this spirit, ARCA promotes the following practices and behaviors:

1. Know the collaborating agency's treatment court contact
    a. Is the agency the treating agency for clients in the drug-related court, the mental health-related court, or both?
    b. What is the history and the culture of the treatment court?
    c. How are prescription medications viewed? Opioid agonists? Opioid antagonists? Other controlled substances? Other medications?
    d. What are typical practices on duration of treatment/program? Duration of medication coverage?
    e. How is psychotherapy integrated? Individual therapy? Group therapy? Family therapy?
    f. What happens when a client "graduates" from the treatment court?
    g. What is the best way to communicate? Routinely? Urgently?
2. Minimize prescription of controlled medications.
    a. Trial use of non-controlled medications before utilization of controlled medications. (See ARCA medication guidelines for treatment of anxiety disorders and responsible benzodiazepine prescribing).
    b. If benzodiazepines are prescribed for stabilization or on as needed basis, clearly document this in the encounter. Utilize the GAD-7 (or similar appropriate tool) to monitor treatment progress, https://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf
    c. When buprenorphine (BUP)—and other controlled substances--are prescribed, prescribing providers and RN's collaborate with agency treatment court contacts on defining best fill and refill practices for their program.

Resources

1. Do Drug Courts Work? Findings from Drug Court Research, https://www.nij.gov/topics/courts/drug-courts/Pages/work.aspx
2. The First 20 Years of Drug Treatment Courts: A Brief Description of Their History and Impact, http://www.uscourts.gov/sites/default/files/72_1_2_0.pdf
3. Adult Drug Courts and Medication-Assisted Treatment for Opioid Dependence, https://store.samhsa.gov/system/files/sma14-4852.pdf
4. ADHD Justice Support Center, http://adhdjustice.add.org/

ARCA Policy on Lost and Reported Stolen Medications

The following policy is part of the Buprenorphine Treatment Agreement; however, it applies to all controlled substances:

I understand that my medication must be protected from theft or unauthorized use. I understand that BUP/Ntx must be stored safely, and securely where it cannot be taken accidentally by children, pets, or be stolen. If my medications are stolen, I will file a report with the police and bring a copy to my next visit. If another person ingests my BUP/Ntx, I will immediately call 911 or Poison Control at 1-800-222-1222. I agree to take full responsibility for the safekeeping of my buprenorphine. Lost or stolen buprenorphine will not be refilled before the date it was due to be renewed unless I can give the clinic a copy of the police report of the loss. I understand my provider reserves the right to refuse refills. I also understand that if more that if my medications are reported lost or stolen more than twice, I may be dismissed from the buprenorphine maintenance clinic and I may not be given any refills for my medication.

If a patient reports a second prescription lost or stolen, more than twice, the ARCA RN engaged in the patient's care calls the Medical Director (or his/her designate) to report the event using the SBAR technique:

Situation (Why are you calling?)
Background (What are the facts around the patient situation?)

Assessment (What do you think is going on with the patient that has created this event?)

Recommendation (What do you think we should do in this situation? This serves as the start of the conversation).

ARCA Policy on Missed Appointments

The following policy is part of the Buprenorphine Treatment Agreement; however, it applies to all patient appointments:

If I miss an appointment or if I need to reschedule an appointment for a later date, I understand that my medications may not be refilled until the time of my next scheduled appointment with a buprenorphine provider. I understand that if I miss, or am late to, three appointments and did not call the clinic in advance, and provide at least 24hr notice, I may be dismissed from the buprenorphine maintenance clinic and I may not be given any refills for my medication. I may also be given a lower dose, enough to sustain and avoid withdrawal.

If a patient misses a third consecutive appointment, the ARCA RN engaged in the patient's care calls the Medical Director (or his/her designate) to report the event using the SBAR technique:

Situation (Why are you calling?)
Background (What are the facts around the patient situation?)

Assessment (What do you think is going on with the patient that has created this event?)

Recommendation (What do you think we should do in this situation? This serves as the start of the conversation)

Appendix A

Naloxone Patient Information

Narcan nasal spray

Missouri Opioid State Targeted Response

UMSL MIMH

What is naloxone?

Naloxone is a medication that quickly reverses the effects of an opioid overdose, usually within 1-3 minutes. Naloxone only works to reverse an overdose when someone has taken an opioid, and when given, it will restore breathing and prevent death.

Risk Factors for Overdose

- Previous overdose
- Physical illness/respiratory disease (flu, pneumonia, broncitis)
- Period of abstinence (e.g., following rehab or jail)
  * Tolerance decreases in as little as 3-5 days
- Change in strength, amount, supplier of the opioid, or location of use
- Using opioids with benzos, sedatives, alcohol
- Injecting or using alone

Signs of an Opioid Overdose

- Not responsive
- Shallow breathing/no breathing
- Small "pinpoint pupils"
- Cold, clammy skin
- Gurgling/snoring
- Blue or gray lips and nails

Opioid Overdose Response

1. Identify signs of opioid overdose and check for response and breathing
2. Lay person on back and give Narcan nasal spray

Narcan nasal spray instructions

- PEEL back the package to remove the device
- PLACE the tip of the nozzle in either nostril until your fingers touch the bottom of the person's nose
- PRESS the plunger firmly to release the dose into the person's nose

3. Call 911 (if you must leave the person, turn the person on their side in the recovery position)
4. Administer rescue breaths (1 breath every 5 seconds)
5. Repeat step 2 with new Narcan nasal device if no response in 2-3 minutes
6. Stay with the person until medical help arrives to ensure safety and prevent repeated use/overdose
7. Complete Overdose Field Report
   MOHOPEPROJECT.ORG/ODREPORT

Naloxone access at a pharmacy:
Naloxone is available with or without a prescription in most pharmacies. People at risk or those that know others at risk of opioid overdose are eligible to purchase naloxone. Ask the pharmacist for more information.

A limited supply of naloxone is available for free at NCADA (M-F from 9AM to 5PM)

9355 Olive Boulevard
St,Louis, MO 63132
314-962-3456

3033 Highway A, Ste 102
Washington, MO 63090
636-239-7652

ncada-stl.org

Naloxone is available for free at Missouri Network for Opiate Reform and Recovery (available upon request)

4022 S. Broadway
St. Louis, MO 63118
844- Rebel Up (844-732-3587)
monetwork.org

MissouriOpioidSTR.org/Prevention

naabt.org • naabt.org • naabt.org • naabt.org • naabt.org • naabt.org • naabt.org • naabt.org •

Clinical Opiate Withdrawal Scale (COWS)

Flowsheet for measuring symptoms over a period of time during buprenorphine induction.

For each item, write in the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal.
For example: If heart rate is increased because the patient was jogging just prior to assessment, the increased pulse rate would not add to the score.

Patient Name: _____ Date: _____

Buprenorphine Induction: _____

Enter scores at time zero, 30 minutes after first dose, 2 hours after first dose, etc.	Times of Observation:			
Resting Pulse Rate: Record Beats per Minute Measured after patient is sitting or lying for one minute 0 = pulse rate 80 or below 1 = pulse rate 81-100 • 2 = pulse rate 101-120 • 4 = pulse rate greater than 120				
Sweating: Over Past 1/2 Hour not Accounted for by Room Temperature or Patient Activity 0 = no report of chills or flushing 1 = subjective report of chills or flushing 2 = flushed or observable moistness on face • 3 = beads of sweat on brow or face • 4 = sweat streaming off face				
Restlessness Observation During Assessment 0 = able to sit still 1 = reports difficulty sitting still, but is able to do so • 3 = frequent shifting or extraneous movements of legs/arms • 5 = Unable to sit still for more than a few seconds				
Pupil Size 0 = pupils pinned or normal size for room light 1 = pupils possibly larger than normal for room light • 2 = pupils moderately dilated • 5 = pupils so dilated that only the rim of the iris is visible				
Bone or Joint Aches if Patient was Having Pain Previously, only the Additional Component Attributed to Opiate Withdrawal is Scored 0 = not present 1 = mild diffuse discomfort • 2 = patient reports severe diffuse aching of joints/muscles • 4 = patient is rubbing joints or muscles and is unable to sit still because of discomfort				
Runny Nose or Tearing Not Accounted for by Cold Symptoms or Allergies 0 = not present 1 = nasal stuffiness or unusually moist eyes • 2 = nose running or tearing • 4 = nose constantly running or tears streaming down cheeks				
GI Upset: Over Last 1/2 Hour 0 = no GI symptoms 1 = stomach cramps 2 = nausea or loose stool • 3 = vomiting or diarrhea • 5 = multiple episodes of diarrhea or vomiting				
Tremor Observation of Outstretched Hands 0 = no tremor 1 = tremor can be felt, but not observed • 2 = slight tremor observable • 4 = gross tremor or muscle twitching				
Yawning Observation During Assessment 0 = no yawning 1 = yawning once or twice during assessment • 2 = yawning three or more times during assessment • 4 = yawning several times/minute				
Anxiety or Irritability 0 = none 1 = patient reports increasing irritability or anxiousness • 2 = patient obviously irritable/anxious • 4 = patient so irritable or anxious that participation in the assessment is difficult				
Gooseflesh Skin 0 = skin is smooth 3 = piloerection of skin can be felt or hairs standing up on arms • 5 = prominent piloerection				
Score: 5-12 = Mild 13-24 = Moderate 25-36 = Moderately Severe More than 36 = Severe Withdrawal	Total score			
	Observer's Initials			

The National Alliance of Advocates for Buprenorphine Treatment
PO Box 333 • Farmington, CT 06034 • MakeContact@naabt.org
naabt.org

*Source: Wesson et al. 1999.

5M 11/11

Appendix C: SOWS (Subjective Opioid Withdrawal Scale)

Instructions: We want to know how you're feeling. In the column below today's date and time, use the scale to write in a number from 0-4 about how you feel about each symptom right now.

Scale: **0 = not at all 1 = a little 2 = moderately 3 = quite a bit 4 = extremely**

DATE		
TIME		
SYMPTOM		**SCORE**
1	I feel anxious	
2	I feel like yawning	
3	I am perspiring	
4	My eyes are tearing	
5	My nose is running	
6	I have goosebumps	
7	I am shaking	
8	I have hot flushes	
9	I have cold flushes	
10	My bones and muscles ache	
11	I feel restless	
12	I feel nauseous	
13	I feel like vomiting	
14	My muscles twitch	
15	I have stomach cramps	
16	I feel like using now	
TOTAL		

Addiction Research Foundation

Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA – Ar)

Patient: _____ Pulse or heart rate, take for 1 minute: _____

Date: _____ Time: _____ Blood Pressure: _____

Anxiety: Ask, "Do you feel nervous?" Observation: 0 No anxiety, at ease 1 Mildly anxious 2 3 4 Moderately anxious, or guarded, so anxiety is inferred 5 6 7 Equivalent to acute panic states, as seen in severe delirium or acute schizophrenic reactions	**Headache, Fullness in Head:** Ask, "Does your head feel different? Does it feel like there is a band around your head?" Do not rate dizziness or lightheadedness. Otherwise, rate severity. 0 Not present 1 Very mild 2 Mild 3 Moderate 4 Moderately severe 5 Severe 6 Very severe 7 Extremely severe
Agitation: Observation 0 Normal activity 1 Somewhat more than normal activity 2 3 4 Moderately fidgety and restless 5 6 7 Paces back and forth during most of the interview, or constantly thrashes about	**Orientation and Clouding of Sensorium:** Ask, "What day is this? Where are you? Who am I?" Observation: 0 Oriented and can do serial additions 1 Cannot do serial additions or is uncertain about date 2 Disoriented for date by no more than 2 calendar days 3 Disoriented for date by more than 2 calendar days 4 Disoriented for place and/or person

Total **CIWA – Ar** Score _____
(maximum possible score = 67)

Rater's Initials _____

Patients scoring less than 10 do not usually need additional medication for withdrawal.

Note: The CIWA – Ar is not copyrighted and may be used freely. Source: Sullivan JT, Sykora K, Schneiderman J, Naranjo CA & Sellers EM (1989) Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA – Ar) British *Journal of Addiction 84:1353 – 1357*

ASAM Patient Placement Criteria, Second Edition - Revised

Prediction of Alcohol Withdrawal Severity Scale (PAWSS)

Maldonado et al, 2015

Part A: Threshold Criteria:

("Y" or "N", no point)

Have you consumed any amount of alcohol (i.e., been drinking) within the last 30 days? OR did the patient have a "+" BAL on admission? _____

IF the answer to either is YES, proceed with test:

Part B: Based on patient interview:

(1 point each)

1. Have you been recently intoxicated/drunk, within the last 30 days? _____
2. Have you ever undergone alcohol use disorder rehabilitation treatment or treatment for alcoholism? (i.e., in-patient or out-patient treatment programs or AA attendance) _____
3. Have you ever experienced any previous episodes of alcohol withdrawal, regardless of severity? _____
4. Have you ever experienced blackouts? _____
5. Have you ever experienced alcohol withdrawal seizures? _____
6. Have you ever experienced delirium tremens or DT's? _____
7. Have you combined alcohol with other "downers" like benzodiazepines or barbiturates, during the last 90 days? _____
8. Have you combined alcohol with any other substance of abuse, during the last 90 days? _____

Part C: Based on clinical evidence:

(1 point each)

9. Was the patient's blood alcohol level (BAL) on presentation ≥ 200? _____
10. Is there evidence of increased autonomic activity? (e.g., HR > 120 bpm, tremor, sweating, agitation, nausea) _____

Total Score: _____

Notes: Maximum score = 10. This instrument is intended as a SCREENING TOOL. The greater the number of positive findings, the higher the risk for the development of AWS.
A score of ≥ 4 suggests HIGH RISK for moderate to severe (complicated) AWS; prophylaxis and/or treatment may be indicated.

PAWSS, https://medicine.med.ubc.ca/files/2015/06/Alcohol-2015.pdf

Appendix F

Assessing patient's readiness to change tobacco use

Getting a better understanding of your smoking:

How much do you smoke? _____
How long have you smoked? _____
Have you tried to quit before? How many times? _____
What methods did you use? Which helped? _____
Have you been successful? For how long? _____
Why did you relapse in the past? _____
What is different this time? _____
Why do you smoke? _____
What scares you about quitting? _____
Why do you want to quit? (Motivators for quitting)
1) _____
2) _____
3) _____
4) _____
How badly do you want to stop smoking? _____
Do you think you can successfully stop smoking with our help? _____

TRIGGERS FOR SMOKING:

_____
_____

Assessing nicotine dependence: Fagerstrom score

Points to assign	**0**	**1**	**2**	**3**
How soon after you wake do you smoke your first cigarette?	>1 hr	½ - 1 hr	6-30 min	<5 min
Do you find it difficult to refrain from smoking in places where it is forbidden?	No	Yes		
Which cigarette would you hate to give up the most?	Any other	1st one in the AM		
How many cigarettes/day do you smoke?	<10	11-20	21-30	>31
Do you smoke the most in the morning?	No	Yes		
If you are so ill that you are in bed most of the day, do you still smoke?	No	Yes		

Total score of 0-5: LOW to MODERATE nicotine dependence **SCORE:**
Total score of 6-10: HIGH nicotine dependence

Addendum G

QUIT DATE: _____

Getting ready for the quit date!

- *Tell friends about quitting and quit date*
- *Identify support system*
- *Mark calendar*
- *Post signs of why you want to quit around your house/apartment*
- *Start to cut down on cigarettes (very slowly)*
- *Change brands*
- *Different hand / side of mouth*
- *Rate how much you really need each cigarette (1-10; if 5 or less, put it away)*
- *Different room; only smoke outside or in garage*
- *Change routine*

Day before quit date

- *Clean and "freshen" house and car*
- *Do laundry; take coats to dry cleaner*
- *Throw away cigarettes, ashtrays, lighters, matches (outside of home)*
- *Make sure you have plenty of gum, candy, mints, toothpicks, straws, etc.*

On quit date

- *Keep busy; plan activities*
- *Stay away from favorite chair, room*
- *Eat meals in different room*
- *Stay in nonsmoking areas*

Rewards

- Reward yourself for not smoking:
- On quit date, each month, 1 year, then every year
- Buy something special, take time for yourself
- Open up new account; deposit $$ normally spent on smoking
- At the end of 1 year of not smoking; do something really nice!

Enforce total abstinence

1) This is a lifetime commitment
2) Can't even have "just one puff"!!
3) If you slip just once, renew your commitment and remember, this time you CAN stay off cigarettes

Addendum H Sample model for buprenorphine induction in a residential program

1. Initiate comfort meds as soon as patient is admitted
    a. Administer comfort meds per guideline—upon admission and at each medication pass
    b. Promote hydration—frequent sips of water and other non-caffeinated fluids
2. Provide the patient a SOWS assessment sheet and instruct the patient to take the SOWS assessment immediately and at every 1-2 hours until the patient has a score of about 15. The patient will report the SOWS score to the nurse or med tech at each medication pass.
3. When the SOWS score is about 15 or more, initiate BUP induction at the next medication pass
    a. When BUP is prescribed at 8 mg or less
        i. Provide the max dose to the patient at the first possible med pass, with the strip cut in quarters.
        ii. Instruct the patient to take the quarter strips as needed at 15-minute intervals
        iii. Instruct the patient to complete the SOWS assessment 1-2 hours after ingestion of the full dose
    b. When BUP is prescribed greater than 8 mg
        i. Provide one 8 mg dose to the patient at the first possible med pass, with the strip cut in quarters.
        ii. Instruct the patient to take the quarter strips as needed at 15-minute intervals
        iii. Instruct the patient to complete the SOWS assessment 1-2 hours after ingestion of the full dose
        iv. When the total dose is 12 mg
            1. Provide one 4 mg dose to the patient at the second possible med pass, with the strip cut in quarters.
            2. Instruct the patient to take the quarter strips as needed at 15-minute intervals
            3. Instruct the patient to complete the SOWS assessment 1-2 hours after ingestion of the full dose
        v. When the total dose is 16 mg
            1. Provide one 8 mg dose to the patient at the second possible med pass, with the strip cut in quarters.
            2. Instruct the patient to take the quarter strips as needed at 15-minute intervals
            3. Instruct the patient to complete the SOWS assessment 1-2 hours after ingestion of the full dose
        vi. When the total dose is greater than 16 mg
            1. Provide the remainder of the dose—up to 8mg-- to the patient at the third possible med pass, with the strip cut in quarters.
            2. Instruct the patient to take the quarter strips as needed at 15-minute intervals
            3. Instruct the patient to complete the SOWS assessment 1-2 hours after ingestion of the full dose

APPROVED MEDICATIONS LIST: (PROCEDURE CODE 99199)

All CSTAR, Primary Recovery Plus (PR+), DOC and SROP Programs

SUBSTANCE USE DEPENDENCE MEDICATIONS:

acamprosate (Campral)
buprenorphine/naloxone products (Zubsolv; Suboxone; Buavail)
buprenorphine products (without naloxone: Subutex; Probuphine)
disulfiram (Antabuse)
naltrexone (oral)
Probuphine (buprenorphine implant)
Vivitrol (bill as 99199 with modifier HK)

ANTIDEPRESSANTS:

amitriptyline (Elavil)
bupropion (Wellbutrin, Zyban)
citalopram (Celexa)
doxepin (Sinequan)
duloxetine (Cymbalta)
escitalopram oxalate (Lexapro)
fluoxetine (Prozac)
fluvoxamine maleate (Luvox)
imipramine (Tofranil)
mirtazapine (Remeron)
nortriptyline (Pamelor)
paroxetine (Paxil)
sertraline (Zoloft)
trazodone (Desyrel)
venlafaxine (Effexor)

ANTI-PSYCHOTICS:

haloperidol (Haldol)
olanzapine (Zyprexa)
risperidone (Risperdal)
quetiapine (Seroquel)
chlorpromazine (Thorazine)
loxapine (Loxitane)

MOOD STABILIZERS:

divalproex(Depakote)
lithium (Eskalith, Lithobid)

TOBACCO DEPENDENCE:

bupropion SR (Wellbutrin SR)
Nicotine gum
Nicotine inhaler
Nicotine lozenge
Nicotine nasal spray
Nicotine patch
varenicline (Chantix)

OTHER Classifications:

atomoxetine hydrochloride (Strattera)
amantadine (Symmetrel)
baclofen (Lioresal)
benztropine (Cogentin)
buspirone (Buspar)
carbamazepine (Tegretol)
clonidine (Catapres)
gabapentin (Neurontin)
hydroxyzine pamoate (Vistaril)
hydroxyzine hydrochloride (Atarax)
methylphenidate (Ritalin)
mixed salts amphetamine (Adderell)
prazosin (Minipress)

Other: (Only available if the drug override box is checked on the Admissions page in CIMOR; requires authorization from DBH)

Last Updated 11-2-2018

MODIFIED MEDICAL INPATIENT DETOX MEDICATION LIST:

(BILLED AS PROCEDURE CODE 99199 SC)

baclofen (Lioresal)
chlordiazepoxide (Librium)*
clonazepam (Klonopin)
Folic Acid
lorazepam (Ativan) *
naloxone (Narcan)
olanzapine (Zyprexa)
prochlorperazine (Compazine)
propranolol (Inderal)
Thiamine
trimethobenzamide (Tigan)

(BILL AS PROCEDURE CODE 99199)

benztropine (Cogentin)
buprenorphine/naloxone products (Zubsolv; Suboxone; Buavail)
buprenorphine products (without naloxone: Subutex; Probuphine)
naltrexone (oral)
carbamazepine(Tegretol)
clonidine (Catapres)
divalproex sodium (Depakote)
gabapentin (Neurontin)
haloperidol (Haldol)
hydroxyzine (Vistaril)
prazosin (Minipress)
quetiapine fumarate (Seroquel)
trazodone (Desyrel)

Other: (Only available if the drug override box is checked on the Admissions page in CIMOR; requires authorization from DBH)

***Note:**

- **All medications billed as 99199 are available to MMID programs. (See previous page for full listing of 99199 medications).**
- **Two medications were added to address alcohol withdrawal symptoms: chlordiazepoxide (Librium) and lorazepam (Ativan). (08/31/17)**
- **Eight medications were added above (effective 9/1/18) to address alcohol withdrawal symptoms: Thiamine; Folic Acid; trazodone (Desyrel); naloxone (Narcan); buprenorphine/naloxone products (Zubsolv; Suboxone; Buavail); buprenorphine products (without naloxone: Subutex; Probuphine); Vivitrol and oral naltrexone.**
- **One medication, Ondansetron (Zofran), was removed from the above list but can be requested through Clinical Review via the DBH Help Desk. (08/31/17)**
- **Five medications were removed from the above list (effective 12/1/18): diazepam (Valium); dicyclomine (Bentyl); lithium; methocarbamol (Robaxin); phenobarbital (Solfoton).**
- **One medication was removed from the list effective July 2017: cyclobenzaprine (Flexeril).**

Last Updated 11-2-2018

Appendix J

ARCA Buprenorphine (BUP) Home Induction:

1. In order to start BUP, **you will need to wait** approximately 36-48 hours until you are in withdrawal and feel very sick. We ask you to wait this long, so you don't have precipitated withdrawal. This happens when you take BUP and still have some opioids in your bloodstream. Precipitated withdrawal will feel like the worst withdrawal sickness you have ever experienced--this includes diarrhea and vomiting. Use the SOWS scale (on the opposite side of this page) to help you know when to take the first dose of BUP. If you use this scale, wait to take your first BUP until you hit a score of 18-22.

2. **Prepare for taking BUP** by sipping water every few minutes starting as soon as you start this process.

3. **Take your first dose.** For tablets and films, **you will need to cut or break the medication into fourths**. They probably won't be perfectly even, but that is okay. You want to start with the smallest piece first. Put it under your tongue to let it dissolve—it may take several minutes. Do not chew or swallow the medication. Do not eat or drink anything while it is under your tongue.

    a. After the piece of film or tablet dissolves completely, wait another 15 minutes to see if your feel worse before you take any more of the medicine.

    b. If you feel worse, **do not** take any more BUP right away; you may still have some opioids in your system. So, wait 2-3 hours before you try again.

    c. You may not feel better after the first piece of film or tablet, and this is fine as long as you don't feel worse. If this is the case, put another piece of film or tablet under your tongue and let it dissolve, then wait another 15 minutes. Repeat until you have taken the full amount of BUP prescribed for you for that day

4. The key is to get the prescribed amount in your system without feeling worse.

Comfort medications, use as needed for problem with the following:

- Baclofen or Flexeril– muscle aches and cramps
- Compazine – nausea
- Trazodone or doxepin– Sleep
- Clonidine –agitation, rapid heart rate, anxiety

ASSISTED RECOVERY CENTERS OF AMERICA
Leaders in Addiction Medicine

October 21, 2019

ARCA Patient,

ARCA is committed to supporting you as you work towards your recovery. As you move through this journey, we are honored that you have chosen us as your medical provider.

Part of our responsibility as a medical practice is to provide both effective and frugal medicine. Frugal medicine means that we do not waste money or resources in our practice, this is especially important when we prescribe medications.

We routinely try to prescribe generic medications to make sure we are practicing frugally. Generic medications have the same active ingredients but once a generic form of a medication is available, it is available at a lower cost.

One example of a medication being offered in a generic alternative is buprenorphine/naloxone. Brands of this medication include Suboxone and Zubsolv. The tablet form of buprenorphine/naloxone is now available at half the cost of the film form.

Moving forward, we will prescribe the tablet form of buprenorphine/naloxone whenever possible. This allows us to stretch the funding we receive from state and federal programs to serve more people.

While we understand that some patients prefer the film over the tablet, we ask you to work with us by using the tablet. Help us stretch our budgets so we can help more people in their recovery.

Thank you,

Fred Rottnek, MD

Medical Director

Table of Contents

ARCA Medication Guidelines and Guidelines, Supplemental COVID -19 Edition (3/31/2020)

Our team at ARCA has done an extraordinary job of adapting clinical guidelines and best practices with the burgeoning opioid epidemic in Missouri. This has required dedication to patient care, modifying delivery venues, and creatively thinking about success in treatment.

Now with the COVID-19 pandemic, we need to look at further adjustments to treatment plans to adjust to social distancing, partnering agencies closing, and patients' fear of leaving their homes for medical appointments.

National experts are recommending that we minimize and/or eliminate UDSs during COVID-19. Similar messages are shared about phlebotomy for lab draws—unless such assessment is absolutely necessary. On Thursday, 3/26/2020, Adam Bisaga, MD, presented a clinical roundtable addressing these concerns through PCSS. Slides are attached to this email. https://pcssnow.org/event/how-covid-19-epidemic-will-affect-the-provision-of-moud/

According to Dr. Bisaga, the big question we have now with SUD medications is starting patients on BUP (buprenorphine) or Ntx (naltrexone) without initial labs or an initial UDS. There are risks and benefits to doing this with either medication:

1. **Risks**: Precipitated withdrawal
2. **Benefit**: Patient is protected with BUP since the affinity of BUP for the mu opioid receptor is higher than those of most opioids. Patient is protected with Ntx, since Ntx is an antagonist

Benefits outweigh risks for our patients presenting for treatment. BUP and Ntx are metabolically safe and effective medications. With both of these medications, warnings about liver functions have greatly relaxed over time, so, unless a patient is in full hepatic failure, benefit outweighs risk. See SAMHSA TIP 63 for additional information.

So the question becomes who we practice ourselves and our own license if we consider benefit outweighs risk in prescribing BUP or Ntx without initial labs, when initial labs are not possible?

1. While we can still do UDS's and labs at ARCA, many partnering agencies are not seeing patients on site.
2. The day may come when we cannot do UDSs and labs at ARCA—due to shortages in PPE (Personal Protective Equipment), health department limitations, staff illness, etc.

So my recommendations as ARCA's medical director,

1. Relax rules on UDS's and labs as outlined in the ARCA Medication Guidelines COVID-19 edition
2. When absolutely necessary, start patients on BUP and Ntx without initial labs. In these situations, the prescribing provider should still
    a. Write for the initial labs (we are compiling a list of Quest lab collection sites throughout the state) and explain the importance of lab data to the patient. Encourage the patient to get the labs at the first opportunity.
    b. Explain the risk of precipitated withdrawal to the patient
    c. Document that benefits outweigh risk for this patient, i.e., medical decision-making
    d. Document, is so desired, that your medical director supports these practices during the COVID-19 pandemic

This modified and abbreviated set of guidelines reflects these adjustment necessary during the pandemic. If people cannot stay on medications during times of economic distress, elevated unemployment, and social isolation, no one wins.

While we must remember that these times are temporary, we must acknowledge that they are frightening.

I speak for all of us at ARCA when we wish all of our clients and partnering agencies the best possible health and well-being in days to come.

Fred Rottnek, MD

Fred Rottnek, MD, MAHCM
Medical Director, Assisted Recovery Centers of America
Professor and Program Director, Addiction Medicine
Department of Family and Community Medicine
Saint Louis University School of Medicine

Limited access to patients

In this document, I'll describe three levels of interaction with patients: standard operating procedure (SOP), limited patient contact (LC), and Virtual.

1. SOP: This was the period prior to COVID-19. Previous guidelines pertained to this level of interaction. This is our preferred method of operation and we will return to SOP as soon as we are able.
2. LC: This began 3/09/20 through the present. The only contact among staff and patients are with phlebotomy, injection, trouble-shooting use of interactive equipment, and in case of urgency/emergency. Staff and clients use PPE (Personal Protective Equipment) according to CDC standards.
3. Virtual: Staff and patient have no contact except for injections, if possible.

We acknowledge that we are in a temporary situation. As soon as we can, as indicated by our political leaders, we will return to SOP and associated practices. Likewise, if we need to go to Virtual status, we will return to LC as soon as possible. In all situations, if interventions are not performed at the more restrictive status, we will reintroduce them when we move back to the less restrictive status. The ARCA leadership team will inform the staff of all changes in status so that we are unified in our practice.

Lab testing

1. For the most part, in addiction medicine and psychiatry, medications are crucial to treatment success and patient well-being. And lab tests are a normal part of monitoring dose and safety. However, limitations in access to patient will limit our ability to test. In most situations, we will want to maintain our patient on medications during these limited access times.
2. In this document, ideal lab practice will be provided in three tiers--SOP, LC, and Virtual. To easily differentiate these tiers, SOP will be in regular font, *LC in italics,* and Virtual underlined.
3. In all situations, providers should document the ARCA COVID-19 Guidelines if they are using these guidelines as part of their clinical decision-making.
4. Patients should always be given the option of discontinuing medications if the patient is uncomfortable with the decreased frequency of lab testing during LC and Virtual status.
5. Psychiatric medications other than BUP, NTX
    a. Always check the chart for labs from the last year.
    b. Check with patients see if they've have the desired labs drawn from another provider with the last year. If so, proceed with an ROI for this information to use as baseline.
    c. *But*, If no information is available from 5a and 5b, for all new medication starts of meds that typically require baseline labs
        i. SOP
            1. Order typical initial labs
            2. Order follow up labs as typical
        ii. LC
            1. Order typical initial labs
            2. Order follow up labs in 3-6 months if patient feels and looks well
        iii. Virtual: Ask provider, who can consult medical director and/or PharmD for guidance

Obtaining vital signs

1. SOP
    a. Per routine guideline
2. *LC*
    a. Take temperature of patient—when supplies exist, provider or staff documents in chart
    b. Have patient BP and pulse with designated devices, provider or staff documents in chart
    c. Monitor patient's respiration via monitor, provider or staff documents in chart
3. Virtual
    a. Ask patient to take temperature if he/she has a thermometer (share this request at the time of making an appointment), *provider or staff documents in chart if obtained*
    b. Direct the patient to take his/her pulse), *provider or staff documents in chart if obtained*
    c. Monitor patient's respiration via monitor), *provider or staff documents in chart if obtained*

Comfort Medications (Customize to substance(s) being addressed *and the age and health status of client*)

5. Trazodone 100mg - Take one tablet daily 30 mins before bedtime as needed for sleep. Allow 7-8hours of sleep #10 (no routine refill) OK to continue through all levels of interaction
6. Prochlorperazine (Compazine) 10mg- Take one tablet three times daily as needed for Nausea #30 (no routine refill) OK to continue through all levels of interaction
7. Clonidine 0.1mg- Take one tablet every 12 hours daily as needed for anxiety, agitation, rapid heart rate, headache #20 Hold for BP less than 100/60 (no routine refill) OK to continue through all levels of interaction with proper provider guidance regarding low HR and BP. Baseline should be documented, and caution should be used if no baseline HR or BP available.
8. Baclofen 10 mg orally three times daily as needed for cramping (#30) (no routine refill) OK to continue through all levels of interaction
9. Hydration, hydration, hydration

Alcohol Detoxification Guideline

4. Naltrexone 50mg - Take 1/2 tablet the first day and then one tablet by mouth daily AFTER eating #30
5. Librium/ Chlordiazepoxide 25mg, DO NOT drive on this medication. DO NOT drink on this medication:
    a. Take 1 capsule every 6hrs for the first 2 days
    b. Take 1 capsule every 8 hours for the next 2 days
    c. Take 1 capsule every 12 hours for the next 2 days
    d. Take 1 capsule every 24 Hours for the final 2 days (no routine refill)
6. Folic Acid (Vitamin B9) - 1mg Take 1 tablet daily for 14 days (no routine refill)
7. Thiamine (vitamin B1) - 100mg - Take 1 tablet daily for 14 days (no routine refill)
8. Seizure prophylaxis: Choose one if client has had history of complicated alcohol withdrawal
    a. Tegretol/carbamazepine 200 orally two times daily for 7 days
    b. Gabapentin 300 orally three times daily for 7 days

Do not take more than the prescribe medication unless authorized. If you have any questions or concerns, contact ARCA Medical Staff.

Labs and other monitoring

3. Initial labs
    a. SOP
        i. CMP, CBC
        ii. Qualitative HCG (if female and at each visit if on medications);
        iii. UDS (and at each visit)
    b. LC
        i. CMP, CBC
        ii. Qualitative HCG (if female and at each visit if on medications);
        iii. UDS (per staff and/or prescribing provider discretion)
    c. Virtual
        i. CMP, CBC (not unless patient is feeling or appears unwell) Check with patient to see if he/she has labs from another provider within the year
        ii. Qualitative HCG is not needed unless patient is concerned. Always ask about possibility of pregnancy. Encourage patient to get a home test if she has concerns.
        iii. UDS is not needed unless provider is concerned. Consider asking patient (and/or patient caregiver) to get a home UDS kit and report results if provider is concerned

4. Follow up labs:
    a. SOP
        i. Routine labs and frequency if labs are within normal limits
            1. CMP, CBC, qualitative HCG, UDS every three months if client is on naltrexone, for year 1
            2. CMP, CBC, qualitative HCG, UDS every six months if client is on naltrexone, for year 2 and following
        ii. Routine labs and frequency if labs are not within normal limits.
            1. CMP and CBC every month if client is asymptomatic and until each panel is within normal limits, or
        iii. Check with provider for frequency of labs

b. LC:

i. Routine labs and frequency if labs are within normal limits: CMP, CBC, qualitative HCG, UDS every six months if client is on naltrexone

ii. Routine labs and frequency if labs are not within 3x of normal limits

1. CMP and CBC every 3 months if client is asymptomatic, patient is feeling and appearing well, and until each panel is within normal limits, or

2. Check with provider for frequency of labs

iii. Routine labs and frequency if labs are not above 3x normal limits

1. Check with provider for frequency of labs

c. Virtual:

i. Routine labs and frequency if labs are within normal limits: CMP, CBC, qualitative HCG, UDS at first six months—if possible--if client is on naltrexone; then as indicated by provider

ii. Routine labs and frequency if labs are not within 3x of normal limits

1. CMP and CBC every 6 months if client is asymptomatic, patient is feeling and appearing well, and until each panel is within normal limits, or

2. Check with provider for frequency of labs

iii. Routine labs and frequency if labs are not above 3x normal limits

1. Check with provider for frequency of labs

As we know, we have seen moving from one substance to another as drug supplies and availability change and alcohol sales soar.

So please keep this in mind when checking in with patients.

1. Ask patient if they have increased their alcohol, tobacco, and/or cannabis use.
2. Ask patients if their have increased use has become a problem, and, if yes, ask if they would like help/treatment. Use DSM V criteria
3. If someone wants treatment, review the revised medication guidelines attached. (I've also attached a PowerPoint presentation I've given to our residents).
4. The safest option for alcohol withdrawal is hospitalization; however, that is not always possible or desirable.
5. If we cannot get a breathalyzer screen or blood alcohol level, use the PAWSS screening tool—p. 22 in the attached slides. It will provide an idea of the safety of withdrawal in an outpatient setting.
6. If a patient is started on treatment at home
    a. Ensure that the patient has someone with them through the detox
    b. An ARCA team member, an RN if possible, should call at least twice daily for the first 3 days to check on status
    c. Reinforce the need for hydration—caffeinated drinks don't count. Sips during each commercial break and ice chips are good tactics
7. **Call me** at any time in this process for support/questions, etc.

Check on increased tobacco and cannabis use

Safety of naltrexone and Vivitrol

- NIAAA, https://pubs.niaaa.nih.gov/publications/combine/faqs.htm
- Mayo Clinic Patient Education, https://www.mayoclinic.org/drugs-supplements/naltrexone-oral-route/precautions/drg-20068408?p=1
- SAMHSA, https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone
- SAMHSA, https://www.integration.samhsa.gov/Intro_To_Injectable_Naltrexone.pdf

Opioid Detox Guideline (and Home BUP/Ntx Induction)

BUP/Ntx: 8mg/2mg tablets (Preferred form of medication)

5. Routine Dose
    a. Take the prescribed tablet under the tongue daily x 8 days
    b. When starting medication, you must wait until you are in active withdrawal. On a scale of 1-10, you want your withdrawal symptoms to be at a 7-8. If you are using the COWS or SOWS scale, you should be in moderate withdrawal. Start by taking one tablet of your prescribed dose. IF you take the first tablet and are feeling worse, DO NOT take any more, and contact the ARCA staff. DO NOT take more than the prescribed medication unless authorized.
6. Custom Dose
    a. Check with provider for schedule, rationale, and documentation needs

BUP/Ntx: 8mg/2mg films

7. Routine Dose
    a. Take 1, 1.5, or 2 films under the tongue daily x 8 days
    b. When starting medication, you must wait until you are in active withdrawal. On a scale of 1-10, you want your withdrawal symptoms to be at a 7-8. Start by taking 1/4 of a film under your tongue. Wait 15mins, and then take another 1/4 of a film. Continue this until you have taken a full film. IF you take the first 1/4 of a film and are feeling worse, DO NOT take any more, and contact the ARCA staff. DO NOT take more than the prescribed medication unless authorized.
8. Custom Dose
    a. Check with provider for schedule, rationale, and documentation needs

Zubsolv Dosing

3. 1.4 mg buprenorphine with 0.36 mg naloxone is equivalent to 2mg BUP/Ntx (1/4 strip)
4. 5.7 mg buprenorphine with 1.4 mg naloxone is equivalent to 8mg/2mg BUP/Ntx (1 strip)

Labs and other monitoring

1. Initial labs
    a. SOP
        i. CMP, CBC
        ii. Qualitative HCG (if female and at each visit if on medications);
        iii. UDS (and at each visit)
        iv. Strongly encourage each patient to get an HIV and PPD
    b. LC
        i. CMP, CBC
        ii. Qualitative HCG (if female and at each visit if on medications);
        iii. UDS (per staff and/or prescribing provider discretion)
    c. Virtual
        i. CMP, CBC (not unless patient is feeling or appears unwell) Check with patient to see if he/she has labs from another provider within the year

ii. Qualitative HCG is not needed unless patient is concerned. Always ask about possibility of pregnancy. Encourage patient to get a home test if she has concerns.
iii. UDS is not needed unless provider is concerned. Consider asking patient (and/or patient caregiver) to get a home UDS kit and report results if provider is concerned

2. Follow up labs:
   a. SOP
      i. Routine labs and frequency if labs are within normal limits
         1. CMP, CBC, qualitative HCG, UDS every three months for year 1
         2. CMP, CBC, qualitative HCG, UDS every six months if client is on naltrexone, for year 2 and following
      ii. Routine labs and frequency if labs are not within normal limits.
         1. CMP and CBC every month if client is asymptomatic and until each panel is within normal limits, or
      iii. Check with provider for frequency of labs
   b. LC:
      i. Routine labs and frequency if labs are within normal limits: CMP, CBC, qualitative HCG, UDS every six months
      ii. Routine labs and frequency if labs are not within 3x of normal limits
         1. CMP and CBC every 3 months if client is asymptomatic, patient is feeling and appearing well, and until each panel is within normal limits, or
         2. Check with provider for frequency of labs
      iii. Routine labs and frequency if labs are not above 3x normal limits
         1. Check with provider for frequency of labs
   c. Virtual:
      i. Routine labs and frequency if labs are within normal limits: CMP, CBC, qualitative HCG, UDS at first six months—if possible; then as indicated by provider
      ii. Routine labs and frequency if labs are not within 3x of normal limits
         1. CMP and CBC every 6 months if client is asymptomatic, patient is feeling and appearing well, and until each panel is within normal limits, or
         2. Check with provider for frequency of labs
      iii. Routine labs and frequency if labs are not above 3x normal limits
         1. Check with provider for frequency of labs

Safety of BUP and BUP/Ntx

SAMHSA, https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine

NIDA, https://www.drugabuse.gov/nidamed-medical-health-professionals/discipline-specific-resources/initiating-buprenorphine-treatment-in-emergency-department

Dosing Schedule (ARCA Routine BUP/Ntx Dosing Schedule)[1]

(Assuming client is doing well, has no new complaints, does not need to see the provider, is taking BUP/Ntx, and has negative UDS). Based on positive drug screens for controlled substances, the client may be taken back to any previous month in the guideline, or the client may be restarted at Week #1

Month	Week	Visit	Prescription	Refill?
1	1	Prescribing Provider	2 weeks	Three refills available, but must be authorized by RN or trained staff [2]
	2	Phone Call: RN or trained staff		
	3	Phone Call: RN or trained staff	RN or trained staff authorizes refill[3]	
	4	Phone Call: RN or trained staff		
2	1	Prescribing Provider	30 days[4]	
	3	Phone Call: RN or trained staff	RN or trained staff authorizes refill	No
3	1	Prescribing Provider	30 days (if 16 mg or less)[5]	One refill available, but must be authorized by RN or trained staff

*Defined here as a 4-week block

Notes:

6. If a prescribing provider deviates from this process, he/she must document medical decision-making in the encounter.
7. The prescribing provider indicates if follow-up checks and prescription authorization visits are in-person or via telephone.
8. RN or trained staff completes *Staff Check-in Sheet for Patients on BUP/Ntx form (TBD)*
9. If a client is on more than 16 mg of BUP/Ntx, refills can only be called in for 2 weeks supply. Scripts may be written for a 2-week supply with one refill, but the nurse must call the pharmacy to authorize the refill.
10. Provider decides with RN or trained staff at agency site if the client has demonstrated behaviors and treatment adherence that allow a complete 30-day prescription fill.

Additional Dosing Instructions

BUP/Ntx tapering

3. Tapering and discontinuing BUP/Ntx for a client who wants BUP/Ntx maintenance and is responding well to BUP/Ntx therapy is not a recommended treatment priority.
4. When a client responds well to a therapeutic dose of BUP/Ntx, the therapeutic goal is
    a. Patient's ongoing engagement in treatment
    b. Patient utilization of resources to stabilize his/her life—including appropriate therapy, utilizing of agency and partner resources
    c. Time on BUP/Ntx therapy to allow the client's neurological system to heal/repair
5. If anyone on the treatment team becomes aware that a client wants to discontinue BUP/Ntx, inform the prescribing provider and the RN or staff member coordinating the client's care.
    a. Explicitly share risks associated with BUP/Ntx discontinuation, including 50-90% relapse, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4382404/
    b. Ask the client for reasons why the client wants to discontinue treatment
        i. Is it the client's choice, or is the client receiving pressure from an external source, e.g., family member, loved one, criminal justice system?
        ii. What isn't working with the current treatment plan?
        iii. Assess for under-dosing
6. If the client still wants to discontinue BUP/Ntx,
    a. Encourage a slow taper and use of Vivitrol or another agent
    b. Use comfort meds to minimize discomfort
    c. Encourage continued participation in other elements of the treatment plan and other agency programs

Naltrexone (Vivitrol) Induction Guideline

5. On the initial visit, client is started on oral naltrexone 50mg #30
    a. 1/2tab with food if UDS negative for opiates, BUP/Ntx, and methadone, and the urine qualitative HCG is negative.
    b. If tolerated take other 1/2 tab in 30 mins, then take 1 tab daily with food.
    c. CBC, CMP and qualitative HCG (if female) is drawn
    d. Patient is scheduled to come back to the office in 2-3 days.
6. If client's labs are WNL and qualitative HCG is negative, client may receive a Vivitrol injection. (If client's labs are not WNL/negative, check with the medical provider or medical director for additional orders).
7. Initial Vivitrol injection
    a. All clients receiving Vivitrol must sign a consent with two contacts. The first could be a family member and the second an emergency contact.
    b. Once this is completed, the client may receive an injection.
        i. Vivitrol 380mg #1 Administer deep IM every 4 Weeks. Start if Labs are within normal limits.
        ii. Once Vivitrol is started, client may take Naltrexone 50mg daily as needed for cravings.
    c. Schedule a return visit for 24-28 days. Schedule this as a provider visit or nurse visit, based on the provider's orders.
8. Delayed or missed visits
    a. If the client does not show up the scheduled day, call the client and remind him/her of the appointment. If you cannot contact the client, and the client has not shown up within a 32-day window, call the family member and if no response within 24 hours, call the emergency contact.
    b. Window for Vivitrol injections: Vivitrol can be safely administered up to 33 days past the last shot.
    c. Although the product information states the therapeutic effects last 28 days, the medication lasts longer, especially after the second injection. If there is any concern on the part of the client or clinical staff, a naltrexone tablet can be administered. Give half tablet (25 mg), wait 15 minutes and if the client shows no signs of withdrawal, administer the injection. This procedure can often be utilized up to 35 days even in cases of the client testing positive for opioids.
    d. If the client comes to the clinics after 35 days or longer, assume the client has relapsed and needs detox. Contact the client's provider or the medical director for orders. The best approach is a short detox using buprenorphine. If the client does not want buprenorphine, other detox guidelines can be utilized.
    e. Under no circumstances should a client on Vivitrol be sent away without the Vivitrol, direct observed ingestion of oral naltrexone, or opioid detox meds--with or without buprenorphine. Contact the client's provider or medical director for orders.

Labs and other monitoring

1. Initial labs
   a. SOP
      i. CMP, CBC
      ii. Qualitative HCG (if female and at each visit if on medications);
      iii. UDS
      iv. Strongly encourage each patient to get an HIV and PPD
   b. LC
      i. CMP, CBC
      ii. Qualitative HCG (if female and at each visit if on Vivitrol);
      iii. UDS (per staff and/or prescribing provider discretion)
   c. Virtual
      i. CMP, CBC (not unless patient is feeling or appears unwell) Check with patient to see if he/she has labs from another provider within the year
      ii. Qualitative HCG is not needed unless patient is concerned. Always ask about possibility of pregnancy. Encourage patient to get a home test if she has concerns.
      iii. UDS is not needed unless provider is concerned. Consider asking patient (and/or patient caregiver) to get a home UDS kit and report results if provider is concerned

2. Follow up labs:
   a. SOP
      i. Routine labs and frequency if labs are within normal limits
         1. CMP, CBC, qualitative HCG, UDS every three months for year 1
         2. CMP, CBC, qualitative HCG, UDS every six months if client is on naltrexone, for year 2 and following
      ii. Routine labs and frequency if labs are not within normal limits.
         1. CMP and CBC every month if client is asymptomatic and until each panel is within normal limits, or
         2. Check with provider for frequency of labs
   b. LC:
      i. Routine labs and frequency if labs are within normal limits: CMP, CBC, qualitative HCG, UDS every six months
      ii. Routine labs and frequency if labs are not within 3x of normal limits
         3. CMP and CBC every 3 months if client is asymptomatic, patient is feeling and appearing well, and until each panel is within normal limits, or
         4. Check with provider for frequency of labs
      iii. Routine labs and frequency if labs are not above 3x normal limits
         5. Check with provider for frequency of labs
   c. Virtual:
      i. Routine labs and frequency if labs are within normal limits: CMP, CBC, qualitative HCG, UDS at first six months—if possible; then as indicated by provider
      ii. Routine labs and frequency if labs are not within 3x of normal limits
         6. CMP and CBC every 6 months if client is asymptomatic, patient is feeling and appearing well, and until each panel is within normal limits, or
         7. Check with provider for frequency of labs
      iii. Routine labs and frequency if labs are not above 3x normal limits
         8. Check with provider for frequency of labs

BUP/Ntx to Vivitrol Guideline

12. At the initial visit, the provider will order lab tests (CMP, CBC with Diff, and qualitative HCG Qualitative, if applicable).
13. Follow the BUP/Ntx taper guideline above.
14. Comfort medications:
    e. Trazodone 100mg - Take one tablet daily 30 mins before bedtime AS NEEDED for sleep. Allow 7-8hours of sleep #14 (no routine refill)
    f. Compazine 10mg- Take one tablet three times daily AS NEEDED for Nausea #30 (no routine refill)
    g. Clonidine 0.1mg- Take one tablet EVERY 12 hours daily AS NEEDED for anxiety, agitation, rapid heart rate, headache #20 Hold for BP less than 100/60 (no routine refill)
    h. Baclofen 10 mg orally three times daily as needed for cramping (#30) (no routine refill)
15. While on a slow BUP/Ntx taper, the client must see the provider every month.
16. If the client tests positive for opiates 2 consecutive times after the initial appointment with the provider, the client will be scheduled with the provider the following week. The provider will determine whether BUP/Ntx will be continued until seeing provider.
17. For the client to receive naltrexone, their system needs to be free of BUP/Ntx and opiates, preferably for 3-8 days.
    a. If client returns to start naltrexone/Vivitrol but is positive for BUP/Ntx, schedule an RN appointment for approximately 3 days later, and continue to do this until negative for BUP/Ntx (and opioids).
    b. If client returns to start naltrexone/Vivitrol, but is positive for opiates, reschedule with the provider for their next available appointment time.
18. When the client returns after their “BUP/Ntx wash-out period” for their transition to naltrexone/Vivitrol, and the client is negative from BUP/Ntx and opiates, RN will administer naltrexone 25 mg orally with food. After receiving dose, client will be observed for 30 minutes. If no negative reaction is noted or reported, dose will be repeated, and client will be observed for an additional 30 minutes, unless otherwise indicated.
19. If there is no negative reaction, the client will receive either a 1-month prescription for naltrexone or the Vivitrol injection (per MDO).
20. Patient will return approximately every 28 days for an additional prescription or injection.
21. During this time the client will be seen by the provider every 3 months, unless otherwise indicated.
22. Follow up labs as outlined above

General medication guidance, *with benefit outweighing risk,* only to be used during period of limited patient contact or virtual-only visits due to COVID-19 pandemic

- If the medication is not listed, assume that it is NOT OK to start or continue without labs. Instead, contact medical director or PharmD.
- All recommendations assume that patient history has been taken and no significant medical history is revealed.
- ***New start*** is any medication never before taken by patient. If there is a history of medication (taken more than 12 months ago, consult with medical director or PharmD).

New medication starts:

OK to start without close monitoring	NOT OK to start without close monitoring	Other exceptions, as noted below
Buprenorphine Comfort medications in ARCA treatment guidelines (trazodone, prochlorperazine, clonidine, baclofen) Chlordiazepoxide (for alcohol detoxification only) Folic acid, thiamine Buspirone Nicotine replacement Prazosin, doxazosin for psych indications Hydroxyzine Beta-blockers	Tricyclic antidepressants Antipsychotics Antiseizure medications Lithium ACE-I/ARB	Naltrexone (oral and XR) – UDS strongly recommended for new start Seizure prophylaxis – only if no way to obtain lab, history of withdrawal seizures SSRI and SNRI for depression and anxiety, weigh risk of electrolyte abnormality Benzodiazepines – strongly consider risk vs. benefit

Refills:

- Assumes baseline labs available in electronic health record or via Request of Information and all values are within normal limits
- Assumes refills for less than 12 months total. If more than 12 months, contact medical director or PharmD

OK to refill without close monitoring	**NOT OK to fill without close monitoring**	**Other exceptions, as noted below**
Buprenorphine Naltrexone (oral and XR) All antidepressants – except for sleep and other non-psych indications All antipsychotics – when used for non-sleep indications Comfort medications in ARCA treatment guidelines (trazodone, prochlorperazine, clonidine, baclofen) Stimulant medications Non-stimulant ADHD medications Gabapentin (other seizure medications see exceptions) Buspirone Nicotine replacement Prazosin, doxazosin for psych indications Hydroxyzine Beta-blockers	Clozapine – Due to REMS ACE-I/ARB	All antidepressants – being used for sleep or other non-psych indications, caution refilling after 6 months Anti-seizure medications – OK to refill after asking toxicity screening questions Benzodiazepines – strongly consider risk vs. benefit Antipsychotics for sleep only - strongly consider risk vs. benefit Lithium – consider risk of stopping with duration of previous treatment and discussion of toxicity warnings