Substance Use Disorder Medication Pocket Guide

Medications for Opioid Use Disorder (OUD): Select for patient-specific situation/mechanism

Buprenorphine	Methadone	Naltrexone
No longer requires a DATA-waiver. Requires only standard DEA registration with Schedule III authority. See also: https://www.hca.wa.gov	Specific eligibility criteria. Must be dispensed as part of an Opioid Treatment Program and includes mandatory counseling	Any clinician can prescribe without additional requirements. Approved for alcohol and opioid dependence
Partial opioid agonist Relieves or precipitates withdrawal – depending on if opioids in system.	*Long-acting Full opioid agonist* Prevents withdrawal symptoms for ≥24 hours, reduces craving for opioids, reduces the euphoric effects of subsequent opioid use by maintaining high level of opioid tolerance.	*Opioid antagonist* Blocks opioid receptors and reverses or prevents opioid euphoric effects
Initiate when patient abstinent from opioids and entering mild to moderate withdrawal	*Close monitoring on initiation, ECG screening recommended, multiple drug interactions. >40 years of data support safety and efficacy. Stigma persists re "substituting one drug for another."*	*Will precipitate withdrawal if opioids in system.* *Completed withdrawal is needed prior to starting*
Sublingual tablets (Subutex); Films (Belbuca), Transdermal patch (Butrans). Injections (Buprenex, Sublocade, Brixadi*)	Oral solution (Methadose), oral tablets (Dolophine, Methadose)	Oral tablet (ReVia) and injection (Vivitrol)
Can be used in pregnancy	Can be used in pregnancy	Current data on safety during pregnancy is limited.
Day 1: 2 mg/0.5 mg to 4 mg/1 mg titrated in 2 to 4 mg increments q 2-hours. Day 2: Single 16 mg/ 4mg dose. Day 3 onwards: Adjust in 2 to 4 mg increments to dose that holds individual in treatment and suppresses opioid withdrawal. Doses > 24 mg/6 mg have no demonstrable clinical advantage. *Brixadi (XR) FDA 2023. Test dose 4 mg, if no withdrawal; 16 - 32 mg/wk→128 mg/mo.	Induction: 20 mg and observe for 2 to 3 hours with an additional 5 to 10 mg if needed. Dose can be increased by 5 to 10 mg every few days to a maximum of 20 mg per week. Maintenance: The usual effective dose of methadone is between 60 to 120 mg per day.	OUD: 25 mg per day increased to 50 mg daily, 100 mg every other day, or 150 mg every third day. AUD: Same dosing guidelines as OUD. *Once monthly IM injection (380 mg) is available.

Medication for opioid overdose: Naloxone (Narcan) : Opioid Antagonist

Nasal: 4 mg IN (1 spray into 1 nostril), do not prime as each device only works once; repeat q2-3 min until response.
<u>OR</u> *Inject IM/SC*: 1 mL (0.4 mg) into upper arm or thigh; repeat q3 minutes until response if needed.
All patients on high-risk opioids should be prescribed. Training should be provided to patient and household members. FDA approved OTC in March 2023. More info: WA Department of Health Naloxone Instructions

Medications for Alcohol Use Disorder (AUD): Select for patient-specific situation/mechanism

Naltrexone	Acamprosate (Campral)	Disulfiram (Antabuse)
First-line agent. Discourages drinking by blocking opioid receptors; reduces euphoria when alcohol is consumed - *reduces positive reinforcement*	First-line agent. Reduces post-acute withdrawal symptoms that may cause cravings for alcohol - *reduces negative reinforcement*	Second-line agent. Discourages drinking by making a person physically ill when alcohol is consumed – *aversive effect*
Oral (ReVia), intramuscular (Vivitrol)	Oral	Oral
May begin while patient is still drinking. Will cause opioid withdrawal.	Typically initiated 5 days after cessation of alcohol use. Can be used by patients taking opioids and during relapses to alcohol use.	Effective principally when taken under supervised conditions. Typically initiated 48 hours after cessation of alcohol use.
Similar to dosing for OUD above.	Two tablets (666 mg per dose) administered three times daily.	One to two tablets (250 or 500 mg) daily. No benefit noted above 500 mg.