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TREATING OPIOID USE DISORDER

A FACT BOOK

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NOTES FROM THE AUTHORS

The goal of these fact sheets is to provide need-to-know information that can be easily and quickly absorbed and utilized during a busy day of seeing patients.

COST INFORMATION

We obtained pricing information for a one-month supply of a common dosing regimen from the website GoodRx (www.goodrx.com), accessed in October 2023. These are the prices patients would have to pay if they had no insurance (GoodRx also offers coupons to purchase certain medications at reduced prices). Because of wide variations in price depending on the pharmacy, we list price categories rather than the price in dollars. The categories are: $: Inexpensive (<$50/month); $$: Moderately expensive ($50–$100/month); $$$: Expensive ($100–$200/month); $$$$: Very expensive ($200–$500/month); $$$$$: Extremely expensive ($500/month).

FINANCIAL DISCLOSURES

Dr. Carlat, Dr. Capurso, and Dr. Puzantian have disclosed that they have no relevant relationships or financial interests in any commercial company pertaining to the information provided in this book.

DISCLAIMER

The information in this book was formulated with a reasonable standard of care and in conformity with current professional standards in the field of psychiatry. Treatment decisions are complex, and you should use these fact sheets as only one of many possible sources of medical information. Please refer to the *PDR (Physicians' Desk Reference)* when you need more in-depth information on medications. The information is not a substitute for informed medical care. This book is intended for use by licensed professionals only.

If you have any comments or corrections, please let us know by writing to us at info@thecarlatreport.com or The Carlat Psychiatry Report, P.O. Box 626, Newburyport, MA 01950.

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Opioids: The Basics of Street Drugs

Introduction

The global supply of illicit opioids is rapidly shifting and unstable. Fentanyl went from being an occasional contaminant to nearly completely taking over street opioids in the span of just a few years. More often than not, patients obtain different opioid drugs from a variety of sources. Depending on what is available at a given time, the same person may be sniffing, smoking, injecting, or swallowing different varieties of opioids, some illegal (such as heroin), some legal but illicitly obtained (such as OxyContin), and some legal drugs that were manufactured illicitly (such as fentanyl). In this fact sheet, we introduce you to the landscape of street opioids in order to help you understand what your patients are using and allow you to speak their language.

Heroin

- *Basics:* A prodrug of morphine, heroin is a natural product manufactured from poppy plants most commonly grown in Southern Asia and Central America. For decades, it was the dominant illicit opioid available on the street, until it was overtaken by fentanyl in recent years. Heroin can come in various forms, most commonly a white powder, a brown powder, or a black sticky substance called "black tar."
- *Street names:* Dope, H, smack, junk, snow, China white, black tar, brown; also known as speed ball when mixed with cocaine.
- *How it's obtained:* Street dealers sell heroin in small plastic or paper bags, each of which is supposed to contain a single dose. The actual amount of heroin per bag varies from as little as 25 mg to as much as 100 mg. Ten bags

- *Average daily use:* Difficult to estimate, but a typical user might use 50–200 mcg or more, divided into multiple doses throughout the day.

Oxycodone/OxyContin/Percocet

- *Basics:* OxyContin, the long-acting formulation of oxycodone, is a semi-synthetic prescription opioid introduced in 1996. The high doses contained within a single pill, intranasal bioavailability, and aggressive marketing campaign have been cited as supercharging the "first wave" of the opioid epidemic. Cheap and widely available heroin eventually replaced OxyContin as the main driver of opioid-related morbidity and mortality in the late 2000s once prescriptions were dialed back. Oxycodone and OxyContin are less commonly seen on the streets these days, though they are still available. Percocet is branded oxycodone co-formulated with acetaminophen.
- *Street names:* Oxy, roxy, OC, greenies, perc, hillbilly heroin.
- *How it's obtained:* Tablets on the street originate from one of two sources. Some are actual pharmaceutical-grade tablets. Others are counterfeits. These "pressed pills" can be nearly indistinguishable from the real thing but contain dangerous amounts of contaminants, often fentanyl or fentanyl analogues.
- *How it's used:* Swallowed or sniffed.
- *Cost:* Individual tablets sell for $5–$20 apiece or more.

Opioid Use Disorder: How to Conduct the Initial Assessment

Initial Questions

As with any psychiatric interview, start by building an alliance and showing interest in your patient in a general way. The first few questions, although not explicitly related to psychiatric issues, will typically naturally transition to the patient's reason for their visit.

- "Where are you from?"
- "What do you do for work and fun?"

Core Questions

We suggest you ask some version of the following questions to every patient you evaluate with opioid use disorder. RIPTEAR is a useful mnemonic that gets you the information needed for both acute and long-term treatment planning (www.coursera.org/learn/addiction-treatment).

***R**isk*—Assess for acute risks that might need immediate intervention, including current intoxication that could lead to overdose (nodding off, not responding), acute suicidality, or active medical issues.

- "You've been going through a lot recently; have you been having any thoughts of harming yourself?"
- "Do you have any medical issues that need to be addressed right away, such as infections at injection sites?"

***I**nitiation*—Learn when the patient started using opioids to give you an idea about the trajectory of their use disorder.

- "How old were you when you first started using?"

sobriety.

- "Help me understand what role drugs play in your life."
- "What do you get out of them?"
- "What sorts of problems do they cause for you?"

***A**bstinence*—Find out if the patient has ever had significant periods of abstinence in their life and how they were able to achieve that.

- "Tell me about periods in your life when you were able to stay sober."
- "What was going on that allowed you to achieve sobriety?"

***R**eturn to use*—Investigate the circumstances around return to use to help you and the patient look ahead to potential problems.

- "Have you ever had a return to use after a period of sobriety?"
- "What were the circumstances that led you to return to use?"
- "What might you be able to change in order to prevent that from happening again?"

the dose if SBP<90 or DBP<60. If outpatient, have patients check blood pressure before taking a dose. Consider the following adjunctive medications as well:

Symptom	Medication	Notes
Autonomic symptoms	Clonidine: 0.1–0.2 mg Q1hr; max 0.8 mg/day Lofexidine: 0.54 mg Q6hrs; max 2.88 mg/day	Give 0.1 mg if COWS or SOWS<12 Give 0.2 mg if COWS or SOWS>12 Take total dose in the first 24 hours; give in divided doses QID for several days; taper 0.1–0.2 mg/day until discontinuation (slow taper avoids rebound hypertension)
Anxiety	Hydroxyzine: 25–50 mg Q6hrs; max 200 mg/day Lorazepam: 1 mg Q4–6hrs; max 4 mg/day	Reserve benzos for inpatient Avoid benzos if patient takes other CNS depressants
Nausea/vomiting	Ondansetron: 4 mg Q4–6hrs; max 16 mg/day Prochlorperazine: 5 mg QID; max 20 mg/day	Prochlorperazine is an antipsychotic and can help relieve anxiety, though risks akathisia as well
Diarrhea	Loperamide: 4 mg first, then 2 mg after each loose stool; max 16 mg/day	
Abdominal cramps	Dicyclomine:	

BUPRENORPHINE MONOTHERAPY (Subutex, others) Fact Sheet [G]

Bottom Line:

Buprenorphine (Subutex, available now only as generic) is the active ingredient in Suboxone (buprenorphine/naloxone) and is responsible for the effectiveness of the combination medication in opioid use disorder (OUD). In the past, buprenorphine alone was preferred for the initial (induction) phase of treatment, while Suboxone was preferred for maintenance treatment (unsupervised administration). Currently, the combination is favored for both induction and maintenance as it, at least theoretically, decreases misuse and diversion.

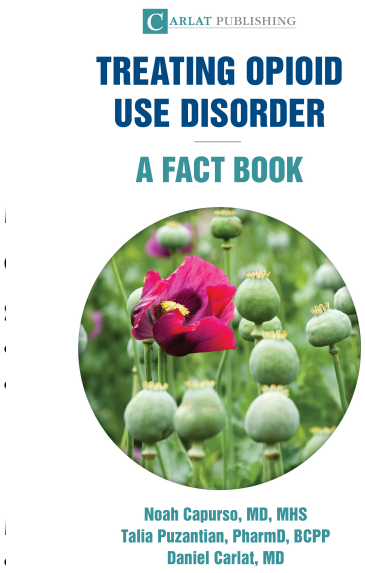
FDA Indications:

OUD: induction, maintenance; moderate to severe pain (Belbuca, Buprenex, Butrans).

Dosage Forms:

- **SL tablets (Subutex, [G]):** 2 mg, 8 mg (scored).
- **Buccal film (Belbuca, [G]):** 75 mcg, 150 mcg, 300 mcg, 450 mcg, 600 mcg, 750 mcg, 900 mcg (used for pain).
- **Transdermal patch (Butrans):** 5 mcg/hr, 7.5 mcg/hr, 10 mcg/hr, 15 mcg/hr, 20 mcg/hr (used for pain).
- **Short-acting injection (Buprenex, [G]):** 0.3 mg/mL (used for pain).
- **Extended-release injection:** For OUD; see "Buprenorphine Extended-Release Injection Monotherapy" fact sheet.

Dosage Guidance for OUD:



- Metabolized primarily through CYP3A4, t ½: 24–48 hours.
- Avoid concomitant use with opioid analgesics (diminished pain control). Additive effects with CNS depressants. CYP3A4 inhibitors and inducers may affect levels of buprenorphine.

Clinical Pearls:

- Schedule III controlled substance. Prescribing buprenorphine for OUD no longer requires having a special "X-license."
- Though buprenorphine/naloxone products are recommended for maintenance treatment, buprenorphine monoproduct can be used during pregnancy and for the handful of patients who may have adverse effects to the small amount of naloxone absorbed sublingually from the combination product (headache, anxiety, GI distress, palpitations).
- Patients with moderate to severe OUD and who have been stabilized with SL or buccal buprenorphine 8–24 mg for >7 days may convert to monthly or weekly subcutaneous injections.

Fun Fact:

The subcutaneous implant formulation of buprenorphine (Probuphine) was discontinued. Its use was severely limited as it was invasive, expensive, and an option only for patients stable on ≤8 mg/day of SL buprenorphine. Other implants currently in development include medications for schizophrenia, breast cancer, photosensitivity, and Parkinson's disease.

TREATING OPIOID USE DISORDER

A FACT BOOK

This Carlat Fact Book provides you with all the tools and information needed to assess and treat your patients who are struggling with opioid use disorder. Unlike traditional textbooks, this Fact Book distills each critical aspect of clinical decision making into a single sheet, with tips and bullet points that you can use at the point of care. Topics covered include conducting an initial assessment, treating opioid withdrawal symptoms, psychosocial approaches to treating opioid use disorder, and relapse prevention strategies.

PRACTICAL TOPICS INCLUDE:

- ✔ How to Choose the Right Medications for Opioid Use Disorder
- ✔ How to Discuss and Initiate Buprenorphine
- ✔ Buprenorphine Microinduction
- ✔ How to Use Sublocade and Brixadi
- ✔ How to Manage Buprenorphine
- ✔ How to Manage Methadone
- ✔ Managing Opioid Withdrawal
- ✔ How to Discuss and Initiate Extended-Release Naltrexone (Vivitrol)
- ✔ Medication Interactions
- ✔ Pain Management for Patients With Opioid Use Disorder
- ✔ How to Educate Your Patients About Overdose Prevention

MEDICATION FACT SHEETS INCLUDE:

- ✔ Buprenorphine Extended-Release Injection Monotherapy (Brixadi, Sublocade)
- ✔ Buprenorphine Monotherapy (Subutex, others)
- ✔ Buprenorphine/Naloxone (Bunavail, Suboxone, Zubsolv)
- ✔ Lofexidine (Luc
- ✔ Methadone (Me
- ✔ Nalmefene (Op\
- ✔ Naloxone (Klox
- ✔ Naltrexone (Re\

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