Magellan Behavioral Health of Pennsylvania, Inc.*

Introduction to the Use of Medication for Substance Use Disorder: An Abridged Guide for Practitioners

Magellan HEALTHCARE®

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Introduction

As the number of opioid-related overdose deaths in the U.S. reached a record high in 2021, our nation has increasingly embraced evidence-based treatment options that best support our communities, loved ones, friends, and families in their recovery efforts.

One growing approach—often considered as the gold standard of treatment—is Addiction Medication, (formerly known as medication-assisted treatment (MAT)). Addiction Medications are FDA-approved medications used for the treatment of Substance Use Disorders (SUDs), with or without counseling and behavioral therapies. The use of this treatment approach has grown in all facilities and is increasingly leveraged by primary care providers nationwide—but more still must be done for widespread adoption.

In 2019, while 900,000 U.S. physicians prescribe opioids, physicians were certified to prescribe buprenorphine, one of three medications approved to treat opioid addiction. And even fewer actually prescribe buprenorphine to patients. Because of this, 2021 brought some changes in that the burdensome 8-hour training course previously required for the X-waiver has been eliminated. Buprenorphine remains a Schedule III controlled substance and prescriptions for buprenorphine require a standard DEA registration number. There are no longer limits or patient caps on the number of patients a provider may treat for OUD with buprenorphine. MAT prescribing is not limited to psychiatrists. In fact, primary care providers provide more access to MAT than any other type of provider.

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The impact of limited access to MAT on health outcomes cannot be overlooked. One analysis found only one-third of individuals who experienced a non-fatal opioid overdose received access to MAT. Those who received methadone were linked to a 59 percent decrease in mortality rates after one year, according to the analysis. Additionally, individuals who were treated with buprenorphine were associated with a 38 percent decrease in mortality after a year.

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Increasing Access to Medication for Substance Use Disorder (MSUD)

The SUPPORT for Patients and Communities Act, passed by Congress and signed in October 2018, expands the ability to prescribe MSUD by increasing clinician eligibility for certification. This provision is a solid and necessary step toward broadening access to treatment; however, to make a true impact on the opioid epidemic, we must break the stigma surrounding MSUD.

When it comes to recovery, the potential for relapse is high, especially in the early stages when resolve is fragile. It is important to note that for individuals with co-occurring mental health conditions, chronic pain, or other addictions, MSUD should be supplemented by treatment for those conditions, such as cognitive behavioral therapy. Building in care management support to assist in navigating the treatment process may reduce the possibility of relapse and/or readmission to a substance abuse inpatient or residential rehabilitation program. It also helps provide individuals with the tools needed to live addiction-free.

By taking the time to dispel the myths about non-traditional addiction treatment like MSUD, we create an environment that more fully supports a return to complete health—physical, mental, and emotional. Fighting the stigmas around MSUD is an important step toward enabling those suffering from Opioid Use Disorder (OUD) to recover from their addiction and live healthy, vibrant lives. – Dr. Caroline Carney, Chief Medical Officer for Magellan Rx Management.

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MBH Position Statement on MSUD

Magellan supports the use of MSUD as a best practice in the treatment of individuals impacted by substance use disorders, particularly those diagnosed with Opioid or Alcohol Use disorders. Magellan defers to the prevailing practice standards, as articulated by the American Society for Addiction Medicine (ASAM), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Pennsylvania Department of Drug and Alcohol Programs (DDAP). This guide is intended for use as a resource, which points practitioners toward these best practice standards, but in no way seeks to establish independent standards of practice or to supersede those that exist. Practitioners are encouraged to access these resources directly, to ensure adherence to the most current evolution of prevailing practice recommendations.

Social Determinants of Health

As identified by the Centers for Disease Control (CDC), "Conditions in places where people live, learn, work, and play affect a wide range of health risks and outcomes. These conditions are known as social determinants of health (SDOH)". SDOH have significant implications for the health of an individual and the population as a whole. As a result, these factors must be considered as health care providers assess and intervene with individuals whom they serve.

The five primary SDOH are:

- Food insecurity
- Housing instability
- Utility needs (electricity, heating, cooling, etc.)
- Transportation
- Interpersonal violence

Direct correlation between SDOH and substance use treatment-need-identification can be found in ASAM's Dimension 6, Recovery/Living Environment. It is critical for providers to accurately identify and respond to needs in this domain as the literature is clear on the impact on outcome success, sustainability of sobriety and cost of care.

With MSUD treatment, lack of understanding and stigma contribute to discouraging messaging from loved ones, and unfortunately some treatment providers, about the use of these medications for recovery maintenance. Many recovery housing supports will not accept individuals on MSUD, hence further limiting access to safe, supportive recovery environments.

As a result, treatment providers must prioritize the education of loved ones around the use, necessity, and course of treatment with MSUD. In addition, they must be proactive in assisting individuals in finding MSUD-supportive housing and recovery support communities. Support options may include case management (CM), assertive community teams (ACT,) and peer supports such as Certified Recovery Specialists (CRS) and Certified Peer Specialists (CPS).

Overview of Medication for Substance Use Disorder Treatment (MSUD)

MSUD is defined as the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of Substance Use Disorders. (SAMHSA ATTC Network)

Increasingly the "T" has been designated as "Therapy" rather than "Treatment". While perhaps seemingly semantic, this shift highlights the use of medications to support an individual in the course of therapy, as has become the standard of care with psychotropic medications. However, the "medication first" philosophy, has helped to frame the notion that individuals may require access to, and treatment with MSUD, prior to being able to actively participate in psychosocial therapy. As such, a person's initial inability to participate in therapy should not serve as a barrier to accessing MSUD. *(Recommend consulting with the respective Single County Authority (SCA) regarding funding parameters)]*

Medications for the Treatment of Opioid Use Disorders (OUD)

Methadone, buprenorphine, and naltrexone are the three medications currently approved by the Food and Drug Administration (FDA) for the treatment of Opioid Use Disorders. These medications work by more safely mimicking the effects of opioid and/or by blocking the effects of the opioids. Research evidence demonstrates that individuals utilizing Medication for OUD (MOUD) are more likely to maintain abstinence as compared with those who complete withdrawal management (detoxification) alone. In randomized clinical trials they have all been found to be effective in reducing the illicit use of opioids. Methadone and buprenorphine specifically have been found to be effective in reducing overdose deaths. SAMHSA indicates that there is no empirical data to indicate which individuals will respond more successfully to one OUD medication versus another, and rather recommend counseling individuals on the effectiveness, risks and benefits of each medication, as well as options for treatment without medication and no treatment. (SAMHSA 2018, 3-7)

Table #1: Overview of Medications for Treatment of OUD

Medication (Classification)	Mechanism of Action	Route of Administration	Timing of Use	Treatment Setting	Clinical Outcomes

Methadone (Schedule II)	Agonist (Reduces opioid withdrawal and craving; blunts or blocks euphoric effects of self-administered illicit opioids through cross-tolerance and Opioid receptor occupancy.)	Oral	Medically supervised withdrawal management; Maintenance	Waiver not required but can only be administered in federally certified Opioid Treatment Program (OTP)	Reduced overdose deaths; reduced risk of HIV & HepC; reduced criminal behavior; increased treatment retention
Naltrexone (Not Scheduled) (Vivitrol)	Antagonist (Blocks euphoric effects of self-administered illicit opioids through opioid receptor occupancy. Causes no opioid effects.)	Oral; Intramuscular extended-release	Post-withdrawal management (typically after individual has abstained from short-acting opioids for at least 7–10 days and long-acting opioids for at least 10–14 days)	Available through any prescriber; Range of settings from office-based to ambulatory and 24-hour SUD treatment	Decreased relapse rates; Increased sobriety periods
Buprenorphine (Schedule III) (Suboxone)	Partial Agonist (Reduces opioid withdrawal and craving; blunts or blocks euphoric effects of self-administered illicit opioids through cross-tolerance and opioid receptor occupancy.)	Sublingual, buccal, subdermal implant, subcutaneous extended release	Medically supervised withdrawal management; Maintenance	Can be prescribed by physician, nurse practitioner and physician assistant and in OTP	Increased treatment retention; decreased relapse

General Practice Recommendations

The American Society for Addiction Medicine (ASAM) recommends the following regarding treatment of patients with medication to address the Opioid Use Disorders[1] (this summary is not inclusive of all recommendations):

Assessment

- Identify and make appropriate referral for any medical or psychiatric conditions, including impairment related to drug use or overdose
- Gather a complete medical history, including screening for co-occurring medical conditions, including infectious diseases, trauma and pregnancy
- Conduct physical examination or ensure that physical examination exists within patient record
- Conduct laboratory testing including, complete blood count, liver function test, Hepatitis C and HIV testing. Consider testing for TB and sexually transmitted diseases. Offer Hepatitis B vaccine, as appropriate.
- Test women of child-bearing age for pregnancy and query regarding use of contraception, and counsel as appropriate
- Conduct assessment of mental health status and possibility of psychiatric disorders
- Assess current and past substance use
- Be cognizant of concurrent substance use that may compromise effectiveness of treatment, particularly benzodiazepine and other sedative hypnotics
- Query tobacco use and counsel on cessation, as appropriate
- Assess social and environmental factors which may impact treatment participation and efficacy

Diagnosis

- Confirm diagnosis of Opioid Use Disorder (OUD)
- Utilize comprehensive assessment and patient history to confirm diagnosis
- Utilize validated clinical scales to assist in the evaluation of OUD. This may include: the Objective Opioid Withdrawal Scale (OOWS); the subjective Opioid Withdrawal Scale (SOWS); the Clinical Opioid Withdrawal Scale (COWS)

Treatment Options

- Jointly decide on treatment options with the patient
- Consider patient preferences, past treatment history, and treatment setting when deciding on the type of MOUD to be utilized. See section “Considerations for Treatment Setting”.

Treating Withdrawal

- Use of medications for withdrawal management is recommended
- Patients should be counseled about the risk of relapse from opioid withdrawal management and that it is not a standalone treatment
- Specific dosage guidelines for the use of methadone, buprenorphine, naltrexone, and clonidine can be found in the ASAM National Practice guidelines (link provided below).

[1] ASAM, 2015

Psychosocial Treatment

- Concurrent psychosocial treatment is recommended with all forms of MOUD to treat OUD
- Such treatment should include, at minimum: psychosocial needs assessment; provision of supportive counseling; linkage to existing family supports referral to community services

The foregoing is an adaptive summary of the ASAM recommendations. A thorough presentation of the National Practice Guidelines is available here: https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24

Methadone

Methadone is the oldest and most researched MOUD for OUD, having been in use since 1947. Methadone, an agonist, is a synthetic opithathich acts on the opioid receptors more slowly than do typical opioids of abuse. As a result, it reduces withdrawal and cravings without producing euphoria in opioid-addicted individuals.

It has been listed by the World Health Organization (WHO) as an essential medication, given consistently superior outcomes for methadone maintenance as compared with placebo, withdrawal management, and no treatment in clinical studies.

In longitudinal studies with individuals utilizing methadone maintenance evidence has pointed to:

- Reduced risk of death by over-dose
- Reduced risk of HIV and Hepatitis C
- Decreased rates of cellulitis
- Decrease risk of HIV-risk behavior
- Decreased criminal behavior (www.samhsa.gov)

Positive effects were realized regardless or psychosocial treatment frequency or lack of counseling.

Treatment Setting & Methadone Induction

Methadone is indicated for physiological dependence to opioids. ASAM (2015) recommends a starting dose of 10 to 30 mg, with reassessment in 3 to 4 hours, followed by a second dose, not to exceed 10 mg on the first day. Typical maintenance doses range from 60 to 120mg. It is recommended that dosage increases in increments of 5 to 10 mg every 7 days, so as not to result in sedation, toxicity, or overdose death.

Based on federal regulations, Methadone may only be administered in the context of a federally certified and accredited Opioid Treatment Program (OTP). The Federal Code for Opioid Treatment Programs may be found here. SAMHSA' Federal Guidelines for Opioid Treatment Programs may be obtained here.

Buprenorphine

Buprenorphine is classified as a partial agonist, indicating that while it binds with the same opioid receptors as methadone and other opioids it activates them less strongly. It is also associated with increased retention in treatment and is classified as an essential medication by the WHO. Buprenorphine maintenance was found to be superior to buprenorphine taper in reducing rates of illicit opioid use.

Buprenorphine has demonstrated similar effectiveness to methadone, when administered at a sufficient therapeutic dose (typically around 16 mg), over a sufficient period. Due to concerns about the potential for diversion, discussed later in this document, some practitioners have dosed patients at insufficiently high levels, hence compromising effectiveness.

Buprenorphine is available in tablet, sublingual film, 6-month subdermal implant (Probuphine) and once-monthly injectable (Sublocade) formulations. The latter has been approved to treat individuals with moderate to severe OUD who have first been treated with transmucosal buprenorphine for at least one week. There is conservative evidence pointing to the effectiveness of buprenorphine implants (Probuphine) in clinically stable individuals. More research is needed in order to establish validity of these findings.

Buprenorphine is also available in combination with an antagonist, naloxone (Suboxone – sublingual tablets and strips & Zubsolv – sublingual tablet).

Treatment Setting & Buprenorphine Induction

The Drug Addiction Treatment Act of 2002 increased the accessibility of MOUD by establishing that buprenorphine it could be prescribed by certified physicians in a variety of settings rather than in specialized clinics. Traditionally, buprenorphine induction has occurred in an office/treatment setting where the individual could be observed. However, increasing evidence indicates that home induction is equally safe. In either instance, the individual being inducted should not exhibit signs of intoxication or sedation. The Clinical Opiate Withdrawal Scale (COWS) can be used to evaluate and document withdrawal symptoms. Buprenorphine can be prescribed in an OTP,

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act has attempted to respond to the opioid crisis by, among other things, supporting increased training in addiction medicine, expanding the list of practitioners who may have

prescribing authority for buprenorphine and expanding the number of individuals who may be treated by a practitioner. Additional information may be viewed here: https://www.asam.org/advocacy/the-support-for-patients-and-communities-act-(h.r.-6)

Naltrexone

Naltrexone is an opioid antagonist. This means that rather than differentially stimulating the opioid receptors, it binds with and blocks them, hence preventing the effect of opioids of abuse. While Naltrexone does not provide relief from cravings or withdrawal, it does prevent the euphoria associated with opioid abuse.

Naltrexone was initially available in a tablet formulation, which demonstrated limited research effects due to poor medication adherence by patients. The introduction of an extended-release injectable, XR-NTX (Vivitrol), has enhanced compliance and overall effectiveness. It is administered monthly, hence removing the burden of daily adherence.

Treatment with Naltrexone requires full detoxification prior to initiation. This can serve as a barrier to individual actively using opioids. However, if this hurdle is overcome, naltrexone demonstrates similar effectiveness as buprenorphine and naloxone in combination.

Treatment Setting & Naltrexone Induction

Since Naltrexone is not a scheduled medication, it may be prescribed by any practitioner with prescription authority and in any healthcare setting.

Medications for the Treatment of Alcohol Use Disorders

Despite indication that 10-20 percent of individuals treated in primary care and hospital settings may meet criteria for Alcohol Use Disorder (AUD) many do not access treatment. According to SAMHSA (2018), only 1.4 million of the 18 million individuals meeting criteria for AUD in 2013 received treatment. While, the impact of alcohol use remains high, the utilization of MSUD as an avenue of treatment is disproportionately low. The medications presented below are indicated for the treatment of individuals who are actively dependent on alcohol, as well as those at risk for relapse due to the continued experience of cravings.

Disulfiram

Disulfiram, commonly known as Antabuse, induces nausea when combined with consumption of alcohol. As such, it serves as a deterrent for consuming alcohol and can only be initiated after the individual has been detoxed from alcohol (if required). Disulfiram is available as a tablet that is taken daily. It is not a controlled substance and can be utilized in any health care setting. The need for daily self-administration of the dose is a consideration for compliance, as relapse may be facilitated by neglecting to take the dose.

Acamprosate

Acamprosate (Campral) is available as a tablet that is taken three times daily. Detox is not required for initiation of the medication but is recommended. Acamprosate does not impact withdrawal symptoms, but rather reduces cravings for alcohol. It is not a controlled substance and can be utilized in any health care setting. As with Disulfiram, the need for daily self-administration of the dose is a consideration for compliance, as relapse may be facilitated by neglecting to take the dose.

Naltrexone

Naltrexone operates by binding to opioid receptors that are implicated in the reward and cravings associated with alcohol consumption. As a result, it blunts these effects. Naltrexone is available as a daily tablet (Revia) or monthly injection (Vivitrol). Naltrexone is not a controlled substance and can be utilized in any health care setting. Detox is required before beginning treatment with Naltrexone. Relapse is more easily facilitated by individuals utilizing the oral formulation as they can simply discontinue the use of the daily pill.

Implications for Treatment Setting & Treatment Choice

None of the medications indicated for treatment of Alcohol Use Disorder are controlled substances. As a result, there is great flexibility in their utilization across treatment settings.

There are considerations related to the compliance requirements for the individual being treated. Practitioners should assess the likelihood that the individual can be compliant with daily, or three times daily self-administer dosages.

In addition, practitioners should determine if there are any additional risk factors associated with use of injectables or that may compromise pain management by blocking the opioid receptors.

Reported side-effects have been minimal. Stomach aches, dizziness, dry mouth, and anxiety or depression have been experienced by individuals taking Acamprosate. Headache, drowsiness, and rash have been associated with use of Disulfiram.

Overview of Medications for Treatment of AUD

Medication (Classification)	**Mechanism of Action**	**Route of Administration**	**Timing of Use**	**Treatment Setting**	**Clinical Outcomes**
Disulfiram	When taken in combination with alcohol, causes a significant physical reaction, involving nausea/vomiting, flushing, and heart palpitations. The knowledge that such reactions are likely if alcohol is consumed acts as a deterrent to drinking	Oral	Candidates include patients dependent on alcohol who have completed alcohol withdrawal. Ideally, candidates are committed to abstinence and willing to take disulfiram under the supervision of a family member or treatment program.	Available through any prescriber; Range of settings from office-based to ambulatory and 24-hour SUD treatment	Decreased relapse rates; Increased sobriety periods

Naltrexone (Not Scheduled) (Vivitrol)	Antagonist Blocks opiate receptors that are involved in the rewarding effects of drinking and craving for alcohol.	Oral	Oral naltrexone and extended-release injectable naltrexone are indicated for the treatment of alcohol dependence in patients who can abstain from alcohol in an outpatient setting before the initiation of treatment. Naltrexone has not been shown to be effective in patients who are drinking at treatment initiation.	Available through any prescriber; Range of settings from office-based to ambulatory and 24-hour SUD treatment	Decreased relapse rates; Increased sobriety periods
Acamprosate	Is thought to reduce symptoms of protracted abstinence by counteracting the imbalance between the glutamatergic and GABAergic systems associated with chronic alcohol exposure and alcohol withdrawal.	Oral	Acamprosate is indicated for the maintenance of abstinence in patients who are dependent on alcohol and are abstinent at treatment initiation.	Can be prescribed by physician, nurse practitioner and physician assistant	The efficacy of acamprosate in promoting abstinence has not been demonstrated in subjects who have not completed detoxification or who have not achieved alcohol abstinence before beginning treatment.

Medications for the Treatment of Tobacco Use Disorders

Tobacco products are considered to include cigarettes, vaporizers, hookah, and smokeless tobacco products. All the medications listed below can be prescribed by physicians, nurse practitioners, and physician assistants. Most, if not all, of these medications are covered under Health Choices formulary, although some require step therapy and/or prior authorizations. It should be noted that E-cigarettes and vaporizers are not recommended forms of MSUD for Tobacco Use Disorder. Each of the below listed medications are more effective when combined with counseling.

Nicotine Replacement Therapy (NRT)

- Patches 21 mg, 14 mg, 7 mg- deliver nicotine via the skin over a 24-hour period
- Nicotine Gum 4mg, 2mg- deliver nicotine via the mucous membrane of the mouth
- Nicotine Lozenge 4mg, 2mg- deliver nicotine via the mucous membrane of the mouth
- Nicotine (Nicotrol) Nasal Spray- 1mg of nicotine per spray delivered intranasal */**
- Nicotine (Nicotrol) Inhaler- cartridges deliver nicotine from inhaler device via puffing */**

** Often require step therapy and/or prior authorizations, **likely not to be included in formulary*

Risks & Benefits

Patch

The most commonly reported side effect is potential rash reaction. There are 2 types of patches, tan and clear. If a person has a rash reaction to one type, they can be tried on the other. The prescription must be specifically for a tan patch or clear patch, and it is noted that not all pharmacies carry both.

Nicotine Gum

Sore throat and upset stomach are the most commonly reported side effects. These are often caused by using the gum improperly. This gum is not to be used like typical chewing gum. Nicotine gum should be chewed a few times until the user tastes pepper and a tingling sensation is felt, and then should be tucked between the user's cheek and gum.

Lozenge

Most commonly reported side effects are sore throat and upset stomach. These symptoms often occur due to incorrect use. The user should tuck the lozenge between their cheek and gum line. Lozenges should not be chewed.

Nicotine nasal sprays and inhalers

The most commonly reported side effect is dizziness. If this occurs, users should reduce the frequency of administration and talk with prescriber. Other important risks to be aware of include vivid dreams and nightmares, but these typically resolve during the first week or two of treatment. Caution should be used with pregnancy and prescribing should be deferred to treating OB/GYN physician.

A benefit of all these methods is that they deliver nicotine and only nicotine, aimed at reducing felt withdrawal symptoms including cravings. NRT is one of the first line MSUDs for tobacco dependence and shows strong efficacy in research. When considering dosage, it is recommended to start with highest level patch and work down. Also, combination therapy is more effective than single therapy (e.g. patch plus gum). When discontinuing, medications should be decreased over a period of months.

Varenicline (Chantix)*

Varenicline is a partial agonist/antagonist delivered in pill form taken twice per day. This medication does not deliver nicotine, but instead binds with nicotinic receptors to reduce feelings of withdrawal including cravings.

Risks & Benefits

Use with caution with psychiatric population, as adverse psychiatric events have been reported, but research has shown it is safe and effective (see Pfizer's EAGLES study). Side effects including vivid dreams and nightmares have been reported, but typically resolve during the first week or two of treatment.

Varenicline significantly reduces withdrawal symptoms, which are the primary reason for relapse. It is a pill taken twice daily, which offers convenience. Additionally, patients smoke during the first week of treatment, which many patients report eases their transition. Varenicline shows high efficacy in research and is considered a first line treatment for tobacco dependence.

When considering dosage, it is noted there is a starter pack and a continued therapy pack. Prescribing guidelines indicated up to 1 year of therapy is safe and effective.

Bupropion (Wellbutrin, Zyban)

Bupropion is an antidepressant medication used off label to treat Tobacco Use Disorder.

Risks & Benefits

The side effect panel of bupropion is consistent with anti-depressant medications. Alcohol should be avoided while using this medication.

Bupropion is aimed at reducing cravings and urges to use tobacco. It is often prescribed for depression and can be used as combination therapy without having to introduce multiple new medications at once. Bupropion should be considered as combination therapy. Its standalone efficacy is lower than NRT or Varenicline, so it is most often used in combination with NRT. When discontinuing Bupropion, typical protocol is followed for discontinuation of an anti-depressant.

Confidentiality

Title 42 of the Code of Federal Regulations (CFR) part 2 (42 CFR part 2) establishes federal regulations for the confidential of patient records of individuals seeking substance use treatment services. The intent of the regulations is to ensure that individuals seeking treatment for Substance Use Disorders do not experience more detrimental impact (e.g. legally, employment, child custody, etc.), by the disclosure of their status in substance abuse treatment than individuals with similar disorders who do not seek treatment. 42 CFR Part 2 is available in full here.

Considerations for Special Populations

Individuals in the Criminal Justice System

In the initial two weeks following release from incarceration, an individual's risk of death is 12 times that of the general population, with overdose being the leading cause. As with any individual who has experienced a period of abstinence (voluntary or involuntary) return to use presents a high risk of overdose due to decreased tolerance levels. The World Health Organization recommends the availability of withdrawal management and a full range of MSUD in prison settings.

Research evidence indicates that:

- Methadone treatment and counseling during incarceration increases post-release engagement with a community methadone center. There were also significantly lower rates of relapse at one-month post release (27.6% vs. 62.9% for counseling only and 41% for counseling and referral to a treatment center).
- Individuals receiving buprenorphine treatment during incarceration engaged with post-release services sooner and remained in treatment longer.

Barriers still exist, as a 2013 report showed that half of drug courts did not allow participants to use agonist medications. The 2015 National Drug Control Policy statement made clear that drug courts receiving federal grants could not deny a participant access to FDA-approved medication which were appropriately prescribed and could not make medication disuse a stipulation of participation, provided that such a mandate was inconsistent with the clinical guidance of a medical practitioner.

Pregnant & Parenting Women

According to ASAM (2015) practice recommendations, as a matter of priority, pregnant women should be evaluated for medical conditions requiring urgent medical intervention and referral should be made for treatment of the same. Co-management of care with an obstetrician is recommended, as is psychosocial treatment. Withdrawal management is not indicated for pregnant women who are opioid dependent, but rather treatment with methadone or buprenorphine is the standard of care. Naloxone is only recommended in the circumstance of a life-threatening overdose. Use of methadone and buprenorphine is not contraindicated in women who are breastfeeding.

Substance use/abuse during pregnancy increases health-related, withdrawal and developmental risk for the infant, including Fetal Alcohol Spectrum Disorders, Neonatal Opioid Withdrawal Syndrome/Neonatal Abstinence Syndrome. With awareness of these risks, it is imperative that providers coordinate with prenatal and pediatric care providers in order to assure that the mother and baby are receiving adequate support and care during pregnancy and after birth.
ASAM's National Practice Guidelines provide specific recommendations related to MSUD dosing and management of pregnant women addicted to opioids.

Veterans

Despite the Veterans Health Administration's (VHA) support of the use of medications in the treatment of Substance Use Disorders, such treatment remains underutilized in this population. Studies have indicated that barriers such as limited availability of prescribers within the VA system. As recently as 2018, it was identified that only 35% of veterans with Opioid Use Disorders were utilizing MSUD.

Overdose Survivors

Naloxone is the recommended standard of care in cases of opioid overdose. ASAM recommends that a naloxone prescription, and associated education/training on use, should be given to individuals being treated for OUD and their families/significant others. It is similarly recommended that first responders and emergency services personnel be trained in the administration of naloxone. In the state of Pennsylvania, the Physician General has executed a standing order for naloxone, making it available to the public at any licensed pharmacy.

Adolescents

The American Academy of Pediatrics released a policy statement in 2016 which endorsed the use of MSUD for adolescents experiencing severe OUD. It is further recommended that the buprenorphine/naloxone combination and naltrexone could be prescribed for teens. While there was no specific recommendation against the prescription of methadone for teens, it was noted that the practice is uncommon.

Parents/caregivers should be educated on the use of the prescribed MSUD and strongly encouraged to supervise the use of any such medications at home. There should also be additional education on safeguarding the medication from others in the home, particularly underage siblings, as well as how to respond in situations of accidental ingestion. In 2002, the US Food and Drug Administration approved the use of buprenorphine for patients 16 years and older.

Individuals with Pain Management Concerns

The Center for Disease Control (CDC) estimates that approximately 20% of individuals presenting for non-cancer-related pain in primary care settings receive treatment with prescription opioids (2016). While opiates can be an effective means of treating chronic pain, addiction is an unfortunately frequent outcome of long-term use. The evidence of pain's association with opioid addiction is robust. Studies indicate that approximately half of veterans seeking treatment of opioids report moderate to severe pain concerns and 37-61% of those in methadone maintenance experience chronic pain (2000). There is also indication that individuals who abuse opioids and those on maintenance therapy have decreased pain tolerance as compared with non-opioid dependent individuals (2015).

Due to their analgesic effects, methadone and buprenorphine may be utilized in the management of pain in individuals concurrently on maintenance therapy for Opioid Use Disorders. Conversely, Naltrexone may alter the effects of opioid analgesics. ASAM (2015) summarizes its pain management recommendations thusly:

1. For all patients with pain, it is important that the correct diagnosis be made and that a target suitable for treatment is identified.
2. If pharmacological treatment is considered, non-narcotic medications such as acetaminophen and NSAIDs should be tried first.
3. Opioid agonists (methadone or buprenorphine) should be considered for patients with active Opioid Use Disorder who are not under treatment.
4. Pharmacotherapy in conjunction with psychosocial treatment should be considered for patients with pain who have Opioid Use Disorder.
5. Patients on methadone for the treatment of Opioid Use Disorder will require doses of opioids in addition to their regular daily dose of methadone to manage acute pain.
6. Patients on methadone for the treatment of Opioid Use Disorder and who are admitted for surgery may require additional short-acting opioid pain relievers. The dose of pain relievers prescribed may be higher due to tolerance.
7. Temporarily increasing buprenorphine dosing may be effective for mild acute pain.
8. For severe acute pain, discontinuing buprenorphine and commencing on a high-potency opioid (such as fentanyl) is advisable. Patients should be monitored closely and additional interventions such as regional anesthesia should also be considered.
9. The decision to discontinue buprenorphine before an elective surgery should be made in consultation with the attending surgeon and anesthesiologist. If it is decided that buprenorphine should be discontinued before surgery, this should occur 24–36 hours in advance of surgery and restarted postoperatively when the need for full opioid agonist analgesia has passed.
10. Patients on naltrexone will not respond to opioid analgesics in the usual manner. Therefore, it is recommended that mild pain be treated with NSAIDs and moderate to severe pain be treated with ketorolac on a short-term basis.
11. Oral naltrexone should be discontinued 72 hours before surgery and extended-release injectable naltrexone should be discontinued 30 days before an anticipated surgery. (Kampman 2015 et. al., p.45)

Individuals with Co-occurring Disorders

Whether due to a shared biological predisposition, an attempt to self-medicate, or another pathway yet to be specified by research, the linkage between co-occurring psychiatric disorders and substance abuse is well established. As a best practice, it is essential to screen, and assess as appropriate, all individuals presenting for substance use treatment for possible co-morbid psychiatric concerns. Common comorbidities include, mood disorders, anxiety disorders and trauma/post-traumatic stress. Imminent risk such as suicidality, and psychiatric instability require immediate intervention, often including hospitalization for stabilization. For individuals with co-occurring psychiatric concerns, linkage with appropriate psychosocial treatment is important for ongoing disease stabilization. It is also essential for practitioners to be cognizant of the potential for drug interactions between MSUDs and other prescribed psychotropics.

Diversion Control

Practitioners and programs treating individuals with controlled substances must maintain a plan for diversion control. Diversion control measures should at minimum include:

- patient education on policies around diversion and potential implication for discontinuation of medication/treatment;
- a plan outlining how onsite medication is stored securely, who is responsible for storing, prescribing and dispensing medications held onsite;
- policies around the utilization of take-home dosages;
- procedures for monitoring compliance with dosing (one example is the utilization of urine drug screens);
- measures for ensuring that the individual is not simultaneously receiving the MSUD from another prescriber, such as utilization of the Prescription Drug Monitoring Program (PDMP)

Combating Stigma

Addressing Common Misconceptions Related to MSUD

- **MSUD just substitutes one addictive substance for another**: Opioid agonist such as buprenorphine and methadone metabolize more slowly than opioids of abuse do not produce the same euphoric effects in individuals addicted to opioids. Instead, they help to reduce cravings and withdrawal symptoms, enhancing an individual's ability to engage in functional activities.
- **Using MSUD is not worth the risk of diversion:** Two research studies indicate that most misuse of buprenorphine and methadone is associated with attempts to control withdrawal (90%) and cravings (97%). The proportion of individuals attempting to use buprenorphine illicitly tended to reduce when legitimate access to MSUD increased and otherwise over time as the limited "high" in comparison to other opioids is recognized. No diversion risk has been found to be associated with Naltrexone.
- **MSUD medications should only be used for brief periods**: As with other diseases which impact organ functioning, the brain of addicted individuals may require the support of MSUD to slowly return to functioning. This may take many months or years and there are some individuals who may require indefinite support.

Contracting with Magellan Behavioral Health of PA

Frequently Asked Questions

- **What is the Magellan's process for contracting with providers for MSUD?** Magellan contracts with providers for clinic services in which the provider may offer MSUD. Magellan reimburses for the cost of Methadone and have reimbursement codes for Suboxone therapy but do not pay for the medication. Methadone is the only MSUD treatment for which Magellan specifically contracts.
- **How does a provider contract with Magellan?**
    - All providers must be enrolled with the Pennsylvania Department of Human Services' Office of Medical Assistance Programs. Enrollment information may be found here
    - New providers must then complete Magellan's Interested Provider Information Application (available here: Interested Provider Form.docx) and submit it to the Provider Network Department along with a program description, including treatment philosophy, and staffing information to Magellan's Network Department
    - A Magellan Network representative will contact you to request in person meeting
    - All new providers or providers adding services to their repertoire will undergo an Implementation and Oversight Audit within their first ninety days of operation.
- **If the individual's physical health insurance does not cover the cost of the medication does Magellan provide coverage/assistance in anyway? If so, how is this accessed?** Methadone is the only MOUD that is covered by Magellan. All others are not covered for payment through Magellan or other BHMCOs.

DDAP Requirements and Guest dosing

As the ASAM Criteria use was adopted by Pennsylvania, so were the expectations for SUD Treatment Providers to allow for the admission and treatment of any person using any form of Medication for their Substance Use Disorder. The State has issued guidelines for providers in order to assist them in providing care in an effective manner. Because of these guidelines, providers are required to cooperate with Methadone Clinics who are the prescribers for their clients. The guidelines are available here:

Methadone Maintenance Therapy - Magellan of PA

At times, this requires guest dosing by a Methadone Clinic located near the residential provider in the event that the home clinic is too far away to allow for daily or weekly travel to and from in order to obtain doses.

In addition to the criteria offered by Pennsylvania, the American Association of Treatment for Opioid Dependence (AATOD) offers guidelines found here: http://www.aatod.org/advocacy/policy-statements/aatod-guidelines-for-guest-medication/#:~:text=Guest%20dosing%20takes%20careful%20planning,mechanism%20to%20discharge%20a%20patient

Addendum-SCA Funded Providers

Effective July 29, 2021

Medication Assisted Treatment (MAT) is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of SUD and can help some people to sustain recovery. *SAMHSA-HRSA Center for Integrated Health Solutions. (2020, January 14). MAT Overview. Retrieved from:* *https://www.integration.samhsa.gov/clinical-practice/mat/mat-overview*

A. The coordination of care between therapeutic and pharmaceutical interventions is critical. Individuals with SUD who have a disorder for which there is an FDA-approved medication treatment must have access to those treatments based upon their individual needs and preferences. SCAs must:

1) ensure the availability of FDA-approved medication and assist with payment for medication;

2) educate individuals about MAT options;

3) ensure medication and clinical therapeutic interventions are available in all levels of care, even if the SUD treatment provider is not the prescriber of the medication;

4) ensure that the individual's needs are met directly or through an appropriate referral to a prescriber;

5) ensure that treatment and non-treatment providers do not exclude individuals on MAT from being admitted into services;

6) ensure coordination of care, with proper consent occurs in situations where a prescriber and the SUD treatment provider are not the same;

7) ensure contracted providers admit and provide services to individuals who use MAT for SUD;

8) ensure provider capacity is sufficient to treat individuals who use MAT for SUD;

9) provide information and referral regarding access to MAT to individuals who can obtain medications through other resources, such as medical assistance or third party insurance.

B. All treatment, including medication, must be individualized. SCAs may not place limits on a type of service or medication or restrict the length of service.

C. DDAP will identify state or federal funds that are available only to providers that permit use of FDA-approved medications in the treatment of SUD. Contracted providers that restrict admission based upon medication use may not receive those funds to treat any individual or provide any type of prevention, intervention, treatment, or treatment related service.

D. An SCA may only use DDAP funds to pay for MAT, other than methadone, for individuals who have either:

1) Had a LOCA and are in the process of placement into licensed SUD treatment;

2) Enrolled in licensed SUD treatment; or

3) Successfully completed licensed SUD treatment.

E. SCAs that pay for MAT, other than methadone, must have written procedures explaining the coordination and payment of such services.

F. An SCA that is unable to provide the full array of MAT due to geographical limitations, lack of access to prescribing medical personnel, or lack of service provision may request a waiver of this Section through the SCA's DDAP Project Officer.

G. SCAs may use DDAP funds only to pay for MAT using FDA-approved medications. The Substance Abuse and Mental Health Services Administration's (SAMHSA) website: https://www.samhsa.gov/medication-assisted-treatment contains a list of FDA-approved medications.

Resource Guide

(Source: SAMHSA, TIP 63, 2018, Section 2, pp.28-31)

Alcohol and Drug Use Screening

American Academy of Addiction Psychiatry: Provides Performance in Practice Clinical Modules for screening of tobacco use and AUD. www.aaap.org/education-training /cme-opportunities

NIAAA, Professional Education Materials: Provides links to screening, treatment planning, and general information for clinicians in outpatient programs. www.niaaa.nih.gov /publications/clinical-guides-and-manuals

NIDA, Medical and Health Professionals: Provides resources for providers to increase awareness of the impact of substance use on patients' health and help identify drug use early and prevent it from escalating to misuse or addiction. www.drugabuse.gov /modemed-medical-health-professionals

Tobacco Screening

American Psychiatric Nursing Association, Tobacco & Nicotine Use Screening Tools and Assessments: Provides the Fagerström screening tools for nicotine dependence and smokeless tobacco and a screening checklist for tobacco use. www.apna.org/i4a/pages /index.cfm?pageID=6150

U.S. Department of Health and Human Services' Be Tobacco Free: Provides information for individuals struggling with nicotine addiction and links for clinicians that provide guidance on caring for patients with nicotine addiction. https://betobaccofree.hhs.gov /health-effects/nicotine-health

U.S. Department of Health and Human Services' Million Hearts Initiative: Provides templates for developing and guidance on implementing tobacco cessation programs and guidance on implementing them as part of clinical care. https://millionhearts.hhs.gov /tools-protocols/protocols.html

Centers for Disease Control and Prevention (CDC): Offers resources and information for patients and clinicians; includes a webpage with resource links for clinicians on treating tobacco dependence. www.cdc.gov/tobacco /index.htm and www.cdc.gov/tobacco/basic _information/related_links/index.htm

Buprenorphine Treatment Locator

SAMHSA, Buprenorphine Treatment Practitioner Locator: Provides a state-by-state list of providers who offer buprenorphine. www.samhsa.gov/medication-assisted -treatment/physician-program-data /treatment-physician-locator

SAMHSA, Buprenorphine Training for Physicians: Provides links to organizations that train physicians on buprenorphine treatment. www.samhsa.gov/medication -assisted-treatment/training-resources /buprenorphine-physician-training

Medication Treatment for OUD

SAMHSA, *Medication-Assisted Treatment of Opioid Use Disorder:* Provides a clinical pocket guide for medication treatment for OUD. https://store.samhsa.gov/shin/content /SMA16-4892PG/SMA16-4892PG.pdf

SAMHSA, MATx Mobile App to Support Medication-Assisted Treatment of OUD: Provides a mobile app to support healthcare professionals providing medication treatment for OUD. https://store.samhsa.gov/apps/mat

SAMHSA, *Advisory,* Sublingual and Transmucosal Buprenorphine for Opioid Use Disorder: Review and Update: Summarizes information on the use of buprenorphine to treat OUD. https://store .samhsa.gov/product/Advisory-Sublingual -and-Transmucosal-Buprenorphine-for -Opioid-Use-Disorder-Review-and-Update /SMA16-4938

SAMHSA, *Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide:* Provides a brief review of the use of XR-NTX. https://store.samhsa.gov/product/Clinical -Use-of-Extended-Release-Injectable -Naltrexone-in-the-Treatment-of-Opioid -Use-Disorder-A-Brief-Guide/SMA14-4892R

ASAM, *The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use:* Provides national practice guidelines for the use of medications to treat OUD. www.asam.org/docs/default-source/practice -support/guidelines-and-consensus-docs /asam-national-practice-guideline-supplement .pd

Department of Veterans Affairs/ Department of Defense, *VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders:* Provides substance use disorder practice guidelines. https://www.healthquality.va.gov/guidelines/MH/sud/VADoDSUDCPGRevised22216.pdf

PCSS-MAT: Provides training and mentorship for healthcare professionals (physicians, NPs, and PAs) on medications for OUD treatment including buprenorphine, naltrexone, and methadone. https://pcssmat.org

Syringe Exchange

North American Syringe Exchange Network: Provides a national directory of syringe exchange programs in the United States. https://nasen.org/directory

Opioid-Related Overdose Prevention

Prescribe To Prevent: Provides information about naloxone prescribing for overdose prevention, including educational patient handouts and videos. http://prescribeto prevent.org Could the Narcan nasal spray BioSolutions

SAMHSA Opioid Overdose Prevention Toolkit: Provides healthcare professionals, communities, and local governments with material to develop practices and policies to help prevent opioid-related overdoses and deaths. It addresses issues for healthcare professionals, first

responders, treatment providers, and those recovering from opioid overdose as well as their families. https:// store.samhsa.gov/product/SAMHSA -Opioid-Overdose-Prevention-Toolkit /SMA16-4742

CDC—Injury Prevention and Overdose: Provides links and tools for clinicians to help prevent opioid overdose deaths. https://www .cdc.gov/drugoverdose/prevention/index.html

NIDA, Opioid Overdose Reversal with Naloxone (Narcan, Evzio): Provides naloxone information for providers. www.drugabuse .gov/related-topics/opioid-overdose -reversal-naloxone-narcan-evzio

Opioid Withdrawal Scales

WHO Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence: Annex 10: Provides COWS and other opioid withdrawal scales. www.ncbi.nlm.nih.gov/books/NBK143183

The Clinical Institute Narcotic Assessment Scale for Withdrawal Symptoms: Provides a scale that measures signs and symptoms observed in patients during withdrawal. www .ncpoep.org/wp-content/uploads/2015/02 /Appendix_7_Clinical_Institute_Narcotic _Assessment_CINA_Scale_for_Withdrawal _Symptoms.pdf

Patient and Family Education on Medications to Treat OUD

SAMHSA Store: Provides patient and family educational resources about OUD and medication treatment for OUD; some resources are available in multiple languages, including Spanish. https://store.samhsa.gov Buprenorphine. https://store.samhsa.gov /product/The-Facts-about-Buprenorphine -for-Treatment-of-Opioid-Addiction /SMA15-4442

Methadone. https://store.samhsa.gov /product/What-Every-Individual-Needs-to -Know-About-Methadone-Maintenance /SMA06-4123

ASAM Resources: Provides patient and family education tools about addiction in general and OUD specifically. Patient Resources. www.asam.org /resources/patientresources

Opioid Addiction Treatment: A Guide for Patients, Families, and Friends. https:// www.asam.org/docs/default-source /publications/asam-opioid-patient-piece _-5bopt2-5d_3d.pdf

Referral and Treatment Locators

SAMHSA, OTP Directory: Provides a state-by-state directory of methadone OTPs. https:// dpt2.samhsa.gov/treatment/directory.aspx

SAMHSA, Behavioral Health Treatment Services Locator: Provides a directory of treatment facilities. https://fndtreatment.samhsa.gov

SAMHSA, Behavioral Health Treatment Services Locator—Self-Help, Peer Support, and Consumer Groups: Provides a directory for mutual-help groups. https://fndtreatment.samhsa.gov/locator/link-focSelfGP

Screening, Assessment, and Drug Testing Resources

NIDA, Screening, Assessment, and Drug Testing Resources: Provides an evidence-based screening tool chart for adolescents and adults, drug use screening tool support materials, and a clinician resource and quick reference guide for drug screening in general medical settings, including a brief version of the ASSIST-lite. www.drugabuse.gov/nidamed -medical-health-professionals/tool-resources -your-practice/additional-screening-resources

ASAM, *The ASAM Appropriate Use of Drug Testing in Clinical Addiction Medicine:* Discusses appropriate use of drug testing in identifying, diagnosing, and treating people with or at risk for SUDs. www.asam.org /quality-practice/guidelines-and-consensus -documents/drug-testing

Treatment Planning ***The ASAM Criteria:*** Provides criteria and a comprehensive set of guidelines for placement, continued stay, and transfer/ discharge of patients with addiction and co-occurring conditions. The ASAM six-dimensional assessment tool is designed to guide treatment planning and offers a template to organize assessments and to determine level of care.[98] www.asam.org /quality-practice/guidelines-and-consensus -documents/the-asam-criteria

SAMHSA, Decisions in Recovery— Treatment for Opioid Use Disorder: Provides an online interactive tool to support people with OUD in making informed decisions about their care. https://archive.samhsa.gov /MAT-Decisions-in-Recovery An accompanying handbook is also available. https://store.samhsa.gov/product/Decisions-in -Recovery-Treatment-for-Opioid-Use -Disorders/SMA16-4993

SAMHSA, TIP 42, *Substance Abuse Treatment for Persons with Co-Occurring Disorders:* Provides comprehensive treatment guidance for individuals with co-occurring mental and substance use disorders. https:// store.samhsa.gov/shin/content//SMA13-3992 /SMA13-3992.pdf

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