MEDICATION ASSISTED TREATMENT FREQUENTLY ASKED QUESTIONS

1. **Should you start buprenorphine inductions if a person is using benzodiazepines?**

This is a complex question and recommendation should be tailored to the individual patient. There is a specific section of SAMHSA Tip 63 related to this: “A 2017 Food and Drug Administration Drug Safety Communication noted that although concomitant use of buprenorphine or methadone with benzodiazepines increases the risk of adverse reaction, including overdose death, opioid agonist treatment should not be denied to patients solely on the basis of their taking benzodiazepines, because untreated OUD can pose a greater risk of morbidity and mortality. FDA advises careful medication management by healthcare professional can reduce risk.” ([https://www.fda.gov/Drugs/DrugSafety/ucm575307.htm](https://www.fda.gov/Drugs/DrugSafety/ucm575307.htm)).

We would recommend assessing based on if benzodiazepine use is taken as prescribed or not (or assessing for a benzodiazepine use disorder), if the patient also has alcohol use disorder (i.e., an additional respiratory depressant) and if use of either drug is intermittent or daily. Finally, it’s most importantly dose/quantity. We recommend using an online benzodiazepine conversion tool to really calculate actual dose (e.g., alprazolam and clonazepam should be converted to lorazepam equivalents). For patients who you think are reliably reporting relatively low doses and taking consistently, this would not prohibit buprenorphine induction or maintenance therapy. You may want to work with them on tapering benzodiazepines after starting buprenorphine. Patients that you’re more concerned about (misusing/abusing benzodiazepines, using higher doses) may need more frequent visits, consultation with specialists, or higher level of care/specialty referral.

2. **For alcohol use disorder patients who are taking naltrexone to reduce their alcohol use, do you recommend daily treatment, targeted treatment, or a hybrid of the two?**

We have not seen good evidence of PRN naltrexone dosing (though see this more often with disulfiram). If there is concern about adherence, IM extended release naltrexone may be a good option.

3. **For opioid use disorder patients who wish to take naltrexone as their form of MAT, what medications do you use to help them get through the hurdle of opioid withdrawal?**

IM extended release naltrexone induction should be done in a patient specific way. The specifics of medication choice/treatment depend on the specific opioids they have been using and severity of their OUD (i.e., use of long acting vs. short acting and likelihood of being successful w/ detox) and patients initiating on naltrexone (who are being detoxed) often benefit from frequent follow-up. Also this probably goes without saying, but we definitely want to emphasize long acting naltrexone/Vivitrol, given lack of effectiveness of oral naltrexone. However, we do typically initiate with oral just to make sure patients can tolerate before starting IM naltrexone.

There are some reasonable general things to consider. First, the naltrexone section in the SAMHSA Tip 63 guide may help (provides some detox advice). We would in general advise minimizing use of other controlled meds including benzodiazepines and stimulants when possible. Clinically, we more often see use of general opioid withdrawal supportive medications (clonidine, etc.) used.

4. **How do you transition from one form of MAT to another form?**

This can be a challenging situation; we recommend you contact us to discuss the case prior to doing the transition.

*For switching from methadone to buprenorphine:* We would recommend slowly tapering the patient down to 30mg of methadone which they should hold for 72 hours prior to induction. If their COWs score is below a 12 at time of induction, we would wait. This is not a situation that would be appropriate for a home induction, it would need to be done in the office. There is a higher risk of precipitated withdrawal with these patients and we recommend contacting the MOC team to discuss the case in advance of the induction.
For switching from naltrexone to buprenorphine:
The ASAM National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use gives a good overview of this. Switching from an antagonist such as naltrexone to a full agonist (methadone) or a partial agonist (buprenorphine) is generally less complicated than switching from a full or partial agonist to an antagonist because there is no physical dependence associated with antagonist therapy and thus no risk of precipitated withdrawal. Patients being switched from naltrexone to buprenorphine or methadone will not have physical dependence on opioids and thus the initial doses of methadone or buprenorphine used should be low. Patients should not be switched until a significant amount of the naltrexone is no longer in their system, about 1 day for oral naltrexone or 30 days for extended release injectable naltrexone.

For switching from buprenorphine to naltrexone:
The patient must be completely opioid-free prior to starting naltrexone. For patients using opioid agonist therapy, we generally recommend 7-14 day opioid free period prior to doing a naltrexone or naloxone challenge test.

5. What do you do when your patient has a UDS positive for other illicit substances?
Talk to your patient! Ask them what is going on and see what else you can do to support them. We would recommend to have them come in more frequently for appointments. It is important to keep working with these patients rather than discharging them from care. Most people with addiction have many relapses before sustained abstinence and relapse is a hallmark of the disease. A therapeutic relationship can strengthen and trust can develop when you don’t discharge a patient for a positive UDS. This will encourage the patient to be honest with you about his/her drug use and aid his/her recovery.

6. How long do you prescribe buprenorphine maintenance therapy?
Currently the evidence supports keeping patients on buprenorphine for long term maintenance treatment; this could be one year to lifelong treatment. It is important to work with the patient and follow their lead. If they want to discontinue the medication, it is important to work through why with the patient and how they plan to be successful without their medication. What is different now? What supports do they have in place? Continue to see them frequently even when they have discontinued the medication, as they will be high risk for relapse in this time period.

7. Are buprenorphine and methadone just trading one addiction for another?
No. Addiction is a disease of maladaptive behavior. Patients who take opioid agonist therapy will have dependence on the medication, but many medications clinicians prescribe cause physical dependence. For patients with opiate use disorder who are taking their medications as the prescribed dose, these medications do not produce a euphoric high but instead minimize withdrawal symptoms and cravings and allow patients to have a functional life instead of being consumed by their cravings and urges.

8. Doesn’t buprenorphine have diversion potential?
Research has repeatedly demonstrated that making buprenorphine more readily available to those who need it will help minimize the presence of the illicit market. NIDA reports in regards to diversion “most data suggest that the majority of buprenorphine and methadone misuse (use without a prescription) is for the purpose of controlling withdrawal and cravings for other opioids and not to get high. Among all opioid agonist medications, methadone and buprenorphine together make up 15 percent of diversion reports, while oxycodone and hydrocodone are responsible for 67 percent.”